TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 6 DENTAL SERVICES

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

002. DEFINITIONS. The following definitions apply:

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

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

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

(A) Craniofacial birth defect that is affecting the occlusion; or

(B) Mutilated and severe malocclusions.

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

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

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

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. Providers of dental services must comply with all applicable provider participation requirements codified in this title ~~.~~ In the event that provider participation requirements in this title ~~471 NAC 2 or 3~~ conflict with requirements outlined in this chapter, the individual provider participation requirements in this chapter will govern.

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

003.02(A) PROVIDER AGREEMENT. Providers of dental services must complete the appropriate Nebraska Medicaid approved ~~and sign Form MC-19,~~ Service Provider

Agreement form~~,~~ and submit it ~~the completed form~~ to ~~the Department~~ Nebraska Medicaid for approval to participate in ~~Medicaid~~ the program.

004. SERVICE REQUIREMENTS.

004.01 GENERAL REQUIREMENTS.

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

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

004.01(B) PRIOR AUTHORIZATION. Specific documentation must be submitted along with each prior authorization request. Submitted documentation that is inadequate, or does not otherwise meet the criteria for review, may be disapproved, or returned for additional information or correction. The provider must receive prior authorization approval before initiating the following services:

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

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

(a~~1~~) Electronically using the standardized process ~~Health Care Services Request for Review and Response~~; or
(b~~2~~) ~~Submission of a dental claim~~ By mail with the Nebraska Medicaid approved version of the American Dental Association (ADA) form ~~and required documentation by mail~~ to Nebraska Medicaid ~~the Department.~~; and
(c) With dental records and a narrative to establish medical necessity.

004.01(B)(ii) ~~ADULT~~ EMERGENCY TREATMENT OF PRIOR AUTHORIZED DENTAL SERVICES ~~AND EXTENSIVE TREATMENT CIRCUMSTANCES~~. The ~~request must clearly indicate~~ medical necessity for emergency services must be documented in the client's dental record. ~~that it is either an emergency services or extensive treatment circumstances request, and be accompanied by sufficient documentation to determine the emergent medical necessity. In the event that the~~ If a service requiring prior authorization must be rendered immediately, the ~~dental~~ provider must submit a retrospective request for coverage~~, post treatment,~~ with documentation of ~~the emergent~~ medical necessity~~,~~ for ~~payment~~ review.

004.01(C) SERVICES FOR INDIVIDUALS AGE 21 AND OLDER. Dental coverage is limited to $750 per fiscal year. The annual limit is calculated at the Medicaid dental fee schedule rate for the treatment provided or on the all-inclusive encounter rate paid to Indian health service (IHS) facilities or federally qualified health centers (FQHC) facilities.

004.01(C)(i) PROVIDER RESPONSIBILITY AND CLIENT RESPONSIBILITY REGARDING THE YEARLY DENTAL LIMIT. Providers must inform a client before treatment is provided of the client's obligation to pay for a service if the client's annual limit has already been reached or if the amount of treatment proposed will cause the client's annual limit to be exceeded.

004.01(C)(ii) EMERGENCY DENTAL SERVICES. Adult dental services provided in an emergency situation are not subject to the annual per fiscal year limits imposed in this chapter. Adult dental services provided in an emergency situation will be considered for coverage on a case-by-case basis. Only the most limited service(s) needed to correct the emergency condition will be covered. Medicaid will cover emergency dental services that were not prior authorized. The provider must submit a completed coverage request with supporting documentation of the emergent nature of the services provided. Medicaid considers the following conditions to be emergent:

(1) Extractions for the relief of:
  (a) Severe and acute pain; or
  (b) An acute infectious process in the mouth;
(2) Extractions and necessary treatment for repair of traumatic injury; and
(3) Full mouth extractions as necessary for catastrophic illness such as an organ transplant, chemotherapy, severe heart disease, intra-oral radiation workup, or other life-threatening illnesses.

