Nebraska Provider Manual

Last Updated: August 2017
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Welcome
Dear MCNA Provider:

Managed Care of North America (MCNA) would like to take this opportunity to welcome you and your staff as part of our national network of dental providers. We are pleased that you have chosen to participate with us. Throughout your ongoing relationship with MCNA this Provider Manual will give you useful information concerning the MCNA plans in which you have chosen to participate.

MCNA was founded by a group of dentists with extensive backgrounds in the field of dental care and dental plan operations. MCNA’s goal is to provide quality dental services to members and providers. 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 MCNA’s administrative policies and procedures, provisions, and the role you play as a dentist.

When communicating with our network providers, we make every effort to be clear and concise. Our expectation is to answer questions promptly when they arise. We strive to provide accurate and effective information that allows you and your dental team to understand which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered and what to expect from MCNA.

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

If you require assistance or information that is not included within this manual, please contact our Provider Hotline at 1-844-353-6262.

We will communicate changes in MCNA’s policies and procedures as well as state and federal laws to you through the dissemination of provider bulletins.

Again, we welcome you and your staff to the growing list of MCNA providers. We look forward to a successful relationship with you and your practice.

Sincerely,
MCNA Provider Relations Department

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

http://portal.mcna.net

or visit:

http://manuals.mcna.net/Nebraska
to download a PDF version directly.
Contact Information

For the quickest service, please use the contact information listed below. Please note that calls may be recorded for quality assurance purposes.

MCNA Member Hotline
Member Services Representatives are available from 7 a.m. – 7 p.m. CST, Monday – Friday, excluding national holidays.

Main: 1-844-353-MCNA (1-844-353-6262)
TDD/TTY: 1-800-833-7532

MCNA Automated Eligibility Verification
Our Automated Member Eligibility Hotline is available 24 hours a day, 7 days a week.

Main: 1-844-351-MCNA (1-844-351-6262)
Online: http://portal.mcna.net/

MCNA Provider Hotline
Our Provider Hotline is open from 7 a.m. – 7 p.m. CST, Monday – Friday, excluding national holidays.
(For provider enrollment, direct deposit issues, reporting practice and ownership changes, NPI, etc.)

Main: 1-844-353-MCNA (1-844-353-6262)
eFax: 1-877-563-8560

MCNA Credentialing
Our Credentialing Department is available from 8 a.m. – 6 p.m. EST, Monday – Friday, excluding national holidays.

Main: 1-844-353-MCNA (1-844-353-6262)
Main Fax: 1-954-730-7131

MCNA Grievances and Appeals
Our Grievances and Appeals Department is available from 7 a.m. – 7 p.m. CST, Monday – Friday, excluding national holidays.

Main: 1-844-353-MCNA (1-844-353-6262)
Main Fax: 1-954-628-3330
Mailing Address: MCNA Dental
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309
MCNA Utilization Management (Pre-Authorizations)
Our Utilization Management Department is available from 7 a.m. – 7 p.m. EST, Monday – Friday, excluding national holidays.

Main: 1-844-353-MCNA (1-844-353-6262)
eFax: 1-954-628-3331
(Not for pre-authorization/referral submissions.)
Email: um_ne@mcna.net
(For questions and status updates only, not for pre-authorization submissions.)

MCNA Provider Portal Helpdesk

MCNA Hotlines
Fraud, Waste, and Abuse: 1-855-FWA-MCNA (1-855-392-6262)
Compliance: 1-855-683-MCNA (1-855-683-6262)

MCNA Corporate Headquarters
Our Corporate Headquarters is open from 8 a.m. – 6 p.m. EST, Monday – Friday, excluding national holidays.
When sending mail to a specific department, please address it to the attention of that department.

Main: 1-800-494-MCNA (1-800-494-6262)
Main Fax: 1-954-730-7875
Website: http://www.mcna.net/
Mailing Address: MCNA Dental
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

Nebraska Medicaid Health Care Fraud or Abuse
Formerly MLTC Bureau of Appeals.
Main: 1-800-727-6432
Website: https://ago.nebraska.gov/medicaid-fraud or https://dhhs.net.gov/medicaid/Pages/med_pi_fraud.aspx
Email: ago.medicaid.fraud@nebraska.gov
Mailing Address: Medicaid Fraud and Patient Abuse Unit
1221 N Street, Suite 500
Lincoln, Nebraska 68509-8920

Nebraska Medicaid & Long-Term Care (MLTC) Provider Screening and Enrollment/Maximus
Main: 1-844-374-5022
Email: nebraskamedicaidPSE@maximus.com
Website: http://dhhs.ne.gov/medicaid/Pages/Provider-Screening-and-Enrollment.aspx
Mailing Address: MAXIMUS NE Provider Screening and Enrollment
P.O. Box 81890
Lincoln, Nebraska 68501
# Revision History

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<th>Date</th>
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<tr>
<td>1.0</td>
<td>08/2017</td>
<td>Initial version.</td>
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<td>1.1</td>
<td>08/2017</td>
<td>Updated codes billable by public health dental hygienist.</td>
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Program Overview

MCNA has a contract with Nebraska Medicaid to manage the Medicaid Dental Benefit Program. The oral health goals for the program include:

- Improved access to routine and specialty dental care.
- Improved coordination of care.
- Better dental health outcomes.
- Increased quality of dental care.
- Outreach and education to promote dental health.
- Increased personal responsibility and self-management.
- Overall savings to the Nebraska Medicaid program by preventing treatable dental conditions from becoming costly medical conditions.
Criteria for Network Participation

All participating providers must be enrolled to participate in the Nebraska Medicaid Program as an approved service provider. Participating providers must meet MCNA’s criteria for participation. These requirements include standards regarding dental office physical attributes, practice coverage, member access, office procedures, office records, insurance and professional qualifications, and staff work history. The criteria are used in our credentialing and re-credentialing process and are incorporated into our current Provider Agreement.

Applicability

The participation criteria apply to each new applicant for participation in MCNA’s network, and to all providers currently participating. They shall be enforced by MCNA as required by the Nebraska Medicaid Dental Program. Any provider applying to join MCNA’s network must be licensed in the State of Nebraska and must adhere to the Nebraska Board of Dentistry requirements concerning the delivery of dental services.

An applicant must satisfactorily document evidence that they meet the criteria, and must be approved for participation by MCNA's Credentialing Committee prior to being able to be reimbursed for services. In order to qualify for payment, dates of service must be after the provider’s effective date in MCNA’s network.

The following additional requirements for continued participation in MCNA’s network apply to all participating providers:

- All MCNA participating providers in a group practice must meet MCNA credentialing criteria. If one or more of the providers in the group fail to meet the criteria, the entire group cannot participate.
- All MCNA participating providers must be credentialed, execute a Provider Agreement, and agree to provide all services to members as set forth by the program. Providers who offer only diagnostic and preventive services do not meet the necessary criteria for participation.
- All MCNA participating providers must apply for re-credentialing every three (3) years.

On-Site Office Survey

On-site office surveys are conducted on an ongoing basis for participating offices. These surveys focus on essential areas of office management and dental care delivery. During the survey, which may or may not be scheduled in advance, the following areas are evaluated:

1. **General Information** – the name of the practice, address, name of principal owner and all associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office, availability of appointments, method of providing 24 hour coverage (e.g., answering machine or answering services), and the name of the covering dentist when a provider is unavailable (e.g., office closed or provider on vacation).
2. **Practice History** – information regarding malpractice suits, settlements, and disciplinary actions, if applicable.
3. **Office Profile** – overview of services routinely performed.
4. **Facility Information** – description of location, accessibility (including handicap accessibility), interior office and the reception area, operatories and lab, type of infection control, general equipment, and radiographic equipment.
5. **Risk Management** – review of personal protective equipment (e.g., gloves, masks, equipment to handle waste disposal, equipment and methods to handle sterilization and disinfection), training programs for
6. **Recall System** – review of procedures for assuring members are scheduled for recall examinations and follow-up treatment.

7. **Provider Credentials** – 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. Our 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 Medicaid and site visits, as appropriate.
- **Monitoring** – 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 Medicaid. Monitoring is conducted on a regular basis between credentialing and re-credentialing cycles.
- **Re-credentialing** – re-evaluation of provider’s credentials at least once every three (3) years through a process that updates the information obtained during initial credentialing. Re-credentialing considers performance indicators such as those collected through the Quality Improvement (QI) program, the Utilization Management system, the Grievance and Appeal system, enrollee satisfaction surveys, and other activities of the organization.

Additionally, MCNA will:

- Verify licenses through the appropriate licensing agency
- Review state and federal 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 for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

All providers are required to complete the Dental Credentialing Form and Dental Re-Credentialing form.

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

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

- License
- National Provider Identifier (NPI)
- Controlled Substance Registration Certificate from the Drug Enforcement Agency (DEA)
- Professional Liability Insurance Face Sheet
- Curriculum Vitae
• Board Certificate or Evidence of adequate training
• Completed W-9 Form
• Signed Provider Agreement/Contract
• Signed Provider Application

It is the provider’s responsibility to submit any renewal certification documentation or changes in information to MCNA within 10 business days of any change. MCNA encourages all eligible providers to seek applicable Board Certification.

MCNA will send a letter to a provider with a license nearing expiration, according to the most current information received from the provider.

**Credentialing Committee Appeals**

In the event an applicant is credentialed with restrictions or denied, the Credentialing Committee offers an 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 Credentialing Department (See Section 2: Contact Information).

**Practice Requirements**

Each dentist’s office must:

• Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.
• Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
• Be accessible to all members in all areas, including but not limited to, the entrance, parking, and bathroom facilities.
• Have offices that are clean, presentable, and professional in appearance.
• Be a non-smoking facility and have a no-smoking sign prominently displayed in the waiting room.
• Have clean and properly equipped non-staff toilet and hand-washing facilities.
• Have a waiting room that will accommodate at least four (4) members.
• Have treatment rooms that are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
• Have at least one (1) staff person (in addition to the provider) on duty during normal office hours.
• Provide a copy of current licenses and certificates for all providers, dental hygienists, and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement Agency, and State Controlled Drug Substance licenses and certification (where applicable).
• 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.
• Have appropriate, safe x-ray equipment. Radiation protection devices including, but not limited to, lead aprons shall be available and used according to professionally recognized guidelines, such as Food and
Drug Administration guidelines. Signs warning pregnant women of potential exposure must be prominently displayed.

- Use appropriate sterilization procedures for instruments and use gloves and disposable needles. All staff shall maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state, and local laws and regulations including, but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (ADA) and state and local societies.
- 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.
- Make appointments in an appointment book or the electronic equivalent accepted by MCNA. Appointments should be made in a manner that will prevent undue member waiting time and in compliance with the access criteria listed in this manual.
- Have documented emergency procedures, including procedures addressing treatment, evacuation, and transportation plans to provide for the safety of members.
- Upon request, provide members with the MCNA Member Services Hotline number to receive a copy of their rights and responsibilities as listed in the Member Handbook.
- Provide translation assistance services to any member whose native language is other than English.
- Have a functional recall system in place to notify members of the need to schedule dental appointments. The recall system must meet the following requirements for all enrolled members:
  - The system must include either written or verbal notification
  - The system must have procedures for scheduling and notifying members of routine checkups, follow-up appointments, and cleaning appointments
  - The system must have procedures for the follow-up and rescheduling of missed appointments

MCNA encourages its providers to attempt to decrease the number of “no shows.” Provider offices should contact the member prior to a scheduled appointment either by phone, text, email, or in writing to remind them of the time and place of the appointment. Follow-up communication should be provided to encourage the member to reschedule the appointment in the event the appointment is missed.

**Sterilization and Infection Control**

Members and all office staff must be protected from infectious and environmental contaminants.

The following OSHA requirements must be met, without exception:

- All personnel should wash with anti-bacterial soap before all oral procedures.
- Dental gloves, facemask, and eye protection should be worn.
- All debris should be removed from instruments before sterilization.
- 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.
- ADA-approved sterilization solutions should be utilized.
- All equipment should be monitored using process indicators with each load and spore testing on a weekly basis.
- Handling of all environmental waste, including the disposal of waste and solutions, must be completed in compliance with all applicable federal, state, and local laws and regulations.
Medical Emergencies
The following recommended guidelines by the American Dental Association suggest that all office staff shall be prepared to deal with any medical emergency through the implementation of the following:

- The provider and at least one other staff member must be currently certified in CPR procedures.
- The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. All emergency numbers must be posted.
- Members with medical risk shall be identified in advance.
- All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff, and stethoscope.

Additional information or training on these guidelines can be found on the ADA website at http://www.ada.org/en/member-center/oral-health-topics/medical-emergencies-in-the-dental-office
Provider Roles and Responsibilities

Provider Rights
Each MCNA contracted provider that furnishes services to MCNA members shall be assured of the following rights:

1. A dental provider, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
   a. Member health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   b. Any information the member needs in order to decide between all relevant treatment options
   c. The risks, benefits, and consequences of treatment or non-treatment
   d. Member right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
2. The right to receive information on the Complaint, Grievance, Appeal, and State Fair Hearing procedures.
3. The right to access MCNA’s policies and procedures covering the authorization of services.
4. The right to be notified of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
5. The right to challenge, at the request of a Nebraska Medicaid Dental Program member and on their behalf, the denial of coverage of, or payment for, medical assistance.
6. The right to be free from discrimination with regard to MCNA’s provider selection policies and procedures based on a provider’s service to high-risk populations or specialization in conditions that require costly treatment.
7. The right to be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

Dental Home/Primary Care Dentist Role and Responsibilities
MCNA defines a Primary Care Dentist as the provider of Dental Home services. Establishment of a member’s Primary Care Dentist begins no later than six (6) months of age.

Nebraska defines the Dental Home in accordance with the American Academy of Pediatric Dentistry (AAPD) as an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Principles for Dental Homes include:

i. Care that is comprehensive and includes acute, corrective, and preventative services.
ii. Care that is individualized to each member based upon a dental exam for tooth decay and gum problems.
iii. Care that is preventative and includes information about proper care for the member’s teeth and gums, and correct diet.
iv. For children, care that prepares parents and guardians with guidance about what to expect for their child’s age for the growth of teeth and the jaw.
v. For children, care that is educational and helps parents and guardians learn about their child’s dental health now and as their child grows.
vi. Care that is provided in a culturally competent manner.
Within a Dental Home, dental care experts work together as a team with the member and/or the member’s family to ensure that the member receives the care he or she needs. Primary Care Dentists (PCDs) include general or pediatric dentists that practice in solo or group practices, and the following facilities: Federally Qualified Health Centers, Rural Health Clinics, or Indian Health Service facilities. PCDs provide preventive care and therapeutic care to members.

Members are encouraged to select their own primary care dentist (PCD) to serve as their Dental Home. They may change their PCD any time by contacting MCNA’s tool-free Member Hotline. When a member does not select a Primary Care Dentist, DentalTrac™ will auto-assign to a Primary Care Dentist based on the following considerations:

1. Providers who are not in good standing are not considered during the auto-assignment methodology.
2. MCNA strives to keep families together. If a member of a family is assigned to a PCD, other members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family member from being assigned, we will assign that family member to another PCD in the same office that meets the age restrictions if possible.
3. If there is historical claims data available that identifies a dentist that performed dental services on the member, we will assign the member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the member.
4. For each member that needs to be auto-assigned to a PCD, we will generate a pool of participating PCDs that meet the age restrictions of the member who are located near the members residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan. Once a pool of providers is generated, members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence in order to equalize the patient load amongst providers within such radius.

Participating providers must offer the same services to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, participating providers have the responsibility to develop a provider-member 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.

Dental Home providers are required to educate members about the importance of good oral hygiene and timely preventive care such as sealants, cleanings, and fluoride applications. For members ages 6-35 months of age the education efforts are focused around providing anticipatory guidance to the parents or guardians in order to establish a lifetime of healthy dental habits.

All PCDs are required to educate members about what to do in a dental emergency. The PCD is responsible for coordination with other involved health care providers in the case of acute dental trauma or in situations involving members with cleft or craniofacial anomalies.

Within the 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. Dental Home providers must assess the dental needs of members for referral to specialty care providers and provide referrals as needed. The PCD must ensure that an appropriate referral is made as expeditiously as the patient's clinical condition requires. The PCD/Dental Home must coordinate the member’s care with specialty care providers after a referral takes place and ensure that all appropriate treatment was received.
Dentist Role and Responsibilities
Nebraska defines a provider as any individual or entity engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services. General and pediatric dentists must provide services, such as dental services and laboratory services customarily furnished by or through a general or pediatric dentist, for the evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures. These services must be provided directly by the general or pediatric dentist to the member when possible, or through the appropriate referral to specialist and/or ancillary providers.

Dentists may also practice in Federally Qualified Health Centers, Rural Health Clinics, or Indian Health Care Clinics. They provide comprehensive care to Nebraska members and complete referrals for specialty care as needed.

Participating providers must offer the same services to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by Nebraska Medicaid. In addition, participating providers have the responsibility to develop a provider-member 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.

General and pediatric dentists must assess the dental needs of members for referral to specialty care providers and complete referrals as needed. Dentists are responsible for coordinating care with specialty providers after referral.

Public Health Dental Hygienist Role and Responsibilities
Nebraska defines a public health dental hygienist as an individual who has a public health permit that allows for specific services to be completed without direct supervision of a dentist. These services can be completed in a health care or related facility defined as a hospital, a nursing facility, an assisted living facility, a correctional facility, a tribal clinic or a school based preventive health program. A public health setting means a federal, state or local public health department or clinic, community health center, or similar program or agency that serves primarily public health care program recipients.

The following procedure codes are covered under a public health dental hygienist:

- D1110 – Dental prophylaxis (Adult)
- D1120 – Dental prophylaxis (Child)
- D1206 – Topical fluoride varnish
- D1208 – Topical application of fluoride
- D1351 – Dental Sealant

Specialist Role and Responsibilities
The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Pedodontist, Periodontist, and Prosthodontist) is to provide covered services to members for medically necessary treatment. Once treatment is complete, the specialist discharges the member back to their Primary Care Dentist for follow-up. MCNA allows Pedodontists to serve as primary care dentists for our pediatric members.
Medically Necessary Services

Medically necessary services are those healthcare services that are delivered in accordance with generally accepted, evidence-based medical standards, or are considered by most dentists (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction.
- Those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the member.

Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. They may be neither more nor less than what the member requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.”

