

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-49. Dental, Oral and Maxillofacial Surgeons and Orthodontia.

R414-49-1. Introduction.

The Medicaid Dental Program provides a scope of dental services for Medicaid recipients in accordance with the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual and Attachment 4.19-B of the Medicaid State Plan, as incorporated into Section R414-1-5.

R414-49-2. Definitions.

In addition to the definitions in Rule R414-1 and the Utah Medicaid Provider Manual, Section I: General Information, the following definitions apply to this rule:

- (a) "Anterior tooth" means tooth numbers 6 through 11; 22 through 27; C through H; and M through R.
- (b) "Dental services" whether furnished in the office, a hospital, a skilled nursing facility, or elsewhere, means covered services performed within the scope of the Medicaid enrolled dental provider's license as defined in Title 58, Occupations and Professions.
- (c) "Posterior tooth" means tooth numbers 1 through 5; 12 through 21; 28 through 32; A through B; I through L; and S through T.

R414-49-3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

This section defines the scope of dental services available to members who are eligible under the EPSDT program, and includes comprehensive and preventive health care services.

- (1) Program Access Requirements.
 - (a) Dental services are available only through an enrolled dental provider that complies with all relevant laws and policy.
- (2) Coverage and Limitations.
 - (a) Dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid.
 - (b) Dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions.
 - (c) Additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.
 - (d) Medicaid will reimburse one evaluation per member per day, even if more than one provider is involved from the same office or clinic. Multiple exams for the same date of service are not covered.
 - (e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture.
 - (f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove the remaining third molars during the same procedure.
 - (g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments.
 - (h) The laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.
- (3) Medicaid does not cover the following types of dental services:
 - (a) Composite resin fillings on posterior teeth;
 - (b) Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth;
 - (c) Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;
 - (d) Fixed bridges or pontics;
 - (e) All types of dental implants;
 - (f) Tooth transplantation;
 - (g) Ridge augmentation;
 - (h) Osteotomies;
 - (i) Vestibuloplasty;
 - (j) Alveoloplasty;
 - (k) Occlusal appliances, habit control appliances, or interceptive orthodontic treatment;
 - (l) Treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;
 - (m) Procedures such as arthroscopy, meniscectomy, or condylectomy;
 - (n) Nitrous oxide analgesia;
 - (o) House calls;
 - (p) Consultation or second opinions not requested by Medicaid;
 - (q) Services provided without prior authorization;
 - (r) General anesthesia for removal of an erupted tooth;
 - (s) Oral sedation for behavior management;
 - (t) Temporary dentures or temporary stayplate partial dentures;
 - (u) Limited orthodontic treatment, including removable appliance therapies;
 - (v) Removable appliances in conjunction with fixed banded treatment; and

- (w) Extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.
- (4) Dental Spend-Ups.
- (a) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes the responsibility for the difference in fees for the following dental procedures:
 - (i) Covered amalgam fillings to non-covered composite resin fillings;
 - (ii) Covered stainless steel crowns to non-covered porcelain or cast gold crowns; or
 - (iii) Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab-prepared facings).

R414-49-4. Pregnant Members.

This section defines the scope of dental services available to pregnant members who are eligible for Traditional Medicaid. Dental services extend for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60 days lapse.

- (1) Program Access Requirements.
 - (a) Dental services are available only through an enrolled dental provider that complies with all relevant laws and policy.
- (2) Coverage and Limitations.
 - (a) Dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid.
 - (b) Dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions.
 - (c) Additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.
 - (d) Medicaid will reimburse one evaluation per member per day, even if more than one provider is involved from the same office or clinic. Multiple exams for the same date of service are not covered.
 - (e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture.
 - (f) Medicaid may cover third molar extractions when at least one of the third molars has documented pathology that requires extraction. By discretion, a provider may remove the remaining third molars during the same procedure.
 - (g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments.
 - (h) The laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.
- (3) Medicaid does not cover the following types of dental services:
 - (a) Composite resin fillings on posterior teeth;
 - (b) Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth;
 - (c) Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;
 - (d) Fixed bridges or pontics;
 - (e) All types of dental implants;
 - (f) Tooth transplantation;
 - (g) Ridge augmentation;
 - (h) Osteotomies;
 - (i) Vestibuloplasty;
 - (j) Alveoloplasty;
 - (k) Occlusal appliances, habit control appliances, or interceptive orthodontic treatment;
 - (l) Treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;
 - (m) Procedures such as arthroscopy, meniscectomy, or condylectomy;
 - (n) Nitrous oxide analgesia;
 - (o) House calls;
 - (p) Consultation or second opinions not requested by Medicaid;
 - (q) Services provided without prior authorization;
 - (r) General anesthesia for removal of an erupted tooth;
 - (s) Oral sedation for behavior management;
 - (t) Temporary dentures or temporary stayplate partial dentures;
 - (u) Limited orthodontic treatment, including removable appliance therapies;
 - (v) Removable appliances in conjunction with fixed banded treatment; and
 - (w) Extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.
- (4) Dental Spend-Ups.
 - (a) A Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes the responsibility for the difference in fees for the following dental procedures:
 - (i) Covered amalgam fillings to non-covered composite resin fillings;
 - (ii) Covered stainless steel crowns to non-covered porcelain or cast gold crowns; or
 - (iii) Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab-prepared facings).