004.01(C)(iii) DENTURES AND EXTENSIVE TREATMENT CIRCUMSTANCES. Medicaid will review, and consider coverage of, services that cause the client to exceed the annual coverage limit, where the client is in need of dentures and extensive treatment in a hospital setting due to a disease or medical condition, or the client is disabled and it is in the best interest of the client's overall health to complete the treatment in a single setting. A prior authorization request must be submitted with medical necessity documentation.

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

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

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

004.01(G)(D) MEDICAL AND SURGICAL SERVICES OF A DENTIST OR ORAL SURGEON. Medically necessary covered services of provided by a dentist or oral surgeon not otherwise covered in this chapter, are covered and reimbursed as a physician's service in accordance with this title the 471 NAC 18.

004.02 COVERED SERVICES. ~~Medicaid does~~ ~~n~~Not ~~cover~~ all American Dental Association (ADA) procedure codes are covered. ~~Covered procedure codes are listed in the Nebraska Medicaid Dental Fee Schedule.~~

004.02(A) ORAL SCREENINGS. Covered two times every 365 days when provided by a licensed provider practicing within their scope of practice to determine a client's need to be evaluated by a dentist for diagnosis.

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

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

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

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

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

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

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

~~004.02(A)(i)(2) LIMITED ORAL EVALUATION. Oral evaluation is limited to twice in a one year period for each client, and for treatment of a specific oral health problem or complaint. Documentation which specifies the medical necessity is required.~~

004.02~~(A)~~(B)(i)~~(3)~~(2) ORAL EVALUATION FOR ~~INFANT~~ CHILDREN (UNDER ~~3~~THREE YEARS OF AGE). Oral evaluation is covered for clients under age ~~3~~ three ~~and younger~~ and includes counseling ~~with~~ of the primary caregiver.

004.02(B)(i)(3) LIMITED ORAL EVALUATION. Covered two times every 365 days, and for treatment of a specific oral health problem or complaint. This code may be utilized for a new patient presenting with a specific oral health problem or complaint who is receiving permanent treatment on the same day. This code is not to be utilized in other instances on the same day of service as permanent treatment or by a secondary provider upon referral.

004.02(B)(i)(4) DIAGNOSTIC CONSULTATION BY A DENTIST OTHER THAN THE REQUESTING DENTIST. Covered for a client one time every 365 days. Not payable if another exam procedure is billed by the same dental practice on the same day.

004.02~~(A)~~(B)(i)~~(4)~~(5) COMPREHENSIVE ORAL EVALUATION. ~~Benefit is limited to one per three year period per client, per provider, and location.~~ Covered one time every 1095 days, for a client, per dental practice. It is not payable in conjunction with emergency treatment visits, denture repairs, or ~~similar~~ treatment appointments.

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

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

004.02~~(A)~~(B)(i)~~(7)~~(6) COMPREHENSIVE PERIODONTAL EVALUATION. ~~Comprehensive periodontal evaluation is a benefit limited to~~ Covered one time every 1095 days. ~~per three year period per client.~~

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

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

004.02~~(A)(iii)~~(B)(ii)(1) PERIOD~~O~~ICITY OF RADIOGRAPHS. ~~Medicaid covers~~The following services are covered:

(~~1~~a)A maximum of four bitewing~~s~~ radiographs every 365 days. An additional four bitewing radiographs may be covered for clients age 20 and younger if they are medically necessary, and clinical justification must be documented in the client's dental record. ~~per date of services~~;
(~~2~~b)Intraoral complete series one time every 1095 days~~three years~~;
(~~3~~c)Panorex one time every 1095 days~~three years~~. Covered more frequently if medically necessary for treatment. Clinical justification must be documented in the client's dental record ~~Documentation is required for more frequent panorex in dental chart~~; and
(4d)Cephalometric image ~~film~~ for clients age 20 and younger~~, as follows:~~ for orthodontic treatment as defined in section 004.02(I)(i).
(a) ~~Orthodontic treatment is covered if the client will qualify for Medicaid coverage of treatment as outlined in the orthodontic coverage criteria.~~

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

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

004.02~~(B)~~(C)(i)(1) AGE 13 AND YOUNGER. ~~For age 13 and younger, prophylaxis is covered~~ Covered ~~one time~~ two times every ~~180~~ 365 days and must be billed as a child prophylaxis.

