

POLICY ISSUES IN THE DELIVERY OF DENTAL SERVICES TO MEDICAID CHILDREN AND THEIR FAMILIES

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This document is intended to address a number of Medicaid policy issues affecting the delivery of dental services to children and their families. It was developed in collaboration by the Center for Medicare and Medicaid Services (CMS) and the previous Maternal and Child Health Technical Advisory Group and finalized by the Oral Health Technical Advisory Group. This document is intended to serve as a resource. It is not intended to change current Medicaid policies nor does it impose any new requirements on States.

Policy Issue: Periodicity schedule

Question 1.a

Who establishes the periodicity schedule for dental service delivery as required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service?

Answer:

Section 1905(r)(3) of the Social Security Act (the Act) requires that each State provide dental *services*. These services must be provided in accordance with a periodicity schedule which, for dental services, must be developed at intervals which meet reasonable standards of dental practice, *as determined by the State after consultation with recognized dental organizations involved in child health care*, and, at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition. The dental periodicity schedule reflects when a child should receive dental services not when a referral should take place.

“Recognized dental organizations” may include a State’s Dental Association, Dental Advisory Committee or other groups or associations involved in child health care. Alternatively, States may choose to adopt a nationally recognized dental periodicity schedule for example, Bright Futures, the American Dental Association or the American Academy of Pediatric Dentistry.

States are required to establish their own dental periodicity schedules after appropriate consultations. In the absence of a State-specific dental periodicity schedule CMS has requested that States adopt the schedule from the American Academy of Pediatric Dentistry to ensure compliance with this important requirement. It is also important that States inform providers and beneficiaries of the schedule the State will be adhering to under its EPSDT benefit.

Question 1.b

Is the periodicity schedule for dental services the same as for medical examinations?

Answer:

No. The periodicity schedule for dental services, including dental diagnostic examinations, is not governed by the schedule for general health and physical examinations. Dental examinations for older children generally occur with greater frequency than is the case with physical examinations. The dental diagnosis must be provided by a dentist. In addition, when any screening (whether furnished as part of a general health and physical examination or as part of a dental examination) indicates, even as early as the neonatal examination, that oral health or dental services are needed at an earlier age, the needed services must be provided.

Policy Issue: Oral screening and direct referral**Question 2.a**

If a five year old child receives an oral health screening by a physician as part of a physical examination and no dental problems are apparent, is the State able to claim that it has met the requirements of EPSDT with respect to oral health?

Answer:

No. Although an oral health screening may be part of a physical examination, it does not substitute for dental services furnished by direct referral to a dentist according to the State's dental periodicity schedule.

Question 2.b

Who is responsible for assuring that needed dental examination and treatment (which may be discovered at an EPSDT screening or in another setting) is received?

Answer:

Under section 1902(a)(43) of the Act, the State is responsible for providing or arranging for dental examinations upon request, and arranging for corrective treatment. These responsibilities can be met through direct referral to ensure that the child gets to the dentist in a timely manner. Prior to enactment of OBRA 1989, CMS issued regulations that required direct referral to a dentist at age 3 or an earlier age, if determined medically necessary. The law, as amended by OBRA 1989, has superseded that requirement and instead requires that dental services (including initial direct referral to a dentist) conform to the State's periodicity schedule, and that the schedule must be established after consultation with recognized dental organizations involved in child health care. As noted

in Part 5 of the State Medicaid Manual, it is up to the State to determine if the direct referral to the dentist in accordance with the State's dental periodicity schedule is provided by the EPSDT screening provider or the State agency. The "referral" may be completed in several ways depending on the State's Medicaid dental program. However, one important aspect of the referral is that the beneficiary is informed of the availability and importance of receiving dental services, and how and where to access those services. As noted in the response to Question 1, recognized dental organizations may include State Dental Associations, State Dental Advisory Committees or other groups or associations involved in child health care.

Question 2.c

Under certain conditions, may alternative resources be used in assessing oral health status when there is an apparent lack of dental providers available to serve Medicaid-enrolled children? For example, if a physician has received training in oral health diagnostic procedures and if malpractice coverage and licensure permit, is a screening by the physician then considered sufficient for providing the required dental services according to the State's periodicity schedule?

