

8.310.7 UR DENTAL SERVICES UTILIZATION REVIEW INSTRUCTIONS

This material has been prepared to assist a provider in understanding and complying with utilization review (UR) requirements for the New Mexico Medical Assistance Division (MAD) Dental Program. General utilization review program policy is contained in Sections 8.302.5. NMAC, *Prior Approval and Utilization Review*, and 8.310.7.13 NMAC, *Prior Approval and Utilization Review*, of the New Mexico MAD Provider Program Manual.

The applicable policy sections for this service are:

- 8.302.1 NMAC General Provider Policies*
- 8.302.2 NMAC Billing for Medicaid Services*
- 8.302.3 NMAC Third Party Liability Provider Responsibilities*
- 8.302.4 NMAC Out-of-State Providers*
- 8.302.5 NMAC Prior Approval and Utilization Review*
- 8.310.7 NMAC Dental Services*
- 8.351.2 NMAC Sanctions and Remedies*

MAD program rule sections can be obtained from MAD or its Fiscal Agent. These utilization review instructions do not supersede or replace the applicable rule manual sections or manual revisions. The utilization review instructions serve only to quantify specific documentation requirements and utilization review processes.

A provider must use correct codes, give accurate and applicable information, and supply clarifications, as requested.

Please address any questions concerning these instructions to the MAD Dental Program Manager (505-827-1341).

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8.310.7 UR DENTAL SERVICES UTILIZATION REVIEW INSTRUCTIONS

8.310.7.1 UR PRIOR APPROVAL REVIEW: Prior approval is required for certain dental services, including some diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontic, fixed prosthodontic, maxillofacial prosthetic, oral surgery, and orthodontic services to determine medical necessity and program compliance.

- A. **Review Agency:** Molina Healthcare of New Mexico is the UR Contractor for the State of New Mexico. Prior approval reviews for dental services have been delegated to Doral Dental:

DentaQuest

12121 North Corporate Parkway

Mequon, WI 53092

Molina Healthcare Customer Service Telephone: 1(866)916-3250.

B. **Dental Reviews**

- (1) **Method of Review:** Abstract (Dental Claim Form) or electronically with attachments.
- (2) **Prior Approval Request Procedures:**
 - (a) All requests for authorization of dental services must be submitted on the 2006 ADA Dental Claim Form or its successor to the review agent.
 - (b) Provide all information on the claim form as is required for filing for payment except "Date Service Performed".
 - (c) Check the appropriate box for "Pre-Treatment Estimate".
 - (d) Include any required x-rays, reports or supporting documentation. When submitting reports or other supporting documentation attach them to the back of the form and prints the words "*SEE ATTACHMENT*".
 - (e) Traditional x-rays should be mounted originals or duplicates of diagnostic quality and stapled to the right corner of the claim form. Copies of digital x-rays will be accepted if the x-rays are of diagnostic quality. If duplicate x-rays are submitted, identify left and/or right side. Also include the date x-rays were taken. If x-rays are applicable for documentation and the x-rays are not available, the provider must document the reason(s) for the unavailability.

(f) Reports must include the diagnosis, area, oral cavity designations for quadrants 10 - UR, 20 - UL, 30 - LL and 40 - LR or tooth number(s) and the necessity of the procedure.

(g) X-rays and attachments must be clearly labeled with the dental provider's name, address and the patient's full name.

(h) Requests must be submitted by the dental provider *before* rendering a service payable by MAD.

(i) Dental prior authorizations are valid for 180 calendar days from the date of approval. Prior authorizations can be updated when the prior approval period expires before the service is rendered. The provider initiates the update by resubmitting the original claim request. After one year, the provider must submit all current and pertinent information together with the request.

C. Retroactive Recipient Eligibility or Retroactive Approval of MAD

Provider Participation Review Process: Prior approval can be done after a service is furnished when the effective date of the individual's MAD eligibility or the provider's MAD participation is retroactive to a date before the service was furnished. Requests for retroactive prior approval will be granted only in the following instances:

- (1) Service is furnished before the determination of the effective date of the recipient's eligibility for MAD or the servicing provider's MAD Provider Participation Agreement. Retroactive requests for prior approval based on retroactive recipient or provider eligibility must be reviewed in writing by the review agency within thirty (30) calendar days of the date of the eligibility determination; and
- (2) In cases of medical emergency.

