2025 Medicaid Statewide Provider Training

Dental Providers

Utah Department of Health & Human Services

Agenda

- Dental program for adults
- Sodium fluoride update
- Denture preparation procedures and periodontal maintenance
- Dental code for reporting extended care facility calls
- Member billing

Utah Medicaid now offers **comprehensive dental benefits** to all members.

- Adult members, age 21 years and older, are now able to receive dental services through the new Adult Dental Program benefit plan.
- These members must use Medicaid-enrolled dental providers who are paneled with the University of Utah School of Dentistry (UUSOD). Eligible dental providers can be found all over the state.
- Members can find dental providers on the Medicaid Adult Dental Provider List. The list is on the Medicaid website (https://medicaid.utah.gov/dental-coverage-and-plans/) under the “Individuals Aged 21 and Older” drop down list.
- Providers are encouraged to refer to the **Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual** and the PRISM Coverage and Reimbursement Code Lookup Tool for additional policy information related to these services.

Dental program for adults

- **Children** receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits and **pregnant women** will continue to receive dental services through their Managed Care Entity (MCE) dental plan (Premier Access or MCNA).

- Members **19-20 years of age** will receive dental services through the EPSDT Fee for Service dental plan. These members may use any dental provider that accepts Medicaid. They can find eligible providers on the Medicaid Adult Dental Provider List.

- Members enrolled in the Emergency Services Program for Non-Citizens (EOP) are **only** eligible for emergency dental services.

- The Medicaid website and the PRISM Coverage and Reimbursement Code Lookup Tool have been updated to reflect these changes.

Dental program for adults

- Utah Medicaid now covers **chewable fluoride supplements** for members ages **6 up to 16 years**.
- For more information, please refer to the Preferred Drug List & Resource Document and R414-60-5.

Sodium fluoride update

Utah Medicaid now covers the following **alveoloplasty** dental codes:

- **D7310** - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant – Open coverage for members once in preparation for denture or partial denture.

- **D7311** - Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant - Open coverage for members once in preparation for denture or partial denture.

Alveoloplasty will be covered in cases where these services are medically necessary in preparation for dental prosthetic placement. Prior authorization is required.

Providers are encouraged to refer to the PRISM Coverage and Reimbursement Code Lookup Tool for additional policy information related to these services.

Denture preparation procedures and periodontal maintenance

Utah Medicaid now covers the following **vestibuloplasty** dental codes:

- **D7340** - Vestibuloplasty - ridge extension (secondary epithelialization) - Open coverage for members once in preparation for denture or partial denture.

- **D7350** - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophic and hyperplastic tissue) - Open coverage for members once in preparation for denture or partial denture.

Vestibuloplasty will be covered in cases where these services are medically necessary in preparation for dental prosthetic placement. Prior authorization is required.

Providers are encouraged to refer to the PRISM Coverage and Reimbursement Code Lookup Tool for additional policy information related to these services.

Denture preparation procedures and periodontal maintenance

Medicaid now covers CDT code **D4910** - Periodontal maintenance.

Periodontal maintenance will be covered for members who have previously been treated for periodontal disease with periodontal scaling and root planing.

D4910 cannot be used in conjunction with or billed within six (6) months of any other prophylaxis procedure (e.g. D1110, D1120).

Reimbursement for D4910 is limited to **once per six (6) months**.

Providers are encouraged to refer to the PRISM Coverage and Reimbursement Code Lookup tool for additional policy information related to these services.

Denture preparation procedures and periodontal maintenance

Utah Medicaid now covers CDT code **D9410** - House/extended care facility call.

D9410 is open for coverage for the following Provider Allowable Codes (PACs):

- 115-Group practice
- 028-Dental
- 007-Maxillofacial surgery
- 169-Dental hygienist

D9410 is limited to the following places of service (POS):

- 13-Assisted living facilities
- 31-Skilled nursing facilities
- 32-Nursing facilities
- 54-Intermediate Care Facility/ individuals with intellectual disabilities

Dental code for reporting extended care facility calls

- A provider who accepts a member as a Medicaid patient must accept the Medicaid or state payment as reimbursement in full.
- A provider who accepts a member enrolled by Medicaid in a Managed Care Entity (MCE) must accept the payment from the plan as reimbursement in full.
- The provider **may not bill the member for services covered by Medicaid** or by an MCE.
- For more information, please see the Section I: General Information Provider Manual.

Member billing prohibited

The only circumstances in which a provider may bill a Medicaid member are:

- Non-covered services (see next slide)
- Spenddown medical claims
- Medicaid cost sharing (co-payments and co-insurance)
- Broken appointments

The specific policy for each must be followed **before** the Medicaid member can be billed.

Exceptions to prohibition on billing members

Non-covered services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, a provider may bill a Medicaid member **when the following conditions are met**:

- The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid members.)
- The member is advised **prior** to receiving a non-covered service that Medicaid will not pay for the service.
- The member agrees to be personally responsible for the payment.
- The agreement is made in writing between the provider and the member, which details the service and the amount to be paid by the member.

Unless all conditions are met, the provider may not bill the member for the non-covered service. Further, the member's Medicaid Member Card may not be held by the provider as a guarantee of payment by the member, nor may any other restrictions be placed upon the member.

Exceptions to prohibition on billing members

Medical transportation

Transportation of minors with Modivcare

- A parent, legal guardian, or other adult authorized by the legal guardian must accompany a child under the age of 16.
- A minor aged 16 or 17 may travel unaccompanied with written consent from the parent or legal guardian, except when those services do not require parental consent in accordance with state law.
- Minors exempt from the attendant requirements are:

    1. Pregnant minors
    2. Minors seeking treatment for tobacco and nicotine cessation
    3. Minors seeking treatment for sexually transmitted diseases
    4. Emancipated minors
    5. Lawfully married minors
    6. Homeless and 15 years old or older
    7. Minor parents

Transportation over 75-miles with Modivcare

- All non-emergent medical transportation (NEMT) must be to the nearest appropriate Medicaid provider or facility that can provide the service.
- Members requesting trips above 75 miles (one-way) must provide a medical necessity form signed by their provider indicating that closer providers are unsuitable for the member.
- The Medical Necessity Certification form can be found on the Modivcare website and must be filed with Modivcare to request that those rides be authorized.
- The form is provider-specific and not location specific; each provider further than 75 miles will require a separate medical necessity form.
- When denied transportation due to excessive provider distance, members may receive transportation for **up to 4 weeks** allowing for the filling of the form or the transition of care to a closer provider.

Ambulance transportation updates

- Coverage for ground ambulance is limited to:
  - Base rate billed with the appropriate modifiers
  - Mileage for the loaded ambulance only
  - Waiting time (when necessary)
- The ambulance base rate includes medical supplies, interventions, and oxygen, which should not be billed separately.
- Ambulance response and treatment, no transport—HCPCS code A0998 may be used in situations when member transport is not necessary.

Contact us

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