Ohio | Department of Medicaid

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TO: Contracted Medicaid Managed Care Plans
Contracted MyCare Ohio Plans

FROM: Roxanne Richardson, Deputy Director
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DATE: October 20, 2020, updated October 21, 2020

SUBJECT: Dental Services Coverage and Encounter Submissions

In response to inquiries received from the dental community, ODM has researched managed care plan dental claims to ensure Ohio Department of Medicaid (ODM) policy is being implemented appropriately. Please see below and update your dental benefit administrator to ensure Medicaid recipients are receiving medically necessary dental services.

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. The Food and Drug Administration (FDA) provided updated recommendations about the use of dental amalgam. High risk populations for mercury exposure due to amalgam restorations include women who are pregnant or who are planning to become pregnant, nursing mothers, children (especially those under the age of six), people with a known allergy to mercury, and people with neurological impairment or kidney dysfunction. When a dental provider submits a claim for a composite restoration, the plan or their dental administrator must cover the composite restoration when medically necessary. If no medical necessity review is completed, the service cannot be categorically denied. Please see the recent communication from the FDA on dental amalgam.

https://www.fda.gov/medical-devices/safety-communications/recommendations-about-use-dental-amalgam-certain-high-risk-populations-fda-safety-communication

Extractions & Alveoloplasty

OAC rule 5160-5-01 allows for payment of both the tooth extraction (D7140-D7250) and the alveoloplasty (D7310-D7311), which is the surgical preparation of the alveolar ridges for the reception of dentures after extraction of teeth, as separate and distinct procedures. When a Medicaid recipient needs dentures the extraction and subsequent alveoloplasty must be covered separately. These are NOT bundled codes.

Dental Service Coverage and Encounter Submissions
October 2020

Coverage of Braces Removal

There are situations when a member needs braces removed but does not have a need for a retainer. Typically, the provider would bill for the combination of braces removal and retainer (D8680). There is no code specifically for the removal of braces only. When no retainer is necessary the provider may bill a miscellaneous code such as D8999 or D9999 for removal of braces only. The plan, or dental administrator must review those codes for medical necessity and pay for the service accordingly.

Under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations, plans must review claims and prior authorization requests for children under the age of twenty-one for medical necessity and cannot categorically deny claims simply because the service is not listed as a covered service in Ohio Administrative Code.

Encounters for Dental Services

The plan or the plan's dental administrator must pay for the service code rendered to the patient as submitted on the claim from the dental provider and the procedure code must not be altered. All encounters, including dental encounters submitted through a third-party dental administrator, must document the services or goods rendered by the provider/supplier to the beneficiary. The procedure code must be maintained throughout the payment and encounter cycle regardless of the amount reimbursed for the service.

For example, if the dental provider submits a composite restoration procedure code on the claim to the payer (plan or plan's dental administrator), the composite restoration code must be sent in the encounter data. A composite restoration procedure code may not be replaced with an amalgam restoration procedure code. Dental procedure codes must never be changed from what was submitted on the claim to what's sent to ODM in the encounter. Payment rates for services are dependent on the contract between the plan and provider.

Effective immediately, please ensure all submitted encounters include the appropriate code for the services provided to the managed care member.

Submit questions to managed care policy at managedcarepolicy@medicaid.ohio.gov.