PROVIDER REQUIREMENTS

A dentist must enroll as a Louisiana Medicaid dental provider to receive reimbursement for covered dental services performed on eligible Medicaid beneficiaries. Providers must be licensed in the state of Louisiana from the Louisiana State Board of Dentistry and must adhere to the Louisiana State Board of Dentistry requirements concerning the delivery of dental services.

Enrolled providers are not allowed to provide services to a Medicaid beneficiary beyond the intent of Medicaid guidelines, limitations and/or policies for purposes of maximizing payments. If this practice is detected, Medicaid will apply 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.

NOTE: Dentists not enrolled in the Louisiana Medicaid program may not use the name and/or provider number of an enrolled dentist in order to bill Medicaid for services rendered.

Dental Groups

For Louisiana Medicaid purposes, a dental group is defined as two or more dentists offering dental services to the Louisiana Medicaid beneficiary population. Dental groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid beneficiary.

Dental groups are required to complete an enrollment packet for the group, which includes information for the group as well as the individual dentists comprising the group.

Individual Dentists

The Louisiana Medicaid Program will assign only one provider number per individual provider type. For this reason, an individual dentist may have only one "Pay To" address regardless of the number of locations where individual services are rendered. For example, if an individual dentist practices at multiple locations, Medicaid payments will be sent to only one address for all services provided.

However, if an individual dentist practices with an enrolled group and maintains a private practice, the group must bill for services performed in the group setting and the individual dentist must bill individual services rendered in the private practice. This is the only situation in which payment for services provided by one dentist would be made to more than one address.

Program Guidelines

A Medicaid dental provider must offer the same services to a Medicaid beneficiary as those offered to a non-Medicaid beneficiary, provided these services are reimbursable by the Medicaid program. A Medicaid dental provider cannot limit his/her practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid Early and Periodic Screening and Diagnosis Treatment (EPSDT) Dental or Adult Denture programs.

Medicaid enrolled dental providers reimbursed under the Medicaid Program and conducting business at locations other than their principal place of practice shall provide the physical address and business telephone number of their principal place of practice to the Provider Enrollment Unit (PEU) and the Louisiana Department of Health (LDH). This address must be on file with the Louisiana State Board of Dentistry. Records documenting the services provided shall be maintained at this location.

To be eligible for reimbursement, the service must be performed in the parish where the provider's principal place of practice is located, any surrounding parish with a contiguous border of at least one mile, or any parish with a land border of at least one mile contiguous with those parishes.

Louisiana Medicaid requires all dental providers to identify a place of treatment (service) on the 2006 American Dental Association (ADA) Claim Form. If services are to be or were provided at a location other than the address entered in Block 38 of the 2006 ADA Claim Form, use the Place of Service Codes for Professional Services to identify where the services are being rendered. The number of the corresponding location in the "other" box on the form must be entered as well as the address of the location in Box 56.

Required Changes to Report

All changes of address, group affiliation, contact information, status, and bank account information, etc. must be reported in writing to the PEU. Refer to Appendix J for contact information. For more information on required reportable changes, see chapter one, General Information and Administration of the Medicaid Manual.

Securing Beneficiaries

Eligible beneficiaries who are in need of dental services should schedule an appointment with a participating provider. It is the responsibility of the beneficiary to choose a participating dental provider and to schedule appointments.

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

Picking and Choosing Beneficiaries and/or Services

Providers may choose whether to accept a beneficiary as a Medicaid patient. Providers are not required to accept every Medicaid beneficiary requiring treatment. However, providers must be consistent with this practice and not discriminate against a Medicaid beneficiary based on the beneficiary's race, religion, national origin, color or handicap.

Providers must bill Medicaid for all covered services performed on eligible beneficiaries whom the provider has accepted as a Medicaid patient. This policy prohibits Medicaid providers from "picking and choosing" the services for which they agree to accept reimbursement from Medicaid. Providers must accept Medicaid reimbursement as payment in full for all services covered by Medicaid.

Subsequent Treatment Visits

Subsequent visits should be scheduled by the dentist to correct the dental defects that were found during the initial examination**. If no subsequent visit is required, the bitewing radiographs, prophylaxis, and fluoride must be provided at the initial visit.** If subsequent treatment is required, these diagnostic and preventive services must be provided at the first treatment visit if they were not provided at the initial comprehensive or periodic oral examination.

