INDEX

8.310.7 DENTAL SERVICES

This page intentionally left blank

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 7 DENTAL SERVICES

8.310.7.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[1/1/95; 8.310.7.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 10/1/02; A, 8/1/10]

8.310.7.2 SCOPE: The rule applies to the general public.
[1/1/95; 8.310.7.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 10/1/02]

8.310.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq.
[1/1/95; 8.310.7.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 10/1/02; A, 8/1/10]

8.310.7.4 DURATION: Permanent
[1/1/95; 8.310.7.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 10/1/02]

8.310.7.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[1/1/95, 2/1/95; 8.310.7.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 10/1/02; A, 8/1/10]

8.310.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid program.
[1/1/95, 2/1/95; 8.310.7.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 10/1/02; A, 8/1/10]

8.310.7.7 DEFINITIONS: [RESERVED]

8.310.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[2/1/95; 8.310.7.8 NMAC - Rn, 8 NMAC 4.MAD.002, 10/1/02; A, 8/1/10]

8.310.7.9 DENTAL SERVICES: Dental services are covered as an optional medical service for eligible recipients. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of the recipient [42 CFR Section 440.100(a)]. MAD also covers dental services, dentures and special services for recipients who qualify for services under the early and periodic screening, diagnosis and treatment (EPSDT) program 42 CFR Section 441.55.
[2/1/95; 8.310.7.9 NMAC - Rn, 8 NMAC 4.MAD.716, 10/1/02; A, 8/1/10]

8.310.7.10 ELIGIBLE PROVIDERS:

A. Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners of facilities that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instruction, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions and other pertinent material, and to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims

processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Eligible providers include the following:

(1) Dental hygienists certified for collaborative practice as defined by NMSA 1978 Section 61-5A-4(D&E) may be enrolled to provide any of those services specified for collaborative practice dental hygienists in 8.310.7.12 NMAC. Certified collaborative practice dental hygienists must be in good standing with the New Mexico board of dental health care and the New Mexico dental hygienist committee and must verify their current certificate with the New Mexico board of dental health care annually.

(2) Individuals who are licensed and those in professional corporations, associations or other types of group dental practices licensed to practice dentistry are eligible to participate as medicaid dental providers.

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[2/1/95; 8.310.7.10 NMAC - Rn, 8 NMAC 4.MAD.716.1 & A, 10/1/02; A, 11/1/06; A, 8/1/10]

8.310.7.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and centers for medicaid and medicare services (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies.*

C. Services must be provided within the scope of practice, licensure and must be in compliance with the statues, rules and regulations of the applicable practice act.

[2/1/95; 8.310.7.11 NMAC - Rn, 8 NMAC 4.MAD.716.2, 10/1/02; A, 8/1/10]

8.310.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: MAD covers the following types of dental services with the specified limitations.

A. **Emergency services:** MAD covers emergency care for all eligible recipients. "Emergency" care is defined as services furnished when immediate treatment is required to control hemorrhage, relieve pain or eliminate acute infection. For eligible recipients under the age of 21 years care includes operative procedures necessary to prevent pulpal death and the imminent loss of teeth, and treatment of injuries to the teeth or supporting structures, such as bone or soft tissue contiguous to the teeth.

(1) Routine restorative procedures and root canal therapy are not emergency procedures.

(2) Prior authorization requirements are waived for emergency care, but the claims can be reviewed prior to payment to confirm that an actual emergency existed at the time of service.

B. **Diagnostic services:** MAD coverage for diagnostic services is limited to the following:

(1) for an eligible recipient under 21 years of age, diagnostic services are limited to one clinical oral examination every six months and upon referral one additional clinical oral examination by a different dental provider every six months;

(2) one clinical oral examination every 12 months for an eligible recipient 21 years and over; and

(3) MAD covers emergency oral examinations which are performed as part of an emergency service to relieve pain and suffering.

C. **Radiology services**: MAD coverage of radiology services is limited to the following:

(1) one intraoral complete series every 60 months per eligible recipient; this series includes bitewing x-rays;

(2) additional bitewing x-rays once every 12 months per eligible recipient; and

(3) panoramic films performed can be substituted for an intraoral complete series, which is limited to one every 60 months per eligible recipient.