D. New Mexico Medicaid Utilization Review (NMMUR) Prior Approval Review Procedures

- (1) The abstract (dental claim form) is date stamped on the day NMMUR receives the request and is checked for clarity of the request. A decision on requests for prior authorization will be issued within thirty (30) days of receipt of the request.
- (2) The request is checked for completeness. The request is returned to the provider under the following conditions:
 - (a) If the following items are not completed on the claim form:

- (i) Eligible Recipient's Name
 - (ii) Eligible Recipient's ID Number
 - (iii) Appropriate Tooth Number(s) Indicated
 - (iv) Dental Procedure Code(s) Indicated
 - (v) Provider's Name and Addresses
 - (vi) Provider's National Provider Identifier (NPI)
 - (vii) Dentist's Pre-Treatment Estimate
 - (viii) Charting of Teeth Necessary for Adequate Review
- (b) If required x-rays are not attached or do not show the area in question or are not of diagnostic quality.
- (c) If required reports or supporting documentation are not attached.
- (3) The request will be denied under the following conditions:
- (a) If the procedure is not a MAD covered service.
 - (b) If the procedure is not medically necessary as determined by MAD's criteria.
- (4) If the request is denied, the provider may resubmit with additional information as a re-review.
- (5) After a review decision is made, the results are mailed back to the provider. If the request was approved, a unique prior authorization number will be given to that request.
- (6) Prior approval of services does not guarantee that individual is eligible for MAD services. A dental provider must verify that the individual is eligible for MAD services at the time services are furnished and determine if the MAD eligible recipient has other health or dental insurance.

8.310.7.2 UR DENTAL SERVICES THAT REQUIRE PRIOR APPROVAL

A. **Diagnostic: D01000-D0999**

- (1) Radiographs/Diagnostic Imaging
 - (a) Codes: D0310, D0320, D0321, D0322.
 - (b) Documentation Required: Patient history and report.

(c) Allowable Age: All ages.

(d) Review Criteria: Radiographs and diagnostic imaging procedures are covered when medically necessary and when furnished in conjunction with an orthodontic case that has previously been approved for records. Medical necessity is based on the symptomatology.

(2) Tests and Laboratory Examinations

(a) Codes: D0415, D0502, D0999.

(b) Documentation Required: Patient history and report.

(c) Allowable Age: All ages.

(d) Review Criteria: Bacteriologic studies and oral pathology procedures are covered when medically necessary and when the supporting documentation includes a description of the pathological condition, type of study, and rationale. Unspecified diagnostic procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

B. Preventive: D1000-D1999

(1) *Dental Sealants (This only applies to replacement of molar dental sealants furnished within a 60 month period.)*

(a) Procedure code: D1351.

(b) Documentation Required: Patient history and report.

(c) Allowable Age: Under twenty-one (21) *years of age*.

(d) Review Criteria: Dental sealants are reimbursed once every 60 months per permanent *first and second molars teeth numbers 2,3,14,15,18,19, 30 and 31*. MAD does not cover sealants when an occlusal restoration has been completed on the tooth. Replacement of a sealant on any *qualified* tooth within the 60 month period requires prior authorization. Report with documentation is required prior to treatment or with claim after treatment.

C. Restorative: D2000-D2999

(1) *Crowns-Single Restorations Only*

(a) Procedure Codes: D2710, D2751, D2752, D2791, D2792.

(b) Documentation Required: Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review:

full mouth x-rays bitewings, and periapicals or panorex. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age: Under twenty-one (21) years of age.

(d) Review Criteria: Crowns—single restorations are covered for permanent teeth. Full cast metal crowns (noble metal and predominately base metal) and porcelain fused to metal crowns (noble metal and predominately base metal) are covered for all permanent teeth, except for teeth numbered 1, 16, 17, and 32. The tooth for which the crown is being requested must be periodontally sound and must be at least 50% supported in the alveolar bone. Documentation is required when the need cannot be verified or documented by radiographs alone. Crowns are covered only when necessary due to a fracture, *extensive* decay, or an endodontically treated tooth. Crowns for any other purpose, such as cosmetics, abrasion, attrition, or erosion are not covered. Cast crowns on permanent teeth are expected to last, at a minimum, 60 months.

(2) *Other Restorative Services*

(a) Procedure Codes: D2980, D2999.

(b) Documentation Required: Full mouth x-rays, panoramic x-ray or current periapical x-ray(s). Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age: Under twenty-one (21) *years of age*.

(d) Review Criteria: Repairs to crowns are approved only when the documentation supports the high probability of success of the repair. Unspecified restorative procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

D. **Endodontics: D3000-D3999**

(1) *Endodontic Therapy*

(a) Procedure Codes: D3310, D3320, D3330.

(b) Documentation Required: Full mouth x-rays, panoramic x-ray or current periapical x-ray(s). Tooth number(s) of missing tooth/teeth indicated on claim form. In cases where pathology is not apparent, a written narrative justifying treatment is required.

