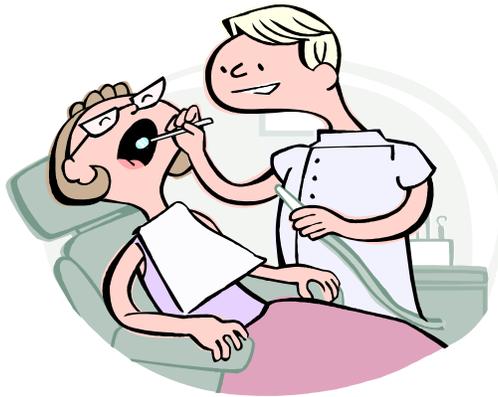


# MO HealthNet Dental Billing Book



Missouri Department of Social Services  
MO HealthNet Division

Created by the Provider Education Unit

# **MO HealthNet Dental Billing Book**

## **Preface**

This Dental training booklet contains information to help you submit claims correctly. The information is only recommended for MO HealthNet dental providers and billers. This booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

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## **SECTION 1**

### **MO HealthNet PROGRAM RESOURCES**

<http://dss.mo.gov/mhd/providers/>  
**CONTACTING MO HealthNet**

#### **PROVIDER COMMUNICATIONS**

##### **573-751-2896**

MO HealthNet providers can contact the Provider Communications Unit with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and participant eligibility questions and verification.

The IVR (Interactive Voice Response) system is accessed by calling the 573-751-2896 number. The IVR system can address participant eligibility, last two check amounts and claim status inquiries. At anytime during the IVR options, providers may select "0" to speak with the next available specialist. Calls are put into a queue and will be answered in the order received. Providers must use a touchtone phone to access the IVR.

Providers may send and receive secure E-mail inquiries to MO HealthNet Provider Communications and Technical Help Desk Staff. This application is available through the MO HealthNet web portal at [emomed.com](http://emomed.com). Once logged in and on the eProvider page, click on the 'Provider Communications Management' icon, this opens the 'Manage Provider Communications' page. From here, click on 'New Request' to open the 'Create New Request' form to enter and submit an inquiry. Providers are limited to one inquiry per E-mail. The user submitting the E-mail inquiry will be notified via E-mail when they have a response available to their inquiry.

The Provider Communications Unit also responds to written inquiries. Written inquiries should be sent to:

Provider Communications Unit  
PO Box 5500  
Jefferson City, Missouri 65102

#### **WIPRO INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK**

##### **573-635-3559**

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Wipro Infocrossing Internet billing service.

**PROVIDER ENROLLMENT**

Providers are required to notify Missouri Medicaid Audit Compliance, Provider Enrollment Section regarding changes to the Provider Master File. Changes include, but are not limited to, physical address, tax identification, ownership, individual's name or practice name, or NPI number.

Changes may be reported via E-mail at [mmac.providerenrollment@dss.mo.gov](mailto:mmac.providerenrollment@dss.mo.gov) or by mail to:

Missouri Medicaid Audit and Compliance  
Provider Enrollment Section  
PO Box 6500  
Jefferson City, Missouri 65102

**THIRD PARTY LIABILITY****573-751-2005**

Call the Third Party Liability Unit to report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a MO HealthNet participant.

**PROVIDER EDUCATION****573-751-6683**

Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for MO HealthNet claims. Contact the unit for training information and scheduling. Providers may also send E-mails to the unit at [mhd.provtrain@dss.mo.gov](mailto:mhd.provtrain@dss.mo.gov).

**PARTICIPANT SERVICES****800-392-2161 or 573-751-6527**

The Participant Services Unit assists participants regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

**MO HEALTHNET PHARMACY AND CALL CENTER****800-392-8030**

Providers can call this toll free number to:

- Request pre-certification for specific DME items;
- Initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the MO HealthNet program;
- Request information on Medicare Part D;
- Request a drug prior authorization; or,
- Request medical pre-certification for a CT scan or MRI.

Providers are encouraged to sign up for the MO HealthNet web tool – CyberAccess<sup>SM</sup> – which automates the pre-certification process. To become a CyberAccess<sup>SM</sup> user, contact the Xerox Care and Quality Solutions help desk at 888-581-9797 or 573-632-9797 or send an E-mail to CyberAccessHelpdesk@xerox.com. The CyberAccess<sup>SM</sup> tool allows each pre-certification to automatically reference the individual participant's claim history, including ICD-9 diagnosis codes and procedure codes.

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION**

Billing providers who want to exchange electronic information transactions with MO HealthNet can access the HIPAA-EDI Companion Guide online by going to the MO HealthNet Division web page at <http://dss.mo.gov/mhd/providers/> and click on the HIPAA-EDI Companion Guide link in the column on the right hand side of the page. This will take you directly to the EDI Companion Guide and X12 Version 5010 Companion Guide links.

For information on the MO HealthNet Trading Partner Agreement, click on the link to Section 1- Getting Started; then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Wipro Infocrossing Healthcare Services Help Desk, 573-635-3559.