Answer:

While oral health screening by a physician or other provider is encouraged and may be considered by many health professionals to be an integral component of a general physical examination, **it does not substitute** for a definitive dental examination by a dentist provided in accordance with the State's periodicity schedule. States may, however, use other practitioners to supplement dental examinations so that dentists can be used more efficiently. In some States, licensed primary care practitioners (physicians, nurse practitioners, etc.) who have demonstrated successful completion of a special in-service training program receive Medicaid payment for furnishing a combination of oral health "risk-assessment services," fluoride varnish application, and health educational services for young children. Children are then referred to a dentist for definitive oral diagnosis (which usually includes radiographs, as appropriate), and additional preventive and treatment services. Such practices may enhance the efficiency and effectiveness of dentists. Medicaid programs that adopt such practices should attempt to evaluate the accuracy of licensed primary care providers' oral assessments, the appropriateness of their referral recommendations, and children's success in obtaining additional dental services. These evaluations should provide a basis to determine the success of the program.

Policy Issue: Dental hygienists and EPSDT referral requirements.**Question 3**

Can a State establish a program whereby the dental referral requirement for diagnostic, preventive and corrective procedures may be met *solely* through the services of independently practicing licensed dental hygienists?

Answer:

No. CMS regulations are clear that “dental services” are furnished by or under the supervision of a dentist. As noted above, however, States may cover such other licensed practitioners as a separate matter, which could result in more efficient use of dental services. In some States dental hygienists and other practitioners may provide dentally related services (e.g., cleanings, radiographs, fluoride varnish applications) as outlined in their State practice acts. Reimbursement is available to the licensed practitioner for delivery of these services. But such services would not meet the requirements for dental services because they were not delivered by or under the supervision of a dentist.

Policy Issue: Alteration of EPSDT benefits.**Question 4**

Can EPSDT dental benefits be altered/reduced in scope?

Answer:

No, except in limited circumstances. EPSDT services generally must be provided in full, as required by section 1905(r) of the Act. There may be additional flexibility under section 1115 demonstration. For example, the Oregon Statewide 1115 demonstration allows the State to provide services based on its priority list of services which may not include all medically necessary oral health services. Also, a State that has an approved benchmark plan is not required to provide all EPSDT services to individuals ages 19 and 20.

Policy Issue: Medically necessary services**Question 5.a**

If a State does not include a dental service in its Medicaid State plan, may a State refuse to provide that service to a child?

Answer:

No. The State must provide or arrange for the provision of any medically necessary dental services, even if the service is not otherwise covered in the State plan for the rest of the Medicaid population, with limited exceptions under 1115 demonstration or benchmark authority as noted in the response to question 4 above.

Question 5.b

Are States required to provide or arrange for the provision of all services, including orthodontic services, fixed bridges and implants that a child's dentist says are needed?

Answer:

No, only those services that are medically necessary, as determined by the State, must be provided. Although health care, diagnostic and treatment services to correct or ameliorate any defects and chronic conditions discovered are to be provided, the State is not required to provide or arrange for services which it deems are not "medically necessary." The State has the responsibility for ensuring that medical necessity determinations are made on an individual, case-by-case basis (and not based solely on a pre-selected set of criteria) and must be able to support medical necessity determinations with documentation of the individual case. States often limit orthodontic services to more severe conditions, as determined *tentatively* by use of various numerical scales for classifying malocclusions, with final determinations made after individual cases are reviewed by expert dental consultants.

States may wish to consider using a dental advisory committee, similar to the medical advisory committees required under the State plan and described in 42 CFR 431.12 to assist in applying appropriate standards of dental practice. Dental services that are deemed "aesthetic" or "cosmetic" rather than medically necessary may not be covered.

Question 5.c

Must a provider specify that they are requesting authorization of an EPSDT service in order to invoke medical necessity criteria?

Answer:

A State determination of medical necessity for an individual eligible for EPSDT services must be made on a case by case basis. A provider should not be required to specify they are requesting an “EPSDT” service (or identify any other service category) in order to provide medically necessary treatment services to an eligible individual, as long as it is a covered service. Medicaid eligibility status and the age of the beneficiary (under 21) generally confers that the service is for an EPSDT eligible and the State must review the request for services in light of the EPSDT requirements.

