Title 23: Division of Medicaid

Part 204: Dental Services

Part 204 Chapter 1: General

Rule 1.1: Dental Programs

The Division of Medicaid is authorized to furnish:

A. Dental care that is an adjunct to treatment of an acute medical or surgical condition,

B. Services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and

C. Emergency dental extractions and treatment related thereto. Medicaid defines a dental emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.2: Provider Enrollment

A. Dentists must comply with all requirements set forth in Miss. Admin. Code Part 200, Chapter 4, Rule 4.8 for all providers in addition to the provider specific requirements below:

    1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Copy of current licensure card or permit, and

    3. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.3: Covered Services

A. Covered dental services include:

    1. Limited oral evaluation, problem-focused,

    2. Radiographs,

3. Gingivectomy and/or gingivoplasty for Dilantin therapy only,

4. Oral surgery,

5. Extractions, and

6. Alveoloplasty.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.4: Non-covered Services

A. Non-covered dental services include, but not limited to, the following:

1. Comprehensive oral evaluation,

2. Preventive services,

3. Amalgams, composites, and crowns,

4. Endodontics,

5. Dentures, and

6. Orthodontia.

B. The Division of Medicaid does not cover for scheduling/rescheduling for any dental or oral surgical procedure in any treatment setting.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.5: Dental Benefit Limits

A. The Division of Medicaid covers dental expenditures, excluding orthodontia-related services, up to twenty five hundred dollars ($2,500.00) per beneficiary per state fiscal year.

B. All American Dental Association (ADA) dental procedure codes, except orthodontia-related services, are applied to the $2,500 annual limit.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.6: Prior Authorization

A. The Division of Medicaid requires prior authorization, except for emergencies, from the Utilization Management/Quality Improvement Organization (UM/QIO) of the following dental services:

1. Surgical access of an unerupted tooth,
2. Radical resection of mandible with tooth bone graft,
3. Arthrotomy,
4. Complicated suture greater than five (5) cm,
5. Osteoplasty – for orthognathic deformities,
6. Osteotomy – mandibular rami,
7. Osteotomy – mandibular rami with bone graft, includes obtaining the graft,
8. Osteotomy – segmented or subapical – per sextant or quadrant,
9. Osteotomy –body of mandible,
10. Lefort I (maxilla – total),
11. Lefort I (maxilla – segmented),
12. Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia),
13. Repair of maxillofacial soft and hard tissue defect,
14. Closure of salivary fistula,
15. Coronoidectomy,
16. All procedures billed under unspecified dental procedure codes, and
17. The following types of analgesia and sedation for dental office-based procedures:
    a. Analgesia, anxiolysis, inhalation of nitrous oxide,
    b. Non-Intravenous conscious sedation,
    c. Deep sedation/general anesthesia, and
    d. Intravenous conscious sedation/analgesia.

B. In the case of an emergency, documentation justifying the medical necessity for the urgent or emergency procedure must be provided to the UM/QIO to receive a Treatment Authorization Number (TAN) for billing purposes.

C. The prior authorization will apply only to those procedures on the treatment plan which were approved.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 204, Rule 1.6.A.17. eff. 05/01/2014.

Rule 1.7: Laboratory Services, Diagnostic Casts and Photographs

The Division of Medicaid covers lab and pathology services if the provider performs the service in their office and must have a Clinical Laboratory Improvement Amendment (CLIA) certificate number on file with Medicaid.

Source: Miss. Code Ann. §§ 43-13-171, 43-13-121.

Rule 1.8: Radiographs

A. The Division of Medicaid covers the following types of dental radiographs:

1. Intraoral - complete series, including bitewings,

2. Intraoral – periapical,

3. Bitewings, and

4. Panoramic film.

B. The Division of Medicaid requires radiographs be of sufficient quality to be readable.

C. The Division of Medicaid covers an intraoral complete series radiograph or panorex only once every two (2) years per beneficiary per provider.

1. The Division of Medicaid requires that two (2) years must have elapsed from the date the previous intraoral complete series radiograph or panorex was given before the same provider can be covered for the next intraoral complete series radiograph or panorex.

2. The Division of Medicaid requires an intraoral complete series radiograph to include fourteen (14) to twenty-two (22) periapical and posterior bitewing images.

3. The Division of Medicaid does not cover for both intraoral complete series radiograph and panorex on the same day.

4. The Division of Medicaid does not cover additional radiographs if an emergency extraction is performed on the day that an intraoral complete series radiograph or panorex is taken.