## **INTERACTIVE VOICE RESPONSE (IVR) 573-751-2896**

The Provider Communications Unit Interactive Voice Response (IVR) system, 573-751-2896, requires a touchtone phone. The ten-digit NPI (National Provider Identifier) number must be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options listed below. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

### **Option 1     Participant Eligibility**

Participant eligibility must be verified each time a participant presents and should be verified prior to the service. Eligibility information can be obtained by a participant's MO HealthNet number (DCN), social security number and date of birth, or if a newborn, using the mother's MO HealthNet number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

- Option 2     Last Two Check Amounts  
Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.
- Option 3     Claim Status  
After entering the participant's MO HealthNet ID number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

## **INTERNET SERVICES FOR MO HealthNet PROVIDERS**

The MO HealthNet Division (MHD), in cooperation with Wipro Infocrossing Healthcare Services, has an Internet service for MO HealthNet providers. MO HealthNet providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify participant eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The web site address for this service is [emomed.com](http://emomed.com). Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate in the service, the provider must apply online at <http://dss.mo.gov/mhd/providers/>. At this site choose the "Apply for Electronic/Internet system access" link in the right hand column. Each user is required to complete this online application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the [emomed.com](http://emomed.com) web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the online Internet application should be directed to the Wipro Infocrossing Healthcare Services Help Desk, 573-635-3559.

*An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.*

This web site, emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

### **VERIFYING PARTICIPANT ELIGIBILITY THROUGH THE INTERNET**

Providers can access MO HealthNet participant eligibility files via the web site. Functions include eligibility verification by participant ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

### **MO HealthNet CLAIMS SUBMISSION THROUGH THE INTERNET**

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

### **OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET**

The MO HealthNet program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive paper RAs. All providers and billers must have Internet access to obtain the printable electronic RA via the Wipro Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services.

### **RECEIVE PUBLIC FILES THROUGH THE INTERNET**

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

## **MO HealthNet PROVIDER MANUALS AND BULLETINS ONLINE**

**<http://dss.mo.gov/mhd/providers/>**

MO HealthNet provider manuals are available online at the MHD web site, <http://dss.mo.gov/mhd/providers/>. To access the provider manuals, click on the "Provider Manuals" link at the bottom of the page or in the right-hand column under "Featured Links". This brings up the <http://manuals.momed.com/manuals/> page where a search by manual and specific criteria can be done.

MO HealthNet provider bulletins are also available at the MHD web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear online at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

## CLAIM PROCESSING SCHEDULE FOR FISCAL YEAR 2014

<u>FINANCIAL CYCLE DATE**</u>		<u>PROVIDER CHECK DATE</u>	
Friday	06/21/2013	Friday	07/05/2013
Friday	07/12/2013	Friday	07/19/2013
Friday	07/26/2013	Tuesday	08/06/2013
Friday	08/16/2013	Friday	08/23/2013
Friday	08/30/2013	Tuesday	09/10/2013
Friday	09/13/2013	Tuesday	09/24/2013
Friday	09/27/2013	Monday	10/07/2013
Friday	10/11/2013	Tuesday	10/22/2013
Friday	10/25/2013	Tuesday	11/05/2013
Friday	11/08/2013	Wednesday	11/20/2013
Friday	11/22/2013	Thursday	12/05/2013
Friday	12/13/2013	Friday	12/20/2013
Friday	12/27/2013	Tuesday	01/07/2014
Friday	01/10/2014	Thursday	01/23/2014
Friday	01/24/2014	Wednesday	02/05/2014
Friday	02/07/2014	Thursday	02/20/2014
Friday	02/21/2014	Wednesday	03/05/2014
Friday	03/07/2014	Thursday	03/20/2014
Friday	03/21/2014	Friday	04/04/2014
Friday	04/04/2014	Friday	04/18/2014
Friday	04/18/2014	Friday	05/02/2014
Friday	05/09/2014	Friday	05/16/2014
Friday	05/23/2014	Thursday	06/05/2014
Friday	06/06/2014	Friday	06/20/2014

**\*\*Closeout is 5:00 p.m. on the date shown**

### State Holidays

July 4, 2013 Independence Day

September 2, 2013 Labor Day

October 14, 2013 Columbus Day

November 11, 2013 Veteran's Day

November 28, 2013 Thanksgiving Day

December 25, 2013 Christmas Day

January 1, 2014 New Year's Day

January 20, 2014 Martin Luther King's Birthday

February 12, 2014 Lincoln's Birthday

February 17, 2014 Washington's Birthday

May 8, 2014 Truman's Birthday

May 26, 2014 Memorial Day

## **SECTION 2**

# **ADA 2002, 2004 CLAIM FILING INSTRUCTIONS**

The ADA (American Dental Association) 2002, 2004 version dental claim form should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

Wipro Infocrossing Healthcare Services  
P.O. Box 5300  
Jefferson City, MO 65102

Or submitted electronically at [www.emomed.com](http://www.emomed.com).