General Coding Information

The EPSDT Dental and Adult Denture Program Fee Schedules include a complete list of Medicaid covered procedure codes (see Appendix A and B). These codes conform to the ADA Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care.

Tooth Numbering System and Oral Cavity Designators

Specific tooth numbers/letters and/or oral cavity designators may be required when requesting Medicaid prior authorization (PA) or reimbursement for certain procedure codes. Services

requiring specific tooth numbers/letters and/or oral cavity designators are identified in Appendix A and B.

Medicaid uses Tooth Numbers 1 through 32 and A through T when identifying specific teeth. Certain oral surgery procedure codes may be billed for supernumerary Teeth. The supernumerary teeth are identified with Tooth Numbers 51 through 82 and AS through TS as per ADA policy. Only one tooth number or letter is allowed per claim line.

The following ADA oral cavity designators are used to report areas of the oral cavity:

00 – entire oral cavity
01 – maxillary area
02 – mandibular area
03 – upper right sextant
04 – upper anterior sextant
05 – upper left sextant
06 – lower left sextant
07 – lower anterior sextant
08 – lower right sextant
10 – upper right quadrant
20 – upper left quadrant
30 – lower left quadrant
40 – lower right quadrant.

Only one oral cavity designator is allowed per claim line.

Referrals

Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the beneficiary or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer beneficiaries for restorative, surgical and other treatment services is subject to recoupment.

Missed Appointments

Providers cannot charge beneficiaries for missed/failed appointments.

Third Party Liability

Medicaid is the payer of last resort. Therefore, providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. Third party insurance carrier is an individual or company who is responsible for the payment of medical services. Examples of third parties are Medicare, private health insurance, automobile, or other liability carriers. Refer to General Information and Administration, Chapter One for additional information on third party liability.

Questions regarding Dental third party payments can be directed to the LDH Medicaid Dental Prior Authorization Unit (see Appendix J).

Record Keeping

State law and Medicaid regulations require that all services provided under the EPSDT Dental and Adult Denture dental programs are documented. **Services not adequately documented are considered not to have been delivered.** Providers are required to maintain radiographs, and treatment records of all appointments that should reflect all procedures performed on those appointments.

For services provided to beneficiaries under the EPSDT Dental program, records and radiographs must be maintained for at least six years from the date of the patient's last treatment. It is strongly suggested that the Adult Denture Provider maintain records for at least eight years as the program allows for the provision of prosthetics once every eight years. Failure to produce these records on demand by the Medicaid program or its authorized designee 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 patient visit indicating what services were provided or what conditions were present on those visits. Also included in the beneficiary's record are copies of all claim forms submitted for prior authorization including any attachments, all PA Letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs would constitute examples of additional supporting documentation. A check off list 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 beneficiary's dental treatment record.

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

Interruption of Treatment

The interruption of treatment guidelines applies to codes D5110, D5120, D5211, D5212, D5213 and D5214 ONLY. No other codes are eligible for payment under the interruption of treatment guidelines.

A provider must make every effort to deliver the denture. The provider must document in the beneficiary's record, all attempts to deliver the denture and the reasons the denture was not delivered in the beneficiary's dental treatment record.

If due to circumstances beyond the provider's control, the beneficiary discontinues treatment, or loses eligibility during the course of the construction of a denture qualified under the interruption of treatment guidelines, the provider should not bill Medicaid using the procedure code as originally prior authorized.

As the original procedure has not been completed, the case must be resubmitted to the prior authorization unit at LDH so the PA number can be reissued the proper procedure code relating to the service attempted. The provider will then be able to bill Medicaid for that portion of the treatment that has been completed using the reissued procedure code and PA number.

An immediate denture that is not delivered cannot be reimbursed nor will Medicaid reimburse any payment under the interruption of treatment guidelines for an immediate denture.

For purposes of determining the amount the provider will be paid for interrupted services, the denture fabrication process is divided into four stages:

- Impressions (initial impression, construction of custom dental impression tray and final impressions);
- Bite registration (wax try-in with denture teeth);
- Processing; and
- Delivery.

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to the Medicaid Program. If treatment is

interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made. If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to the Medicaid Program. If treatment is interrupted after completion of Stage 3 (Processing), 75% of the Medicaid reimbursement fee will be paid upon submission of the denture to the Medicaid Program.

For further information concerning billing of interrupted services, providers may contact the LDH Medicaid Dental Prior Authorization Unit (see Appendix J).