D. **Preventive services:** MAD coverage of preventive services is subject to certain limitations.

(1) **Prophylaxis:** MAD covers for an eligible recipient under the age of 21 years one prophylaxis service every six months. MAD covers for an eligible recipient 21 years of age or older who has a developmental disability as defined in 8.314.12 NMAC, *Eligible Recipients*, one prophylaxis service every six months. For an individual 21 years of age or older without a developmental disability as defined in 8.314.12 NMAC, *Eligible Recipients*, MAD covers one prophylaxis service once in a 12 month-period.

(2) **Fluoride treatment:** MAD covers for an eligible recipient under the age of 21 years, one fluoride treatment every six months. For an individual 21 years of age or older. MAD covers one fluoride treatment once in a 12-month period.

(3) **Molar sealants:** MAD only covers for an eligible recipient under the age of 21 years, sealants for permanent molars. Each eligible recipient can receive one treatment per tooth every 60 months. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant within the 60-month period requires a prior authorization. For an individual 21 years of age or older, MAD does not reimburse sealant services.

(4) **Space maintenance:** MAD covers for an eligible recipient under the age of 21 years fixed unilateral and fixed bilateral space maintainers (passive appliances). For an individual 21 years of age or older, MAD does not reimburse for space maintenance services.

E. **Restorative services:** MAD covers the following restorative services:

(1) amalgam restorations (including polishing) on permanent and deciduous teeth;

(2) resin restorations for anterior and posterior teeth;

(3) one prefabricated stainless steel crown per permanent or deciduous tooth;

(4) one prefabricated resin crown per permanent or deciduous tooth; and

(5) one recementation of a crown or inlay.

F. **Endodontic services:** MAD covers therapeutic pulpotomy for an eligible recipient under 21 years of age if performed on a primary or permanent tooth and no periapical lesion is present on a radiograph.

G. **Periodontic services:** MAD covers for an eligible recipient certain periodontics surgical, non-surgical and other periodontics services subject to certain limitations:

(1) collaborative practice dental hygienists may provide periodontal scaling and root planning, per quadrant after diagnosis by a dentist; and

(2) collaborative practice dental hygienists may provide periodontal maintenance procedures with prior authorization.

H. **Removable prosthodontic services:** MAD covers two denture adjustments per every 12 months per an eligible recipient.
MAD also covers repairs to complete and partial dentures.

I. **Fixed prosthodontics services:** MAD covers one recementation of a fixed bridge.

J. **Oral surgery services:** MAD covers the following oral surgery services:

(1) **simple and surgical extractions for an eligible recipient:** coverage includes local anesthesia and routine post-operative care; "erupted surgical extractions" are defined as extractions requiring elevation of mucoperiosteal flap and removal of bone, or section of tooth and closure;

(2) autogenous tooth reimplantation of a permanent tooth for an eligible recipient under 21 years of age; and

(3) incision and drainage of an abscess for an eligible recipient.

K. **Adjunctive general services:** MAD covers emergency palliative treatment of dental pain for an eligible recipient. MAD covers general anesthesia and intravenous sedation for an eligible recipient. Documentation of medical necessity must be available for review by MAD or its designee. MAD covers nitrous oxide analgesia for an eligible recipient under 21 years of age. For an individual 21 years of age or older, MAD does not reimburse for nitrous oxide analgesia.

[2/1/95; 8.310.7.12 NMAC - Rn, 8 NMAC 4.MAD.716.3 & A. 10/1/02; A, 7/1/04; A, 11/1/06; A, 8/1/10]

8.310.7.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. **Prior authorization:** MAD covers certain services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services only when prior authorization is received from MAD or its designee. MAD covers medically

necessary orthodontic services to treat handicapping malocclusions for an eligible recipient under 21 years of age with prior authorization.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for MAD services. A dental provider must verify that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with prior authorization denials or other review decisions can request a re-review and a reconsideration. See Part 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions.*

[2/1/95; 8.310.7.13 NMAC - Rn, 8 NMAC 4.MAD.716.4, 10/1/02; A, 7/1/04; A, 11/1/06; A, 8/1/10]

8.310.7.14 HOSPITAL CARE: MAD covers dental services normally furnished in an office setting if they are performed in an inpatient hospital setting only with prior authorization, unless one of the following conditions exist:

A. the eligible recipient is under 21 years of age; or

B. the eligible recipient under 21 years of age has a documented medical condition for which hospitalization for even a minor procedure is medically justified;

C. any service which requires prior authorization in an outpatient setting must be prior authorized if performed in an inpatient hospital.