Information about ordering claim forms and provider labels is in Section 3 of the MO HealthNet Provider Manual available at <http://www.dss.mo.gov/mhd/providers/index.htm>.

**NOTE:** An asterisk (\*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (\*\*) beside the field number indicates a field is required in specific situations.

<b><u>Field number and name</u></b>	<b><u>Instructions for completion</u></b>
1-2.	Not required.
3* Primary Payer Information	Enter Name, Address, City, State and Zip Code for the insurance company or third-party payer.
4-11** Other Coverage	Required only if participant has a second dental policy. Leave blank if there is no other Dental Coverage
12-17** Primary Insured Information	When verifying the participant's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field #32, section: "Other Fees". Leave blank if there is no other dental coverage.
18-19.	Not required.
20* Patient Name	Enter the participant's last name, first name and middle initial as shown on the participant's MO HealthNet ID card. Enter the participant's street address, city of residence and state.
21. Date of Birth	Not required.

22.	Sex	Not required.
23*	Patient ID Number	Enter the participant's eight-digit MO HealthNet identification number (DCN) exactly as shown on the participant's ID card.
24*	Procedure Date	Enter the actual date services were rendered in MM/DD/CCYY numeric format. Reminder: The date of service for dentures (full or partial) is the date of placement.
25.**	Oral Cavity	<p>Report the area of the oral cavity. Alveoloplasties, gingivectomies, and gingivoplasties should be billed using 10 for upper right quadrant, 20 for upper left quadrant, 30 for lower left quadrant and 40 for lower right quadrant. In any of the following instances, leave this field blank:</p> <ul style="list-style-type: none"><li>a. the procedure identified in #29 requires the identification of a tooth or a range of teeth;</li><li>b. the procedure identified in #29 incorporates a specific area of the oral cavity in its nomenclature; or,</li><li>c. the procedure identified in #29 does not relate to any portion of the oral cavity.</li></ul>
26.	Tooth system	Not required.
27**	Tooth Number or Letter	<p>Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, this field may be left blank. The valid values are:</p> <ul style="list-style-type: none"><li>A-T - Deciduous teeth</li><li>1-32 - Permanent teeth</li><li>AS-TS - Deciduous supernumerary teeth</li><li>51-82 - Permanent supernumerary teeth</li></ul> <p>When billing for partial dentures, enter the tooth number of one of the teeth being replaced in this field.</p>
28**	Tooth Surface	<p>Enter the appropriate service code, if applicable, otherwise, leave blank. The valid values are:</p> <ul style="list-style-type: none"><li>M – Mesial</li><li>D – Distal</li><li>O – Occlusal</li><li>L – Lingual</li><li>I – Incisal</li><li>F – Facial</li><li>B – Buccal</li></ul>

29*	Procedure Code	Enter the five-digit procedure code for the service performed as well as any applicable modifiers.
30**	Description	Only required in specific situations as described in Section 13 of the MO HealthNet Provider Manual.
31*	Fee	Enter the provider's usual and customary fee for the procedures(s) performed. Do not subtract the copay or coinsurance amounts from the charge.
32.**	Other Fees	When other charges are applicable to dental services provided, this field must be reported. Enter the amount here.
33*	Total Fee	Enter the total of the charges shown.
34.	Missing Teeth	Not required.
35**	Remarks	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.  If applicable, provide the billing provider taxonomy code.
36-38		Not required.
39**	Number of Enclosures	Complete whether or not radiographs, oral images, or study models are submitted with the claim. If no enclosures are submitted, enter 00 in each of the boxes to verify that nothing has been sent and therefore, no possible attachments are missing.
40.	Is treatment Orthodontics?	If no, skip to #43. If yes, answer #41.
41.	Date Appliance placed	Required if answer to #40 was yes.
42.	Months of Treatment Remaining	Not required.
43.	Replacement of Prosthesis	This item applies to crowns and all fixed or removable prosthesis: a. If claim does not involve a prosthetic restoration check "no" and proceed to #45. b. If claim is for the initial placement of a crown or fixed or removable prostheses, check "no" and go to #45 c. The participant has previously had these teeth replaced

- by a crown, check "yes" and go to #44.
44. Date of Prior Placement Complete if the answer to #43 was yes.
45. Treatment Resulting From If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box and proceed to items #46 & 47. If services are not the result of an accident, skip to item #48. The valid values are:  
AA – Auto Accident  
EM – Employment Related  
OA – Other Accident
46. Accident Date Enter the date on which the accident in #45 occurred, otherwise leave blank.
47. Auto Accident State Enter the state in which the auto accident in #45 occurred, otherwise leave blank.
- 48\* Name, Address, City, State Enter the name and complete address of the billing dental provider.
- 49\* Provider ID Enter the NPI assigned to the billing dentist or dental entity.
50. License # Not required.
51. SSN or TIN Not required.
52. Phone Number Enter provider's phone number
- 53.\* Signature & Date Signature of treating dentist and the date form is signed.
- 54.\*\* Provider ID Enter the NPI of the treating dentist (performing provider).
55. License # Not required.
- 56.\*\* Address, City, State, MO Enter the name and complete address of the treating dentist (performing provider).
57. Phone Number Enter treating dentist phone number.
- 58.\*\* Treating Provider Specialty If applicable, provide the treating dentist (performing provider) taxonomy code.