004.02~~(B)~~(C)(i)(2) AGE 14 THROUGH 20. ~~For age 14 through 20, prophylaxis is covered~~ Covered ~~one time~~ two times every ~~180~~ 365 days and must be billed as an adult prophylaxis.

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

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

004.02~~(B)~~(C)(i)(4)(a) DOCUMENTATION REQUIREMENTS. ~~Documentation of client's special needs or disability is required.~~ The client's special need diagnosis and medical necessity for the frequency of prophylaxis must be documented in the client's dental record.

004.02~~(B)~~(C)(ii) TOPICAL FLUORIDE AND FLUORIDE VARNISH. ~~Topical fluoride and fluoride varnish are covered~~ Covered for adults and children two times every 365 days. Covered more frequently if it is medically necessary, and clinical justification must be documented in the client's dental record. ~~at the frequency determined appropriate by the treating dental provider.~~

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

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

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

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

004.02~~(C)~~(D)(i) AMALGAM OR RESIN. Resin refers to a broad category of materials including but not limited to composites, and glass ionomers. Full labial veneers for cosmetic purposes are not covered.

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

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

004.02~~(C)~~(D)(ii) CROWNS. ~~Crowns are covered~~ Covered for anterior and bicuspid teeth when other restoration procedures are ~~is~~ not possible. Crowns are covered for molar teeth that have been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam, or resin restoration. Crowns are not covered for third molars. A replacement crown for the same tooth in less than 1,825 days, due to failure of the crown, is not covered and is the responsibility of the dentist who ~~originally~~ initially placed the crown. ~~Coverage for crowns is specified in the Nebraska Medicaid Dental Fee Schedule~~.

004.02~~(C)~~(D)(ii)(1) DOCUMENTATION REQUIREMENTS. ~~Submit x-ray~~ Radiograph showing the entire apex and crown of the anterior ~~and~~ or bicuspid~~s~~ tooth, or of the molar that has been treated with a completed root canal procedure ~~x-ray of molar that shows completed root canal~~. A request should not be submitted for unusual or exceptional situations not covered herein.

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

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

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

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

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

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

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

004.02~~(D)~~(E)(ii) ROOT CANAL THERAPY ~~AND RE-TREATMENT OF PREVIOUS ROOT CANALS.~~ ~~Root canal therapy and re-treatment are covered~~ Covered for permanent teeth. ~~Root canal treatment includes a treatment plan, necessary~~

~~appointments, clinical procedures, radiographic images and follow up care. Re-treatment of previous root canals may be covered if at least 365 days have passed since the original treatment, and failure has been demonstrated with x-ray documentation and narrative summary.~~

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

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

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

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

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

004.02~~(E)~~(F)(i) GINGIVECTOMY OR GINGIVOPLASTY. ~~Medicaid covers g~~Gingivectomy or gingivoplasty is covered per tooth or per quadrant~~.~~ for any of the following reasons:

(1) When there is generalized suprabony pocketing measuring 5mm or greater and gingival tissue has not responded with measurable reduction in suprabony pockets through dental prophylaxis or full mouth scaling in the presence of generalized moderate to severe gingivitis combined with proper home care;

(2) When the above measures combined with proper home care do not result in measurable reduction in suprabony pockets; or

(3) When drug therapy, hormonal disturbances, or congenital defects have caused gingival hyperplasia or hypertrophy.