R414-49-5. Blind or Disabled Members.

This section defines the scope of dental services available to blind or disabled members eligible for Traditional Medicaid who are 18 years of age or older, as defined in Subsection 1614(a) of the Social Security Act. Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under Section 1115 of the Social Security Act.

- (1) The following program access requirements apply:
 - (a) dental services are available only through an enrolled dental provider that complies with all relevant laws and policy; and
 - (b) dental services provided to this population shall only be performed through the University of Utah School of Dentistry and their associated in-state provider network.
- (2) The following coverage and limitation provisions apply:
 - (a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;
 - (b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions;
 - (c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;
 - (d) Medicaid will reimburse one evaluation per member per day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;
 - (e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;
 - (f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;
 - (g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments; and
 - (h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services.
- (3) Medicaid does not cover the following types of dental services:
 - (a) composite resin fillings on posterior teeth;
 - (b) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;
 - (c) fixed bridges or pontics;
 - (d) all types of dental implants;
 - (e) tooth transplantation;
 - (f) ridge augmentation;
 - (g) osteotomies;
 - (h) vestibuloplasty;
 - (i) alveoloplasty;
 - (j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;
 - (k) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;
 - (l) procedures such as arthroscopy, meniscectomy, or condylectomy;
 - (m) nitrous oxide analgesia;
 - (n) house calls;
 - (o) consultation or second opinions not requested by Medicaid;
 - (p) services provided without prior authorization;
 - (q) general anesthesia for removal of an erupted tooth;
 - (r) oral sedation for behavior management;
 - (s) temporary dentures or temporary stayplate partial dentures;
 - (t) limited orthodontic treatment, including removable appliance therapies;
 - (u) removable appliances in conjunction with fixed banded treatment; and
 - (v) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.
- (4) The following dental spend-ups apply:
 - (a) a Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes the responsibility for the difference in fees for the following dental procedures:
 - (i) covered amalgam fillings to non-covered composite resin fillings; and
 - (ii) covered stainless-steel, porcelain, and cast crowns to cast gold crowns, which means porcelain fused to metal.

R414-49-6. Targeted Adult Medicaid (TAM).

This section defines the scope of dental services available to eligible targeted adult Medicaid members who are actively receiving treatment in a substance abuse treatment program as defined in Section 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities. Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under Section 1115 of the Social Security Act.

- (1) The following program access requirements apply:

(a) dental services are available only through an enrolled dental provider that complies with all relevant laws and policy; and
(b) dental services provided to this population shall only be performed through the University of Utah School of Dentistry and their associated in-state provider network.

(c) Before performing any dental services, SOD shall obtain verification of active treatment for substance use disorder (SUD) from the substance abuse treatment program. The SOD shall then submit an SUD verification form to Medicaid for each eligible TAM member. The SUD verification form is available in "All Providers General Attachments" on the Utah Medicaid website at <https://medicaid.utah.gov>.

(2) The following coverage and limitation provisions apply:

(a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;

(b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions;

(c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;

(d) Medicaid will reimburse one evaluation per member per day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;

(e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;

(f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;

(g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments;

(h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services;

(i) Medicaid covers porcelain crowns and cast crowns. Cast crowns are porcelain fused to metal.

(3) Medicaid does not cover the following types of dental services:

(a) composite resin fillings on posterior teeth;

(b) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;

(c) fixed bridges or pontics;

(d) all types of dental implants;

(e) tooth transplantation;

(f) ridge augmentation;

(g) osteotomies;

(h) vestibuloplasty;

(i) alveoloplasty;

(j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;

(k) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;

(l) procedures such as arthroscopy, meniscectomy, or condylectomy;

(m) nitrous oxide analgesia;

(n) house calls;

(o) consultation or second opinions not requested by Medicaid;

(p) services provided without prior authorization;

(q) general anesthesia for removal of an erupted tooth;

(r) oral sedation for behavior management;

(s) temporary dentures or temporary stayplate partial dentures;

(t) limited orthodontic treatment, including removable appliance therapies;

(u) removable appliances in conjunction with fixed banded treatment; and

(v) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.