Preventive Treatment

The American Academy of Pediatric Dentistry (AAPD) recognizes that caries risk assessment and management can assist with oral health education and lead to the prevention of dental caries. Primary Care Dentists must perform the completion of a caries risk assessment as part of comprehensive oral examination. Documentation and the completion of the caries risk assessment tool should be used and maintained in the member’s dental record. These are essential elements of preventative oral health care services for members under the age of 21. The guidelines on caries risk assessment and management can be found on the ADA website at www.ada.org.

Members under age 21 should be encouraged to return for a recall visit as frequently as indicated by their individual oral health status and within plan time parameters in accordance with EPSDT guidelines. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride, if indicated
- Sealant application, if indicated

Please refer to the American Academy of Pediatric Dentistry’s recommendations for treatment of pediatric patients by age below for further guidance.
Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf

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 (AAPD) 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.

<table>
<thead>
<tr>
<th>AMERICAN ACADEMY OF PEDIATRIC DENTISTRY</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 TO 12 MONTHS</td>
</tr>
<tr>
<td>Clinical oral examination 1</td>
<td>●</td>
</tr>
<tr>
<td>Assess oral growth and development 2</td>
<td>●</td>
</tr>
<tr>
<td>Caries-risk assessment 3</td>
<td>●</td>
</tr>
<tr>
<td>Radiographic assessment 4</td>
<td>●</td>
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<tr>
<td>Prophylaxis and topical fluoride 5,6</td>
<td>●</td>
</tr>
<tr>
<td>Fluoride supplementation 5</td>
<td>●</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling 6</td>
<td>●</td>
</tr>
<tr>
<td>Oral hygiene counseling 7</td>
<td>●</td>
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<tr>
<td>Parent</td>
<td>Parent</td>
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<tr>
<td>Diet counseling 8</td>
<td>●</td>
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<tr>
<td>Injury prevention counseling 9</td>
<td>●</td>
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<tr>
<td>Counseling for nonnutritive habits 10</td>
<td>●</td>
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<tr>
<td>Counseling for speech/language development</td>
<td>●</td>
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<tr>
<td>Substance abuse counseling</td>
<td>●</td>
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<tr>
<td>Counseling for intranasal/peroral piercing</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>●</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants 11</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>●</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>●</td>
</tr>
</tbody>
</table>

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. Use 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, partly 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, reducing the importance of mouthguards.
10. At first, discuss the need for additional sucking; digital 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 finger/tooth sucking, brushing, 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.
Access Requirements

Availability and Accessibility
Providers must provide the same availability to MCNA members as is done for all other patients as stated in the MCNA 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.

Providers conducting business at locations other than their principal place of practice shall provide the physical address where services are rendered to MCNA’s Credentialing Department. This address must be on file with both MCNA and the Nebraska State Board of Dentistry. Records documenting the services provided shall be maintained at this location.

Providers should be familiar with additional Nebraska Board of Dentistry requirements concerning the delivery of dental services in locations other than private offices.

Missed Appointments
Providers cannot charge members for missed or failed appointments. For assistance with members who routinely break appointments, please use the Member Outreach Form, which is available to download from the Forms section located at the back of this manual.

After Hours Standards
When a provider’s office is closed, the office should have an answering service or answering machine that offers the following information:

- Instructions for contacting someone who can render clinical decisions or someone who can reach a dentist for clinical decisions (if the office has an on-call service or similar program)
- Instructions for emergency services (including directing the member to dial 9-1-1 if necessary)
- List of the office hours
- Instructions for the caller to leave a message so that someone can return their call

The answering service or machine must also offer all of the information listed above in any additional languages based on cultural population prevalence as required by the Patient Protection and Affordable Care Act.

Appointment Availability, Access to Care, and Wait Time Standards
The Provider Agreement outlines appointment availability standards. The State of Nebraska requires following appointment availability and wait time standards. These standards are monitored through the Quality Improvement Program:

- Urgent Care must be provided within 24 hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by MCNA through other arrangements.
- Routine or preventative dental services within six (6) weeks.
- Wait times for scheduled appointments should not routinely exceed 45 minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an
emergency. If a provider is delayed, the member should be notified immediately. If a wait time of more than 90 minutes is anticipated, the member should be offered a new appointment.

**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 also an act of omission.

If suspected cases are discovered, a verbal report should immediately be made by telephone or another means to law enforcement and/or a representative of the local Department for Social Services office. Reports of suspected cases of abuse or neglect can also be made by calling the MCNA Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262).

Adult abuse is defined as “the infliction of physical pain, mental injury, or injury of an adult.” An adult is defined 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**

State law and Medicaid regulations require that all services provided under the Nebraska Medicaid Dental Program are documented. Services not adequately documented are considered not to have been delivered. Providers are required to maintain radiographs and treatment records that should reflect all procedures performed during all appointments. MCNA dentists must ensure that dental records are maintained for each member enrolled. The record shall include the quality, quantity, appropriateness, and timeliness of services performed as described by the remainder of this section of the manual.

All documentation, radiographs, and/or records must be maintained for at least seven (7) years after the last good, service, or supply has been provided to a member or an authorized agent of the state or federal government, or any of its authorized agents, unless those records are subject to review, audit, investigations, or subject to an administrative or judicial action brought by or on behalf of the state or federal government. Failure to produce these records upon demand for the Medicaid program or MCNA will result in sanctions against the provider.

Records must include a detailed charting of the oral condition that is updated on each visit and a chronological (dated) narrative account of each appointment indicating what services were provided or what conditions were present during those visits. Providers should also include in the member’s treatment record copies of all pre-authorization requests (including any attachments), all pre-authorization letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs are examples of additional supporting documentation.

A checklist of codes and services billed is insufficient documentation. The claim forms or copies of the claim forms submitted for reimbursement are not considered sufficient to document the delivery of services; however, these items must also be maintained in the member’s treatment record.

The following dental record standards must be followed for each member’s record as appropriate.
Providers shall ensure dental records are:

- All pages contain member name and/or member ID
- Biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
- Documentation of the member’s race and language spoken.
- All necessary forms completed, signed, and present in the record. This includes procedure/treatment consent, incident reports, pre-authorization, member outreach, non-covered services, and criteria for dental therapy under General Anesthesia forms.
- Current medical and dental history (including illness, medical conditions, psychological health, and substance abuse documentation) beginning with, at a minimum, the first member visit to the dental office.
- Documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
- Identification and history of nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
- Documentation of medication list and/or prescribed therapies including medication strength, directions, dose, and the amount and number of refills given.
- Progress notes, lab results, and imaging studies.
- Documentation of written denials for service and the reason for those denials.
- Documentation of imaging reports, initialed by the provider to indicate they have been reviewed.
- Documentation of allergies (e.g., medications or latex) and all known adverse reactions. If no allergies are known, “NKA” or “NKDA” is clearly indicated.
- Documentation of advance directives, as appropriate.
- Indication of the chief complaint or purpose of each visit, objective findings, diagnosis, and proposed treatment.
- The record is legible, accurate, and maintained in detail. (Staff can read the record)
- All entries dated and signed by the provider who rendered services, including credentials (DDS, DMD, or RDH).
- Documentation of all dental examinations.
- Documentation of emergency and/or after-hours encounters, as well as follow-up for emergency services.
- Documentation of working diagnosis consistent with clinical findings and treatment plan.
- Documentation of schedule for return visit(s) following the AAPD Periodicity Schedule.
- Documentation that unresolved problems from previous visits achieve resolution. This includes diagnostic tests, referral forms, and the outcomes of referrals.
- Evidence of appropriateness and timeliness of care.
- Documentation of outcomes of studies and evidence that they were appropriately ordered.
- Documentation of any known member comments/dissatisfaction.
- Documentation of service site.
- Documentation of each visit, which must include:
  - Date and beginning/ending times of service
  - Chief complaint or purpose of the visit
  - Diagnoses or dental impression
  - Objective findings
  - Member assessment findings
  - Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG)
  - Medications prescribed
Health education provided
- Name and credentials of the provider rendering services (e.g., DDS) and the signature or initials of that provider (initials of providers must be identified when correlating signatures)

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. On-site access to these dental records must be made available to MCNA’s authorized personnel, its designated representatives, review organizations, and government agencies during regular business hours. If requested, you must provide MCNA with member dental records according to timelines, definitions, formats, and instructions specified by MCNA.

A request from MCNA may be for any information required under the Provider Agreement including, but not limited to, dental records, reports, and other information related to the performance of your obligations under the agreement. You are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Participating 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 Nebraska and/or federal regulatory agencies
- MLTC-authorized personnel

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

- 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
MCNA recommends that your office request that all new members authorize the release of their dental records to you from the practitioner(s) who treated them prior to visiting your office.

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

The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)
As a health care 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 HIPAA rules.
MCNA is a covered entity and has taken the 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 of media, whether electronic, paper, or verbal. The Privacy Rule calls this information protected health information (PHI), and the requirements apply to both electronic medical records and 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 is any information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information (IIHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number).

A central component 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 protected health information 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:

- Disclosure to or a request by a healthcare provider for treatment
- Disclosure to an individual who is the subject of the information, or the individual's personal representative
- Use or disclosure made pursuant to an authorization
- Disclosure to IDHW for complaint investigation, compliance review, or enforcement
- Use or disclosure that is required by law
- Use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules

Because dental records are legal documents, providers should be familiar with additional Nebraska State Board of Dentistry requirements in the area of record keeping and of delivery of dental services in locations other than private offices.

Marketing Rules

It is a violation of the Nebraska Dental Practice Act and the Nebraska Medicaid Program Integrity Act to solicit or subsidize anyone by paying or presenting any person with money or anything of value for the purpose of securing members. Providers, however, may use lawful advertising that abides by the rules and regulations of the Nebraska State Board of Dentistry regarding advertising by dentists. Any provider found to be in violation shall be reported to the Nebraska State Board of Dentistry.
Provider Information Updates

It is important to keep MCNA informed of all information updates for your office. Providers are required to submit in writing the following information and provider changes to both MCNA and MLTC:

- Immediate notification of changes in license status, board actions, practice address or name, DBA name, and tax ID
- Notification 30 days prior to the removal a treating dentist from practice
- Notification three (3) to four (4) weeks prior to addition of a new treating dentist
- Notification 90 days prior to termination of participating provider from MCNA network to allow for continuity of care coordination

Please send updated provider information to MCNA at this address:

**MCNA Dental**
Attn: Credentialing Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

**Phone:** 1-844-353-6262

Please send updated provider information to MLTC/Maximus at the website if you have changes to your provider enrollment information:

**Maximus NE Provider Screening and Enrollment**
P.O. Box 81890
Lincoln, Nebraska 68501

**Phone:** 1-844-374-5022  
**Website:** www.NebraskaMedicaidProviderEnrollment.com

Termination of Dental Contract

MCNA may terminate a provider from the network for any misrepresentation(s) made on his/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 being barred from participation in any state Medicaid program
- Loss or suspension of the provider’s 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
- Commission of one (1) or more acts of fraud in connection with the provision of dental services
- Conduct injurious to MCNA’s business reputation
Providers who wish to terminate participation with MCNA must provide a 90-day notice of termination in writing mailed with a certified return receipt that includes the final termination date.

When a provider’s pending termination is identified, we will contact all members currently assigned to that provider and assist them with finding a new dentist (general dentist or pediatric specialist) based on the following considerations:

- A participating dental provider within the same group practice and at the same office location, if possible
- A participating dental provider closest to the member’s geographic location
Verification of Eligibility

Member eligibility varies daily. Therefore, each participating provider is responsible for verifying member eligibility with MCNA before providing services.

Eligibility can be verified 24 hours a day, 7 days a week via the following methods:

- Electronically through MCNA’s online Provider Portal (http://portal.mcna.net)
- By calling the MCNA Provider Hotline at 1-844-353-6262
- By calling the MCNA Member Hotline at 1-844-351-6262
- By calling Nebraska Medicaid Eligibility System (NMES) at 1-800-642-6092 or 1-402-471-9580
- Electronically through Medicaid Eligibility Verification System (MEVS) for internet access at http://dhhs.ne.gov/medicaid/Pages/med_internetaccess.aspx

You should verify member eligibility before providing any services. MCNA strongly recommends using our Provider Portal or the Medicaid Eligibility Systems to easily and quickly verify all member eligibility. Access your Provider Portal account at http://portal.mcna.net.

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

Second Opinion

The provider should discuss all aspects of a member’s treatment plan with the member and parent/guardian prior to beginning treatment. If the member or parent/guardian indicates they would like a second opinion, let them know that MCNA will have to authorize the second opinion visit to a provider in the MCNA network.

If no appropriate provider is available within the network to provide the second opinion, MCNA will cover the cost of seeing a non-network dentist. The provider must provide copies of the chart, radiographs, and any other information to the non-network dentist performing the second opinion upon request.

Out-of-Network Referrals

General Dental Care

If there are no contracted MCNA network general dentists or pediatric dentists available to treat MCNA members within a geographic area, MCNA will process an out-of-network referral. We will initiate the process with select dentists in the area and advise them of the guidelines for payment. All out-of-network treatment must be pre-authorized unless it is for emergency treatment services.

Specialty Care

If a required service is not available within the MCNA provider network, the member’s Primary Care Dentist may request an out-of-network referral. However, the Primary Care Dentist must obtain a pre-authorization from the MCNA Utilization Management Department. They will provide the necessary guidance on a case-by-case basis to ensure that all necessary pre-authorizations and agreements are provided and successfully complete the process.
Reimbursements made for the examination, prophylaxis, bitewing radiographs, and/or fluoride to providers who routinely refer members for restorative, surgical, and other treatment services are subject to recoupment. Please contact MCNA’s Utilization Management Department if you have questions (See Section 2: Contact Information).
Pre-Authorization of Care

We recommend using our Provider Portal (http://portal.mcna.net) to easily and quickly submit your pre-authorization requests. Pre-authorization requests will be processed by MCNA within two (2) business days of receipt. Urgent/expedited pre-authorization requests will be processed within 72 hours of receipt by MCNA.

MCNA’s utilization management criteria incorporate 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. Pre-authorization requests are reviewed against MCNA-approved criteria.

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

In addition to submitting pre-authorization requests electronically through the MCNA Provider Portal, providers may submit them through EMDEON (MCNA Payor ID: 65030) or by mail the completed 2012 ADA Claim Form (we will accept the 2006 ADA Claim Form as well, for a transitional period) to this address:

**MCNA Dental**
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

Approved pre-authorization requests are valid for 180 days from the date of approval. If orthodontic treatment does not begin within the valid 180-day period of the approved pre-authorization the case must be resubmitted.

Once a determination is made, the authorization will be available to view on the Provider Portal. The Utilization Management department staff will mail the authorization letter to those providers not utilizing the Provider Portal within three (3) business days of the determination for standard requests and within one (1) business day for emergency requests. Members also receive a copy of this notice.

All approvals will be assigned an authorization number for the service. This number must be submitted with the claim after services are rendered. After the provider receives approval of a pre-authorization request, they are required to contact the member to let them know of the approval and schedule the authorized services.

Please note, MCNA does not accept faxed pre-authorization requests at this time.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

Adult members in Nebraska are subject to a $750 annual limit. Certain exemptions are permitted under state regulation and requests for those services must be pre-authorized. Please note on the submission that the request is to exceed the $750 annual adult limit in the notes field. MCNA will review, and consider coverage of, services that cause the member to exceed the annual coverage limit, where the member is in need of dentures or extensive treatment.
Emergency Treatment Authorization

MCNA ensures that members have access to emergency care without pre-authorization, and to services and treatment as provided through the State agreement and defined in other state and federal 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 Provider Hotline at 1-844-353-6262 for assistance with coordination of the member’s care.

Authorization prior to emergency treatment may not be possible. In those instances the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for pre-authorization. Claims submitted without this documentation will be denied. All submissions will be evaluated for medical necessity and compliance with plan rules.

To submit the required documentation with a claim using MCNA’s Provider Portal, please indicate in the “office remarks” section that the service was provided on an emergency basis and pre-authorization does not apply. If submitting the claim on a paper ADA claim form, please indicate this information in Box 35.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures that are required to prevent pulpal death and the imminent loss of teeth (e.g., excavation of decay and placement of appropriate temporary fillings)
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

Pre- and Post-Authorization

Requests for pre-authorization can be submitted electronically using MCNA’s Provider Portal or by using an ADA Claim Form (the same paper claim form used for billing). Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the “Remarks” section of the electronic Provider Portal form or the paper ADA Claim Form submitted for the pre-authorization request. You must also document this reason in the member’s record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA’s Utilization Management Department.

For ease of billing it is preferable to group services requiring authorization on a single form so that only one (1) pre-authorization request need be issued per member.

Nebraska Medicaid Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided above. The need for pre-authorization is noted below in the column labeled “Benefit Limits” for all covered procedure codes.
A provider may choose to submit a post-authorization request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims submitted without a pre-authorization noted in Box 2 of the claim form or without the narrative and documentation required for post-authorization review will be denied. Pre-authorizations are valid for 180 days. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.

It is the provider’s responsibility to utilize the appropriate procedure code in a pre-authorization request. The pre-authorization approval of a requested service does not constitute approval of the fee indicated by the provider.

When requesting a pre-authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for the clinical reviewer making a decision about the case to fully understand the general dental health and condition of the member for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the member’s name and Medicaid ID number, the provider’s name, and the provider’s Medicaid ID number.
Covered Services

Children's Medicaid Dental Covered Services Overview

- Preventative
- Diagnostic
- Restorative services (fillings and crowns)
- Endodontic services (root canals)
- Periodontal services (treatment of gums)
- Prosthodontics fixed services
- Oral and maxillofacial surgery
- Orthodontic services (braces) – based on necessity
- Adjunctive general services

Adult Medicaid Dental Covered Services Overview

- Preventative
- Diagnostic
- Restorative services (fillings and crowns)
- Endodontic services (root canals)
- Periodontal services (treatment of gums)
- Prosthodontics fixed services
- Oral and maxillofacial surgery
- Adjunctive general services

Adult Special Needs Dental Covered Services Overview

- Preventative
- Diagnostic
- Restorative services (fillings and crowns)
- Endodontic services (root canals)
- Periodontal services (treatment of gums)
- Prosthodontics fixed services
- Oral and maxillofacial surgery
- Adjunctive dental services

Continuity of Care

When a 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 Primary Care Dentists must furnish members with copies of their records, including x-rays, free of charge.