## **SECTION 3 ADJUSTMENTS & RESUBMISSIONS**

Providers who are paid incorrectly for a claim should submit an individual adjustment via the Wipro Infocrossing web portal at, [www.emomed.com](http://www.emomed.com). Adjustments may not be requested when the net difference in payment is less than \$4.00, or \$.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the \$4.00, or \$.25 minimum limitation does not apply.

Providers receive real time notification of receipt for adjustments for claim credits submitted via the Internet. The status of the adjustment is provided.

### **Paid Claim Options on eMomed**

Only claims in 'paid' or 'to be paid' status can be voided or replaced. Voiding and replacing claims are done through "Claim Management" on the [emomed.com](http://emomed.com) website. Providers may do claim search by the ICN (Internal Control Number), the participant's DCN (MO HealthNet ID number) or by the date the claim was originally submitted.

**VOID** - To void a claim from the claim status screen on eMomed, select 'Void' from the menu bar. When the claim is brought up, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The claim has now been submitted to be voided or credited in the system.

**REPLACEMENT** – To replace a claim from the claim status screen on eMomed, select 'Replacement' from the menu bar. When the claim is brought up, corrections can be made to the claim by selecting the appropriate edit button then saving the changes. Once all corrections have been made scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button. The replacement claim with corrections has now been submitted.

### **Resubmitting Denied Claims on eMomed**

Providers can resubmit denied claims electronically on the eMomed website. Claims may be resubmitted by entering a new claim. Claims may also be resubmitted by selecting 'Timely Filing' or 'Copy Claim' from the menu bar.

**Timely Filing** – To reference timely filing, choose the 'Timely Filing' tab on the claim status screen on eMomed. This function automatically places the ICN of the claim chosen. Make certain the ICN chosen meets MO HealthNet's timely filing criteria. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim' button.

**Copy Claim/Original** – This option is used to copy a claim just as it was originally entered on eMomed. Corrections can be made to the claim by selecting the appropriate edit button, then saving the changes. Once corrections are made and saved to the claim, scroll to the bottom of the claim and click on the highlighted 'Submit Claim'.

**Copy Claim/Advanced** – This option is used when the claim was filed using the wrong NPI number or wrong claim form. An example would be if the claim was entered under the individual or performing provider NPI and should have been submitted under the group NPI. If the claim was originally filed under the wrong claim type, only the participant DCN and name information will transfer over to the new claim type. An example would be if the claim was submitted as a medical claim and should have been submitted as a dental claim.

**Claim Status Codes**

Once a claim is submitted, 'Claim Received' is given in real time on the 'Claim Status' page. In addition, one of the following claim status codes is provided:

**C** – Claim has been **Captured** and is still processing. This claim should not be resubmitted until it has a status of I or K.

**I** – Claim is to be **Paid**.

**K** – Claim is to be **Denied**. This claim can be corrected and resubmitted immediately.

## SECTION 4 PRIOR AUTHORIZATION

### Prior Authorization

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to participants under the age of 21 through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request form must be completed and mailed to Wipro Infocrossing Healthcare Services, Inc., PO Box 5700, Jefferson City, MO, 65102. Providers should keep a copy of the original PA request form as the form is not returned to the provider.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- PA requests are not to be submitted for services prescribed to an ineligible participant. State Consultants review for medical necessity only and do not verify a participant's eligibility.
- Expanded HCY (EPSDT) services are limited to participants under the age of 21 and are **not** reimbursed for participants 21 and over even if the prior authorization request is approved.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Wipro Infocrossing Healthcare Services.
- An approved prior authorization **does not** guarantee payment.

Whether the prior authorization is approved or denied, a disposition letter will be mailed to the provider containing all of the detail information related to the PA request. All other documentation submitted with the PA request will not be returned, with the exception of study models submitted with requests for orthodontia treatment. Requests for changes to an approved PA must be indicated on the disposition letter and submitted to Wipro Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted. Denied or incomplete PA requests must be resubmitted to Wipro Infocrossing with additional documentation as needed. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request.

Instructions for completing the PA request form are found in Section 8 of the MO HealthNet *Provider's Manual* available on the Internet at <http://www.dss.mo.gov/mhd/providers/index.htm>. Instructions are also self-contained on the back of the PA request form.

## SECTION 5 ELIGIBILITY RESTRICTIONS

A participant must be eligible for MO HealthNet benefits for each date of service provided in order for a provider to receive payment from MO HealthNet for those services. This is also a requirement even when the service has been prior authorized. It is the provider's responsibility to verify a participant's MO HealthNet eligibility. The following ME (medical eligibility) codes have restricted dental benefits:

**55-Qualified Medicare Beneficiary (QMB):** A mandatory coverage group under MO HealthNet providing payment for qualified individuals of deductible and coinsurance amounts for *Medicare covered services*.