Policy Issue: Patient cost-sharing**Question 6a**

May a State require patient copays for EPSDT dental services?

Answer:

Yes, in some instances. The Deficit Reduction Act of 2005 provided State Medicaid Agencies with new options to impose premiums and cost sharing upon certain Medicaid recipients (section 1916A of the Act) and for certain services. States may elect through a State plan amendment to impose premiums upon any group of non-exempt individuals with family incomes over 150 percent of the FPL). States may also elect through a State plan amendment to impose cost sharing upon any group of non-exempt individuals (with family income over 100 percent of FPL) for any non-exempt services specified by the State in its State plan. Exempt groups, for which the State may not impose any premiums or cost-sharing (i.e., enrollment fees, deductibles, coinsurance, copayment, or similar cost-sharing charge) include: children under the age of 18 in mandatory groups, children in foster care or receiving adoption assistance, pregnant women and individuals receiving hospice care. Exempt services, for which the State may not impose co-payments, include: preventive services, family planning services, and emergency services. Dental services are not specified as an exempt service, but some dental services may fall within a State’s definition of preventive services.

As noted earlier, there may be additional flexibility through section 1115 demonstration authority, particularly for expansions to otherwise ineligible populations. For example, under the current Minnesota statewide 1115 demonstration, children and pregnant woman with income up to 275 percent of the federal poverty level may be required to pay monthly premiums on a sliding scale from \$4.00 to \$549 based upon income and family size.

Question 6.b

Can a patient be denied services due to a bad debt resulting from non-payment of co-pays?

Answer:

In some instances. As noted above, the DRA created new section 1916A of the Act which provided States new options with respect to premiums and cost sharing. Section 1916A provides enforceability of premiums and cost sharing. A state may require a group of individuals (with income at or above 150% FPL) to prepay a premium and may terminate an individual from medical assistance on the basis of failure to pay the premium. A state may permit a provider, including a pharmacy, to require an individual, as a condition for receiving the item or services, to pay the cost sharing charge (except for individuals with family incomes at or below 100% FPL). However, the State may not impose any premiums or cost-sharing (i.e., enrollment fees, deductibles, coinsurance, copayment, or similar cost-sharing charge) upon exempt groups of individuals including children under the age of 18 in mandatory groups, children in foster care or receiving adoption assistance, pregnant women and individuals receiving hospice care.

Policy Issue: Billing patients for Medicaid-covered services.**Question 7.a**

May a dentist place limits on the types of procedures he/she will provide for the Medicaid patient? For example, can the dentist *not* provide services to a Medicaid eligible that he/she would provide for a private pay patient? Or, can the dentist decline to provide a denture to a Medicaid patient, yet agree to provide that patient other Medicaid covered services?

Answer:

Yes. Subject to requirements in the provider's agreement with the State, and applicable State licensure requirements, a dentist may refuse to provide particular services to a Medicaid beneficiary.

Question 7.b

Suppose a dentist provides a Medicaid-covered service to a patient who does not tell the dentist he/she is Medicaid-enrolled. When the dentist tries to bill the patient, the patient then admits to being enrolled in Medicaid. Is the provider unable to bill the patient directly for the service and not be paid by the patient the originally agreed-upon fee (i.e., must the provider accept the Medicaid payment)?

Answer:

Any provider of health services (or their staff) should always inquire as to a patient's insurance coverage prior to the delivery of services and ensure that the patient understands any payment obligations. A Medicaid provider should fully inform a patient if the provider will not accept the patient as a Medicaid patient or if the provider will not

accept Medicaid reimbursement for a particular service. Absent communication of such information, a Medicaid beneficiary should not be billed for a Medicaid covered service furnished by a Medicaid provider.

If the provider expressly informs the patient (or in the case of a child, the patient's parent) that he/she would not accept Medicaid with respect to the patient--and there is no *State* law requiring the dentist to do otherwise--then the provider may bill the patient as a private pay client.

Policy Issue: Billing patients for non-Medicaid covered services

Question 8.a

If a State does not provide a specific service (e.g., adult dentures) under its Medicaid program, can the dentist bill the patient for the non-covered service?