(c) Allowable Age:

- Under twenty-one (21) years of age-Procedure Code D3310, D3320, and D3330
- Twenty-one (21) years of age and over-Procedure Code D3310

(d) Review Criteria: Root canal therapy is covered for permanent teeth only. The tooth for which the root canal therapy is being requested must be periodontally sound. MAD does not cover root canal therapy if the eligible recipient qualifies for maxillary or mandibular partial dentures or is missing 2 or more teeth in an arch or can be met by adding to a proposed or existing prosthesis.

(i) In arches where one tooth is missing, root canal therapy may be approved under the following conditions:

- If the space is closed;
- The missing tooth is the most distal in the arch; or
- If review criteria would not allow approval of a removable partial denture.

(ii) Root canal therapy is not covered on teeth numbered 1, 16, 17 and 32.

(2) *Other Endodontic Procedures*

(a) Procedure Code: D3999.

(b) Documentation Required: Current x-ray(s). Tooth number(s) of missing tooth/teeth indicated on claim form, patient history and report.

(c) Allowable Age: Under twenty-one (21) years of age.

(d) Review Criteria: Unspecified endodontic procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

E. **Periodontics: D4000-D4999**

(1) *Surgical Service*

(a) Procedure Codes: D4210, D4211, D4240, D4249, D4260, D4263, D4264, D4266, D4267, D4270, D4271, D4273, D4274

(b) Documentation Required: Full mouth x-rays, bitewing x-rays or current periapical x-ray(s) and complete periodontal charting with AAP Case Type. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age:

- Under twenty-one (21) years of age-Procedure Codes D4240, D4249, D4260, D4263, D4264, D4266, D4267, D4270, D4271, D4273, D4274
- Twenty-one (21) years of age and over-Procedure Codes D4210 and D4211

(d) Review Criteria: Gingivectomy or gingivoplasty procedures are covered for the elimination of suprabony pockets of 4 mm or greater, for the elimination of suprabony pockets, regardless of their depth, if the pocket wall is fibrous and firm, and for the treatment of gingival hyperplasia caused by prescription drug therapies. All other periodontal surgical services are covered when periodontal disease is present as indicated by pocket depths of 4 mm or greater and radiographic evidence of bone loss in at least 1 tooth in the quadrant. The documentation must support that the proposed treatment will establish and maintain the health of the periodontium. Periodontal surgical procedures are limited to once every 36 months. For approval within the 36 month period, documentation must be furnished which indicates that a medical condition is a major contributing factor in the periodontal condition.

(2) *Other Periodontal Services*

(a) Procedure Codes: D4341, D4910, D4999.

(b) Documentation Required: Full mouth x-rays, or panoramic x-ray and bitewing x-rays or current periapical x-ray(s) and complete periodontal charting with AAP Case Type. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age:

- Under twenty-one (21) years of age-Procedure Codes D4341, D4910, and D4999
- Twenty-one (21) years of age and over-Procedure Code D4341

(d) Review Criteria:

(i) Procedure code D4341 Periodontal Scaling and Root Planing procedures require a minimum of four (4) teeth affected in the quadrant. Complete periodontal charting with AAP Case Type indicating abnormal pocket depths in multiple sites. Additionally, at least one of the following must be present:

- Radiographic evidence of significant root surface calculus.
- Radiographic evidence of significant loss of bone support.

No more than two quadrants of treatment are allowed in a single date of service unless otherwise justified. This procedure is allowed once per quadrant per 24 months.

(ii) Periodontal maintenance procedures are covered once every 6 months following active periodontal treatment.

(iii) Unspecified periodontal procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

F. Removable Prosthodontics: D5000-D5899

(1) *Complete Dentures*

(a) Procedure Codes: D5110, D5120, D5130, D5140.

(b) Documentation Required: Patient history, records and full mouth x-rays or panoramic x-ray. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age: All ages.

(d) Review Criteria: Complete maxillary and mandibular dentures are covered for the replacement of permanent teeth under the following conditions:

(i) Patient is edentulous, or a dental or medical condition indicates extraction of remaining teeth or documentation of a prior appliance.

(ii) It has been more than 60 months since MAD provided the last appliance.

(iii) MAD limits the replacement of one maxillary and one mandibular denture for a period of 60 months from the date the prosthesis was first made:

- if lost, or
- damaged and non-serviceable.

Any replacement before the 60 month period must be documented by the eligible recipient with a signed written statement describing the reason(s) for the replacement.