**58 & 59-Presumptive Eligibility (TEMP):** Coverage is limited to ambulatory prenatal care services only.

**80 & 89-Women's Health Services:** Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases (STDs).

**82-Missouri Rx:** Participants only have pharmacy Medicare Part D wrap around benefits through the MoRx.

### Limited Benefit Package for Adult Categories of Assistance

The following categories of assistance receiving a limited benefit package are eligible for dental care only if it is related to trauma or when the absence of dental treatment would adversely affect the participant's preexisting medical condition.

- 01 Old Age Assistance
- 04 Permanently and Totally Disabled
- 05 MO HealthNet for Families – Adult
- 10 Refugees other than Cuban, Haitian, or Russian Jew
- 11 MO HealthNet Old Age Assistance
- 13 MO HealthNet Permanently and Totally Disabled
- 14 Supplemental Nursing Care – Old Age Assistance
- 16 Supplemental Nursing Care – Permanently and Totally Disabled
- 19 Cuban Refugee
- 21 Haitian Refugee
- 24 Russian Jew
- 26 Ethiopian Refugee
- 83 Breast or Cervical Cancer Control Project (BCCCP) – Presumptive
- 84 Breast or Cervical Cancer Control Project (BCCCP) – Regular
- 85 Ticket to Work Health Assurance Program (TWHAP) – Premium
- 86 Ticket to Work Health Assurance Program (TWHAP) – Non-Premium

Dental services for individuals in the above categories of assistance may be provided if the dental care is related to:

- ❖ Traumatic injury of jaw, mouth, teeth or other contiguous (adjoining) sites (above the neck).
- ❖ Medical condition when a written referral from the participant's physician states the absence of dental treatment would adversely affect the stated preexisting medical condition. This referral must be maintained in the participant's record and made available to the MO HealthNet Division (MHD) or its agent upon request. The referral must include the referring physician's name, type of dental services needed and the medical condition that would be adversely affected without the dental care.

MO HealthNet eligible adults in the assistance categories for pregnant women or the blind and vendor nursing facility residents continue to receive the full comprehensive benefit package.

Additional information regarding the limitations and restrictions for the above categories of assistance can be found in Sections 1 and 13 of the MO HealthNet *Provider's Manual* available on the Internet at <http://www.dss.mo.gov/mhd/providers/index.htm>.

## SECTION 6 COPAYMENT – COINSURANCE

Providers of service are responsible for collecting copayment and coinsurance amounts from participants, unless otherwise exempt. The provider shall collect copayment or coinsurance from the participant at the time each service is provided or at a later date. Providers may not deny or reduce services to participants, otherwise eligible for benefits, solely on the basis of the participant's inability to pay. Whether or not the participant is able to pay the required amount at the time the service is rendered, the amount is a legal debt and is due and payable to the provider of service. The MO HealthNet program shall not increase its reimbursement to a provider to offset any uncollected copayment or coinsurance from a participant.

### Copayment

The following copayment amounts are applied to *dental* services; CPT or surgical procedures are not subject to copayment. The amount of copayment to be collected from the participant is based on the MO HealthNet maximum allowed amount for each procedure code billed according to the following schedule:

<u>MO HealthNet Maximum Allowed Amount for Each Procedure</u>	<u>Participant Copayment</u>
\$10.00 or less	\$ .50
\$10.01 - \$25.00	\$ 1.00
\$25.01 - \$50.00	\$ 2.00
\$50.01 or more	\$ 3.00

### Exemptions to Copayment

- Participants under the age of 19 or receiving MO HealthNet with ME codes 06, 33, 34, 36, 40, 52, 56, 57, 60, 62, 64, 65, 71, 72, 73, 74, 75, 87 and 88;
- Foster Care participants under the age of 21 receiving MO HealthNet with ME codes 07, 08, 28, 29, 30, 37, 49, 50, 51, 63, 66, 67, 68, 69 and 70;
- Participants receiving MO HealthNet services for the blind under ME codes 02, 03, 12 and 15;
- Participants receiving MO HealthNet services for pregnant women under ME codes 18, 43, 44, 45, 58, 59 and 61;
- Services provided to Managed Care enrollees;
- Participants residing in a skilled nursing facility, an intermediate care nursing facility, a residential care home, an adult boarding home or a psychiatric hospital; or participants receiving MO HealthNet under ME codes 23 and 41;
- When coinsurance is charged for dentures

**Denture Coinsurance**

The coinsurance amount applies to each interim, partial and full denture unless one of the following exceptions applies. The amount collected from the participant is 5% of the lesser of MO HealthNet's maximum allowable amount or the provider's billed charge.

- Participants under the age of 19;
- Foster Care participants under the age of 21
- Participants residing in a skilled nursing facility, psychiatric hospital, residential care facility or an adult boarding home; and
- Managed health care plan enrollees for services provided by the plan.