004.02~~(E)~~(F)(ii) PERIODONTAL SCALING AND ROOT PLANING. ~~Medicaid covers f~~Four quadrants of scaling and root planing are covered ~~once~~ one time every 730 ~~365~~ days. Scaling and root planing ~~that~~ requires the use of local anesthesia. ~~Each quadrant is covered one time per client. The request for approval must be accompanied by the following:~~

~~(a) A periodontal treatment plan;~~

~~(b) A completed copy of a periodontic probe chart that exhibits pocket depths;~~

~~(c) A periodontal history, including home oral care; and~~

~~(d) Radiography.~~

004.02~~(E)~~(F)(ii)(1) EXCLUSIONS. ~~For scaling and root planing that requires the use of local anesthesia, Medicaid does not cover m~~More than two quadrants ~~one~~

~~half~~ of the mouth are not covered ~~in one day~~ on the same date of service, except ~~on~~ for hospital cases.

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

(a) A periodontal history, including home oral care;
(b) Radiography;
(c) Periapical ~~x-rays~~ radiographs demonstrating subgingival calculus and loss of crestal bone; ~~and~~
(d) Periodontal probe chart evidencing active periodontal disease and pocket depths of ~~4~~ 5 five millimeters (mm) or greater.~~;~~ and
(e) A periodontal treatment plan that justifies, scaling, or root planning is required instead of prophylaxis.

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

004.02~~(E)~~(F)(iv) PERIODONTAL MAINTENANCE ~~PROCEDURE~~. ~~Medicaid covers periodontal maintenance procedure for clients that have had Medicaid approved periodontal scaling and root planing.~~ Covered three times every 365 days. This procedure cannot be utilized in addition to adult prophylaxis within this 365 day period. Prior authorization must be renewed annually.

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

~~(a) Date the Medicaid approved scaling and root planing completed;~~
(a~~b~~)Periodontal history; ~~and~~
(b) Date the Nebraska Medicaid-approved scaling and root planning was completed; and
(c) Frequency ~~the dental provider is requesting that the client must be seen for~~ of the maintenance procedure being requested.

004.02~~(F)~~(G) PROSTHODONTICS. ~~Coverage of prosthetic appliances includes all materials, fitting, and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Medicaid covers the following prosthetic appliances, subject to service specific coverage criteria:~~

~~(1) Dentures that are immediate, replacement or complete, or interim or complete;~~
~~(2) Resin base partial dentures, including metal clasps;~~
~~(3) Flipper partials that are considered a permanent replacement of one to three anterior teeth only; and~~
~~(4) Cast metal framework with resin denture base partials, covered for clients age 20 and younger.~~

004.02(G)(i) REMOVABLE PROSTHETIC APPLIANCES. Coverage ~~of prosthetic appliances~~ includes all materials, fitting, and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis.

~~Medicaid covers~~ tThe following removable prosthetic appliances are covered, subject to service specific coverage criteria:

(1) ~~Dentures that are immediate, replacement or complete, or interim or complete~~ Complete denture~~s~~, maxillary and mandibular;

(2) Immediate complete denture, maxillary and mandibular;

~~(2)~~(3) Resin base partial denture~~s~~, including metal clasps, maxillary and mandibular;

(4) Cast metal frame partial denture, maxillary and mandibular; and

~~(3)~~(5) Flipper partial~~s~~ denture~~s~~, maxillary and mandibular. ~~that are considered a permanent replacement of one to three anterior teeth only; and~~

~~(4) Cast metal framework with resin denture base partials, covered for clients age 20 and younger.~~

~~004.02(F)(i)~~ ~~REPLACEMENT.~~ ~~Medicaid covers a one-time replacement within the five year coverage limit for broken, lost, or stolen appliances. This one-time replacement is available once within each client's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request. Replacement of any prosthetic appliance is covered once every five years when:~~

