Ohio | Department of Medicaid

Frequently Asked Questions about Medicaid Managed Care and Fee for Service Dental Services

Are Interceptive Orthodontics (D8050 and D8060) covered by Medicaid?

Interceptive Orthodontics (HCPCS codes D8050 and D8060) are not routinely covered and are not listed on the Ohio Medicaid fee for service (FFS) fee schedule. However, per 5160-1-14, Ohio's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires coverage of all medically necessary services for individuals under the age of 21, regardless of a service's covered/non-covered status on the FFS fee schedule. The MCPs must also follow EPSDT requirements and must review all requests for medical necessity for individuals under the age of 21. This does not apply to adults.

How must a physical cast/model be submitted?

Either a digital or physical cast is accepted and covered per the OAC 5160-5-01 Appendix.

What are the coverage limitations for dental sealants?

OAC allows for coverage of one sealant per lifetime per first and second permanent molar for individuals younger than 18. In FFS Medicaid, limits for sealants are set per individual and practitioner. MCPs must cover additional sealants when medically necessary. Additional sealants may be available through prior authorization.

How are fixed appliances, such as an expanders and carrieres, covered prior to braces? Are expanders and carrieres part of the comprehensive orthodontic case or separately reimbursable?

FFS and most MCPs, cover expanders and carrieres as separately reimbursable services when medically necessary using procedure codes D8210 or D8220. OAC 5160-5-01 Appendix.

Under Ohio's Early and Periodic Screening, Diagnostic and Treatment program (EPSDT), all MCPs must review all requests for medical necessity for individuals under the age of 21.

What are the MCPs transition of care (TOC) requirements when a member changes dental providers mid-treatment?

When a patient changes providers mid treatment, the MCP is required to provide continuity of care pursuant to 42 CFR 438.208 and follow applicable requirements within the provider agreement.

The continuity of care mid-treatment should be patient specific. Dental providers should provide clinical documentation including an original approval, if possible, and current information on the progress of the member's treatment. The MCP and dental provider are expected to communicate regarding anticipated time needed to complete treatment; estimated cost; remaining balance of orthodontic funds (quarters) and current x-rays. If treatment is denied, providers have the option to request a peer-to-peer review.

Why are some services authorized for $0?

A miscellaneous code (ex. D8999) may be authorized at $0 because it is used as a marker to flag the claim for manual review. These claims re then routed directly to the Dental Director for review.

Other codes such as D8080, Comprehensive Orthodontic Treatment of the Adolescent Dentition, may be authorized at $0, or denied, if a previous provider received payment because braces are allowed only once per lifetime. If the

provider is not satisfied with the decision, the provider may appeal. If the request is for medically necessary care, even if the code is once per lifetime, plans must review and authorize medically necessary services.

When a member has braces and needs to have them removed, but does not need a retainer; how should a provider bill those charges?

The procedure code D8999 should be utilized and submitted for prior authorization for debanding alone.

Does Medicaid separately reimburse nitrous oxide?

FFS and most MCPs do not separately reimburse for nitrous oxide. If an MCP covers nitrous oxide it will always require prior authorization, narrative of medical necessity, and it is not allowed on the same day as D9222/D9223 (deep sedation/general anesthesia) or D9239/D9243 (intravenous moderate sedation).

Amalgam vs. Composite Restorations

OAC rule 5160-5-01 allows for coverage of amalgam and composite restorations. The decision regarding the type of restoration the Medicaid recipient receives must be based on medical necessity and not solely on the least expensive alternative treatment (LEAT). When a dental provider submits a claim for a composite restoration, the MCP or their dental benefit administrator (DBA) must cover the composite restoration when medically necessary. If no medical necessity review is completed, the service cannot be categorically denied, however the MCP may retrospectively review clinical information to determine medical necessity.

Managed Care Plan Contact Information

MCP	Dental TPA & Contact Info	Provider Services
Aetna	DentaQuest 855-398-8411 Claims Questions: denclaims@dentaquest.com Eligibility or Benefit Questions: denelig.benefits@dentaquest.com	1-855-364-0974
Buckeye	Envolve Health 1-855-735-4395	1-866-246-4358
CareSource	DentaQuest 855-208-6575 Claims Questions: denclaims@dentaquest.com Eligibility or Benefit Questions: denelig.benefits@dentaquest.com	1-800-488-0134
Molina	Skygen (844) 621-4589	(855) 665-4623
United	DentaQuest 855-398-8411 Claims Questions: denclaims@dentaquest.com Eligibility or Benefit Questions: denelig.benefits@dentaquest.com	(855) 322-4079
Paramount	DentaQuest 855-398-8411Claims Questions: denclaims@dentaquest.com Eligibility or Benefit Questions: denelig.benefits@dentaquest.com	419-887-2535 (1-800-891-2542) or by email (paramount.providerrelations@promedica.org)

Additional Resources

DentaQuest Resource Page
Envolve Resource Page
Molina/Skygen Dental Provider Manual
Dental Services Coverage and Encounter Submissions Memo
Medical Necessity Reviews for Non-Covered Services and Prior Authorization Limitations Memo
Managed Care Plans Policy
MCP Prior Authorization Denial Process