When a Member has 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 date of their enrollment in Nebraska Medicaid Dental Program (unless there is a periodicity limit that applies for members who are re-enrolling).
When a Member is in Active Treatment
Medicaid members will be pre-authorized to continue treatment by an out-of-network provider during the course of "active treatment" at the time of enrollment until one (1) of the following conditions occurs, whichever comes first:

- The member’s records, clinical information, and care can be transferred to an in-network provider
- The member is disenrolled
- The course of “active treatment” is completed
- A period of 30 days has passed

Non-Capitated Services
The following services will continue to be provided by the member’s health plan or the Medicaid fee-for-service program:

- Outpatient office fees for dental services
- Fluoride varnish performed by a Primary Care Physician
- Transportation

Emergency Dental Services
MCNA is responsible for coverage or payment of emergency dental services provided to members in a hospital or ambulatory surgical center setting by dentists, billed on an ADA Claim Form. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or, (3) serious dysfunction of any bodily organ or part.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth
Claims Administration

Claim Submission
MCNA requires all dental providers to identify a place of treatment (service) on the 2012 American Dental Association (ADA) Claim Form (MCNA will accept 2006 ADA claim forms for a transitional time frame).

Picking and Choosing Services
Providers must bill MCNA for all covered services performed on any eligible member whom the provider has accepted as a Medicaid patient. This policy prohibits MCNA providers from “picking and choosing” the services for which they agree to accept reimbursement from MCNA. Providers must accept MCNA reimbursement as payment in full for all services covered by MCNA.

Submitting Claims to MCNA
Providers may submit a claim to MCNA using any of the following three (3) methods:

- Electronically through MCNA’s Provider Portal
- Electronically through a clearinghouse (MCNA Payor ID: 65030)
- Using a paper ADA Claim Form (2012 or newer) sent via United States Postal Service. ADA Claim Forms can be obtained from various vendors.

Please note, MCNA does not accept faxed claims or handwritten claims at this time.

Claims Payment
Please see the Nebraska Medicaid Covered Services section of this manual for a list of fees. For any claims questions please contact our Provider Hotline at 1-844-353-6262.

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

Providers have 180 calendar days of the date of service (DOS) to submit a claim. If your claim is not received within 180 calendar days from the date of service, it will be denied for late submission. The following are exceptions to the standard 180-calendar day timely filing submission requirement:

- If a provider files a claim erroneously with MLTC within the 180-calendar day submission requirement and produces documentation of that, MCNA must honor the initial filing date as notification of the claim and process it without denying for timely submission. The provider must submit the claim in question to MCNA within 180 calendar days from the date of notification by MLTC.
- If a claim was unable to be submitted within 180 calendar 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 180 calendar days of the date of notification by the clearinghouse.
- 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.
- Claims for retroactive Medicaid members must be filed within 180 calendar days from the date of eligibility determination.
- Provider-requested adjustments and voids of claims must be filed within 90 calendar days from the date of payment.

Dental services must not be separated or performed on different dates of service solely to enhance reimbursement.

Prompt Pay: MCNA is required to adjudicate a minimum of 90% of clean claims within 15 business days of receipt, 99% within 60 calendar days, and all claims within six (6) months.

The State of Nebraska defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the state’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

All claims should be submitted to MCNA on a 2012 ADA claim form. The claim form must include all of the following information to be considered a clean claim:

- Member name
- Member identification number
- Member and/or guardian signature (or signature on file)
- Member date of birth
- Description of services rendered
- Provider NPI number (included with all claim submissions regardless of format)
- Provider name, state license number, and signature (included with electronic or online submissions)
- Provider Federal Tax Identification Number (TIN) or Social Security number (SSN) of the billing entity
- Provider address, phone number, and facility ID number (included with electronic or online submissions)
- Proper CDT coding with tooth numbers, surfaces, quadrants, and arch, when applicable.
- Full mouth x-ray series, bitewings, and/or periapical x-rays, rationale, photos, sedation time records, or other documentation, when required

Remittance Advice (RA) documents will be available in the MCNA Provider Portal for all offices.
Example of a Clean Claim

ADA American Dental Association® Dental Claim Form

**HEADER INFORMATION**
- Type of Transaction (Mark all applicable boxes):
  - Statement of Actual Services
  - Request for Predetermination/Preevaluation

**POLICYHOLDER/SUBSCRIBER INFORMATION** (For Insurers Company Named in #)
- Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: Brian A. Johnson 1500 Main Street, Apt #3B Lincoln, Nebraska 68501
- Date of Birth (MM/DD/YYYY): 1/15/2009
- Gender: M
- Relationship to Policyholder/Subscriber in #12 Above: Self
- Policyholder/Subscriber ID (SSN or ID): 111-22-3333

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**
- Company/Plan Name, Address, City, State, Zip Code: MCNA Dental 200 West Cypress Creek Road, Suite #500 Fort Lauderdale, Florida 33309
- Provider Number: MCNA_NE-P_PM[1.1]
- Plan/Group Number: 16
- Employer Name: 17

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If none, leave blank.)
- Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
- Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix):
- Date of Birth (MM/DD/YYYY): 1/15/2009
- Gender: M
- Policyholder/Subscriber ID (SSN or ID):
- Relationship to Person named in #5: Self
- Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code:

**RECORD OF SERVICES PROVIDED**

<table>
<thead>
<tr>
<th>50. Procedure Code (ICD-9-CM)</th>
<th>51. Description</th>
<th>52. Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0150</td>
<td>Comprehensive Oral Evaluation</td>
<td>$30.00</td>
</tr>
</tbody>
</table>

**AUTHORIZATIONS**
- Patient/Provider Signature: 5/1/2017
- Date: 5/1/2017

**ANCILLARY CLAIM/TREATMENT INFORMATION**
- Place of Treatment: 511 (e.g. HMO, POS, PPO, etc.)
- Use Office of Services Code for "Professional Services":
- Date of Admission (MM/DD/YYYY): 5/1/2017
- Diagnosis Code(s) (Primary diagnosis is *)

**BILLING DENTIST OR DENTAL ENTITY**
- Name, Address, City, State, Zip Code:
- National Pediatric Dental Care Associates 888 NE 10th Avenue, Suite #100 Lincoln, Nebraska 68505
- Provider Number: 00123456789
- NPI: 1234567890
- License Number: 12345
- SSN or TIN: 1234567890
- Date: 5/1/2017

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**
- Treatment Resulting from:
- Date of Accident (MM/DD/YYYY): 5/1/2017
- Auto Accident State:
- NPI: 00987654321
- License Number: 54321
- Address: 888 NE 10th Avenue, Suite #100 Lincoln, Nebraska 68505
- Provider Specialty Code: 122300000X
- Additional Provider ID: 1234567890

©2012 American Dental Association
A400 (Same as ADA Dental Claim Form - J430, J431, J432, J433, J434)

To reorder call 800.947.4716 or go online at adacatalog.org

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Electronic Submission of Claims via MCNA’s Provider Portal

MCNA’s Provider Portal (http://portal.mcna.net) allows participating providers to easily submit claims to us and track their status. Submitting claims electronically using the Provider Portal is always free.

You have the ability to attach scanned x-rays, periodontal charting, and other documents to your claims. MCNA contracts with NEA FastAttach to allow for the electronic submission of x-rays. For those offices unable to work with digital copies of x-rays, a completed ADA Claim Form (2012 or newer) along with the x-ray(s) must be sent to MCNA at the address listed in the Paper Claim Submission via Mail section below.

Electronic Submission via Clearinghouse and Billing Intermediaries

Providers may submit electronic claims through clearinghouses, which transmit claims to EMDEON (WEBMD). MCNA’s Payor ID code is 65030. MCNA contracts with NEA FastAttach for the electronic submission of digital attachments.

Providers who use a billing intermediary for claims preparation and submission must notify MCNA of their billing arrangements in writing. If a billing intermediary changes or ceases to exist, you must also notify MCNA in writing. A billing intermediary is not considered to be 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 Submission via Mail

Paper claims must be typed or printed and submitted on the ADA Claim form (2012 or newer). Providers can download this form from our Provider Portal (http://portal.mcna.net) and print it. Paper claims may be submitted by mail to:

MCNA Dental
Attn: Claims Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

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.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

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 EFT Form, which you can download from our website (www.mcna.ne.net). Please fax or mail the completed form to MCNA’s Credentialing Department (See Section 2: Contact Information).

MCNA Processing of Deficient Claims

Providers have a total of 180 calendar days from the date of service to submit a claim. If a claim is not received by MCNA within this 180-day time frame it will be denied.

MCNA may also deny your claim as deficient if it does not include all supporting documentation, such as x-rays or narrative, when required. When this occurs, the Explanation of Benefits/Remittance Advice will state the reason...
for the denial. For example, a procedure that has been denied is listed with reason code 48, which states “please submit x-ray(s) and narrative with this request.”

MCNA sends a notification within five (5) days of claim adjudication to inform providers that a determination for the claim has been made. Active Provider Portal users will be notified via a portal alert. To view why a claim is considered non-clean, providers can log in to the Provider Portal and click on “Non-Clean Claim Notices.” Providers who do not use their Provider Portal accounts will receive a letter in the mail with the same information.

Additional information may be required for a non-clean claim to be processed. The provider must send in the required information within 30 calendar days from the date of the deficient denial determination. MCNA considers the official submission date of a corrected claim to be the date that a provider electronically transfers any required additional information and documentation. If a provider mails the information, the official submission date is the date MCNA receives it.

Claims Reconsiderations
Reconsideration requests must be filed within 90 calendar days of the claim determination. Requests for MCNA’s reconsideration of a claim may be filed when a claim has been denied for anything other than medical necessity or benefit coverage including, but not limited to, the following examples:

- Timely filing
- Duplicate
- Member and provider eligibility
- Incorrect fee applied

Any supporting documentation should be included with the reconsideration requests. Providers may submit their request in writing by using the Provider Reconsideration and Appeal form or online using MCNA’s Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on “Support and Downloads” to access the Online Reconsideration/Appeal link. Please complete the electronic form titled “Provider Reconsideration and Appeal” form including all information needed to evaluate your request.

Coordination of Benefits
It is the provider’s responsibility to determine if members have other dental insurance. When other insurance exists and MCNA is the secondary insurer, a copy of the primary insurance Remittance Advice (RA) or 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 RA or EOB is attached. MCNA will deem a claim paid in full when the primary insurance payment meets or exceeds MCNA’s reimbursement rates.

Third Party Liability
Medicaid is the payor of last resort with the exception of members who are covered by Tribal Benefits through Indian Health Services. Providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. A third-party insurance carrier is an individual or company who is responsible for the payment of medical or dental services. Examples of third parties are Medicare, private health insurance, automobile, and other liability carriers. When billing MCNA after payment consideration from a third party (except Medicare), a Remittance Advice (RA) or an Explanation of Benefits (EOB) from the primary insurance carrier must be attached. The six-digit state-assigned carrier code for the primary insurance and the amount paid by the primary insurance carrier (including zero [$0] payment) must be entered in the appropriate places on the claim form. If the third-party
coverage is found to be erroneous, providers may submit a corrected claim to MCNA. In situations where third-party benefits exist, the time frame for filing a claim with MCNA begins on the date that the third-party carrier resolves the claim.

Non-Covered Services
MCNA will not pay a provider for non-covered services. According to the MCNA Provider Agreement, 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. The MCNA Provider Agreement states that the only circumstance in which a provider may bill for non-covered services is when a member has signed a form or letter of understanding agreeing to the fees.

The following services are considered non-covered services:

- Services that are not medically necessary to the member’s dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Plaque control
- Certain types of x-rays (including but not limited to iCat x-rays)
- Routine post-operative services - these services are covered as part of the fee for initial treatment provided
- Treatment of incipient or non-caries lesions (other than covered sealants and fluoride)
- Services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan
- Dental expenses related to any dental services:
  - Started after the member’s coverage ended
  - Received before the member became eligible for these services
  - Prescriptions or drugs
  - Administration of in-office pre-medication

Non-Covered Services Private Payment Agreement Form
MCNA only reimburses for services that are medically necessary or benefits of special preventive and screening programs, such as the federal EPSDT program. The provider may bill a member only if a specific non-covered service or item is provided at the member’s request.

The provider must obtain and keep a written Non-Covered Services Form that is signed by the member and/or responsible party prior to the services being rendered. It must be filled out completely with the following information:

- A statement that the member is financially responsible for the described services
- A complete description of the dental services to be rendered.
- A statement that the plan, MCNA, and the State will not be responsible for payment of the described dental services.
Balance Billing
MCNA network providers may not bill or otherwise attempt to recover from members the difference between the agreed upon contract allowable rate for a service and the provider’s billed charge(s). This practice is called balance billing and is not permitted under your MCNA Provider Agreement.

Fraud Reporting
Providers are expected to bill only for medically necessary covered services delivered to members in accordance with MCNA’s policies and procedures. MCNA and the appropriate governmental agencies actively investigate all suspected cases of fraud and abuse. In our commitment to prevent fraud and abuse in the Medicaid Program, MCNA has implemented an integrity component as a part of our Compliance Program. We monitor and maintain integrity through the following activities:

- Prevention of duplicate payments
- 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
- Profiling of providers to identify over or under utilization of services
- Completion of investigations and audits

Program Integrity
Providers are not allowed to provide services to a member beyond the intent of Medicaid guidelines, limitations, and/or policies for purposes of maximizing payments. If this practice is detected, the provider may be subject to sanctions. Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid-established guidelines, limitations, and/or policies are not exceeded. Providers not participating in the MCNA network may not use the name and/or provider number of a participating provider in order to bill Medicaid for services rendered.

MCNA is committed to controlling fraud, waste, and abuse in the Nebraska Medicaid Dental Program. Our efforts include vigilant 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 through pre- and post-payment reviews. These reviews help us to prevent or recover overpayments paid to providers. An overpayment includes any amount 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 a mistake.

When an overpayment is identified, MCNA begins payment recovery efforts. Providers will be given the opportunity to submit a refund or payment plan within a specified time period. If you fail to submit a refund within the specified time period, the overpayment amount will be automatically deducted from future RAs. Additionally, MCNA will pursue all remedies up to and including the termination of your participation in our network. If you wish to report fraud, please see the contact information for MCNA and the Nebraska resources located at the front of the manual.

Appeal Rights
MCNA affords to any provider or person against whom it enforces payment recoupment requests a right to appeal this action by requesting an informal review. A request for an informal review must be received in writing within 28
days of the date you receive a recoupment notice. Appeals should be mailed to MCNA to the attention of “Corporate Investigations.”

Along with your appeal, you may submit any documentary evidence that addresses whether the recoupment is warranted and any related issues. MCNA will consider your appeal and your evidence carefully. You will be contacted after that consideration is completed and a decision about your case is made.

Please contact MCNA’s Provider Hotline if you have questions.

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 that are allowed to be brought 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 or in reckless disregard of the truth or falsity of the claim.

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
- Up coding
- 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 dental services that were not necessary or actually provided
- Making false statements about a medical condition in order to get medical treatment
- Letting someone else use a MCNA ID card
- Using another person’s MCNA ID card
- Making false statements about the amount of money or resources in order to get benefits

To report waste, abuse, or fraud, choose one of the following:
Call the contact the Medicaid Fraud and Patient Abuse Unit of the Attorney General's Office at (402) 471-3549 or toll free at 1-800-727-6432 or e-mail ago.medicaid.fraud@Nebraska.gov
To report Nebraska Medicaid Provider Self-Disclosure, contact Nebraska Medicaid Program Integrity toll free at 1-877-255-3092 or by e-mail at DHHS.MedicaidProgramIntegrity@nebraska.gov MLTC-61 "Self-Disclosure Form"
Call the MCNA Fraud, Waste, and Abuse Hotline at 1-855-FWA-MCNA (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 office (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and office, 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
- Date(s) of event(s)
- 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 suspected waste, abuse or fraud
Provider Complaint Process

MCNA 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, and our Provider Services team is ready to help. Please contact the Provider Hotline at 1-844-353-6262.

Complaints in the Nebraska Medicaid Dental Program are defined as a verbal or written expression by a provider that indicates dissatisfaction with MCNA policy, procedure, claims processing and/or claim payment, or any aspect of MCNA function. Provider complaints may be reported to the MCNA Provider Hotline by calling 1-844-353-6262. Providers may also submit complaints directly to their Provider Relations Representative, verbally or in writing, via mail to the address below or via email to NebraskaPR@mcna.net, using the Provider Complaint form. You will find links to download this form and others in the Forms section at the end of this manual. Complaints about decisions that are not a unique function of MCNA should be made directly to MLTC. Should a provider (or their representative) wish to present their case in person, we welcome them to contact the Provider Hotline at 1-844-353-6262 to schedule an appointment.

If you would like to file a complaint in writing with MCNA, please send it by mail or email to one of the following addresses:

**MCNA Dental**  
Attention: Complaints Department – Provider Relations  
P.O. Box 29008  
San Antonio, Texas 78229  

**Email:** NebraskaPR@mcna.net

Upon receipt of a complaint, the Provider Relations Department will review the issue and forward it to or solicit the assistance of the appropriate MCNA department(s). We will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties while applying MCNA’s written policies and procedures and resolve the complaint within 30 business days from the date we receive it. 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.

Upon resolution of the complaint, the Provider Relations department will inform the provider in writing of 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. Concerns related to medical necessity are not addressed through the complaint system. They can be submitted through the appeal system found in section 11.11 Claim Appeals on behalf of a member, or the provider can utilize MCNA's peer-to-peer process to speak with one of our licensed dentists. You can find more information about our peer-to-peer process in the Utilization Management section of this manual and instructions for filing an appeal on behalf of a member can be found in section 18, Member Grievances and Appeal Process.

After a provider has exhausted MCNA’s internal complaint process, if the provider is dissatisfied with the resolution they have the right to file a complaint directly with MLTC (Nebraska Medicaid). To file a complaint with MLTC, please visit the DHHS website or email DHHS.DBM@nebraska.gov.
Utilization Management

Utilization Management (UM) is the process of evaluating the necessity and efficiency of healthcare services and affecting member care decisions through assessments of the appropriateness of care. MCNA’s UM Department helps to assure prompt delivery of medically appropriate dental care services to all members and subsequently monitors the quality of care. All participating providers are required to obtain pre-authorization from MCNA’s UM Department. The UM Department is available Monday through Friday, 8 a.m. to 4 p.m., CST, except on weekends and designated holidays. All requests for the authorization of services may be received during these hours of operation.

MCNA provides an opportunity for the provider to discuss a decision with the dentist who reviewed the case or the Dental Director, to ask clinical questions about a UM issue, or to seek information from a clinical reviewer about the clinical aspects of the UM process and the authorization of care. If you contact us after business hours or on a holiday, you may leave a message and a representative will return the call the next business day to schedule your peer-to-peer discussion.