~~(1) The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client;~~

~~(2) The client does not have a history of lost prosthetic appliances;~~

~~(3) A repair will not make the existing denture or partial functional;~~

~~(4) A reline will not make the existing denture or partial functional; or~~

~~(5) A rebase will not make the existing denture or partial functional.~~

004.02(G)(ii) PROVIDER PAYMENT FOR REMOVABLE PROSTHETIC APPLIANCES. Providers may be reimbursed in the event denture treatment is interrupted and the provider is unable to deliver the final dentures to the client. Providers may be reimbursed according to how many stages of the covered denture service they were able to complete prior to interruption. Providers must keep diagnostic models and undelivered dentures for 365 days before they may discard them.

004.02(G)(ii)(1) REIMBURSEMENT STAGES. Providers may submit claims for one of the following stages in denture treatment utilizing the appropriate code ~~noted for this process in the Nebraska Medicaid Dental Fee Schedule~~:

(a) If treatment is interrupted after final impression completion but before initial jaw relation: 25 percent of total rate;

(b) If treatment is interrupted after final jaw relation but before processing: 50 percent of total rate; or

(c) If treatment is not interrupted and the client remains Medicaid eligible, the provider should submit a single claim for full reimbursement noting the date of delivery as the date of service.

004.02(G)(ii)(2) DOCUMENTATION. Providers must keep documentation that includes the provider's attempted outreach to the client to complete the denture service. Providers must make at least three attempts to contact the client in the 30-day period following their initial attempt to set an appointment. If the provider is unable to contact the client after 30 days, they must send the client a letter. If the

provider does not hear from the client for 30 days after the letter is postmarked, the denture service may be considered interrupted.

004.02(G)(ii)(3) CLIENT RETURN. If within 180 days of the denture service being considered interrupted the client returns for delivery and is still Nebraska Medicaid eligible, the provider should complete the denture service and report the completed denture delivery at the remaining allowable rate. Total reimbursement will not exceed 100 percent of provider allowable rate for the denture service. If the client returns after 180 days of the denture service being considered interrupted, the client must restart the denture process. A client may only be considered interrupted one time in five years and should not routinely abandon in-process care.

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

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

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

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

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

(a) ~~Date and list of teeth to be extracted~~ Panoramic image or full mouth series radiographs; and
(b) ~~Narrative documenting medical necessity; and~~ Date and list of teeth to be extracted.
~~(c) Submit panorex or full mouth series radiographs.~~

004.02~~(F)(iv)~~(G)(v) ~~PARTIAL~~ RESIN BASE PARTIAL DENTURE, MAXILLARY OR MANDIBULAR. ~~Partial resin base, maxillary or mandibular, is covered~~ Covered if the client does not have adequate occlusion. More than one posterior tooth must be missing for partial placement, excluding third molars. Cast metal clasps are included in the fee for ~~on~~ partial dentures. One to three missing anterior teeth should be replaced with a flipper partial denture, which is considered a permanent replacement.

Relines, rebases, or adjustments are not billable for the first 180 days after placement of the prosthesis.

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

(a) Chart or list of missing teeth and teeth to be extracted;
(b) Age and condition of any existing partial denture, or a statement identifying the prosthesis as an initial placement;
(c) Narrative documenting how there is not adequate occlusion; and
(d) For initial placements, radiographs of remaining teeth ~~are required~~.

004.02~~(F)(v)~~(G)(vi) ~~PARTIAL~~ CAST METAL FRAME PARTIAL DENTURE ~~BASE~~, MAXILLARY OR MANDIBULAR. ~~Partial cast metal base, maxillary or mandibular is covered for clients age 20 and younger only.~~ Covered if the client does not have adequate posterior occlusion. More than one posterior tooth must be missing for partial placement, excluding third molars. One to three missing anterior teeth should be replaced with a flipper partial denture, which is considered a permanent replacement. Relines, rebases, or adjustments are not billable for the first 180 days after placement of the prosthesis.

