Dental Rate Increases and EPSDT Dental Program Policy Revisions
Effective for Dates of Service On and After November 1, 2007

Dental Rate Increases

Effective for **dates of service on and after November 1, 2007**, certain Medicaid-covered Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental, Expanded Dental Services for Pregnant Women (EDSPW), and Adult Denture Program services will receive a reimbursement rate increase. Medicaid will work diligently to ensure that the reimbursement rate changes are in place by November 1, 2007. However, in the event that a delay is unavoidable we remind you that dental providers are required by Medicaid to bill their usual and customary fees. Providers who bill their usual and customary fees will not be required to manually adjust their claims should a claim recycle be required as Medicaid will automatically adjust the claims. If a dental provider does not bill their usual and customary fees and a claim recycle is required, the dental provider will be responsible for all necessary claim adjustments. For complete fee information, please refer to the revised EPSDT Dental, EDSPW and Adult Denture Program Fee Schedules with revision date November 1, 2007 which are located at **www.lamedicaid.com.**

EPSDT Dental Program Policy Revisions

The following policy revisions replace current policy specific to the information provided below. Additional policy related to each procedure code as stated in the 2003 Dental Services Manual as well as subsequent policy updates still applies.
NOTE: There may be a delay in reimbursement of the service performed at the six month interval due to programming requirements. Once the required programming changes are made, Medicaid will automatically recycle denied claims for these services for dates of service between November 1, 2007 and the date of implementation of the programming changes.

Effective for **dates of service on and after November 1, 2007**, the following EPSDT Dental Program services are limited to one per **six** months (with noted exception), per recipient:

- One D0145 (Oral Examination for a Patient Under Three Years of Age and Counseling with Primary Caregiver; **OR** D0120 (Periodic Oral Examination – Patient of Record – 3 through 20 years of age) per six months, per recipient is covered as is age appropriate. Note: Procedure code D0150 (Comprehensive Oral Examination – New Patient – 3 through 20 years of age) remains the appropriate procedure code for new patients who are 3 through 20 years of age. A new patient is described as a patient that has not been seen by this provider for at least three years; therefore, procedure code D0150 is reimbursable only once in a 3 year period. In addition, the recall visit (D0120) must be scheduled at least six months after the initial visit (D0150) is rendered.

• D0272 (Radiograph – Bitewings, Two Films). This service is limited to one per six months, per recall patient with clinical caries or at increased risk for caries if proximal surfaces cannot be examined visually or with a probe. Documentation in the patient's dental treatment record justifying the need for the bitewing at the six month recall visit is required. The limit of one per 12 months will remain for recipients who do not meet the criteria for the bitewing radiograph (D0272) at the six month recall visit.

• One D1110 (Prophylaxis – Adult – 12 through 20 years of age); **OR** D1120 (Prophylaxis – Child – Under 12 years of age) per six months, per recipient is covered as is age appropriate.

• One D1203 (Topical Application of Fluoride, prophylaxis not included – Child – Under 12 years of age); **OR** D1204 (Topical Application of Fluoride, prophylaxis not included – Adult – 12 through 15 years of age); **OR** D1206 (Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients – Under 6 years of age) per six months, per recipient is covered as is age appropriate.

For new and established patients, dental providers must utilize the electronic Clinical Data Inquiry (e-CDI) application which is available in the provider restricted area of the www.lamedicaid.com website in order to determine whether the recipient has received a Medicaid-reimbursed oral examination, bitewing radiograph, prophylaxis, and fluoride. Providers must select the option for "Ancillary Services" in order to review the recipient's dental claims history. The e-CDI application provides up to 12 months history information. A printout of the dental claims history from the e-CDI application must be placed in the patient's chart prior to each initial or recall visit. If it is determined that it has been less than six months since the recipient has received an oral examination, bitewing radiograph, prophylaxis and fluoride, the recipient must schedule for a later date.

In addition, providers must ask their new patients when they last received a Medicaid-covered oral examination, bitewing radiograph, prophylaxis, and fluoride and record that information in the patient's dental treatment record. If it is determined that it has been less than six months, the recipient must schedule for a later date. For established patients, the provider must also check the office treatment record to ensure that it has been over six months since the patient received these services. If it is determined that it has been less than six months, the recipient must schedule for a later date.