MCNA will not enter into any contractual arrangement that rewards clinical reviewers or any other individuals who may conduct utilization review activities for issuing denial of coverage of a service, or any other financial incentives for utilization decision-making. MCNA’s UM Department ensures that quality of care will not be affected by financial- and reimbursement-related processes and decisions.

MCNA adheres strictly to the following:

- Compensation for utilization management activities is not structured to provide inappropriate incentives for denials, limitations, or discontinuation of authorization of services.
- Compensation programs for MCNA, 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 a standard procedure within the UM process.

Decision Making Criteria

MCNA’s Utilization Management Criteria use 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. For all children under 21, MCNA adheres to all federal EPSDT requirements found in 42 CFR 441.50-441.62 and in the State Medicaid Manual in Chapter 5 at: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:4.0.1.1.10.2.

The procedure codes used by MCNA are described in the American Dental Association’s Code Manual. Requirements 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 annually reviewed and approved by MCNA’s Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

We appreciate your input regarding the criteria used for decision-making. Please contact the Provider Hotline 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. These licensed general dentists, pediatric dentists, and specialty dental providers (e.g., orthodontists and oral surgeons) make all clinical determinations. The peer-to-peer process enables participating providers to discuss cases and clinical issues, including medical necessity denials, with MCNA clinical reviewers.

To request a peer-to-peer discussion, please contact your Provider Relations Representative or call the Provider Hotline.

Clinical Practice Guidelines
The Clinical Practice Guidelines are based on the enrolled membership and dictate the provision of dental care services to members with acute, chronic, and complex conditions to assist providers and members in making appropriate dental care decisions to improve quality of care. These 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 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

The practice guidelines is available to all participating providers upon request. Please contact the Utilization Management Department at 1-844-353-6262.

Clinical Decisions
A pre-authorization request for a service may be denied for failure to meet Clinical Practice Guidelines, clinical criteria, protocols, dental policies, or for failure to follow administrative procedures outlined in your Provider Agreement or this Provider Manual. All pre-authorization request approvals and denials are available through MCNA’s Provider Portal. Providers who do not have access to the Provider Portal will receive their determinations via mail. If a pre-authorization request is missing information that information is noted on the determination. The provider may then resubmit the request with all needed information.

Medical-Necessity Denials
Utilization Management uses dental policies, protocols, and industry standard guidelines to render review decisions. Licensed dentists and specialty dentists serve as clinical reviewers for the plan. All clinical requests are reviewed by an MCNA clinical reviewer who is available to discuss any decision rendered with the attending dental provider through our peer-to-peer process.
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 Dental 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 carries out the following responsibilities:

- Oversees the implementation of the QI Program throughout MCNA’s operational departments
- Establishes a method to measure and quantify improvements in dental care delivery to MCNA members resulting from QI initiatives
- Reviews and makes recommendations, which are identified through the QI process, for approval of all new and revised policies, procedures, and MCNA benefit designs
- Ensures that adequate resources are allocated toward the achievement of MCNA’s QI Program goals
- Oversees the management of all aspects of MCNA’s operations to make sure they are consistent with the goals and objectives of the QI Program
- Monitors the progress of all MCNA-initiated corrective action plans
- Monitors the integration, coordination, and supervision of Risk Management Program activities through the formal reporting of those activities
- Demonstrates compliance with regulatory requirements and delegation standards
- Assesses and confirms that quality care and services are being appropriately delivered to MCNA members
- Reports quarterly to the Board of Directors the status of MCNA QI Program

A copy of the QI Program is available to all participating providers upon request. Please contact the Provider Hotline.

Your Role in Quality
Every MCNA network provider is a participant in the Quality Improvement (QI) 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 QI Program or contribute to the development of audits, Clinical Practice Guidelines, member education programs, or other projects. 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, which is available to download in the Forms section at the end of this manual. This can be submitted to MCNA via fax, email, or regular mail. The MCNA Dental Director might contact your office about an incident report. Please keep a copy of any incident report you file with MCNA in the appropriate member’s 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 one (1) or more state-approved PIPs per year. The PIPs will focus on both clinical and non-clinical areas.

Quality Review of Key Clinical and Service Indicators
One of MCNA’s Quality Improvement (QI) Program objectives is to perform a quality review of key clinical and service indicators through analysis of member and provider data to assess and improve member and provider satisfaction rates. These clinical and service indicators include reviews of:

- Member and provider complaints about 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 Practice Guidelines
- Application of appropriate dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member pre-authorization requests and referrals

In order to support the quality review activities of our QI Program, your office is required to make available upon a request from an MCNA representative the dental records of any MCNA member in your care.

Corrective Action
When Quality Improvement (QI) Program identifies specific cases of substandard quality of care during its 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 include:

- A Quality Correction Letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days (the severity of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Special pre-authorization/claims review
- Post-treatment reviews of members by a licensed dentist who serves as an MCNA Clinical Reviewer
- Requirement for the provider to attend training sessions or participate in continuing education programs
- Restriction on the acceptance of new members until the provider becomes compliant with all standards of care for a specified amount of time
- Recoupment of sums paid where billing discrepancies are found during reviews
- Restriction on a provider’s authorized scope of services.
- Referral of 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
- Termination of the Provider Agreement
Where corrective action is recommended, our 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 Provider Manual. MCNA is willing to provide support for a provider who shows sincere intent to correct deficiencies.

**Member Satisfaction Surveys**

The Member Satisfaction Survey is a tool that assists MCNA in rating the member's experience with network providers and with 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 is conducted on a quarterly basis. This information is used to develop and 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 assess its contracted providers' satisfaction with MCNA on a quarterly basis. Provider Satisfaction Surveys are conducted to evaluate MCNA’s training efforts and other key performance indicators. These surveys are typically conducted through outbound call campaigns, but may also be incorporated into on-site visits as a means to generate productive conversations with the office staff. This activity shall include, but not be limited to, analyses of provider satisfaction with the following operational aspects:

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

We will use the results of our provider satisfaction surveys 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.

**Member Records - Chart Reviews**

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

- Record of 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

A chart review offers an insight into the provider’s practice patterns and allows MCNA to identify deficiencies and suggest areas of improvement. The on-site review is a component of our Quality Improvement (QI) Program; all data is collected and entered into a QI database. This data allows MCNA to perform analysis of utilization and
general network and practice patterns, contributing to valuable feedback and information for network dental offices. This information will also be used as part of the re-credentialing process.
Member Services

Discrimination
Providers may choose whether to accept a member as a Medicaid patient. Providers are not required to accept every Medicaid member requiring treatment; however, providers must be consistent in this practice and not discriminate against a Medicaid member based on the member’s race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, physical or behavioral disability, political beliefs, or source of payment.

Providers must not differentiate or discriminate in the treatment of any member because of the member’s race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, physical or behavioral disability, political beliefs, or source of payment.

Confidentiality Policy
MCNA follows all HIPAA requirements. We require our contracted providers to also adhere to HIPAA requirements. The Provider Agreement requires that all providers maintain member information in a current, detailed, organized, and comprehensive manner, and in accordance with customary dental practices, and applicable state and federal laws and accreditation standards. Providers must have policies and procedures to implement HIPAA 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 member 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 member records and other member information.

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

The provider must obtain and maintain a specific written informed consent form signed by the member, or the 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 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 from the proposed treatment or a procedure exists. Consent should disclose all 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
diagnoses, scope of proposed treatment, including risks and alternatives, 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. As a provider, you may 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.” You can find the guideline online at the AAPD’s website (www.aapd.org).

**Cultural Competence**

We facilitate access to dental services for non-English speaking members. MCNA’s population is culturally and linguistically diverse, and we recognize that this diversity sometimes serves as a barrier to members, affecting 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 CLAS recommendations (www.minorityhealth.hhs.gov) as a guideline in the development of our Cultural Competency Program. MCNA encourages contracted providers to address the care and service provided to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language, and abilities.

We want to ensure that we, along with our network providers, are meeting the communication needs of members with limited English proficiency. MCNA’s Quality Improvement department monitors and evaluates the level of cultural competency throughout our network through dental services provided by our providers. MCNA encourages employees and network providers to utilize their own diverse cultural backgrounds to enhance our program and the services provided to our members.

Please contact the Provider Hotline to request a copy of our Cultural Competency Program.

**Reading/Grade Level Consideration**

All member materials produced by MCNA are written for ease of understanding and typically target a sixth-grade reading level to promote enhanced communication between the Medicaid population, providers, and MCNA. Our goal is to create plain and clearly understandable member communications.

**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 will be presented in a culturally and linguistically appropriate manner utilizing member’s primary spoken or signed language:

- Interpreter services are available through MCNA at no charge when accessing dental care. Please have the member contact the MCNA Member Hotline at 1-844-351-6262 for interpreter assistance.
- Member refusal of interpreter services must be documented.
- Friends and family are only used as an interpreter when specifically requested by the member. A Minor may not to be used as an interpreter.
- Member may request face-to-face or telephone interpreter services to discuss complex dental information and treatment options.
- Informative documents must be translated into and available in threshold languages.
• Member has the right to file a complaint if linguistic needs are not met.
• Dental provider offices are informed of the availability of the TTY contact number (1-800-833-7532) for members with hearing impairment.

Role of Provider’s Bilingual Staff

The role of the bilingual staff in the office 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 an office 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 may affect the provider’s ability to provide dental services.

To get a free copy of MCNA Cultural Competency Program, contact MCNA’s Member Hotline.

Appointment Attendance Concerns

We track the appointment attendance history of members who are consistent “no shows” to their scheduled dental appointments. If you are treating an MCNA member who has a history of being a no show at your office, please download the Member Outreach Form using the link provided in the Forms section at the end of this manual and submit it to us.

Case Management

MCNA has dedicated Case Managers to assist members with special health care needs by coordinating dental care with their general or pediatric dentist, dental specialists, and Medicaid case manager, as applicable.

Members or providers may contact Case Management to initiate the assessment process for members with conditions that are medically compromising or 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, communication services, facilitating treatment pre-authorization, and assisting with scheduling follow-up while the member is in active care. Please call the Provider Hotline at 1-844-353-6262 to refer a member to MCNA’s Case Management Program.
Member Eligibility, Enrollment, and Disenrollment

Nebraska Medicaid Dental Program
MCNA does not perform enrollment functions for Nebraska Medicaid recipients. All eligibility information provided by MCNA is the information that we have received from the Nebraska Department of Health and Human Services (DHHS) Medicaid and Long Term Care (MLTC) or its designee. The effective date of enrollment will be 12:01 a.m. of the first calendar day of the month of Medicaid eligibility.

Eligibility
The goals of the Nebraska Medicaid Dental Program are to provide medically necessary dental services for children, pregnant women and adults. Nebraska Medicaid considers a recipient to be an adult beginning with the month after his or her 21 birthday. A recipient is considered a child through the end of the month in which his or her 21 birthday falls.

To be eligible for the Nebraska Medicaid Dental Program, members must be in one (1) of the following categories:

- Children through the age of 19
- Pregnant women aged 19 or older
- Adults aged 19 or older
- An individual who is blind or disabled according to Social Security Administration criteria

They must also meet all of the following eligibility criteria:

- Be a citizen or legal immigrant
- Be a resident of the State of Nebraska
- Maintain a household income that is less than the program income limits for their household size
- Have resources that do not exceed the program resource limits

Please note that due to possible eligibility status changes, the information provided does not guarantee payment. General information about Nebraska Medicaid eligibility is available at http://dhhs.ne.gov/medicaid/Pages/med_medindex.aspx.

MCNA ID Cards
MCNA strongly recommends all provider offices require each member to present their MCNA identification card and confirm eligibility at each appointment. You may quickly and easily complete eligibility verification by utilizing our Provider Portal (http://portal.mcna.net) or by calling our Provider Hotline at 1-844-353-6262.

MCNA advises that you keep a copy of each member’s ID card on file in the member’s dental record.
Member Rights and Responsibilities

Dental Programs

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

Member Rights as written in the MCNA Member Handbook

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and the right to express preferences about future treatment decisions.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.
- You have the right to be able to request a copy of your medical records (one copy free of charge) and request that they be amended or corrected.
- You have the right to receive healthcare services that are easy to access. These services should be comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service. They should be sufficient in amount, duration, and scope to reasonable be expected to achieve their purpose.
- You have the right to receive services that are appropriate and are not denied or reduced because of diagnosis, type of illness, or dental condition.
- You have the right to receive all information, like enrollment notices, informational materials, instructional materials, and available treatment options and alternatives in a way that is easy to understand.
- You have the right to receive assistance from the Nebraska Department of Health in understanding the requirements and benefits of MCNA.
- You have the right to receive interpretation services for free and in all non-English languages, not just those that are the most common.
- You have the right to be notified that interpretation services are available and how to access those services.
- You have the right to receive information on MCNA’s services, to include, but not be limited to:
  - Benefits covered
  - The way to use benefits, including any authorization requirements
  - Service area
  - Names, locations, telephone numbers of, and non-English language spoken by current network providers, like Primary Care Dentists, specialists, Federally Qualified Health Clinics, Rural Health Clinics, and hospitals.
  - Any restrictions on your freedom of choice among network providers
  - Providers who are not accepting new patients
  - Benefits not offered by MCNA that are available to you and how to obtain them, including transportation
- You have the right to receive notice of any major changes in core benefits and services at least 30 days before the intended effective date of the change.
- You have the right to receive information on grievance, appeal, and State Fair Hearing procedures.
- You have the right to receive detailed information on emergency and after-hours coverage, to include, but not be limited to:
  - What constitutes an emergency medical condition and emergency services, and post-stabilization services
That emergency services do not require prior authorization
The process and procedures for getting emergency services
The locations of any emergency rooms and other places where MCNA has contracted to furnish emergency dental services and post-stabilization services
The right to use any hospital or other setting for emergency care
The rules about post-stabilization services after emergency care

- You have the right to receive MCNA's policy on referrals for specialty care and other benefits not provided by your Primary Care Dentist.
- You have the right to have your privacy protected according to legal privacy requirements.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Nebraska Department of Health and Human Services.

**Member Responsibilities as written in the MCNA Member Handbook**

You and MCNA both have an interest in seeing your dental health improve. You can help by assuming these responsibilities.

- Present your MCNA member ID card when getting services from your dentist.
- Be familiar with MCNA’s procedures to the best of your ability.
- Call or contact MCNA to obtain information and have questions answered.
- Let the dentist know any reasons your treatment cannot be followed as soon as possible.
- Live a healthy lifestyle and avoid behavior that can hurt your health.
- Follow the grievance process that MCNA provides for you if you have a disagreement with a dentist.
- Use the preventive dental services that are a part of your benefits.
- Be respectful of the dentist and their staff.
- Be respectful of the rights of other patients.
- Follow the dentist’s rules and regulations about patient care and conduct while at the dental office.
- Provide the dentist and their office staff with true and complete information so they can give you proper care.
- Obtain services from only in-network Primary Care Dentists or specialists, except if you have a dental emergency.
- Ask the dentist questions about his or her instructions.
- Ask the dentist about the care you receive.
- Understand your dental problems and work with your dentist to decide treatment goals.
- Make good decisions about your dental health and avoid things that can damage it.
- Follow the plan of treatment for dental care agreed upon by you and your dentist agree and/or their staff.
- Make sure that payments for non-covered dental services are fulfilled as soon as possible.
- Report unexpected changes in your dental condition to your dentist.
- Keep all appointments and arrive on time. If you are unable to do so for any reason, call your dentist's office as soon as you can.

**Member Outreach**

MCNA provides an Enrollment Packet for each head of household where at least one member of the family is enrolled in a dental plan under Nebraska Medicaid Dental. The packet includes helpful information such as MCNA’s Provider Directory to help member choose a dentist near their home. It also informs members about how
they can search for a dentist online or receive assistance in finding one by using MCNA’s toll-free Member Hotline.

Our Bright Beginnings Program highlights our commitment to expecting and new mothers with young children enrolled in Nebraska Medicaid Dental. Bright Beginnings is designed to provide face-to-face as well as telephonic outreach to mothers about available benefits and the importance of seeking routine preventive dental care for their child before their first birthday. The program also includes a community outreach component where our Member Advocate Outreach Specialists (MAOS) visit local community agencies and group homes for teen and single mothers. We encourage you to remind expectant mothers about this program and have them contact our Member Hotline at 1-844-351-6262.

Our MAOS partner with local school districts to organize and participate in community health fairs, and provide oral health presentation in schools for students, faculty, staff and parents. They utilize age-appropriate activities to engage children in learning about proper oral health. MCNA provides education materials in English and Spanish to our members throughout the year. We produce a member-focused newsletter to keep member up to date with the latest program information, remind them about existing benefits, and to provide helpful oral health and hygiene tips.

MCNA’s Provider Outreach Form allows providers to inform MCNA when a member is behind in routine dental checkups, a chronic no-show for confirmed appointments, non-compliant with treatment plan, non-compliant with office policies and/or displays unacceptable behavior in office, requires education regarding referral use, requires transfer from office/office pane, or requires follow-up with a MCNA representative after being referred for services, or is a pregnant woman. Once a provider completes this form, it can be mailed or faxed to MCNA. Upon receipts, MCNA’s Care Connections Team (CCT) processes each form and attempts to reach out to the member regarding the reason the provider sent the form. If the member requires assistance finding a provider or scheduling an appointment, the CCT representative conducts a three-way call with the provider’s office and the member to schedule the member with an appointment. When the provider indicates that the member is an expecting mother, the CDT will reach out to the member. If a provider indicates that a member has special needs that member’s information will be forwarded to our Case Management Department to see if they may benefit from our Case Management Services.
Member Grievance and Appeals Processes

A member grievance is any dissatisfaction expressed by a member, or a person acting on behalf of the member, either verbally or in writing, to MCNA concerning any aspect of MCNA’s operation that does not meet the definition of an appeal. This includes, but is not limited to, dissatisfaction with MCNA’s administration or the way a service is provided. A grievance does not include an appeal, which is a request for review of an adverse benefit determination by MCNA related to covered services.

Member grievances and appeals can be filed verbally or in writing. A verbally filed appeal must be followed by a written, signed appeal unless it is an expedited appeal. At no time will a member be discriminated against because he or she has filed an appeal. All information contained within a grievance or appeal and anything that comes to light throughout the grievance and appeal process is kept strictly confidential. A provider acting on behalf of a member or a member’s representative may submit grievances and appeals on behalf of members with their written consent. All appeals submitted by a provider on behalf of a member or by a member’s representative must be submitted in writing with a signed copy of the member consent form.