<u>Procedure Code</u>	<u>MO HealthNet Maximum Allowable</u>
D5110	\$ 503.75
D5120	\$ 504.53
D5130	\$ 549.86
D5140	\$ 550.25
D5211	\$ 377.81
D5212	\$ 379.75
D5213	\$ 542.50
D5214	\$ 542.50
D5225	\$ 466.16
D5226	\$ 467.33
D5820	\$ 286.00
D5821	\$ 286.00
D5860	\$ 621.94
D5861	\$ 620.00

Denture procedure codes D5110 through D5821 are a covered service for participants under the age of 21 or under a category of assistance for pregnant women, the blind or vendor nursing facility residents. Procedure codes D5860 and D5861 require an approved prior authorization and are restricted to participants under the age of 21.

Federally Qualified Health Centers (FQHC) are to collect copayment and coinsurance amounts from MO HealthNet participants according to the maximum allowed amounts on the MO HealthNet fee schedule available at <http://dss.mo.gov/mhd/providers/>. The FQHC should not collect copayments and coinsurance according to the reimbursement amount received from the MO HealthNet program.

## SECTION 7 BENEFITS & LIMITATIONS

MO HealthNet will only consider dental services for adults, age 21 and over, if the dental care is related to trauma of the mouth, jaw, teeth or other contiguous sites as a result of injury or if the absence of dental treatment would adversely affect a preexisting medical condition. Services for participants under age 21 remain unchanged as well as services for adult participants under a category of assistance for pregnant women, the blind, or residents of a vendor nursing facility.

### Oral Evaluation Codes

A comprehensive oral evaluation, D0150, is limited to once per provider for a new patient or when an established patient has not been seen within two (2) years for a periodic oral exam, or when an established patient presents with a significant health change that can be documented in the patient's record.

The periodic oral evaluation code, D0120, must be used for all other general office visits for an established patient.

The limited oral evaluation code, D0140, must be used when the patient presents with a specific problem or dental emergency, to include a visual exam of the mouth by the dental provider.

The oral evaluation of a patient under the age of three (3), D0145 can be used each time the patient presents for a dental visit.

### Office Visit Limitations

An office visit includes, but is not limited to, the following:

- Oral examination of the participant for symptoms or indications of a dental condition requiring treatment;
- Establishment of the written participant record;
- Surgical gloves, drapes, tongue depressors, swabs, gauze, medications, administration of injection(s) and any other items or supplies considered to be routine to the dentist's private practice; and
- Local anesthesia.

Office visits are limited to one visit per participant per provider on any given day and may not be billed on the same date of service as another office or outpatient visit, dental screen, subsequent hospital visit, consultation or nursing home visit. An office visit may be billed on the same date of service as a hospital admission.

Billing for an office visit is *expected only* for the first session in a series of treatments.

Providers cannot bill a participant for missed/broken appointments, nor will the MO HealthNet Division reimburse providers for missed/broken appointments.

**Preventative**

Prophylaxis of either the upper or lower arch or both arches is covered once in a six-month period by the same provider. Prophylaxis must include scaling and polishing of teeth. Prophylaxis must be a separate service from fluoride treatment.

D1110 – Ages 13-125

D1120 – Ages 0-12

Topical fluoride treatment is a covered service for participants under the age of 21.

Fluoride treatment for participants age 21 and over is limited to the following criteria:

- Participants with rampant or severe caries (decay);
- Participants who are undergoing radiation therapy to the head and neck;
- Participants with diminished salivary flow;
- Mentally retarded individuals who cannot perform their own hygiene maintenance; or
- Participants with cemental or root surface caries secondary to gingival recession.

Fluoride varnish is covered for participants under the age of 21 when applied in a dental office.

Fluoride treatment is limited to one (1) application of stannous fluoride, acid-phosphate fluoride or fluoride varnish for each participant, two (2) times per rolling year, per provider.

Dental sealants may be applied only on healthy, without occlusal restorations, first and second permanent molars. Valid tooth numbers are 2, 3, 14, 15, 18, 19, 30 and 31. No payment is made for sealants applied to third molars. Sealants are not a covered service if applied to primary teeth. Sealants may only be applied every three years per provider, per participant, per tooth.

**Antimicrobial Agents**

The localized delivery of antimicrobial agents may only be billed in conjunction with prior authorized scaling and root planning. The following CDT codes for scaling and root planning must be billed on the same date of service as D4381.

- D4341 periodontal scaling and root planning-four (4) or more teeth per quadrant
- D4342 periodontal scaling and root planning-one (1) to three (3) teeth per quadrant

The participant's record must document the specific agent administered. A Chorhexidine rinse is not covered under D4381. The antimicrobial agent must be reported in field #30 in the ADA claim form.

### Restorations

- The same restoration on the same tooth in less than a six-month interval is not allowed.
- Restorations for either permanent or primary teeth include the fees for local anesthesia and treatment base, where required.
- When billing for any of the amalgam, composite or resin restorations, the tooth number and tooth surface code(s) must be entered on the claim.
- Amalgam and resin restorations on posterior teeth are covered; resin restorations are covered on *anterior* teeth.
- Fees for amalgam fillings include polishing.