(iv) If x-rays are applicable for documentation and the x-rays are not available for a recipient in a nursing facility, the provider must

document the reason for the unavailability and may submit study models

- The provider must document the probability of success of the requested prosthesis.
- For the replacement of prosthesis within the 60 month period, an authorized nursing home representative may provide the statement describing the reason(s) for the replacement.

(2) *Partial Dentures*

(a) Procedure Codes: D5211, D5212, D5213, D5214.

(b) Documentation Required: Full mouth x-rays bitewings, and periapicals or panorex, the appropriate radiographs clearly showing the adjacent and opposing teeth, the patient history and any dental or medical condition that indicates extraction of remaining teeth or documentation of a prior appliance. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age: All ages.

(d) Review Criteria:

(i) Maxillary and mandibular partial dentures are covered for the replacement of permanent teeth.

(ii) Abutment teeth must be free of decay and periodontally sound.

(iii) Removable partial dentures are covered for the replacement of 1 or more anterior tooth/teeth.

(iv) Removable partial dentures are covered for the replacement of posterior teeth when 2 or more posterior teeth are missing unilaterally or when 3 or more posterior teeth are missing bilaterally, excluding third molars.

(v) Closed spaces do not count towards missing teeth.

(vi) The documentation must provide evidence of the need for support and/or function.

(vii) A removable partial denture is covered for the replacement of permanent teeth under the following conditions:

(a) It has been more than 60 months since MAD provided the last appliance.

(b) MAD limits the replacement of one maxillary or one mandibular denture per arch for a period of 60 months from the date the prosthesis was first made:

- if lost, or
- damaged and non-serviceable.

Any replacement before the 60 month period must be documented by the eligible recipient with a signed written statement describing the reason(s) for the replacement.

(viii) Recipients in nursing home facilities:

- If x-rays are applicable for documentation and the x-rays are not available, the provider must document the reason(s) for the unavailability and may submit study models.
- The provider must document the probability of success of the requested prosthesis.
- For the replacement of prosthesis within the 60 month period, an authorized nursing home representative may provide the statement describing the reason(s) for the replacement.

(3) *Other Removable Prosthetic Services*

(a) Procedure Codes: D5860, D5861, D5899.

(b) Documentation Required: Full mouth x-rays or panoramic x-ray, patient history and report. Tooth number(s) of missing tooth/teeth must be indicated on the claim form.

(c) Allowable Age: All ages.

(d) Review Criteria: Complete and partial over dentures are covered when there is a medical condition that makes retention difficult to obtain or retention is of primary importance. Examples of these conditions are:

- xerostomia or sialorrhea;
- absence of alveolar residual ridge in the edentulous areas;
- loss of a maxilla or partial loss of a mandible; or
- a congenital deformity, such as cleft palate.

Unspecified removable prosthodontic procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

G. Maxillofacial Prosthetics: D5900-D5999

- (1) Procedure Codes: D5911, D5912, D5913, D5914, D5915, D5916, D5919, D5922, D5923, D5924, D5925, D5926, D5927, D5928, D5929, D5931, D5932, D5933, D5934, D5935, D5936, D5951, D5952, D5953, D5954, D5955, D5958, D5959, D5960, D5983, D5984, D5985, D5986, D5987, D5999.
- (2) Documentation Required: Patient history and x-rays.
- (3) Allowable Age: All ages.
- (4) Review Criteria: Maxillofacial prosthetic services are covered when medically necessary to correct a handicapping condition.

H. Implant Services: D6000-D6199: Implant services are not covered.**I. Fixed Prosthodontics: D6200-D6999:** fixed partial dentures (bridges) are not covered.**J. Oral and Maxillofacial Surgery: D7000-D7999. Other Repair Procedures**

- (1) Procedure Codes: D7940, D7941, D7942, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7955, D7991, D7995, D7996, D7999
- (2) Documentation Required: Patient History and Report - X-rays.
- (3) Allowable Age: All ages.
- (4) Review Criteria: Other repair procedures are covered when necessary to correct acquired defects of the hard and soft tissues of the face and when necessary to correct developmental deformities of the jaws. Unspecified oral surgery procedures are covered when medically necessary and when furnished in conjunction with the treatment of dental or medical condition that is covered by MAD.

K. Orthodontics: D8000-D8999

- (1) *Comprehensive Orthodontic Treatment*
 - (a) Procedure Codes: D8070, D8080, D8090.
 - (b) Documentation Required: Completed orthodontic records and treatment plan. The treatment plan must include the diagnosis, the length, and type of treatment, documentation of a favorable prognosis, and a high probability of compliance in completing the treatment program. The

treatment plan must document if an orthognathic surgery is planned.
Orthodontic records must include:

- (i) Diagnostic casts or digital study models
- (ii) Full mouth or panoramic x-ray
- (iii) Cephalometric film
- (iv) Diagnostic photographs
- (v) A completed orthodontic screening form that states the Handicapping Labiolingual Deviation Index (HLD) score, and indicates the handicapping malocclusion. The provider may submit either the original or a copy.