If you would like to file a grievance or appeal on behalf of a member, please call or send it to MCNA’s Grievance and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at the beginning of this manual.

Member Grievance Process

Members have the right to file a grievance. Grievances can be filed verbally, in writing, or in person. A provider may file a grievance on a member’s behalf. Grievances filed by a provider on a member’s behalf require the member’s written consent.

MCNA will acknowledge receipt of a grievance in writing within 10 calendar days from the date what we receive it. MCNA will resolve and provide written resolution of all member grievances within 90 calendar days from the date the grievance is received.

If you would like to file a grievance on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at the beginning of this manual. At no time will a member be discriminated against because he or she has filed a grievance. We always respect our members’ privacy. Anything said or written is kept confidential.

What is an Informal Consideration?

A member has the right to request an informal reconsideration. An informal request is a request for review of a service authorization because MCNA did not approve a service request or approved a reduced amount of the services requested. MCNA will take no more than one (1) business day from the date we receive the request to make a decision about it. Please note that if a decision by MCNA meets the definition of an adverse benefit determination, the informal reconsideration is not a requirement. Upon an adverse benefit determination, the member has a right to file a formal appeal within 60 days of the notice of adverse benefit determination, regardless of whether the member requests an informal reconsideration.
Member Informal Reconsideration Process

MCNA will notify the member and requesting provider of a decision about the request for a covered services through a Notice of Adverse Benefit Determination Letter. If the member, member’s representative, or provider disagrees with our decision, he or she can request an informal reconsideration. Informal reconsiderations filed by a provider on behalf of a member or a member’s representative require the member’s written consent.

An informal reconsideration may be filed verbally or in writing within 30 calendar days of the date when the member receives the Notice of Adverse Benefit Determination. The MCNA Clinical Reviewer who made the original decision will discuss the determination with the member or their dentist within one (1) business day after receiving the request. We will make our decision regarding the reconsideration at the end of the meeting. Then we will send the member or the member’s representative a letter about our decision within 30 business days of receipt of the informal reconsideration request.

If you would like to request an informal reconsideration on behalf of a member, please call or send it to MCNA’s Grievance and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at the beginning of this manual.

What is a Member Appeal?

A member has the right to file an appeal. An appeal is a request for review of an adverse benefit determination. Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Member Appeal Process

MCNA will notify the member and requesting provider of a decision about the request for a covered service through a Notice of Adverse Benefit Determination Letter. If the member, member’s representative, or provider disagrees with our decision, he or she can file an appeal. Appeals filed by a provider on behalf of a member or a member’s representative require the member’s written consent.

An appeal may be filed verbally or in writing within 60 calendar days of the date when the member receives the Notice of Action Letter. If there is a verbal request, a written notice must be received from the member or the member’s representative unless they request an expedited resolution. We will acknowledge receipt of a member appeal in writing within five (5) calendar days from the date we receive it. We will notify the member or the member’s representative of our decision in writing within 30 calendar days of receipt of the appeal request.

MCNA or the member can request a 14 calendar-day extension if there is a need for additional information and the delay is in the member’s best interest. If an extension is needed by MCNA, we will notify the member in writing of the reason within two (2) calendar days and notify them of their right to file a grievance if they disagree with the reason for the extension.
MCNA must continue the member’s benefits if all of the following occur:

- The member files the request for an appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);
- The appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The member timely files for continuation of benefits.

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 an appeal on or before the latter of (1) ten days following MCNA’s mailing of the Notice of Adverse Benefit Determination, or (2) the intended effective date of the proposed action.

The written appeal 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 agrees with MCNA’s denial, the member may have to pay for the services.

If you would like to file an appeal on behalf of a member, please call or send it to MCNA’s Grievance and Appeals Department. You must have the member’s written consent. You can find the appropriate phone numbers and mailing address in the Contact Information section located at the beginning of this manual. The member has the right to request a State Fair Hearing if they are not satisfied with the resolution provided by MCNA’s appeals process. To request a State Fair Hearing please contact the DHHS Hearing Office.

**Member Expedited Appeals**

An expedited review process is available for a member appeal that is for pre-service medical necessity. This 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. If the member’s appeal is about care that is medically necessary and needed soon, a dental professional who has the relevant clinical experience and who did not render the original denial decision will review the appeal on an expedited basis. You may file an expedited review request verbally (must be followed up in writing) or in writing and you must include the member’s written consent.

MCNA will make a decision about an expedited review request as expeditiously as the member’s health requires but no later than 72 hours after we receive it. 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 send a written notice indicating our denial of the request within two (2) calendar days. If a member disagrees with the decision to follow the standard timeframe, the member (or representative which can be a provider) may file a grievance.

**Member Request for a State Fair Hearing**

If a member is not happy with MCNA’s decision about an appeal, they have the right to ask for a State Fair Hearing within 120 calendar days of the date of MCNA’s Notice of Appeal Resolution. A provider may also request a State Fair Hearing on behalf of the member with the member’s written consent.
To request a State Fair Hearing on behalf of a member, you must first have the member complete and sign a one-page form, which you can request by calling the Provider Hotline or download from our website (www.mcnane.net). This form is located in this manual and will serve as the member’s authorization for you to request a State Fair Hearing for the member.

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf.

To request a State Fair Hearing, please contact the DHHS Hearing Office. Please send a copy of your Adverse Benefit Determination Notice and a completed copy of the Nebraska Department of Health and Human Services Division of Legal and Regulatory Services REQUEST FOR FAIR HEARING form to the address below.

Hearings Coordinator
Nebraska Department of Health & Human Services
Division of Legal and Regulatory Services
Legal Services – Hearing Section
PO Box 98914
Lincoln, Nebraska 68509-8914

Web: www.dhhs.ne.gov

The postmark showing the date the request was mailed will be the date of your State Fair Hearing request. After you ask for a State Fair Hearing, the DHHS will send you and the member a Notice by mail of the date, time and location of your State Fair Hearing.

If the member chooses to continue to receive the services that were denied before the hearing process is complete, the member will have to pay for the services if the final decision is that MCNA does not have to cover them.
## Nebraska Medicaid Covered Services

### Benefit Limits Key

- **A** = Age range limitations
- **TID** = Tooth ID

### Initial Dental Screening and Annual Recall Visits

The dental visit, which includes the initial dental screening (Comprehensive oral evaluation) and annual recall visit (Periodic oral evaluation), must include (but is not limited to) the following diagnostic and preventive services:

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required), and necessary diagnostic or vitality tests (considered part of the examination)
- Bitewing radiographic images
- Prophylaxis, including oral hygiene instructions
- Topical fluoride application (under 16 years of age)
- Sealants

This visit should also include either the initial preparation or the updating of the member’s dental record, as appropriate. It should also include the development of a current treatment plan and the completion of reporting forms. The initial comprehensive oral examination (D0150), or oral evaluation for a patient under three (3) years of age and counseling with primary caregiver (D0145), the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1206 or D1208) are limited to once per six (6) months.
Diagnostic Services
Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for participants.

Examinations

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>Limited to one (1) every six (6) months Not reimbursable if procedure code D0145 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six-month period for the same member. Special needs and disabled patients may receive the periodic evaluation as frequently as determined appropriate by the provider for members with special needs. Documentation of member’s special needs or disability is required. A member with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition.</td>
<td>$22.00</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>Limited to two (2) per 12-month period per member. Not payable for follow-up care.</td>
<td>$22.00</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver</td>
<td>A 0-35 months. This procedure may be reimbursed once in a six-month period, Covered more frequently if necessary for treatment. Include rationale for the need for more frequent evaluation with claim submission. Procedure code D0145 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six-month period for the same member. In addition, procedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to the same billing provider, facility, or group within the prior six-month period for the same member.</td>
<td>$37.00</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>Limited to one (1) every three (3) years by the same provider, facility, or group. Not payable in conjunction with emergency treatment visits, denture repairs, or similar appointments. Procedure code D0150 is not reimbursable if procedure codes D0120 or D0150 have been reimbursed to any billing provider, facility, or group within a six-month period for the same member.</td>
<td>$22.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency</td>
<td>Payment</td>
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<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation - problem focused, by report</td>
<td>Limited to one (1) every three (3) years by the same provider, facility, or group. Not payable for follow-up care or in conjunction denture repairs or similar appointments. Requires TID, quadrant or arch, and rationale.</td>
<td>$27.00</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation, limited problem focused</td>
<td>Limited to one (1) every 12 months per member by the same provider, facility, or group. Not payable for routine post-operative follow up.</td>
<td>$16.00</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation</td>
<td>Limited to one (1) every three (3) years by the same provider, facility, or group. Denied when submitted for the same DOS as D0120, D0140, D0150, or D0170 by the same provider, facility, or group.</td>
<td>$27.00</td>
</tr>
</tbody>
</table>
Radiographic Images

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if MCNA determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for participants.

MCNA utilizes the guidelines published by the U.S. Department of Health and Human Services Center for Devices and Radiological Health. Please consult the following benefit tables for benefit limitations.

In order for MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and/or oral/facial images that are not of good diagnostic quality will be denied.

All radiographs must be of good diagnostic quality, properly mounted, dated, and identified with the member's name, date of birth, indication of tooth ID, and left and right. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. The reason must be documented in the member’s record and be in accordance with the accepted standard of care.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images</td>
<td>MCNA will pay for a full mouth series x-ray (D0210) once every year by the same provider, facility, or group. An alternate benefit of a full mouth series x-ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and/or bitewing x-rays exceeding the reimbursable value of the full mouth series x-ray. Not allowed as an emergency service.</td>
<td>$45.00</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
<td>Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated.</td>
<td>$6.00</td>
</tr>
</tbody>
</table>
D0230  Intraoral - periapical each additional radiographic image

The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of intraoral x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210. When submitting a claim, the tooth number must be indicated.

D0240  Intraoral - occlusal film

Limited to one (1) service in a six-month period per member by the same provider, facility, or group. D0240 occlusal film is 2 1/4 x 3 1/4 size. Not payable if billed in conjunction with any 3000-series code, except D3220.

D0270  Bitewing - single radiographic image

Limited to one (1) service in a six-month period per member by the same provider, facility, or group. Maximum of four (4) per date of service.

D0272  Bitewings - two (2) radiographic images

Limited to one (1) service in a six-month period per member by the same provider, facility, or group.

D0273  Bitewings - three (3) radiographic images

Limited to one (1) service in a six-month period per member by the same provider, facility, or group.

D0274  Bitewings - four (4) radiographic images

Limited to one (1) service in a six-month period per member by the same provider, facility, or group.

D0330  Panoramic radiographic image

Limited to one (1) D0330 every three (3) years on a routine basis per member. Covered more frequently if necessary for treatment. Include rationale for the need for more frequent panorex with claim submission.

Not allowed on emergency claims unless third molars or a traumatic condition is involved.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>D0340</td>
<td>Cephalometric radiographic image</td>
<td>A 1-20. Covered if the client will qualify for Medicaid coverage of orthodontic treatment as outlined in the Orthodontic coverage criteria.</td>
<td>$62.00</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>A 1-20. Diagnostic casts will be covered only when MCNA requests them.</td>
<td>$46.00</td>
</tr>
</tbody>
</table>
Preventive Services
Preventive services include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers, and re-cementation of space maintainer.

<table>
<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>A 14 and older. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). One (1) D1110 or D1120 per six (6) months per patient. Includes scaling and polishing procedure to remove coronal plaque, calculus, and stains. Special needs and disabled patients may receive a prophylaxis as frequently as determined appropriate by the provider. Documentation of member's special needs or disability is required. A member with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition. If, at the initial visit, it is determined that the adult prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full mouth debridement) will not be reimbursed if it is billed within six (6) months subsequent to the date of service of the D1110 (Adult prophylaxis). If any 4000-series code is billed on the same DOS as a D1110, the 4000-series code will be denied. Can only have one (1) D1110, or D4910 in any six-month period.</td>
<td>$33.00</td>
</tr>
</tbody>
</table>
D1120  Prophylaxis - child  
A 0-13. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). One (1) D1110 or D1120 per six (6) months per patient. Includes scaling and polishing procedure to remove coronal plaque, calculus, and stains.

Special needs and disabled patients may receive a prophylaxis as frequently as determined appropriate by the provider. Documentation of member’s special needs or disability is required. A member with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition.

If, at the initial visit, it is determined that the child prophylaxis is the appropriate treatment and code D1120 (Child prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full mouth debridement) will not be reimbursed if it is billed within six (6) months subsequent to the date of service of the D1120 (Child prophylaxis). If any 4000-series code is billed on the same DOS as a D1120, the 4000-series code will be denied. Can only have one (1) D1120, or D4910 in any six-month period.

Preventive Services

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</tr>
</thead>
<tbody>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish</td>
<td>Includes oral health instructions. If any 4000-series code is billed on the same date of service as D1206, the 4000-series code will be denied. Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six-month period, per member. Covered more frequently if necessary, include rationale with claim submission.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride (prophylaxis not included)</td>
<td>Includes oral health instructions. If any 4000-series code is billed on the same DOS as D1208, the 4000-series code will be denied (excluding D4910). Covered more frequently if necessary, include rationale with claim submission.</td>
<td>$18.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
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</tr>
<tr>
<td>D1351</td>
<td>Dental sealant per tooth</td>
<td>A 0-20. Reimbursable once per tooth in a 24-month period. Sealants are not covered when placed over restorations. Teeth must be caries free. In addition to the occlusal surface, benefit includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars. All sealants must be performed on a single date of service, unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services. Requires indication of TID and surface.</td>
<td>$25.00</td>
</tr>
</tbody>
</table>

### Space Maintenance (Passive Appliances)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed unilateral</td>
<td>A 0-20. One (1) D1510, D1515, D1550, and D1555 per year per member. Requires indication of quadrant 10, 20, 30, or 40. The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer. Limited to fixed appliances, including unilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed space maintainers are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (or teeth). Removable maxillary anterior or active space maintainers are not provided.</td>
<td>$110.00</td>
</tr>
</tbody>
</table>
D1515  Space maintainer - fixed bilateral  
A 0-20. One (1) D1515, D1510, D1550, and D1555 per year per member. Requires indication of arch 01 or 02.  
The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer. Limited to fixed appliances, including bilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed space maintainers are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (or teeth). Removable maxillary anterior or active space maintainers are not provided.  
$150.00

D1550  Re-cementation space maintainer  
A 0-20. Limited to one (1) per year per member. Not covered within six (6) months of placement. The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer.  
$21.00

D1555  Removal of fixed space maintainer  
A 0-20. Limited to one (1) per year per member.  
$21.00
Restorative Services

Reimbursement for each covered service includes tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia. Operative dentistry fees include local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 12 months, unless there is recurrent decay or material failure.

All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two (2) or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration.

Restorative procedures should be billed on the date the final restoration is completed.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is disallowed.

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, facility, or group is responsible for the replacement of the original restoration within the first 24 months after initial placement. Duplicate surfaces are not payable on the same tooth in a 12-month period by same provider, office, or group. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 12-month period by same provider, office, or group. Additional restorative services on the same tooth within a 12-month period by the same provider, office, or group do not require prior authorization.

Additional restorative services on the same tooth and surface(s) within a 12-month period by a different provider, office, or group require x-rays.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161); resin-based composite, four (4) or more surfaces, posterior (D2394); or resin-based composite, four (4) or more surfaces or involving incisal angle, anterior (D2335).

Unless contraindicated, for encounter-based reimbursement situations all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there is a circumstance that requires restorative treatment outside of this parameter, the rationale and circumstance must be clearly documented on the claim submission and will be subject to clinical review.
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.

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.

**Permanent Tooth Restorations**

MCNA will reduce payment for a second or subsequent amalgam restoration (procedure codes D2140, D2150, D2160, and D2161); and/or a second or subsequent resin-based composite restoration (procedure codes D2330, D2331, D2332, and D2335) for the same member, same permanent tooth when billed within 12 months from the date of the original restoration by the same, provider, facility, or group. In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same permanent tooth will not exceed the maximum fee of the larger restoration.

For the same provider, facility, or group, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same member, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury, including codes D2140 and D2330, require x-rays and rationale to be included with claims submission in order to consider for payment. MCNA must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The provider is required to submit x-rays and rationale showing the presence of pulpal necrosis (root canal) or traumatic injury with subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee in order to have the claim reconsidered for payment. The pre-authorization number must be entered in the appropriate field on the claim for payment.

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.

**Primary Tooth Restorations**

For the same provider, facility, or group, MCNA will reduce the payment of a second or subsequent amalgam restoration (procedure codes D2140, D2150 and D2160); and/or a second or subsequent resin-based composite restoration (procedure codes D2330, D2331, D2332 and D2335) for the same patient, same primary tooth when the date of service of the second restoration is within 12 months from the date of the original restoration. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee allowed for the combined number of non-duplicated surfaces when performed within a 12-month period. In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration.

MCNA policy allows reimbursement for certain second or subsequent restorations on primary teeth at the full Medicaid reimbursement fee for the same member, same tooth when billed within 12 months from the date of the
original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth.

If two 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.

### Amalgam Restorations (Including Polishing)

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td>Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.</td>
<td>Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.</td>
<td></td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam - one (1) surface posterior - primary or permanent</td>
<td>A 0-21. This procedure is reimbursable for tooth numbers 1-32 and tooth letters A-T.</td>
<td>$50.00</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two (2) surfaces posterior - primary or permanent</td>
<td>A 0-21. This procedure is reimbursable for tooth numbers 1-32 and tooth letters A-T.</td>
<td>$59.00</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three (3) surfaces posterior - primary or permanent</td>
<td>A 0-21. This procedure is reimbursable for tooth numbers 1-32 and tooth letters A-T.</td>
<td>$71.00</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four (4) or more surfaces posterior - permanent</td>
<td>A 0-21. This procedure is reimbursable for tooth numbers 1-32 and tooth letters A-T.</td>
<td>$83.00</td>
</tr>
</tbody>
</table>

### Resin-Based Composite Restorations - Direct

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two (2) restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period, by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same member, same tooth when billed within 12 months from the date by same provider, facility, or group of the original restoration when the need for the restoration is due to pulpal necrosis (root canal), traumatic injury to the tooth, or in the event of failed restoration.

Providers must utilize the MCNA’s Provider Portal or call the Provider Hotline to determine whether the member has received a restoration within the 12 months from the date of original restoration. All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one (1) surface restoration. If the tooth is decayed extensively a crown should be considered.
The resin-based composite – four (4) or more surfaces or involving incisal angle (D2335 and D2394) – is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four (4) surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least one third (1/3) of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two (2) D2332 restorations would not adequately restore the tooth or in cases where two (2) D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

The resin-based composite – four (4) or more surfaces (D2394) – is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two (2) D2393 restorations would not adequately restore the tooth.