### Crowns

- A fixed crown of chrome, porcelain/ceramic or stainless steel is covered.
- A fixed polycarbonate crown is covered for an anterior tooth; a fixed polycarbonate crown for a posterior tooth is not covered.
- The fee for a fixed crown includes all prior preparations.
- Porcelain crowns are covered for participants under the age of 21 on a prior authorized basis.
- Provisional crowns are a covered service if procedure code D2799 is used. A crown utilized as an interim restoration of a least six (6) months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This is not to be used as a temporary crown for a routine restoration.
- Bridges, bridge pontics and bridge retainers are covered for participants age 20 and under but must be prior authorized.
- Recementation of a bridge, crown or inlay is a covered service.
- Replacement of a broken acrylic or porcelain facing where the post backing is intact is covered.
- Replacement of a broken acrylic or porcelain facing where the post backing is broken is covered.
- Replacement crowns are not allowed within six (6) months of the previous placement by the same provider.

### Extractions

- Alpha characters A – T are used to identify primary teeth; AS – TS are for supernumerary primary teeth.
- Tooth numbers 1 – 32 identify permanent teeth; 51 – 82 are used to identify supernumerary permanent teeth.
- The location of a supernumerary tooth must be provided on the claim form.

- Surgical extraction of impacted teeth is a covered service. Claims submitted for removal of impacted teeth other than third molars must include x-rays.
- Pre-operative x-rays involving extractions are not to be submitted unless requested by the State Dental Consultant.
- Post-operative x-rays of extractions are not covered.
- Extraction fees for routine and impacted teeth (including supernumerary teeth) include the fee for local anesthesia and post-operative treatment.

*Please refer to sections 13 and 19 of the MO HealthNet Dental Provider Manual for comprehensive coverage of dental benefits and limitations as well as covered procedure codes. The manual is available on the Internet at <http://dss.mo.gov/mhd/providers/>.*

## **SECTION 8 DENTURES**

Dentures must be dispensed to the participant before the provider bills MO HealthNet; the date of service for dentures is the date of placement. Holding dentures until MO HealthNet payment is received constitutes payment for services not provided and is in violation of State Regulation 13 CSR 70-3.030(2)(A)23. Providers may not request or accept a deposit from a MO HealthNet participant and then refund it after payment is received from MO HealthNet. Accepting a deposit or a portion of the fee or charge is in violation of State Regulation 13 CSR 70-3.030(3)(A)9. *This does not apply to the denture coinsurance requirement.* MO HealthNet reimbursement for dentures includes routine visits necessary in the steps required for the denture, full or partial. This includes impressions, try-ins and adjustments for six months from the date of placement.

Dentures, full or partial, are not covered for those adult participants with a limited benefit package.

**Prior authorization is not required for dentures, full or partial.** Prior authorization is required for overdentures, D5860 and D5861; however coverage is restricted to participants under the age of 21.

Immediate and interim dentures are restricted to once in a lifetime.

Replacement dentures are covered in cases when dentures no longer fit properly due to:

- significant weight loss as a result of illness;
- loss of bone or tissue due to some form of neoplasm and/or surgical procedure;
- normal wear and/or deterioration resulting from use over an extended period of time.

NOTE: Replacement dentures do not require prior authorization. PA requests submitted to Wipro Infocrossing will not be approved. Dentists must use their professional judgment in determining if the participant's denture meets the above replacement criteria. The reason for replacing the denture must be properly documented in the participant's record.

Denture adjustments are covered, but not for the originating dentist of a new denture until six months from the date of placement. It is the responsibility of the dentist who placed the denture to assure correct fit within this period.

**Rebases and Relines**

One reline or rebase is allowed during the 12 months following placement of immediate dentures. The second reline or rebase is allowed 12 months following the first reline. Additional denture relining or rebasing is limited to 36 months from the date of the preceding reline or rebase.

The initial reline or rebase of a partial or replacement denture is not covered until 12 months after the placement of the denture. Additional relining or rebasing is limited to 36 months from the date of the last preceding reline or rebase.

Denture relines or rebases, where necessary, may be accomplished on the same date of service as repair of a broken denture.

Rebasing of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Laboratory reline of any denture, full or partial, must include a new impression of the old denture, check bite, and full-process procedure.

Tissue conditioning, D5820 and D5821, is not covered for the same date of service as a reline and/or rebase.

## SECTION 9 CUSTOM-MADE ITEMS

MO HealthNet provider payment may be made for custom-made items such as dentures when a participant becomes ineligible (either through complete loss of MO HealthNet eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

The following prerequisites apply to all such payments:

- The participant must have been eligible when the service was first initiated (and following receipt of an approved PA request form if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for a medical purpose by any other individual;
- The custom-made device or item must have been delivered or placed if the participant is living;
- The provider must have entered "See Attachment" in the "Remarks" section of the dental claim form (field #35) and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living participant or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value, if any, which the provider estimates is represented in cases where delivery or placement is not possible.