004.02(G)(vi)(1) DOCUMENTATION REQUIREMENTS. The prior authorization request must include:

(a) Chart or list of missing teeth and teeth to be extracted;
(b) Age and condition of any existing partial denture, or a statement identifying the prosthesis as an initial placement;
(c) Narrative documenting how there is not adequate occlusion; and
(d) For initial placements, radiographs of remaining teeth.

004.02(G)(vii) FLIPPER PARTIAL DENTURE, MAXILLARY AND MANDIBULAR. Covered for one to three missing anterior teeth and is considered a permanent replacement. It is not covered for temporary replacement of missing teeth. Relines, rebases, and adjustments are not billable for the first 180 days after placement of the prosthesis.

004.02(G)(vii)(1) DOCUMENTATION REQUIREMENTS. The prior authorization request must include:

(a) Chart or list of missing teeth and teeth to be extracted;
(b) Age and condition of existing partial denture, or a statement identifying the prosthesis as an initial placement; and
(c) Radiographs.

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

004.02~~(F)(vii)~~(G)(ix) REPAIRS TO DENTURES AND PARTIALS. ~~Medicaid covers two~~ One repair~~s~~ per prosthesis is covered every ~~365~~ 730 days.

004.02~~(F)(viii)~~(G)(x) REBASE OF DENTURES AND PARTIALS. Rebase of dentures and partials are covered following the placement of a new prosthesis after the first 180 days have passed and~~,~~ is covered ~~once~~ one time per prosthesis every ~~365~~ 1095 days, whether performed chair side or in a lab. ~~Chair side and lab rebases are covered, but only one can be provided within the 365 day period.~~

004.02~~(F)(ix)~~(G)(xi) RELINE OF DENTURES AND PARTIALS. Reline of dentures and partials are covered following the placement of a new prosthesis after the first 180 days have passed and is covered~~.~~ ~~Covered once~~ one time per ~~prostheses~~ prosthesis every 1095 ~~365~~ days, whether performed chair side or in a lab. ~~Chair side and lab relines are covered, but only one can be provided within the 365 day period.~~

~~004.02(F)(x) INTERIM COMPLETE DENTURES, MAXILLARY AND MANDIBULAR. Interim dentures can be replaced with a complete denture 180 days after placement of the interim denture. Complete dentures require prior authorization in accordance with this chapter.~~

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

~~(a) Date and list of teeth to be extracted;~~
~~(b) Narrative documenting medical necessity; and~~
~~(c) Submit panorex or full mouth series radiographs.~~

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

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

~~(a) Chart or list missing teeth and teeth to be extracted;~~
~~(b) Age and condition of existing partials, or a statement identifying the prosthesis as an initial placement; and~~
~~(c) Radiographs.~~

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

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

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

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

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

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

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

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

004.02~~(G)~~(H)(v) ALVEOLOPLASTY. ~~The Medicaid fee for e~~Extractions coverage includes routine recontouring of the ridge and suturing as necessary. ~~It is not a separate billable procedure.~~ Alveoloplasty not in conjunction with extractions, per quadrant as a separate procedure, is covered only when it is necessary to prepare the ridge for a prosthetic appliance. Removal of tori is considered inclusive in this procedure.

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

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

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

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

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

004.02(I)(i) ORTHODONTIC TREATMENT. Orthodontic treatment is covered when medically necessary for clients who have a handicapping malocclusion and are age 20 or younger, when prior authorization has been approved.

004.02(I)(i)(1) FORMS. A Nebraska Medicaid approved version of the Handicapping Labio-Lingual Deviation (HLD) score sheet is used. A score of 28 or greater or demonstration of an automatic qualifier on the Handicapping Labio-Lingual Deviation (HLD) score sheet is necessary to establish medical necessity.

004.02(I)(i)(2) DIAGNOSTIC RECORDS. Diagnostic records are covered ~~by Medicaid~~ for orthodontic treatment when prior authorization has been approved. Diagnostic records for minor malocclusions are not covered.