If the same tooth requires a second or subsequent restoration on the same surface(s) by a different provider, pre-authorization is required.

### Resin-Based Composite Restorations - Direct

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Resin restoration includes composites or glass ionomer.</td>
<td>Duplicate surfaces are not payable on the same tooth in restorations in resin-based restorations in a 12-month period by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.</td>
<td></td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one (1) surface, anterior</td>
<td>This procedure is reimbursable for TIDs 6-11 and 22-27. This procedure is reimbursable for tooth letters C, H, M, and R. Requires TID and surface with claim submission.</td>
<td>$58.00</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two (2) surfaces, anterior</td>
<td>This procedure is reimbursable for TIDs 6-11 and 22-27. This procedure is reimbursable for tooth letters C, H, M, and R. Requires TID and surface with claim submission.</td>
<td>$72.00</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three (3) surfaces, anterior</td>
<td>This procedure is reimbursable for TIDs 6-11 and 22-27. This procedure is reimbursable for tooth letters C, H, M, and R. Requires TID and surface with claim submission.</td>
<td>$83.00</td>
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<td>Code</td>
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<tr>
<td>D2335</td>
<td>Resin-based composite - four (4) or more surfaces or involving incisal angle</td>
<td>This procedure is reimbursable for TIDs 6-11 and 22-27. This procedure is reimbursable for tooth letters C, H, M, and R. Requires TID and surface with claim submission.</td>
<td>$97.00</td>
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<td>(anterior)</td>
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<tr>
<td>D2391</td>
<td>Resin-based composite – one (1) surface, posterior</td>
<td>This procedure is reimbursable for TIDs 1-5, 12-16, 17-21, and 28-32. This procedure is reimbursable for tooth letters A, B, I, J, K, L, S, and T. Requires TID and surface with claim submission.</td>
<td>$59.00</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two (2) surfaces, posterior</td>
<td>This procedure is reimbursable for TIDs 1-5, 12-16, 17-21, and 28-32. This procedure is reimbursable for tooth letters A, B, I, J, K, L, S, and T. Requires TID and surface with claim submission.</td>
<td>$75.00</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three (3) surfaces, posterior</td>
<td>This procedure is reimbursable for TIDs 1-5, 12-16, 17-21, and 28-32. This procedure is reimbursable for tooth letters A, B, I, J, K, L, S, and T. Requires TID and surface with claim submission.</td>
<td>$87.00</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four (4) or more surfaces, posterior</td>
<td>This procedure is reimbursable for TIDs 1-5, 12-16, 17-21, and 28-32. This procedure is reimbursable for tooth letters A, B, I, J, K, L, S, and T. Requires TID and surface with claim submission.</td>
<td>$92.00</td>
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</tbody>
</table>
Crowns

Crowns services require radiographic images that depict the pre- and post-treatment condition. The documentation supporting the need for crown services must be available for review by MCNA upon request. Providers may submit the following codes for pre-authorization. If a pre-authorization is approved, the provider must submit the post-operative x-ray with the claim submission for review prior to reimbursement.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>D2710</td>
<td>Crown - resin-based composite (indirect)</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$194.00</td>
</tr>
<tr>
<td>D2720</td>
<td>Crown - resin with high noble metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$340.00</td>
</tr>
<tr>
<td>D2721</td>
<td>Crown - resin with predominantly base metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$329.00</td>
</tr>
<tr>
<td>D2722</td>
<td>Crown - resin with noble metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$329.00</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$340.00</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$340.00</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$340.00</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused noble metal</td>
<td>One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale.</td>
<td>$340.00</td>
</tr>
</tbody>
</table>
### D2790 Crown full cast high noble
One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale. $340.00

### D2791 Crown - full cast predominantly base metal
One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale. $340.00

### D2792 Crown - full cast noble metal
One (1) per tooth per five-year period. TIDs 6-11, 22-27. Requires pre-authorization, x-rays, and rationale. $340.00

### Other Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2910</td>
<td>Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration</td>
<td>Not payable for the initial six (6) months after original restoration placement, then limited to one (1) per tooth per six (6) months. The billing provider, office, or group is responsible for recementation within the first six (6) months after placement of the crown. Requires TID 1-32, A-T.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D2915</td>
<td>Re-cement or re-bond indirectly fabricated or prefabricated post and core</td>
<td>Not payable for the initial six (6) months after original placement, then limited to one (1) per tooth every six (6) months. The billing provider, office, or group is responsible for recementation within the first six (6) months after placement of the crown. Requires TID 1-32, A-T.</td>
<td>$38.00</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
<td>Not payable for the initial six (6) months after crown placement, then limited to one (1) per tooth every six (6) months. Not allowed within six (6) months of D2710, D2721, D2750, D2751, D2752, D2790, D2791, D2792, D2930, D2931, D2932, or D2934. The billing provider, office, or group is responsible for recementation within the first six (6) months after placement of the crown. Requires TID 1-32, A-T.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>Requires TID A-T.</td>
<td>$116.00</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>Requires TID 1-32.</td>
<td>$116.00</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
<td>Requires TID 1-32, A-T.</td>
<td>$103.00</td>
</tr>
<tr>
<td>D2933</td>
<td>Prefabricated stainless steel crown with resin window</td>
<td>Requires TID 1-32, A-T.</td>
<td>$134.00</td>
</tr>
<tr>
<td>D2934</td>
<td>Prefabricated esthetic coated stainless steel crown primary tooth</td>
<td>Requires TID C-H, M-R.</td>
<td>$134.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
<td>Price</td>
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<tr>
<td>D2940</td>
<td>Protective restoration</td>
<td>Restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Cannot be used as interim restoration with any of the codes D3220 - D3430. Requires TID 1-32, A-T, and rationale.</td>
<td>$32.00</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins when required</td>
<td>Only for permanent teeth that have undergone endodontic treatment. A core build-up cannot be authorized in conjunction with a post and core, or for primary teeth. Requires TID 1-32.</td>
<td>$73.00</td>
</tr>
<tr>
<td>D2951</td>
<td>Pin retention per tooth, in addition to restoration</td>
<td>Requires TID 1-32, x-rays, and rationale.</td>
<td>$11.00</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>The post and core can be used on endodontically treated permanent teeth (1-32) when there is insufficient natural tooth structure to receive the final full coverage restoration. The post must extend at least one-third the length of the root and must closely approximate the canal walls. Will not be authorized in combination with a core build-up. Requires TID 1-32.</td>
<td>$94.00</td>
</tr>
<tr>
<td>D2980</td>
<td>Crown repair, by report</td>
<td>Requires TID 1-32, x-ray/photo and rationale.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D2999</td>
<td>Unspecified restorative procedure, by report</td>
<td>This procedure code is used for procedures that are not adequately described by another code. This code should not be used to bill for a non-covered service under Medicaid. Requires rationale.</td>
<td>Manually Priced</td>
</tr>
</tbody>
</table>

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.
Endodontic Therapy Services

Reimbursement for a complete root canal therapy includes pulpectomy and radiographs performed pre-, intra-, and post-operatively, local anesthesia, all appointments necessary to complete treatment, temporary fillings, and filling and obturation of canals.

Documentation supporting medical necessity must be kept in the member's record and include the following:

- 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
- the type of filling material used

Only endodontic treatment completed to an acceptable standard of care will be approved for reimbursement. In cases where a root canal filling does not meet MCNA’s general criteria treatment standards, MCNA will require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA’s Clinical Reviewer reviews the circumstances. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Root canal therapy is billable upon completion of the final fill. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

### Pulpotomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and the application of medicament</td>
<td>Not to be considered as first step of root canal therapy. Not allowed on same DOS as endodontic therapy. Requires TID A-T.</td>
<td>$70.00</td>
</tr>
<tr>
<td>D3230</td>
<td>Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)</td>
<td>Requires TID C-H, M-R.</td>
<td>$85.00</td>
</tr>
<tr>
<td>D3240</td>
<td>Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</td>
<td>Requires TID A, B, I-L, S, T.</td>
<td>$90.00</td>
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</tbody>
</table>
Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final</td>
<td>A 6 and older. This procedure is reimbursable for TID 6-11 and 22-27. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.</td>
<td>$243.00</td>
</tr>
<tr>
<td></td>
<td>final restoration)</td>
<td></td>
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</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, bicuspid tooth (excluding final</td>
<td>A 6 and older. This procedure is reimbursable for TID 4, 5, 12, 13, 20, 21, 28 and 29. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.</td>
<td>$251.00</td>
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<tr>
<td></td>
<td>final restoration)</td>
<td></td>
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</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar (excluding final</td>
<td>A 6 and older. This procedure is reimbursable for TID 2, 3, 14, 15, 18, 19, 30 and 31. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.</td>
<td>$334.00</td>
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<td>restoration)</td>
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</tbody>
</table>

Endodontic Retreatment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retreatment of previous root canals may be covered if</td>
<td>Retreatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with x-ray documentation and a detailed narrative.</td>
<td></td>
</tr>
<tr>
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<td>failure has been demonstrated with x-ray documentation and a detailed narrative.</td>
<td>Post-operative x-ray of completed root canal must be available for review upon request.</td>
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<td>Post-operative x-ray of completed root canal must be</td>
<td>Not a benefit for third molars or primary teeth.</td>
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<td>available for review upon request.</td>
<td>Procedure codes D3346, D3347, and D3348 require pre-authorization, x-rays, and rationale. When submitting claims, please include pre- and post-operative films. Procedure may include the removal of post, pin(s), old root canal filling material, and the procedures necessary to prepare the canal and place the canal filling. This includes complete root canal therapy. The reimbursement for this procedure includes all appointments necessary to complete the treatment and all intra-operative radiographic images.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not a benefit for third molars or primary teeth.</td>
<td>The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include pre- and post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the member's treatment records.</td>
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<tr>
<td></td>
<td>Procedure codes D3346, D3347, and D3348 require</td>
<td>Not reimbursable when submitted by the same provider, facility, or group that performed the original root canal therapy.</td>
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<td>pre-authorization, x-rays, and rationale. When</td>
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<td>submitting claims, please include pre- and</td>
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<td>post-operative films. Procedure may include the</td>
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<td>removal of post, pin(s), old root canal filling</td>
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<td>material, and the procedures necessary to prepare</td>
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<td>the canal and place the canal filling. This</td>
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<td>includes complete root canal therapy. The</td>
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<td>reimbursement for this procedure includes all</td>
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<td>appointments necessary to complete the treatment</td>
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<td>and all intra-operative radiographic images.</td>
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<td>The date of service on the payment request must</td>
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<td>reflect the final treatment date. Intra-operative</td>
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<td>radiograph(s), which must include pre- and</td>
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<td>post-operative radiograph, are included in the</td>
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<td>reimbursement for the retreatment of the root canal</td>
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<td>and must be maintained in the member's treatment</td>
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<td>records.</td>
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<td>Not reimbursable when submitted by the same</td>
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<td>provider, facility, or group that performed the</td>
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<td>original root canal therapy.</td>
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</tbody>
</table>
### Other Endodontic Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3351</td>
<td>Apexification/recalciﬁcation – initial visit</td>
<td>A 6 yrs and older. Requires pre-authorization, x-rays, and rationale. When submitting claims, please include preoperative and post-operative films.</td>
<td>$88.00</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>A 6 yrs and older. Requires pre-authorization, x-rays, and rationale. When submitting claims, please include preoperative and post-operative films. Covered on permanent anterior teeth.</td>
<td>$171.00</td>
</tr>
<tr>
<td>D3999</td>
<td>Unspeciﬁed endodontic procedure</td>
<td>Requires x-ray and rationale. Emergency treatment to relieve endodontic pain. Not to be submitted with any other deﬁnitive treatment codes on the same tooth and on the same date of service. Requires TID and narrative.</td>
<td>$40.00</td>
</tr>
</tbody>
</table>
Periodontal Services
Procedure codes D4341, D4342, and D4355 require pre-authorization, x-rays, and rationale with documentation of medical necessity.

Documentation is required when medical necessity is not evident on radiographs for D4355.

Any preventive dental procedure codes D1110, D1206, and D1208 submitted for the same DOS as any D4000 series periodontal procedure codes will be denied.

Periodontal services include periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedures. Local anesthesia is considered to be part of periodontal procedures.

### Surgical Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four (4) or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>Per tooth or per quadrant. This procedure requires pre-authorization, rationale, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. This procedure is reimbursable for oral cavity designators 10, 20, 30 and 40.</td>
<td>$94.00</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty, one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant</td>
<td>Per tooth or per quadrant. This procedure requires pre-authorization, rationale, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. This procedure is reimbursable for oral cavity designators 10, 20, 30 and 40.</td>
<td>$71.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
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</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing, four (4) or more teeth, per quadrant</td>
<td>A 0+. One (1) D4341 or D4342 per 12 months, per member, per quadrant (10, 20, 30, 40). A minimum of four (4) affected teeth in the quadrant. Periapical x-rays must show subgingival calculus and/or loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes or with D1120 or D1110. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10, 20, 30, 40).</td>
<td>$100.00</td>
</tr>
</tbody>
</table>
### D4342 Periodontal scaling and root planing - one (1) to three (3) teeth per quadrant

<table>
<thead>
<tr>
<th>Description</th>
<th>Requirement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 0+. One (1) D4341 or D4342 per 12 months, per patient per quadrant. One (1) to three (3) teeth per quadrant (10, 20, 30, 40). Periapical x-rays must show subgingival calculus and/or loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes or with D1110. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10, 20, 30, 40).</td>
<td>$52.00</td>
<td></td>
</tr>
</tbody>
</table>
### Other Periodontal Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4910</td>
<td>Periodontal maintenance procedures</td>
<td>Must have received Medicaid approved periodontal scaling and root planing. Not payable on the same DOS as D1110, D1120, or D4355. Requires pre-authorization with date of completion of Medicaid approved scaling and root planing, periodontal chart (history), and the frequency the provider is recommending for maintenance procedure.</td>
<td>$29.00</td>
</tr>
</tbody>
</table>
Removable Prosthodontics
Removable prosthodontic services include complete dentures, partial dentures, denture repairs, and denture relines. Documentation requirements are included to conform to state and federal regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

Minimum Standards for Complete and Partial Denture Prosthodontics
Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing, delivery, and adjustment. Although no minimum number of appointments is set, the following minimum standards must be adhered to:

The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member’s signature in the treatment record.

- The denture should be flasked and processed under heat and pressure in a commercial or dental office laboratory using ADA-certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the member’s dental record.
- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasping must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the member (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and esthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The delivery date of the denture and/or partial dentures is the billing date of service (DOS).

The chart record with date of delivery of the dentures, including the member’s signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.

 Extractions for asymptomatic teeth are not covered services unless removal constitutes the most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service. It is generally considered that eight (8) posterior teeth in occlusion constitutes adequate masticatory function. One (1) missing maxillary anterior tooth to three (3) missing mandibular anterior teeth may be considered a serious aesthetic problem and should be replaced with a flipper partial which is considered a permanent replacement. Third molars are not considered for replacement.

 A preformed denture with teeth already mounted forming a denture module is not a covered service and does not include interim dentures.

Billing for space maintainers fixed and removable prosthetics, is to be on the insertion or cementation date.

The dentist/denturist is responsible for all necessary adjustments for a period of six (6) months.
Complete Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following codes require pre-authorization. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.</td>
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<tr>
<td></td>
<td>Prosthetic appliances are covered once every five (5) years when:</td>
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<tr>
<td></td>
<td>• The member’s dental history does not show that previous prosthetic appliances have been unsatisfactory to the client.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The member does not have a history of lost prosthetic appliances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A repair, reline or rebase will not make the existing prosthetic functional.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This one time replacement is available once within each member’s lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5110</td>
<td>Dentures complete maxillary</td>
<td>Only one prosthesis per member, per arch is allowed in a five-year period. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization and pre-operative x-rays.</td>
<td>$663.00</td>
<td></td>
</tr>
<tr>
<td>D5120</td>
<td>Dentures complete mandible</td>
<td>Only one prosthesis per member, per arch is allowed in a five-year period. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-authorization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization and pre-operative x-rays.</td>
<td>$663.00</td>
<td></td>
</tr>
<tr>
<td>D5130</td>
<td>Dentures immediate complete maxillary</td>
<td>Only one (1) prosthesis per member, per arch is allowed in a five-year period. This procedure requires pre-authorization including a narrative of medical necessity and pre-operative x-rays.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If an immediate denture is requested the provider must state the reasons for the request in the “Remarks” section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within six (6) months of the denture delivery.</td>
<td>$538.00</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Description</td>
<td>Requirements</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>D5140</td>
<td>Dentures immediate complete mandible</td>
<td>Only one (1) prosthesis per member, per arch is allowed in a five-year period. This procedure requires pre-authorization including a narrative of medical necessity and pre-operative x-rays. If an immediate denture is requested the provider must state the reasons for the request in the “Remarks” section of the claim form. Immediate dentures are not considered temporary. The provider must inform the member that no reline is covered within six (6) months of the denture delivery. Requires pre-authorization and pre-operative x-rays.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$538.00</td>
<td></td>
</tr>
</tbody>
</table>
Partial Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>Requires pre-authorization including pre-operative x-rays.</td>
<td>$464.00</td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>Requires pre-authorization including pre-operative x-rays.</td>
<td>$464.00</td>
</tr>
<tr>
<td>D5213</td>
<td>Maxillary part denture - cast metal framework with resin denture bases</td>
<td>A 0-20. Requires pre-authorization including pre-operative x-rays. More than one (1) posterior tooth must be missing for partial placement. One (1) to</td>
<td>$472.00</td>
</tr>
</tbody>
</table>

The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:

- Missing three (3) or more maxillary anterior teeth, or
- Missing two (2) or more mandibular anterior teeth, or
- Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or
- Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or,
- Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch.

Replacement prosthetic appliances are covered when:

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

An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Nebraska Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained.

Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth.

Only permanent teeth are eligible for replacement by a partial denture.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries-free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of a partial denture.

