



Administrative Code

Title 23: Medicaid Part 204 Dental Services

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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 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. 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. 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. Medicaid requires prior authorization 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 5cm,
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, and
16. All procedures billed under unspecified procedure codes.

B. All requests for prior authorization must be reviewed and approved by the Medicaid dental consultant before the procedure is performed, except in the case of an emergency.

C. Denied procedures will be marked and the prior authorization will apply only to those procedures on the treatment plan which were approved.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Laboratory Services, Diagnostic Casts and Photographs

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. § 43-13-121

Rule 1.8: Radiographs

A. Medicaid covers the following types of dental radiographs:

1. Intraoral - complete series, including bitewings,
2. Intraoral – periapical,
3. Bitewings, and
4. Panoramic film.

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

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

1. 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. Medicaid requires an intraoral complete series radiograph to include fourteen (14) to twenty-two (22) periapical and posterior bitewing images.
3. Medicaid does not cover for both intraoral complete series radiograph and panorex on the same day.
4. 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. 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

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: Injectable Medications

Medicaid covers approved injectable medications billed by dentists when the appropriate current drug code is used. The amount billed must reflect the dentist's actual cost for the injectable medication.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Dental Services Provided at a Hospital

- A. 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 Utilization Management/Quality Improvement Organization (UM/QIO).
- B. Medicaid covers outpatient hospitalization for dental treatment. Dental services are covered 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

Medicaid defines a limited oral evaluation as an evaluation or re-evaluation limited to a specific oral health problem for beneficiaries of any age.

- A. This may require interpretation of information acquired through additional diagnostic procedures.
- B. Medicaid covers for definitive procedures to be performed on the same date as the evaluation according to this rule.
- C. Medicaid covers limited oral evaluations four (4) times per state fiscal year (July 1 – June 30).

Source: Miss. Code Ann. § 43-13-121

Rule 1.13: Consultations

Medicaid covers consultation services for dentists or dental specialists.

- A. The appropriate code is required for reimbursement.
- B. Medicaid covers diagnostic and therapeutic procedures on the same or different dates of services as the consultation.
- C. Medicaid does not cover the visit or exam on the same day as the initial consultation by the consulting dentist or dental specialist.

Source: Miss. Code Ann. § 43-13-121

Rule 1.14: Anesthesia

- A. 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. Medicaid does not cover the cost of the topical anesthetic and the application of the topical anesthetic separately from the procedure performed.
- B. 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. Medicaid does not cover local anesthesia separately from the procedure performed.
- C. Medicaid defines conscious sedation as an anesthetic used to place the patient in a relaxed state, which helps control fear and anxiety, but the patient can still respond to speech or touch.
 - 1. Conscious sedation can be oral, intravenous, or intramuscular.
 - 2. Medicaid covers the cost of injectable drugs used in conscious sedation for dental and oral surgical procedures and requires the appropriate code be used.
 - 3. Medicaid does not cover the administration fees relating to conscious sedation nor the use of oral medications or gases to achieve conscious sedation.

Source: Miss. Code Ann. § 43-13-121

Rule 1.15: Bone Replacement Graft

- A. 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. 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 code when providing this service.

Source: Miss. Code Ann. § 43-13-121

Rule 1.16: Documentation Requirements

Dental providers must maintain auditable records that substantiate the services provided. Records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3. At a minimum, the records must contain the following on each patient:

- A. Date of service,
- B. History taken on initial visit,
- C. Chief complaint on each visit,
- D. Test, radiographs and results must have the patient's name, the date, must be legible, and must be maintained on file with the patient'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 Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 204 Chapter 2: Oral Surgery

Rule 2.1: Simple Extractions

Medicaid covers for simple extractions and the fee includes local anesthesia and routine post-operative care.

- A. Medicaid covers for alveoplasties with the simple extraction of three (3) or more adjacent teeth in the same quadrant.
- B. Medicaid requires for an alveoplasty by quadrant to be covered, a minimum of five (5) teeth in the quadrant must be done.

Source: Miss. Code Ann. § 43-13-121

Rule 2.2: Supernumerary Tooth Extractions

Medicaid requires prior authorization for the extraction of a supernumerary tooth.

Source: Miss. Code Ann. § 43-13-121

Rule 2.3: Surgical Extractions

- A. Medicaid covers for surgical extractions. The fee for all surgical extractions and removal of impacted teeth include the local anesthesia, smoothing the socket site, suturing, and routine post-operative care. Medicaid defines an impacted tooth as one where its eruption is partially or wholly obstructed by bone, soft tissue, or other teeth.
- B. Medicaid does not cover for the extraction of the unerupted third molar for beneficiaries under age twenty-one (21) unless there is radiographic evidence that the third molars will be severely impacted or there is evidence of chronic infection.

Source: Miss. Code Ann. § 43-13-121

Rule 2.4: Alveoplasty

Medicaid covers alveoplasty not in conjunction with extractions as a separate procedure, in addition to the extractions, only when three (3) or more teeth are extracted per quadrant and there is a need for significant bone recontouring in the area of the extraction to prepare the ridge for a prosthetic appliance.

Source: Miss. Code Ann. § 43-13-121

Rule 2.5: Root Tips

Medicaid does not cover for the surgical removal of residual tooth roots with an extraction separately. The appropriate code for surgical removal of residual tooth roots (cutting procedures) must be used to bill the surgical removal of residual roots when a tooth has been broken off by natural means or when the beneficiary seeks follow-up care from a practitioner other than the dentist or oral surgeon who performed the original extraction.

Source: Miss. Code Ann. § 43-13-121

Rule 2.6: Complicated Sutures

Medicaid covers complicated suturing only in instances of trauma where simple sutures cannot be placed or simple suturing is not possible. Medicaid does not pay separately when done with extractions of unerupted teeth or when the dentist creates the flap or incision. Medicaid requires detailed documentation of the traumatic event in the dental record.

Source: Miss. Code Ann. § 43-13-121

Rule 2.7: 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 Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121