5. The Division of Medicaid covers the following exceptions to this limit if one (1) of the following conditions is documented:

    a) Documented trauma to head or mouth area,

    b) Orthodontic evaluation, or

    c) Rule out malignancy.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.9: Periodontic Procedures

The Division of Medicaid covers gingivectomy or gingivoplasty for beneficiaries only if the beneficiary is on Dilantin therapy. Documentation relating to the beneficiary's Dilantin therapy must be retained in the dental record.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.10:

History: Removed eff. 05/01/2014.

Rule 1.11: Dental Services Provided at a Hospital

A. The Division of Medicaid covers inpatient hospitalization for dental treatment when the beneficiary's age, medical or mental problems, and/or the extent of treatment necessitate hospitalization.

    1. Consideration is given in cases of traumatic accidents and extenuating circumstances.

    2. Inpatient hospitalization must be certified by the UM/QIO.

B. The Division of Medicaid covers dental treatment in the outpatient hospital setting only when there is no other alternative to provide quality, safe, and effective treatment for the beneficiary.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.12: Oral Evaluations

The Division of Medicaid defines a limited oral evaluation as an evaluation or re-evaluation limited to a specific oral health problem.

A. The Division of Medicaid covers limited oral evaluations four (4) times per state fiscal year.

B. This may require interpretation of information acquired through additional diagnostic procedures.

C. The Division of Medicaid covers definitive procedures to be performed on the same date as the evaluation according to this rule.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.13: Consultations

The Division of Medicaid covers consultation services for dentists or dental specialists.

A. The Division of Medicaid does not cover the visit or exam on the same day as the initial consultation by the consulting dentist or dental specialist.

B. The Division of Medicaid covers diagnostic and therapeutic procedures on the same or different dates of services as the consultation.

C. The appropriate dental procedure code is required for reimbursement.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.14: Anesthesia

A. The Division of Medicaid defines a topical anesthetic as an agent used to temporarily anesthetize or numb the tiny nerve endings located on the surfaces of the oral mucosa. The Division of Medicaid does not cover the cost of the topical anesthetic and the application of the topical anesthetic separately from the procedure performed.

B. The Division of Medicaid defines a local anesthetic as an agent used to temporarily prevent the conduction of sensory impulses such as pain, touch, and thermal change from a body part along nerve pathways to the brain. The Division of Medicaid does not cover local anesthesia separately from the procedure performed.

C. The Division of Medicaid defines conscious sedation as an anesthetic, including oral, intravenous and intramuscular, administered to place the beneficiary in a relaxed state, which helps control fear and anxiety, but the beneficiary can still respond to speech or touch. The Division of Medicaid covers conscious sedation for dental and oral procedures using the appropriate dental procedure code.

D. The Division of Medicaid defines deep sedation/general anesthesia as a controlled state of depressed consciousness induced by an anesthetic and accompanied by a partial or complete loss of protective reflexes, including the inability of the beneficiary to maintain an airway without assistance or support. The Division of Medicaid covers deep sedation/general anesthesia for dental and oral procedures using the appropriate dental code.

E. All forms of sedation and anesthesia administered in a dental office-based setting must comply pursuant to Miss. Code Ann. § 73-9-13 to insure that beneficiaries are provided with the benefits of anxiety and pain control in a safe and efficacious manner.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, 73-9-13; MS State Board of Dental Examiners, Board Regulation 29.

History: Revised Miss. Admin. Code Part 204, Rule 1.14.C. and added D. and E.

Rule 1.15: Bone Replacement Graft

A. The Division of Medicaid defines a bone replacement graft as a procedure which involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure. The Division of Medicaid defines the following as:

    1. Osseous autograft as a graft taken from one part of the body and placed in another site on the same individual.

    2. Osseous allograft as a graft between two or more individuals allogenic at one or more loci.

    3. Non-osseous as a graft not composed of bone such as tendon or ligament tissue, and the material can be artificial, synthetic or natural.

B. Providers must bill the appropriate dental procedure code when providing this service.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.16: Documentation Requirements

Dental providers must maintain auditable records containing documentation that substantiate the services provided in accordance with requirements set forth in Miss. Admin. Code Part 200, Chapter 1, Rule 1.3. including, but not limited to:

A. Date of service,

B. History taken on initial visit,

C. Chief complaint on each visit,

D. Test, radiographs and results must have the beneficiary's name, the date, must be legible, and must be maintained on file with the beneficiary's dental records.

E. Diagnosis,

F. Treatment, including prescriptions,

G. Signature or initials of dentist after each visit, and

H. Copies of hospital and/or emergency room records if available.

Source: Miss. Code Ann. § 43-13-121

Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

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