(c) Allowable Age: Under twenty-one (21) years of age.

(d) Review Criteria: Comprehensive orthodontic treatment is to correct a handicapping malocclusion for eligible recipients under twenty-one (21) years of age. Requests for orthodontic treatment to treat conditions considered cosmetic in nature are not eligible for orthodontic services.

(i) Handicapping malocclusions for the purposes of determining eligibility under these regulations shall mean the presence of at least one of the following:

- Cleft palate deformities and other significant craniofacial anomalies;
- Deep impinging overbite, when the lower incisors are destroying the soft tissue. This does not include occasional biting of the cheek.
- Cross bite of individual anterior teeth, when destruction of soft tissue is present, and involves more than two teeth in cross bite.
- Impacted permanent cuspids and/or permanent incisors that will not erupt into the dental arches without orthodontic and/or surgical intervention. This does not include cases where cuspids or incisors will erupt ectopically;
- Overjet in excess of 9mm.

(ii) If none of the above conditions are present, then a minimum score of 30 points or greater is the threshold value on the HLD index for making orthodontic determination of medical necessity. HLD measures the severity of a handicapping malocclusion.

(iii) The following indicators may be considered in the determination of medical necessity:

- A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
- The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Statements that are not supported by professional progress notes indicating the patient has difficulty with eating, chewing, or speaking represent anecdotal information. These conditions may be caused by other medical conditions in addition to the misalignment of the teeth.

(2) *Minor Treatment to Control Harmful Habits*

(a) Procedure Codes: D8210, D8220.

(b) Documentation Required: Full mouth x-rays or panoramic x-ray and patient history and report.

(c) Allowable Age: Under twenty-one (21) years of age.

(d) Review Criteria: Minor treatment to control harmful habits is covered when the documentation indicates the need for an appliance to control tongue thrusting, thumb sucking or other harmful habits.

(3) *Other Orthodontic Services*

(a) Procedure Codes: D8999.

(b) Documentation Required: Orthodontic Screening Form, full mouth or panoramic x-rays, patient history and report.

(c) Allowable Age: Under twenty-one (21) years of age.

L. **Adjunctive General Services: D9000-D9999. Miscellaneous Services**

(1) Procedure Code: D9999.

- (2) Documentation Required: Patient history, report and x-rays.
- (3) Allowable Age: All ages.
- (4) Review Criteria: Unspecified adjunctive procedures are covered when medically necessary and when furnished in conjunction with the treatment of a dental or medical condition that is covered by MAD.

8.310.7.3 UR RETROSPECTIVE (POST-PAYMENT) REVIEW: All services billed to MAD are subject to retrospective review for medical necessity and program compliance. This section describes the retrospective review requirements for dental services, retrospective review process, and the agency performing retrospective reviews for dental services.

A. Retrospective Review Requirements: Retrospective reviews are not routinely performed for dental services. MAD covers emergency dental care for all eligible recipients. Emergency dental care is defined as services furnished when immediate treatment to control hemorrhage, relieve pain, or eliminate acute infection is required. Care includes operative procedures necessary to prevent pulpal death and the imminent loss of a tooth, and treatment of an injury to a tooth or a supporting structure, such as bone or soft tissue contiguous to the tooth.

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

(2) Prior approval requirements are waived for emergency dental care, but the claims can be reviewed after payment to confirm that an actual dental emergency existed at the time of service. This is done in a random sampling and/or targeted manner.

B. Review Agencies:

For random and some targeted samples:

Molina Healthcare of New Mexico
8801 Horizon Blvd. NE
Albuquerque, NM 87113
Telephone: 1(866)916-3250

For some targeted samples:

Human Services Department/ Medical Assistance Division
Long Term Services and Support Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348

Telephone: (505) 827-3100

C. Retrospective Review Process: The responsible agency may select cases for a review. Copies of pertinent medical and dental records may be requested from the selected provider. The responsible agency will then review the records for appropriateness of services and for medical necessity. Services for emergency dental care that do not meet medical necessity will be denied. The responsible agency notifies the appropriate Fiscal Agent. The Fiscal Agent recoups any payments made for these denied services. The responsible agency notifies the provider by letter and the Fiscal Agent by a *Remittance Advise*.