Medicaid covers a one-time replacement within the 5 year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member’s lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.
(including any conventional clasps, rests and teeth) three (3) missing anterior teeth should be replaced with a flipper partial.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases</td>
<td>A 0-20. Requires pre-authorization including pre-operative x-rays. More than one (1) posterior tooth must be missing for partial placement. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial.</td>
<td>$472.00</td>
</tr>
</tbody>
</table>

**Adjustments to Complete and Partial Dentures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture maxillary</td>
<td>Not covered within six (6) months of initial placement. Requires rationale.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture mandibular</td>
<td>Not covered within six (6) months of initial placement. Requires rationale.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture maxillary</td>
<td>Not covered within six (6) months of initial placement. Requires rationale.</td>
<td>$20.00</td>
</tr>
<tr>
<td>D5422</td>
<td>Adjust partial denture mandibular</td>
<td>Not covered within six (6) months of initial placement. Requires rationale.</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

**Repairs to Complete and Partial Dentures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period. A repair is allowed in conjunction with a relining on the same member as long as the repair makes the denture fully serviceable. Reimbursable only for oral cavity designators 01 and 02. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$102.00</td>
</tr>
</tbody>
</table>
**Repairs to Partial Dentures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5610</td>
<td>Repair resin denture base</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative. A repair is allowed in conjunction with a reline on the same prosthesis as long as the repair makes the denture fully serviceable. Requires arch 01 or 02.</td>
<td>$94.00</td>
</tr>
<tr>
<td>D5620</td>
<td>Repair cast framework</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period. Requires arch 01 or 02.</td>
<td>$108.00</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period. Procedure Codes D5630 and D5660 are reimbursable for oral cavity designators 10, 20, 30, and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form. Requires rationale and TID.</td>
<td>$118.00</td>
</tr>
</tbody>
</table>

Cost of repairs cannot exceed replacement costs. Only two (2) repairs per prosthesis in a 12-month period is a covered benefit. A repair is allowed in conjunction with a reline on the same prosthesis as long as the repair makes the denture fully serviceable.
### Code Description

Replace broken teeth (each tooth)

Limited to only two (2) repairs per prosthesis in a 12-month period.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5640</td>
<td>Replace broken teeth (each tooth)</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period.</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. Requires tooth ID.

This procedure is reimbursable for TID 2-15 and 18-31.

Add tooth to existing partial denture

Limited to only two (2) repairs per prosthesis in a 12-month period.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period.</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. Requires TID.

This procedure is reimbursable for TID 2-15 and 18-31.

Add clasp to existing partial denture

Limited to only two (2) repairs per prosthesis in a 12-month period. Procedure Codes D5630 and D5660 are reimbursable for oral cavity designators 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
<td>Limited to only two (2) repairs per prosthesis in a 12-month period. Procedure Codes D5630 and D5660 are reimbursable for oral cavity designators 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.</td>
<td>$103.00</td>
</tr>
</tbody>
</table>

Requires rationale and TID.

### Denture Rebase Procedures

Allowed if the rebase makes the denture serviceable. Rebase of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years.

Not covered within six (6) months of initial placement of dentures. Allowed only if six (6) months has elapsed since the previous complete or partial denture was constructed or last relined. Covered once per prosthesis every 12 months. Chairside and lab rebases are covered, but only one (1) can be provided within the 12-month period.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
<td>One (1) per prosthesis per 365 days. Not covered within six (6) months of initial placement.</td>
<td>$194.00</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
<td>One (1) per prosthesis per 365 days. Not covered within six (6) months of initial placement.</td>
<td>$194.00</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
<td>One (1) per prosthesis per 365 days. Not covered within six (6) months of initial placement.</td>
<td>$194.00</td>
</tr>
</tbody>
</table>
## Denture Reline Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
<td>One (1) per prosthesis per 365 days. Not covered within six (6) months of initial placement.</td>
<td>$194.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Denture Reline Procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allowed if the reline makes the denture serviceable. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. The dentist is responsible for all necessary adjustments for a period of six (6) months. Not covered within six (6) months of initial placement of dentures. Reimbursement for complete and partial denture relines are allowed only if six (6) months has elapsed since the previous complete or partial denture was constructed or last relined. Covered once per prosthesis every 365 days. Chairside and lab relines are covered, but only one (1) can be provided within the 365-day period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$102.00</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$102.00</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$102.00</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$102.00</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$169.00</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$169.00</td>
</tr>
<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>One (1) reline per 365 days per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$169.00</td>
</tr>
<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>One (1) reline per 12 months per prosthesis. Not covered within six (6) months of initial placement.</td>
<td>$169.00</td>
</tr>
</tbody>
</table>
### Interim Complete and Flipper Partial Dentures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5810</td>
<td>Interim complete maxillary denture</td>
<td>Allowed once within 180 days of initial placement. After 180 days from initial placement, two (2) times per 12 months. Requires rationale.</td>
<td>$349.00</td>
</tr>
<tr>
<td>D5811</td>
<td>Interim complete mandibular denture</td>
<td>Allowed once within 180 days of initial placement. After 180 days from initial placement, two (2) times per 12 months. Requires rationale.</td>
<td>$349.00</td>
</tr>
<tr>
<td>D5820</td>
<td>Flipper partial maxillary denture</td>
<td>Limited to once every five (5) years. Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays.</td>
<td>$236.00</td>
</tr>
<tr>
<td>D5821</td>
<td>Flipper partial mandibular denture</td>
<td>Limited to once every five (5) years. Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays.</td>
<td>$236.00</td>
</tr>
</tbody>
</table>

### Tissue Conditioning

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
<td>Allowed once within 180 days of initial placement. After 180 days from initial placement, allowed two (2) times per 12 months. Requires rationale.</td>
<td>$43.00</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
<td>Allowed once within 180 days of initial placement. After 180 days from initial placement, allowed two (2) times per 12 months. Requires rationale.</td>
<td>$43.00</td>
</tr>
</tbody>
</table>
## Fixed Prosthodontics

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>Reimbursement for repairs of partial dentures (excluding interim partial dentures) are allowed only if more than six (6) months has elapsed since denture insertion and the repair makes the denture fully serviceable and eliminates the need for a new denture. If a partial denture is requested for the same arch within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. Must include the location and description of the fracture in the &quot;Remarks&quot; section of the claim form. Requires arch 01 or 02 and rationale.</td>
<td>$42.00</td>
</tr>
</tbody>
</table>
Oral and Maxillofacial Surgery Services
Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic teeth is not a covered benefit. Symptomatic conditions include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. Extractions for dentures are a covered benefit.

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction coronal remnants - deciduous tooth</td>
<td>TIDs A-T and AS-TS. All primary teeth within six (6) months of the ADA’s shed age chart will require an x-ray with claim submission.</td>
<td>$44.00</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>TIDs 1-32 and A-T, as well as 51-82 and AS-TS as needed. All primary teeth within six (6) months of the ADA’s shed age chart will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and rationale. All permanent teeth require an x-ray with claim submission.</td>
<td>$66.00</td>
</tr>
</tbody>
</table>

http://www.ada.org/~/media/ADA/Publications/Files/patient_56.ashx
## Surgical Extractions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member’s treatment record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated.</td>
<td>$93.00</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.</td>
<td>$122.00</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
<td>Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.</td>
<td>$167.00</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
<td>Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.</td>
<td>$202.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis. Which means that providers must submit post-operative x-rays and detailed rationale on the claim submission outlining the unusual surgical complications.</td>
<td>$212.00</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
<td>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.</td>
<td>$88.00</td>
</tr>
</tbody>
</table>

## Other Surgical Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7270</td>
<td>Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth</td>
<td>This procedure is not reimbursable for periodontal splinting. Includes splinting and/or stabilization. Requires TID, pre- and post-operative x-rays, and rationale.</td>
<td>$150.00</td>
</tr>
<tr>
<td>D7280</td>
<td>Exposure of an un-erupted tooth</td>
<td>An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted. This procedure no longer includes the placement of orthodontic attachment. Requires TID 1-32, x-rays, and rationale.</td>
<td>$140.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>D7282</td>
<td>Mobilization of erupted or malpositioned tooth to aid eruption</td>
<td>Permanent TID 1-32 only. May not be paid for the same date of service as D7280. Requires x-rays and rationale.</td>
<td>$114.00</td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>Requires pre-authorization, x-rays, and rationale. Placement of an orthodontic bracket, band, or other device on an unerupted tooth, after its exposure, to aid its eruption. Report the surgical exposure separately using D7280. Limited to covered orthodontics.</td>
<td>$135.00</td>
</tr>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue - hard (bone, tooth)</td>
<td>Requires pre-authorization, color photos and rationale. This procedure is for the removal of specimen only. It involves the biopsy of osseous lesions and is not to be used for apicoectomy/periradicular surgery.</td>
<td>$94.00</td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue - soft</td>
<td>Requires pre-authorization, x-rays, and rationale. For the surgical removal of an architecturally intact specimen only and is not used at the same time as codes for apicoectomy/periradicular curettage. A copy of the pathology report must be submitted with the claim.</td>
<td>$85.00</td>
</tr>
</tbody>
</table>

**Alveoloplasty**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions - four (4) or more teeth or tooth spaces per quadrant</td>
<td>Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the &quot;Remarks&quot; section of the claim form. Requires x-rays, rationale and quadrant 10, 20, 30 or 40.</td>
<td>$88.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>--------</td>
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<td>---------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions – one (1) to three (3) teeth or tooth spaces, per quadrant</td>
<td>Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the “Remarks” section of the claim form. Requires x-rays, rationale and quadrant 10, 20, 30 or 40.</td>
<td>$71.00</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions - four (4) or more teeth or tooth spaces per quadrant</td>
<td>Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the “Remarks” section of the claim form. Requires x-rays, rationale and quadrant 10, 20, 30 or 40.</td>
<td>$94.00</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoloplasty not in conjunction with extractions - one (1) to three (3) teeth or tooth spaces, per quadrant</td>
<td>Covered per quadrant as a separate procedure when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the “Remarks” section of the claim form. Requires x-rays, rationale and quadrant 10, 20, 30 or 40.</td>
<td>$76.00</td>
</tr>
</tbody>
</table>

**Excisions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following codes require pre-authorization and rationale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7410</td>
<td>Excision of benign lesion up to 1.25 cm (1-3-03)</td>
<td>Requires color photos.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7411</td>
<td>Excision of benign lesion greater than 1.25 cm</td>
<td>Requires color photos and rationale.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7412</td>
<td>Excision of benign lesion, complicated</td>
<td>Requires color photos. Requires extensive undermining with advancement or rotational flap closure.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
<td>Priced</td>
</tr>
<tr>
<td>-------</td>
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</tr>
<tr>
<td>D7413</td>
<td>Excision of malignant lesion up to 1.25 cm</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. Requires color photos and rationale.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7414</td>
<td>Excision of malignant lesion greater than 1.25 cm</td>
<td>Requires extensive undermining with advancement or rotational flap closure. Requires color photos and rationale.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7415</td>
<td>Excision of malignant lesion, complicated</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7440</td>
<td>Excision of malignant tumor - lesion diameter up to 1.25 cm</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7441</td>
<td>Excision of malignant tumor - lesion diameter greater than 1.25 cm</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal of benign or odontogenic cyst or tumor-lesion diameter up to 1.25 cm (1-3-03)</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7460</td>
<td>Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm (1-3-03)</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7461</td>
<td>Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7465</td>
<td>Destruction of lesion(s) by physical or chemical method, by report</td>
<td>The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. Requires pathology report.</td>
<td>Manually Priced</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis (maxilla or mandible)</td>
<td>Excision of osseous tuberosities, dentoalveolar structure.</td>
<td>$110.00</td>
</tr>
</tbody>
</table>
## Surgical Incision

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
<td>Not payable on same date of service as D7111, D7140, D7210, D7220, D7230, D7240, D7241, or D7250 for the same tooth per day, per member. Requires TIDs 1-32, 51-82, A-T, AS-TS. Not payable for same tooth on the same date of service as the extraction.</td>
<td>$42.00</td>
</tr>
</tbody>
</table>

## Orthotic Device

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7880</td>
<td>Occlusal orthotic device</td>
<td>A 0-20. For treatment of bruxism or for minor occlusal problems. Reimbursement includes any necessary adjustments. Presently includes splints provided for treatment of temporomandibular joint (TMJ) dysfunction. Requires rationale and type of appliance made. Oral cavity designator 01, 02, 10, 20, 30 and 40.</td>
<td>Manually Priced</td>
</tr>
</tbody>
</table>

## Frenulectomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>D7960</td>
<td>Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure</td>
<td>Requires color photos, and rationale. The frenum may be excised when the tongue has limited mobility, for large diastemas between teeth, or when frenum interferes with a prosthetic appliance, or when it is the etiology of periodontal tissue disease. The specific dental reason is required for authorization. If the specific reason is not dental, e.g., if a speech impediment is the reason for the request, then a written statement from a speech pathologist or physician must be submitted. Requires color photos and rationale. Oral cavity designator 01, 02, 10, 20, 30 and 40.</td>
<td>$92.00</td>
</tr>
</tbody>
</table>
Orthodontic Services
Orthodontic services are available for members age 20 or younger when treatment is authorized, have a handicapping malocclusion, which includes one or more of the following five documented conditions:

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

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

The Handicapping Labiolingual Deviation (HLD) form (See Section: Form) should be used to pre-screen orthodontic cases, scoring a minimum of twenty-eight (28) points, or have another medically necessary documented need for orthodontia such as cleft palate or craniofacial anomalies. Members whose molars and bicuspids are in good occlusion typically will not qualify. Every orthodontic prior authorization meeting eligibility requirements is clinically reviewed by a licensed Orthodontist in order to properly evaluate criteria for services.

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 via email to casemanagement@mcna.net. Please include all documentation including the appropriate ICD-10 diagnostic codes on your completed ADA claim form (2012 or newer).

Pre-authorization requests must be submitted and approved prior to providing orthodontia services. The following documentation must be submitted with the request for pre-authorization. MCNA will not return x-rays, study models, or other related documents. Please submit duplicate sets of these documents when you include them with your preauthorization request and do not submit originals.

- ADA claim form (2012 or newer) outlining treatment to be completed including treatment plan, a narrative description of the diagnosis and prognosis, as well as the total treatment time
- Handicapping Labiolingual Deviation (HLD) Index form
- Full mouth radiographs or Panoramic x-ray
- Diagnostic casts, color photographs (standard eight (8) photo collage template preferred) or OrthoCad equivalent
- Cephalometric x-ray
- On surgical cases include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

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.

A provider should not begin orthodontia treatment until the pre-authorization request has been approved. In order for orthodontic treatment to be initiated the child must have received a prophylaxis (D1110 or D1120) within six (6) months prior to the placement of appliances. Additionally, all 1st and 2nd molars eligible for sealants must be
sealed prior to banding. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for the orthodontic treatment. All services must be pre-authorized and should more treatment be required for a particular case, the request for additional services/extended treatment also requires pre-authorization.

The billing date for orthodontic services is the day that bands, brackets, or appliances are placed in the Member’s mouth. The member must be eligible on this date of service. The member must sign a non-covered treatment form for any services they agree to pay for under a private pay agreement.

Payment for interceptive and comprehensive orthodontic treatment is a one-time fee that includes all appliances, retainers, and follow-up visits. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Broken and loose appliances, broken and loose brackets/bands are reimbursed separately. Members may not be charged for missed appointments. There is no additional reimbursement allowed for the replacement of removable orthodontics.

If the member transfers to another dentist, the dentist who obtained the original authorization and initiated orthodontic treatment, shall refund to MCNA the portion of the amount paid by MCNA that applies to the treatment not completed. The transfer request must be submitted and reviewed by MCNA to determine the amount to be refunded. Transfers are only allowed under hardship circumstances such as long travel distances.

If any prior authorized orthodontic treatment is not completed, the dentist who obtained the original authorization and initiated the treatment shall refund to MCNA the portion of the amount paid by MCNA that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by MCNA to determine the amount to be refunded.
## Orthodontic Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<th>Fee</th>
</tr>
</thead>
</table>
| D8060 | Interceptive orthodontic treatment of the transitional dentition            | A 0-20. Complete set of diagnostic color photos (or OrthoCad equivalent), panoramic x-ray, narrative, and treatment plan. Cephalometric or periapical radiographs are optional. Requires pre-authorization, narrative of medical necessity, HLD form, and FMX or panoramic, cephalometric x-ray and casts/OrthoCad/color photos. Must be submitted with a Malocclusion Index score of 28 points or higher. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. **Procedures covered under code D8060:**  
  - Chrome steel wire clasps-each .036 or minimum .030 $21.00  
  - Inclined plane (hawley) appliance, bite plane, with clasps $156.00  
  - Cross-bite appliance, anterior, acrylic $129.00  
  - Cross-bite appliance, posterior, two bands plus attachments $129.00  
  - Attachment springs for any orthodontic or pedodontic appliance – each $21.00  
  - Adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month) $17.00  
  - Space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan $110.00  
  - Space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan $190.00 |
### Comprehensive orthodontic treatment of the adult dentition

A 0-20. Complete set of diagnostic color photos (or OrthoCad equivalent), panoramic x-ray, narrative, and treatment plan. Cephalometric or periapical radiographs are optional.

Requires pre-authorization, narrative of medical necessity, HLD form, and FMX or panoramic, cephalometric x-ray and casts/OrthoCad/color photos. Must be submitted with a Malocclusion Index score of 28 points or higher.

When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

### Procedures covered under code D8090:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constructing and placing fixed maxillary appliance, active treatment</td>
<td>$335.00</td>
</tr>
<tr>
<td>Constructing and placing fixed mandibular appliance, active treatment</td>
<td>$335.00</td>
</tr>
<tr>
<td>Each one month period of active treatment – maxillary arch</td>
<td>$35.00</td>
</tr>
<tr>
<td>Each one month period of active treatment – maxillary arch, unusual service (surgical correction case)</td>
<td>$51.00</td>
</tr>
<tr>
<td>Each one month period of active treatment – mandibular arch</td>
<td>$35.00</td>
</tr>
<tr>
<td>Each one month period of active treatment – mandibular arch, unusual service (surgical correction case)</td>
<td>$51.00</td>
</tr>
<tr>
<td>Retainer or retention appliance</td>
<td>$95.00</td>
</tr>
<tr>
<td>Each one-month period of retention appliance</td>
<td>$19.00</td>
</tr>
<tr>
<td>Treatment, maxillary arch</td>
<td>$19.00</td>
</tr>
<tr>
<td>Each one-month period of retention appliance treatment, mandibular arch</td>
<td>$19.00</td>
</tr>
<tr>
<td>Rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance</td>
<td>$180.00</td>
</tr>
<tr>
<td>Herbst appliance</td>
<td>$270.00</td>
</tr>
<tr>
<td>Protraction facemask</td>
<td>$162.00</td>
</tr>
<tr>
<td>Slow expansion appliance</td>
<td>$177.00</td>
</tr>
<tr>
<td>Headgear</td>
<td>$162.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D8210</td>
<td>Removable appliance therapy (thumb-sucking &amp; tongue thrust)</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed appliance therapy (thumb-sucking and tongue thrust)</td>
</tr>
<tr>
<td>D8691</td>
<td>Repair of orthodontic appliance</td>
</tr>
<tr>
<td>D8692</td>
<td>Replacement of lost or broken retainer</td>
</tr>
</tbody>
</table>

- Inclined plane (hawley) appliance, bite plane, with clasps $156.00
- Orthodontic appliance not listed Manually Priced
- Orthodontic procedure not listed Manually Priced
- Space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan $110.00
- Space maintainer – fixed – bilateral, part of comprehensive $190.00

D8210

Removable appliance therapy (thumb-sucking & tongue thrust)
A 0-20. Reimbursement includes adjustments.