[2/1/95; 8.310.7.14 NMAC - Rn, 8 NMAC 4.MAD.716.5, 10/1/02; A, 11/1/06; A, 8/1/10]

8.310.7.15 NONCOVERED SERVICES: Dental services are subject to the limitations and coverage restrictions, which exist for other MAD services. See Part 8.301.3 NMAC, *General Noncovered Services.* [~~Medicaid~~] MAD does not cover the following specific dental services:

A. surgical trays are considered part of the surgical procedure; MAD does not reimburse separately for trays;

B. sterilization is considered part of the dental procedure and is not reimbursed separately for sterilization;

C. oral preparations, including topical fluorides dispensed to an eligible recipient for home use;

D. permanent fixed bridges;

E. procedures, appliances or restorations solely for aesthetic, or cosmetic purposes;

F. procedures for desensitization, re-mineralization or tooth bleaching;

G. occlusal adjustments, disking, overhang removal or equilibration;

H. mastique or veneer procedures;

I. treatment of TMJ disorders, bite openers and orthotic appliances;

J. services furnished by non-certified dental assistants, such as radiographs;

K. implants and implant-related services; or

L. removable unilateral cast metal partial dentures.

[2/1/95; 8.310.7.15 NMAC - Rn, 8 NMAC 4.MAD.716.6, 10/1/02; A, 8/1/10]

8.310.7.16 PHARMACY SERVICES: See Part 8.324.4 NMAC, *Pharmacy Services*, for information on the dispensing of drug items.

[2/1/95; 8.310.7.16 NMAC - Rn, 8 NMAC 4.MAD.716.7, 10/1/02]

8.310.7.17 REIMBURSEMENT:

Dental providers must submit claims for reimbursement on the dental claim form. See 8.302.2 NMAC, *Billing for Medicaid Services*. Upon enrollment, a provider receives instructions on documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following:

A. the billed charge which must be the provider's usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

B. the MAD fee schedule for the specific service or procedure.

[2/1/95; 8.310.7.17 NMAC - Rn, 8 NMAC 4.MAD.716.8, 10/1/02; A, 11/1/06; A, 8/1/10]

8.310.7.18 REIMBURSEMENT RESTRICTIONS:

A. **Services performed in violation of dental rules:** A provider is not reimbursed for services performed in violation of the New Mexico Dental Health Care Act, or the rules of the New Mexico board of dental health care, code of ethics of the American dental association or the American dental hygienists' association or accepted principles of good dental and dental hygienist practices.

B. **Services furnished by another provider:** Coverage of dental services can be restricted or limited. It is a dental provider's responsibility to determine if a proposed service has already been furnished by another provider.

C. **Direct recipient payment for services:** A provider can make arrangements for direct payment from an eligible recipient or their personal representative for noncovered services. An eligible recipient or their personal representative can only be billed for noncovered services if:

(1) an eligible recipient or their personal representative is advised by a dental provider of the necessity of the service;

(2) an eligible recipient or their personal representative is given options to seek treatment at a later date or from a different provider;

(3) an eligible recipient or their personal representative agrees in writing to be responsible for payment; and

(4) the provider fully complies with the requirements as stated in Subsection C of 8.302.2.11 NMAC, *billing and claims filing limitations* .

D. **Services considered part of the total treatment:** A provider cannot bill separately for the services included in the payment for the examination, another service, or routine post-operative or follow-up care. See 8.310.7 BI, *Billing Instructions For Dental Services*, for the list of these services.
[2/1/95; 8.310.7.18 NMAC - Rn, 8 NMAC 4.MAD.716.9 & A, 10/1/02; A, 8/1/10]

HISTORY OF 8.310.7 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives.
ISD 310.0900, Dental Services, 2/13/80.
ISD 310.0900, Dental Services, 6/8/81.
ISD Rule 310.0900, Dental Services, 10/14/83.
MAD Rule 310.09, Dental Services, 12/15/87.
MAD Rule 310.09, Dental Services, 4/20/92.
MAD Rule 310.09, Dental Services, 11/12/93.

History of Repealed Material:
MAD Rule 310.09 Dental Services, Repealed 1/18/95.