(4) The following dental spend-ups apply:

(a) a Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes responsibility for the difference in fees for the following dental procedures:

(i) covered amalgam fillings to non-covered composite resin fillings; and

(ii) covered stainless-steel, porcelain, and cast crowns to cast gold crowns, which means porcelain fused to metal.

R414-49-7. Aged Members.

This section defines the scope of dental services available to aged members eligible for Traditional Medicaid who are 65 years of age or older, as defined in 42 U.S.C Sec. 1382c(a)(1)(A). Services are authorized by a federal waiver of Medicaid requirements approved by the Centers for Medicare and Medicaid Services, and allowed under Section 1115 of the Social Security Act.

(1) The following program access requirements apply:

(a) dental services are available only through an enrolled dental provider that complies with all relevant laws and policy; and

(b) dental services provided to this population shall only be performed through the University of Utah School of Dentistry and their associated in-state provider network.

- (2) The following coverage and limitation provisions apply:
- (a) dental services are provided only within the parameters of generally accepted standards of dental practice and are subject to limitations and exclusions established by Medicaid;
 - (b) dental services are subject to limitations and exclusions of medical necessity and utilization control considerations or conditions;
 - (c) additional service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual, and are updated in the Medicaid Information Bulletin;
 - (d) Medicaid will reimburse one evaluation per member per day, even if more than one provider is involved from the same office or clinic, not multiple exams for the same date of service;
 - (e) Medicaid includes in the global payment, and does not reimburse separately, denture adjustments performed by the original provider within six months of a member receiving a denture;
 - (f) Medicaid may cover third-molar extractions when at least one of the third molars has documented pathology that requires extraction, and by discretion, a provider may remove the remaining third molars during the same procedure;
 - (g) Medicaid covers the treatment of temporomandibular joint fractures, but does not cover other temporomandibular joint treatments;
 - (h) a laboratory or pathologist must submit claims directly to Medicaid for payment of laboratory services;
 - (i) Medicaid covers porcelain crowns and cast crowns. Cast crowns are porcelain fused to metal.
- (3) Medicaid does not cover the following types of dental services:
- (a) composite resin fillings on posterior teeth;
 - (b) pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex;
 - (c) fixed bridges or pontics;
 - (d) all types of dental implants;
 - (e) tooth transplantation;
 - (f) ridge augmentation;
 - (g) osteotomies;
 - (h) vestibuloplasty;
 - (i) alveoloplasty;
 - (j) occlusal appliances, habit control appliances, or interceptive orthodontic treatment;
 - (k) treatment for temporomandibular joint syndrome, sequela, subluxation, or other therapies;
 - (l) procedures such as arthroscopy, meniscectomy, or condylectomy;
 - (m) nitrous oxide analgesia;
 - (n) house calls;
 - (o) consultation or second opinions not requested by Medicaid;
 - (p) services provided without prior authorization;
 - (q) general anesthesia for removal of an erupted tooth;
 - (r) oral sedation for behavior management;
 - (s) temporary dentures or temporary stayplate partial dentures;
 - (t) limited orthodontic treatment, including removable appliance therapies;
 - (u) removable appliances in conjunction with fixed banded treatment; and
 - (v) extraction of primary teeth at or near the time of exfoliation, as evidenced by mobility or loosening of the teeth.
- (4) The following dental spend-ups apply:
- (a) a Medicaid member may choose to upgrade a covered service to a non-covered service if the member assumes responsibility for the difference in fees for the following dental procedures:
 - (i) covered amalgam fillings to non-covered composite resin fillings; and
 - (ii) covered stainless-steel, porcelain, and cast crowns to cast gold crowns, which means porcelain fused to metal.

R414-49-8. Emergency Dental.

This section defines the scope of dental services available to members who are otherwise eligible under the Medicaid program.

- (1) Program Access Requirements.
 - (a) Dental services are available only through an enrolled dental provider that complies with all relevant laws and policy.
- (2) Coverage and Limitations.
 - (a) Emergency dental services are the treatment of a sudden and acute onset of a dental condition that requires immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.
 - (b) Emergency dental service limitations and exclusions are maintained in the Coverage and Reimbursement Code Look-up Tool and the Dental, Oral Maxillofacial, and Orthodontia Services Utah Medicaid Provider Manual. These limitations and exclusions are updated in the Medicaid Information Bulletin.

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