Answer:

Yes. A provider may bill a beneficiary for a service as long as the service is not covered under the State's Medicaid program and the provider and beneficiary are both aware that Medicaid will not pay for the service. If there is any question as to whether the service is covered, the provider should request clarification from the State Medicaid program. A provider may wish to have the beneficiary sign a document that indicates their understanding of the situation and their responsibility for payment for the services.

In the case of services for children, the State Medicaid agency must cover any service that it determines to be "medically necessary" for the child. A provider should be aware of any prior authorization requirements or other State procedures that must be followed before providing services to a child to ensure that the State does not deny the claim at a later date.

Question 8.b

Are there other reasons a provider may bill a Medicaid beneficiary for services?

Answer:

Yes. A Medicaid provider may bill a Medicaid eligible individual for services if: 1) the service is not covered under the Medicaid State plan (e.g., cosmetic orthodontia); 2) the patient has exceeded the allowed frequency of services (e.g., more than one prophylaxis a year); or 3) the service exceeds the dollar cap placed on dental services (e.g., \$1,000) available under the State's Medicaid program. In most States, Provider Handbooks specify what dental services are or are not covered for Medicaid beneficiaries as well as any limitations on frequency or caps placed on services. Providers may want to explain in writing and orally to the patient why the patient will be billed for the service to ensure that the patient understands the reason for, and the patient's liability for payment.

Policy Issue: Practice limits**Question 9.a**

May the dentist limit the number of Medicaid patients he/she will accept into the practice? Or, stated another way, must the dentist accept other Medicaid clients if he/she accepts one Medicaid client (and thus is enrolled as a Medicaid provider)?

Answer:

Subject to requirements in the State Medicaid provider agreements, State licensure requirements, and applicable civil rights laws, dentists may limit the number of Medicaid patients to be accepted into the practice. The federal concept of “choice” holds for both provider and patients.

Question 9.b

Is it possible for dentists to limit their practice hours or schedules in a way which may be perceived as restricting patients’ access to the dentist’s practice?

Answer:

There are no federal Medicaid laws or policies that prevent providers from limiting the number of Medicaid clients accepted into the practice.

Question 9.c

Can Medicaid dental providers limit their practices by age of the recipient? For example, can a dental provider treat only adults or only children from the Medicaid population, while treating non-Medicaid patients of all ages?

Answer:

As noted above, there are no federal Medicaid laws that prevent providers from limiting their practice in some way consistent with applicable civil rights laws. Any limitations may be subject to requirements of the State Medicaid provider agreements.

Policy Issue: Denial of dental services based on client behavior

Question 10

Can a dentist deny additional services to a Medicaid eligible child, i.e., can the dentist not complete a “treatment plan” (e.g., not complete orthodontic services), or can the patient be removed from the practice entirely if the patient is non-compliant with the provider’s instructions or otherwise exhibits misbehavior or malfeasance? The misbehavior might include: failure to maintain oral hygiene, adverse behavior such as rudeness, illegal drug seeking behavior or use, missed appointments, etc.

Answer:

Nothing in the federal law obligates a dental provider to serve any particular patient. If, for example, a dentist has a policy to refuse to serve patients after three missed appointments, there is no federal law that prohibits this. Federal law obligates the *State* to provide or arrange for EPSDT services, including required dental services, regardless of client misbehavior. Thus, if a particular dental provider refuses to accept a patient or complete a course of treatment, the State must have a process in place to arrange for an alternate dental provider to furnish the services. The federal obligation to arrange for continuing care does not reside with the dentist, but with the State, although the State is free to place an obligation on the dentist.

Policy Issue: Direct patient billing for broken appointments

Question 11.a

May States permit providers to directly bill patients for missed appointments?

Answer:

Current Medicaid policy does not allow for billing beneficiaries for missed appointments, in part, because if no service was delivered, no reimbursement is available. In addition, missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers’ overall cost of doing business. Dental providers may need to work with their States to ensure that Medicaid reimbursement rates set by the State adequately cover the cost of doing business. In no case may providers may impose separate charges on beneficiaries.

Managed care organizations (MCO) may have more flexibility to pay providers directly for missed appointments. Additionally, States may pay providers for submission of a report (e.g., postcard sized) notifying the State, or a case manager, that a patient has missed, for example, more than one appointment. Such reports could identify beneficiaries who need additional assistance in accessing services.