D8220

Fixed appliance therapy (thumb-sucking and tongue thrust)
A 0-20. Reimbursement includes adjustments.

D8691

Repair of orthodontic appliance
A 0-20. Requires rationale describing repair.

D8692

Replacement of lost or broken retainer
A 0-20. Covered if patient is compliant with wearing the appliance.

D8999

Unspecified orthodontic procedure, by report
Requires pre-authorization and narrative of medical necessity.
Adjunctive General Services
Reimbursement includes local anesthesia.

### Unclassified Treatment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain-minor procedures</td>
<td>Limited to one (1) per date of service per location per patient. Examples of palliative treatment are treatment of soft tissue infection or smoothing a fractured tooth. Palliative treatment on a specific tooth is not covered if definitive treatment (e.g., restorative or endodontic treatment) was provided on the same tooth for the same date of service. Not allowed with any services other than radiographs. 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 on the claim form. May not be used as a follow up to a prior treatment. Requires rationale and TID or area.</td>
<td>$23.00</td>
</tr>
</tbody>
</table>

### Anesthesia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia</td>
<td>Not allowed with D9230, D9243, or D9248. If a claim for payment is received for sedation and there are no restorative, endodontic and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service, the payment for sedation will be denied. Requires narrative of medical necessity, monitored vital signs, anesthesia time log, including start and stop times, medication administered, and dose.</td>
<td>$81.00</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Limitations</td>
<td>Cost</td>
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<tr>
<td>D9230</td>
<td>Inhalation of analgesia, anxiolysis - nitrous oxide</td>
<td>Not allowed with D9223, D9243, or D9248.</td>
<td>$28.00</td>
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<td>May not be submitted more than once per member per day. If a claim for</td>
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<td>payment is received for nitrous oxide and there is no restorative,</td>
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<td>endodontic and/or surgical service listed on the claim form or no</td>
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<td>Medicaid claims history record indicating that a restorative and/or</td>
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<td>surgical service was previously reimbursed for the same date of service as</td>
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<td></td>
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<td>the nitrous oxide, the payment for nitrous oxide will be denied.</td>
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<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia -</td>
<td>Not allowed with D9223, D9230, or D9248.</td>
<td>$51.00</td>
</tr>
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<td></td>
<td>15 minute increment</td>
<td>If a claim for payment is received for sedation and there is no</td>
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<td>restorative and/or surgical service listed on the claim form or no</td>
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<td>Medicaid claims history record indicating that a restorative,</td>
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<td>endodontic and/or surgical service was previously reimbursed for the same</td>
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<td>date of service, the payment for sedation will be denied.</td>
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<td></td>
<td>Requires narrative of medical necessity, monitored vital signs and</td>
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<td></td>
<td>anesthesia time log, including start and stop times, medication</td>
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<td></td>
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<td>administered, and dose.</td>
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<tr>
<td>D9248</td>
<td>Non-intravenous (moderate) conscious sedation</td>
<td>Not allowed with D9223, D9230, or D9243.</td>
<td>$40.00</td>
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<td>Two (2) per 12 months, per member unless additional services are</td>
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<td>prior authorized above the benefit limitation.</td>
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<tr>
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<td></td>
<td>Requires narrative of medical necessity, monitored vital signs and</td>
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<td>anesthesia time log, including start and stop times, medication</td>
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<td>administered, and dose.</td>
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<td>The Conscious Sedation Form (available to download in the Forms section</td>
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<td>located at the end of this manual), must be completed by the member and</td>
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<td>sent with the claim submission. If the restorative/surgical phase of the</td>
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<td>treatment is aborted after the initiation of conscious sedation, the</td>
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<td>provider must document the circumstances in the patient’s treatment</td>
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<td>record.</td>
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<td>Providers must administer drugs of a suitable type, strength, and mode of</td>
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<td>administration that necessitates constant monitoring by the provider or</td>
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<td>staff from administration through the time of discharge.</td>
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<td></td>
<td>Administration of oral pre-medication is not a covered service.</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
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<tr>
<td>D9410</td>
<td>House/extended care office call</td>
<td>One (1) per day per location per provider/group. Requires rationale and address of facility or home where treatment took place.</td>
<td>$35.00</td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital or ambulatory surgical center call</td>
<td>One (1) per day per location per provider/group. Requires rationale and address of facility or home where treatment took place.</td>
<td>$80.00</td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit after regular hours</td>
<td>May be billed in addition to an exam and treatment provided, when treatment is provided after normal office hours. Requires rationale including time of patient arrival.</td>
<td>$45.00</td>
</tr>
<tr>
<td>D9940</td>
<td>Occlusal guards</td>
<td>Covered once per year to minimize the effects of bruxism and other occlusal factors. Occlusal guards are removable appliances. Athletic guards are not covered. Requires rationale describing medical necessity that supports evidence of significant loss of tooth enamel, tooth chipping or headaches and/or jaw pain.</td>
<td>$164.00</td>
</tr>
</tbody>
</table>
Department of Health and Human Services Non-Covered Services

Non-covered services include, but are not limited to, the following:

- Plaque control
- Treatment of incipient or non-caries lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- Administration of in-office pre-medication
- Prescription medications
- Services for cosmetic reasons
- Services that are more costly than another, equally effective available service
- Services not within the coverage criteria
- Services determined to be not medically necessary
- Experimental, investigational or non-FDA approved
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 including but not limited to treatment plans, narratives, radiographs and periodontal charting.

These criteria are approved and annually reviewed by MCNA’s Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the section of this manual titled, “Covered Services,” for a list of all codes covered under the program and additional limitations and requirements for coverage.

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 general dentist or pediatric specialist. The member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the general dentist or pediatric specialist.

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 extractions (requires approval of the orthodontic case)
- Exfoliation of a deciduous tooth not anticipated within six (6) months
- No extractions of third molars if roots are not substantially formed
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent
- Prior placement of restorations will be deducted from the reimbursement of the extraction if performed within a six-month period.

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical, or panorex
- Narrative demonstrating medical necessity

Procedure Codes

- D7210, D7220, surgical removal of erupted tooth, radiographs, and narrative.
- D7230, D7240, D7241, surgical removal of impacted teeth, radiographs, and narrative.
- D7250, removal of residual roots, radiographs, and narrative.
• D7280, exposure of unerupted tooth, radiographs, and narrative.
• D7510, 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 - extraction, erupted tooth or exposed root (Elevation and/or forceps removal)
  Includes removal of tooth structure, minor smoothing of socket of 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 tooth - 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.
• D7241 - removal of impacted tooth-complete bony, with unusual surgical complications
  Most or all of crown covered by bone. Usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, or aberrant tooth position.
• D7250 - removal of residual tooth roots (cutting procedure)
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Guidelines for Endodontics

Criteria
• The tooth is infected and/or abscessed.
• There has been trauma or a 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 (6) months (for pulpotomy or pulpectomy only)
• The tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3.
• Root canal therapy not completed 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
• 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

- Apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; 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

- Provider must submit the appropriate radiographs that demonstrate both crown and apex with authorization request: periapical or panorex. Films must include entire structure of the tooth including the apex.
- 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
- D3240, pulpal therapy on primary teeth (resorbable filling)

Guidelines for Non-Intravenous and IV Sedation

Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the Nebraska State Board of Dentistry for the level of sedation or anesthesia provided.
- MCNA must have on file a copy of the certification prior to rendering sedation services.

Criteria

Acceptable conditions include, but are not limited to, one or more of the following:

- There is documented local anesthesia toxicity.
- Patient displays severe cognitive impairment or developmental disability.
- Patient displays severe physical disability.
- Patient displays uncontrolled behavior management problem.
- Treatment plan requires extensive or complicated surgical procedures.
- Local anesthesia fails.
- There are documented medical complications.
- Patient presents with acute infection(s).
Documentation Required for Claims Processing

- Certain procedures require submission of narrative stating medical necessity.

Procedure Codes

- D9223, deep sedation/general anesthesia - each 15 minutes
- D9243, intravenous conscious sedation/analgesia - each 15 minutes
- D9248, non-intravenous (moderate) conscious sedation (two [2] per 12 months, per patient unless additional services are prior authorized above the benefit limitation)

Criteria for Medical Immobilization Including Papoose Boards

The provider must obtain a written informed consent from the legal guardian. Written informed consent must be documented in the patient’s treatment record prior to medical immobilization.

The patient’s treatment 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

- Providers must submit the appropriate radiographs with pre-authorization request: periapical or panorex.
- Post-operative endodontic x-ray required in order to approve prefabricated post and core.

Procedure Codes

- D2950, core build up
- 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.

Crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- Crowns are being planned to alter vertical dimension

Guidelines for Crowns following Root Canal Therapy

Criteria

- The 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 provider's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material should 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

- Providers must submit appropriate radiographs with authorization request: periapical or panorex. Films must include entire structure of the tooth including the apex.
- The submission of radiographs clearly showing the adjacent and opposing teeth are required to be submitted with the claim for review of payment.
- If RCT was done by dentist who submitted the claims request, the claims request should include a dated radiograph of RCT.

Procedure Codes

- D2930, prefabricated stainless steel crown primary tooth
- D2931, prefabricated stainless steel crown permanent tooth
- D2932, prefabricated resin crown
- D2934, prefabricated esthetic coated stainless steel crown primary
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 pharmacologically 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 code (4210 and 4355)

Procedure Codes
- D4210, gingivectomy and/or gingivoplasty
- D4341, periodontal scaling and root planning requiring radiographs and perio chart

Guidelines for Orthodontics
Please see the “Orthodontic Services” section.

Guidelines for X-Rays

Criteria
- Must be of diagnostic quality
- Must be marked right and left and indicate tooth ID
- Must have the patient’s name
- Must have 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 posterior tooth will be replaced not including third molars.
• A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain provider.

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.

Please see the “Removable Prosthodontics” section of each plan for benefit limitations and guidelines.

Documentation Required for Authorization
• Submit appropriate radiographs with authorization request: bitewings, periapical or panorex. Diagnostic colored photographs are acceptable in lieu of radiographs for denturists.

Procedure Codes
Complete Dentures
• D5110, complete denture maxillary (upper)
• D5120, complete denture mandibular (lower)
• D5130, dentures immediate maxillary
• D5140, dentures immediate mandible

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

Repairs to Complete Dentures
• D5510, repair broken complete denture base
• D5520, replace missing or broken teeth - complete denture (each tooth)

Repairs to Partial Dentures
• D5610, repair resin denture base
• 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 Reline Procedures
• D5730, chairside reline complete maxillary denture
• D5731, chairside reline maxillary partial denture
• D5740, chairside reline complete mandibular denture
• D5741, chairside reline mandibular partial denture
• D5750, reline complete maxillary denture (laboratory)
• D5751, reline complete mandibular (laboratory)
- D5760, reline maxillary partial denture (laboratory)
- D5761, reline mandibular partial denture (laboratory)
Frequently Asked Questions

Program Overview and Contracting with MCNA

How do I sign up with MCNA Dental?
To apply online or to download MCNA’s credentialing application, please visit our website at www.mcna.ne.net. If you have questions and would like to speak with an MCNA Dental representative, please call our Provider Hotline at 1-844-353-6262.

What is the average time to complete the MCNA Dental credentialing process?
Once MCNA Dental receives a completed application, the average turnaround time is 30 days.

Do I need to be credentialed by MCNA Dental if I am already a participating Medicaid provider?
Yes, all dental providers must complete MCNA Dental's credentialing process in order to participate in our plan.

Is there a number I can call with questions about joining MCNA Dental's network or completing the credentialing application?
Yes, we welcome your call! Our Provider Hotline phone number is 1-844-353-6262.

Pre-Authorization Requests, Claim Submissions, and Covered Services

How are requests for pre-authorization accepted?
MCNA Dental has an online Provider Portal where providers can submit requests for pre-authorization. Any supplemental materials such as narratives, charting, or x-rays can be attached and submitted via our Provider Portal. Pre-authorization requests may also be submitted electronically through a clearinghouse using MCNA's payor ID, 65030. A third option for submission is by mail to MCNA at the following address:

MCNA Dental
Attn: Utilization Management
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

What is the turnaround time for processing pre-authorization requests?
MCNA Dental generally processes pre-authorization requests within 48 – 72 hours. Your office can check the status of a pre-authorization request using your Provider Portal account.

Does MCNA Dental accept electronic claims?
MCNA strongly encourages you to consider electronic claims submission if you do not already take advantage of this convenience! You may submit your claims electronically using One (1) of these methods:

- Online using MCNA's Provider Portal – enter and submit your claims directly to MCNA using your Portal account and avoid the need to use a third-party clearinghouse.
- Electronically using a clearinghouse – use MCNA's payor ID 65030.
If you choose not to take advantage of convenient electronic claims submission, you may mail your claims to MCNA at this address:

**MCNA Dental**

Attn: Claims  
200 West Cypress Creek Road, Suite 500  
Fort Lauderdale, FL 33309

What is MCNA Dental's payor ID for electronic submission of claims and pre-authorization requests using a third-party clearinghouse?  
MCNA's payor ID is **65030**.

My office uses the services of a third-party clearinghouse. Do I have to complete any forms in order to submit claims or pre-authorization requests electronically using MCNA's payor ID?  
If you are already submitting claims or pre-authorization requests electronically using a clearinghouse, you do not need to complete any additional forms with your clearinghouse. You may, however, need to take steps to add MCNA Dental as a new payor in your practice management system.

Does MCNA Dental accept NEA FastAttach?  
Yes, MCNA participates as an NEA FastAttach payor. With FastAttach, you are able to transmit along with your claim or pre-authorization request any documentation, like x-rays, perio charts, and narrative, which may be required by MCNA for adjudication. Once you have transmitted your documentation to NEA FastAttach, you can provide your NEA tracking number to us through your claim or pre-authorization request submissions when you submit electronically using MCNA's Provider Portal or a third-party clearinghouse.

What are the periodicity limits for preventive services?  
Preventive services follow the American Association of Pediatric Dentistry (AAPD) periodicity schedule. All periodicity limits are outlined in MCNA Dental's Provider Manual.

Does MCNA Dental cover pharmacy benefits?  
No, pharmacy benefit coverage remains with the member’s medical benefit either through fee-for-service Medicaid or the member’s health plan. The majority of Nebraska Medicaid beneficiaries have their benefits through Heritage Health, which integrates all of their medical, pharmacy, and behavioral health coverage. Please see [http://dhhs.ne.gov/medicaid/Pages/med_medcontracts.aspx](http://dhhs.ne.gov/medicaid/Pages/med_medcontracts.aspx) for more information about Heritage Health.

How frequently do providers receive Remittance Advices (RAs) from MCNA Dental?  
MCNA Dental runs regularly occurring RA cycles each week. Please contact our Provider Hotline at 1-844-353-6262 for specific information about the frequency of this cycle for your office. In order to enjoy the most convenient claims payment experience possible, MCNA encourages your office to sign up for payments using electronic funds transfer (EFT). EFT payments are made with each RA cycle. To take advantage of this convenience, go to our website and download an EFT form.
Provider Portal and Provider Resources

What is MCNA's Provider Portal and what features are available?
MCNA Dental's Provider Portal is a great free, all-in-one tool that allows you to carry out a variety of administrative functions for your office. Using your Provider Portal account you can:

- Instantly submit claims, referrals (if needed), and pre-authorization requests.
- Track the progress of all of your submissions online.
- Instantly verify member eligibility.
- Download important forms and resources like your Provider Manual.
- View a history of your activity with MCNA.
- Stay up to date with important program reminders and updates.
- Sign up for our monthly provider newsletter delivered to your email inbox.
- Access many more convenient tools!

We encourage all of our valued network providers to take advantage of our Provider Portal.

Is there a special application to access MCNA's Provider Portal?
No, you do not need to complete a special application to access the Provider Portal. Once you have successfully completed MCNA’s credentialing process and are an active provider in our network, you automatically qualify for a free account on our Provider Portal and all of the benefits it entails! All you need to do is visit MCNA’s Provider Portal at http://portal.mcna.net and complete the simple process of validating your information, then you are ready to go!

Is there a user guide I can reference for help navigating my Provider Portal account?
Yes, we have created a helpful Provider Portal User Guide to help you learn about the functions available to you on your Provider Portal account. To supplement the information in the User Guide and to demonstrate the benefits available to you with your Portal account, MCNA Dental has also created a series of Provider Portal tutorial videos. To access MCNA’s Provider Portal tutorial videos please visit our YouTube channel at https://www.youtube.com/playlist?list=PL3040EEECC110F60B.

I see that MCNA Dental provides training webinars and seminars for its credentialed providers. If I cannot attend a scheduled webinar or seminar, can I still receive training?
Yes, MCNA Dental will be happy to schedule either an office-specific webinar or other type of training event for any of our credentialed providers. Please call your Provider Relations Representative and we will coordinate it accordingly.
Forms

The following forms can be downloaded using the links provided.

- **Member Outreach Form for Nebraska Providers**
  - [http://forms.mcna.net/ne-member-outreach](http://forms.mcna.net/ne-member-outreach)
- **Nebraska DHHS Request for Fair Hearing Form**
  - [http://forms.mcna.net/ne-fair-hearing](http://forms.mcna.net/ne-fair-hearing)
- **Nebraska Medicaid Handicapping Labio-Lingual Deviations Form (The HLD Index)**
  - [http://forms.mcna.net/ne-hld-index](http://forms.mcna.net/ne-hld-index)
- **Provider Complaint Form**
  - [http://forms.mcna.net/ne-provider-complaint](http://forms.mcna.net/ne-provider-complaint)
- **Provider Appeal Form**
  - [http://forms.mcna.net/ne-provider-appeal](http://forms.mcna.net/ne-provider-appeal)