Payments regarding the aforementioned devices are made as follows:

- If the item is received by the participant following loss of MO HealthNet eligibility or eligibility for the service, the payment is the lesser of the billed charge or the MO HealthNet maximum allowable for the total service, less any applicable coinsurance and any payments made by another insurance company.
- If the item cannot be delivered or placed due to death of the participant, the payment is the lesser of the "net billed charge" or the MO HealthNet maximum allowable for the total service, less any applicable coinsurance. The "net billed charge" is the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

Salvage value exists whenever there is further profitable use that can be made by the provider of materials or components of the device or item.

**Dentures are an example of an item representing no reasonable salvage value.**

The date of service that is shown on the claim form for the item (dentures, etc.) when either of the above situation applies, must be the last date on which service is provided to the eligible participant (and following receipt of an approved PA request if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying participant eligibility each time a service is provided. The use of a date for which the participant is no longer eligible for MO HealthNet coverage of the service results in a denial of the claim. The claim (with attachment) is to be submitted to the fiscal agent (currently Wipro Infocrossing Healthcare Services) in the same manner as other claims.

Payments made as described in the above situations constitute the allowable MO HealthNet payment for the service. Other than any applicable coinsurance due, no further collection from the participant or other persons is permitted.

If the provider determines the participant has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the participant must be immediately advised that completion of the work and delivery or placement of the item is not covered by MO HealthNet. It is then the participant's choice whether to request completion of the work on a private payment basis. If the participant's death is the reason for loss of eligibility, the provider can, of course, proceed no further and there is no claim for the non-provided item of service.

If a participant refuses to accept the item/service, MO HealthNet does not reimburse the provider.

## SECTION 10

# RESOURCE PUBLICATIONS FOR PROVIDERS

### CURRENT DENTAL TERMINOLOGY

MO HealthNet currently uses the CDT 2013 (Current Dental Terminology). This publication is a series of dental procedure codes used for reporting services rendered. All providers should obtain and refer to the CDT 2013 to assure proper coding.

### CURRENT PROCEDURE TERMINOLOGY (CPT)

MO HealthNet also uses the latest version of the *Current Procedural Terminology (CPT)*. All providers are encouraged to obtain and refer to the CPT book to assure proper coding.

Both of the above publications can be ordered from the following:

Practice Management Information Corporation  
4727 Wilshire Blvd., Ste. 300  
Los Angeles, CA 90010  
800/663-7467  
<http://pmiconline.com>

Ingenix Publications  
P.O. Box 27116  
Salt Lake City, UT 84127-0116  
[www.IngenixOnline.com](http://www.IngenixOnline.com)

## SECTION 11 RECIPIENT LIABILITY State Regulation 13CSR 70-4.030

If an enrolled MO HealthNet provider does not want to accept payment from MO HealthNet but instead wants the participant to be responsible for the payment (be a private pay participant), there must be a written agreement between the participant and the provider in which the participant understands and agrees that MO HealthNet will not be billed for the service(s) and that the participant is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the participant and the provider. **The written agreement must be prepared prior to the service(s) being rendered.** A copy of the written agreement must be kept in the participant's medical record.

If there is no evidence of this written agreement, the provider cannot bill the participant and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization), the participant is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

### MO HEALTHNET RECIPIENT REIMBURSEMENT (MRR)

The Medicaid Recipient Reimbursement program (MRR) is devised to make payment to those participants whose eligibility for MO HealthNet benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Participants are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The participant is furnished with special forms to have completed by the provider(s) of service. If MO HealthNet participants have any questions, they should call (800) 392-2161.

# NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS employees, applicants for employment, and contractors are to be treated equitably regardless of race, color, national origin, ancestry, genetic information, pregnancy, sex, sexual orientation, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain nondiscrimination clauses as mandated by the **Governor's Executive Order 94-3**, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

DSS applicants for, or recipients of, services from DSS are to be treated equitably regardless of race, color, national origin, ancestry, sex, age, sexual orientation, disability, veteran status, or religion. Appropriate interpretive services will be provided as required for the visually or hearing impaired and for persons with language barriers. Applicants for, or recipients, of services from DSS who believe they have been denied a service or benefit may file a complaint by calling the DSS Office for Civil Rights at (800) 776-8014 (Toll Free); or Relay Missouri for hearing and speech impaired at (800) 735-2466 (Voice); (800) 735-2966 (Text). Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services  
Office for Civil Rights  
P. O. Box 1527  
Jefferson City, MO 65102-1527

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability, or religion may also file a complaint by writing to:

U.S. Department of Health and Human Services  
Office for Civil Rights  
601 East 12<sup>th</sup> Street, Room 248  
Kansas City, MO 64106  
(816) 426-7277 (Voice); (816) 426-7065 (TDD)

Additionally, any person who believes they have been discriminated against because of race, color, national origin, age, sex, disability, religion, or political belief in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the:

U.S. Department of Agriculture  
Office of Adjudication and Noncompliance  
1400 Independence Avenue, SW  
Washington, DC 20250-9410  
(866) 632-9992 (Voice); (800) 877-8339 (TDD); (800) 845-6136 (Spanish)

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

April 2013