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

004.02(I)(ii)(1) PRIOR AUTHORIZATION. Orthodontic treatment must be prior authorized and is paid for a single procedure code. The request for prior authorization will constitute the provider's acceptance of the Nebraska Medicaid fee, and a commitment to complete treatment.

004.02(I)(ii)(1)(a) DOCUMENTATION REQUIREMENTS. The prior authorization request must include:

(i) The Handicapping Labio-Lingual Deviation (HLD) score sheet;
(ii) Diagnostic records including:
(1) Diagnostic models;
(2) Oral or facial photographic images;
(3) Panoramic image; and
(4) Cephalometric image;
(iii) Dental records that include a narrative of the diagnosis, treatment plan, and prognosis; and
(iv) On surgical cases, include a description of the procedure.

~~004.02(H)(i) COVERAGE CRITERIA FOR DIAGNOSTIC MODELS AND RADIOGRAPHS. Diagnostic records are not covered by Medicaid unless the case will qualify for Medicaid coverage as outlined in this chapter. Diagnostic records for minor malocclusions are not covered by Medicaid. For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized. The end of treatment records must be submitted to the Department for review.~~

~~004.02(H)(ii) FORMS. Medicaid uses the Nebraska Index of Orthodontic Treatment Need (NIOTN) form to determine whether coverage is appropriate based on a handicapping malocclusion. A score of 28 or greater being necessary to qualify for Medicaid coverage of orthodontic treatment. The Nebraska Index of Orthodontic Treatment Need (NIOTN) form must be used to pre-screen orthodontic cases.~~

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

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

004.02(H)(iii)(1) SURGICAL CORRECTION. When the individual has had a surgical correction of a 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.

004.02(H)(iii)(2) AUTHORIZATION. Treatment is prior authorized and paid on a single procedure code. The authorized code will be on the Form MC-9D, Dental Authorization and Treatment. In order for Medicaid clients to receive timely treatment, the request for approval will constitute the providers acceptance of the Medicaid fee, and a commitment to complete care.

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

(a) A pre-treatment request form that outlines treatment and the Nebraska Index of Orthodontic Treatment Need (NIOTN) form;
(b) Diagnostic records including:
    (i) Diagnostic casts and oral or facial photographic images;
    (ii) Full mouth radiographs and panoramic x-ray; and
    (iii) Cephalometric x-ray;
(c) A narrative description of the diagnosis, and prognosis; and
(d) On surgical cases, include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

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

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

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

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

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

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

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

004.02(J)(i) OCCLUSAL GUARD. Covered one time every 1095 days to minimize the effects of bruxism and other occlusal factors. Athletic guards are not covered.

004.02(J)(i)(1) DOCUMENTATION REQUIREMENTS. Medical necessity for the occlusal guard must be documented in the client's dental record. Documentation must include evidence of significant loss of tooth enamel or tooth chipping, or clinically significant headaches and jaw pain.

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

004.02~~(I)~~(J)~~(i)~~(ii)(1) DOCUMENTATION REQUIREMENTS. ~~Providers must document~~ A description of the palliative treatment provided must be documented on ~~or in~~ the dental claim, and in the client's dental ~~chart~~ record.

004.02~~(I)~~(J)~~(ii)~~(iii) GENERAL ANESTHESIA. General anesthesia administered in the provider's office is covered when it is medically necessary to treat the client. Administration of general anesthesia must be performed in full compliance with Nebraska Statutes~~Neb. Rev. Stat. §38-101 §§ 38-1101 to §38-1142.~~

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

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

004.02~~(I)~~(J)~~(iv)~~(v) INTRAVENOUS SEDATION AND ANALGESIA. ~~Intravenous sedation and analgesia administered in the provider's office or location is covered~~ Covered when it is medically necessary to treat the client. These services must be

performed in full compliance with Nebraska Statutes ~~Neb. Rev. Stat. §§ 38-1101 to 38-1142~~.