Question 11.b

Some dentists bill their non-Medicaid patients for reinstatement into their practice if they have missed several appointments and the dentist no longer considers them part of their practice. Can a dental provider bill Medicaid beneficiaries for this reason if they do so with their non-Medicaid patients?

Answer:

No. A Medicaid provider may not bill a Medicaid patient for reinstatement into their practice regardless of whether they bill non-Medicaid patients.

Policy Issue: Loss of Medicaid eligibility during the course of treatment

Question 12

When a beneficiary loses eligibility for Medicaid during the course of treatment, treatment terminates abruptly. There is no recognition that a course of treatment is not complete and no way to pay for services, e.g., the removal of braces. The only recourse is to request payment by the family. Orthodontists or other dentists doing multi-step procedures may be put in a position, for example, of having to take the appliances off (for free), or, if they stop treatment, they may be at risk of abandoning the patient. Could orthodontia be recognized as a long course of treatment and coverage (reimbursement) be allowed to continue for this service even when the individual becomes ineligible?

Answer:

States may pay a single payment (global fee) for a course of treatment furnished to an eligible beneficiary when the State considers it to be a single, indivisible service, when it is a usual and customary industry practice to pay a global fee, and the provider routinely bills all payers through a global fee. Orthodontia is a prime example of this policy. One example occurs when an individual is 19 or 20-years old and is receiving orthodontic services as part of EPSDT requirements. Because that individual will lose eligibility for EPSDT services upon turning 21, a State may elect to pay up front a global fee for the entire course of treatment. As discussed above, there are certain conditions that must be met. They are:

1. It is the usual and customary industry practice to prepay the fee for the service(s);
2. The services are considered as part of a single, indivisible course of treatment accomplished over time; and
3. Treatment was initiated while the individual was Medicaid eligible.

Also, in a separate scenario in which an appliance or orthodontic device is ordered, and the patient then loses Medicaid eligibility, Medicaid may pay for the covered service so long as the device was ordered on a date when the patient was still Medicaid enrolled.

It should be noted that provider who claims payment in full for a course of treatment and then refuses to complete the treatment must, at a minimum, return the payment. The claim for payment would not be valid since the service was not furnished.

Policy Issue: Retroactive coverage

Question 13

An individual is involved in a car accident, is admitted to the hospital and receives extensive and various (medical/dental) treatment services. The individual applies for and receives Medicaid enrollment retroactively which covers the cost of the hospitalization. Is the hospital (and the physician or dentist) required to accept the Medicaid reimbursement?

Answer:

This may depend on the particular State. Please contact your State to determine its rules on Medicaid providers dealing with retroactive coverage issues.

Policy Issue: Time limits for submitting claims

Question 14

May a State accept a dentist's "late" submission of a claim to Medicaid (submission after the time period set by the State)? If the State rejects the claim, can the dentist bill the patient directly as a fee-for-service patient?

Answer:

Federal regulations at 42 CFR 447.45 require that providers submit all claims to the State Medicaid agency no later than 12 months from the date of service. There is no waiver authority in federal regulations for States to increase the time during which providers may submit claims. However, 12 months would seem a reasonable amount of time for a provider to submit a claim.

If a State rejects a claim for a service provided to a Medicaid beneficiary because it is not covered under the State Medicaid plan, the provider may bill the beneficiary for the service. However, if the State rejects the claim for a covered Medicaid service because it was not submitted in a timely manner by the provider, the dentist may not bill the beneficiary for the service. (See also response to Question 8 for additional circumstances when a provider may be billed for a non-covered Medicaid service.)

Policy Issue: Administrative Federal Match

Question 15.a

Can a State obtain administrative match for costs incurred in transporting dentists/mobile dental vans to the patient (rather than for costs of transporting the patient to the dentist)?

Answer:

States may develop provider payment rates that take into account the cost of transportation or other supplies. This would be a service cost, not an administrative cost. For example, a State could have a higher payment rate for "mobile dental services" than for dental services furnished in the office setting. The State would need to have this payment rate approved by submitting a State plan amendment to CMS.

Question 15.b

Is it appropriate to use administrative match for the purpose of paying off dental student debt, in return for the dentist providing care in an area of provider shortage?