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

004.02~~(I)~~(J)~~(v)~~(vi) NON-INTRAVENOUS CONSCIOUS SEDATION. ~~Non-intravenous conscious sedation administered in the provider's office is covered~~ Covered when it is medically necessary to treat the client. ~~The use of oral medications require monitoring.~~ These services must be performed in full compliance with Nebraska Statutes~~Neb. Rev. Stat. §§ 38-1101 to 38-1142~~.

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

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

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

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

~~004.02(I)(viii) OCCLUSAL GUARD. Occlusal guard is covered once every 1095 days to minimize the effects of bruxism and other occlusal factors. Occlusal guards are removable appliances. Athletic guards are not covered.~~

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

004.03 NON-COVERED SERVICES. ~~Medicaid does not cover a~~Any service ~~that~~ listed below is not covered:

(A) Cosmetic;
(B) More costly than another~~,~~ equally effective available service;
(C) Not within the coverage criteria of these regulations;
(D) Determined to be not medically necessary by Nebraska Medicaid ~~the Department~~; or

(E) Experimental, investigational, or ~~non-Food~~ not approved by the Food and Drug Administration (FDA)~~ approved~~.

005. BILLING AND PAYMENT FOR DENTAL SERVICES.

005.01 BILLING.

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

005.01(B) SPECIFIC BILLING REQUIREMENTS.

0005.01(B)(i) BILLING INSTRUCTIONS. The provider must bill Nebraska Medicaid using the appropriate procedure codes ~~outlined in the Nebraska Medicaid Dental Fee Schedule~~ and in accordance with the billing instructions. The fees listed on the dental claim must be the ~~dentist's~~ provider's usual and customary charge for each procedure code.

005.02 PAYMENT.

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

005.02(B) SPECIFIC PAYMENTS REQUIREMENTS.

005.02(B)(i) REIMBURSEMENT. ~~Medicaid pays for c~~Covered dental services are reimbursed at the lower of:

(1) The provider's submitted charge; or

(2) The allowable amount for that procedure code in the Nebraska Medicaid Dental ~~Practitioner~~ Fee Schedule in effect for that date of service.

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

005.02(B)(iii) PAYMENT FOR ~~INTERCEPTIVE AND~~ COMPREHENSIVE ORTHODONTIC TREATMENT. Payment ~~for authorized orthodontic treatment~~ is made upon submittal of a dental claim for treatment that has been approved on prior authorization~~ by Nebraska Medicaid.~~ If limited orthodontic treatment eliminates qualifying comprehensive criteria, payment for comprehensive orthodontic treatment will not be covered. ~~approval of the treatment plan and submittal of a dental claim.~~

005.02(B)(iii)(1) TRANSFER OF ~~INTERCEPTIVE AND~~ COMPREHENSIVE ORTHODONTIC CASES. If the client transfers to another dentist, the dentist who obtained the ~~original~~ initial prior authorization approval and initiated orthodontic treatment, must refund to Nebraska Medicaid the portion of the amount paid by

Nebraska Medicaid that applies to the treatment not completed. The transfer request must be submitted and reviewed by Nebraska Medicaid ~~the Department~~ to determine the amount to be refunded. Transfers are only allowed under hardship circumstances.

005.02(B)(iii)(2) ~~INTERCEPTIVE AND~~ COMPREHENSIVE ORTHODONTIC TREATMENT NOT COMPLETED. If prior authorized orthodontic treatment is not completed, the dentist who obtained the ~~original~~ initial prior authorization approval and initiated the treatment must refund to Nebraska Medicaid the portion of the amount paid by Nebraska Medicaid that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by Nebraska Medicaid ~~the Department~~ to determine the amount to be refunded.

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

~~006. TELEDENTISTRY.~~

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