Answer:

No. The applicable guideline for general administrative expenditures is found at section 1903(a)(7) of the Act and in the regulations at 42 CFR 433.15(b)(7). These references state that Medicaid can pay 50 percent for amounts expended by the States "as found necessary by the Secretary for the proper and efficient administration of the State plan." The appropriate mechanism for reimbursing a provider is through the service rate. Providers do not administer the Medicaid State plan.

Policy Issue: Increase of Federal financial participation (FFP) for dental services.

Question 16

Can CMS increase the rate of FFP (or "federal match") for dental services to, for example, 75 or 90 percent FFP?

Answer:

No. The FFP rate is established by law and based on a formula in the statute. CMS does not have the authority to change the rate either through waivers or other policy mechanisms.

Policy Issue: Need for “waivers” for dental innovations/pilot projects and for “payment incentives.”

Question 17

Under what circumstances can a State use a demonstration or a State plan amendment (SPA) to test a different, innovative approach to delivery of dental care or use special payment incentives to encourage dentists to practice in a specific location?

Answer:

The need for a demonstration or a SPA depends upon whether the proposed innovative project requires a waiver of statutory or regulatory requirements or expenditure authority for costs that are not otherwise matchable. Payment incentive arrangements typically require only a SPA. States interested in such innovations should contact CMS to determine which approach is appropriate for a particular project.

Another option for a State to consider is the use of benchmark benefit packages. The DRA allowed States to provide Medicaid coverage to one or more groups of individuals through enrollment in coverage that provides benchmark or benchmark equivalent coverage. In addition, States have the option of providing additional services (wrap-around benefits) in addition to the benchmark package. For individuals under age 19 in a benchmark plan, States must provide wrap-around benefits consistent with EPSDT benefits as described in section 1905(r) of the Act.

Policy Issue: Federally Qualified Health Centers (FQHC)

Question 18.a

Must an FQHC be reimbursed through a prospective payment system reimbursement?

Answer:

Beginning January 1, 2001, provisions of the Benefits Improvement and Protection Act of 2000 provide for a prospective payment system (PPS) for FQHCs. The PPS rate is based on FQHC costs documented in base years, and is increased each year by the Medicare Economic Index and adjustments will be made for increases/decreases in the scope of services. The State may use an alternative payment methodology that is 1) agreed to by the State and the center; and 2) results in a payment which is at least equal to the PPS rate. States may use this as a vehicle to expand dental services.

Question 18.b

How are dentists reimbursed when they are employed by, or contracting with an FQHC?

Answer:

The FQHC is responsible for deciding the mechanism and level of reimbursement to the dentist.

Question 18.c

If a dental service provided by the FQHC is not covered in the Medicaid State plan (e.g. dentures for adults are not covered in some States), will the FQHC be reimbursed?

Answer:

If, for adults, the dental services are not covered in the State plan, Medicaid will not reimburse the FQHC for providing that service. As with any other service setting or provider type, all medically necessary services must be provided to an EPSDT eligible individual.

Question 18.d

Can State Medicaid agencies deduct section 330 federal grant funds when calculating Medicaid payments for an FQHC?

Answer:

No, deducting section 330 grant funds when calculating Medicaid payments is not permissible.

Question 19.e

Are FQHCs required to submit descriptions of the procedures they provide (procedure codes) in order to claim reimbursement under the prospective payment system?

Answer:

FQHCs must submit sufficient information, as required by the State, to document their claims.

Policy Issue: Adult Dental Benefits**Question 19**

Are there are federally required dental services for adults?

Answer:

Medical and surgical services of a dentist, acting within the scope of practice under State law, that would be covered if furnished by a physician, are generally a mandatory service. One example of such a service may be oral surgery but services will vary by State depending on their practice acts.

Also under section 42 CFR 483.55(b), Medicaid participating nursing facilities are required to provide or arrange for the provision of emergency dental services for **all** residents, regardless of payment source. In addition, for Medicaid residents, the facility must provide or arrange for any routine dental services that are covered under the optional dental benefit in the State's plan. For Medicaid residents, the facility must provide the covered services without charge. The payment for required dental services is included in the Medicaid payment to the facility and the facility must accept Medicaid payment as payment in full.