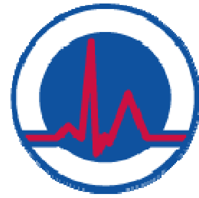
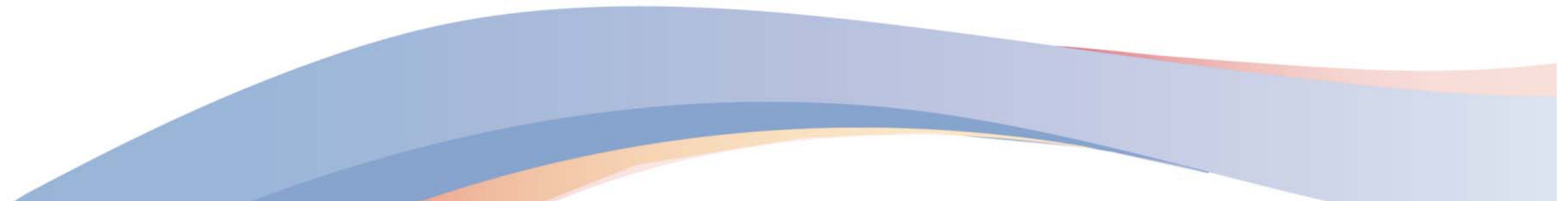


AGENCY FOR HEALTH CARE ADMINISTRATION

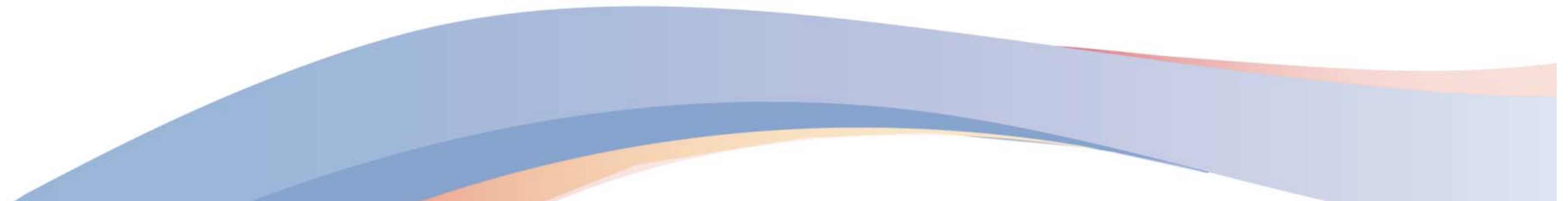
Florida Medicaid Dental Services Coverage Policy

Division of Medicaid
Erica Floyd-Thomas
July 2016



Introduction

- The Florida Medicaid coverage and limitations handbooks/policies provide the minimum requirements for all providers of services.

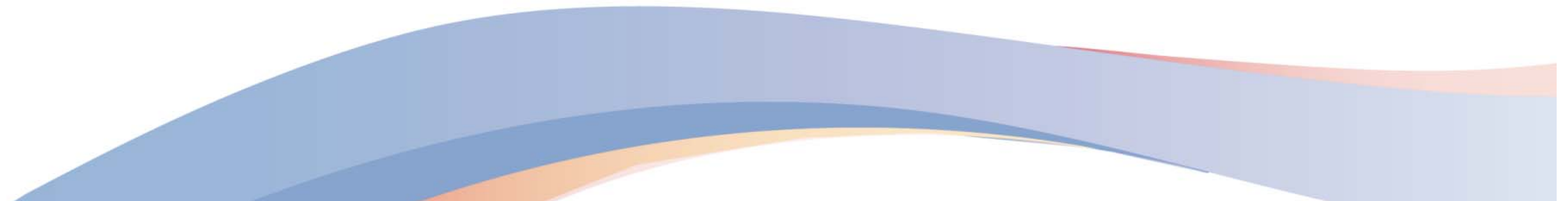


Initial Review of All Coverage Policies

- The Agency reviewed all existing Medicaid related rules during the last state fiscal year.

- The goals were to ensure the coverage policies aligned with the implementation of the SMMC program

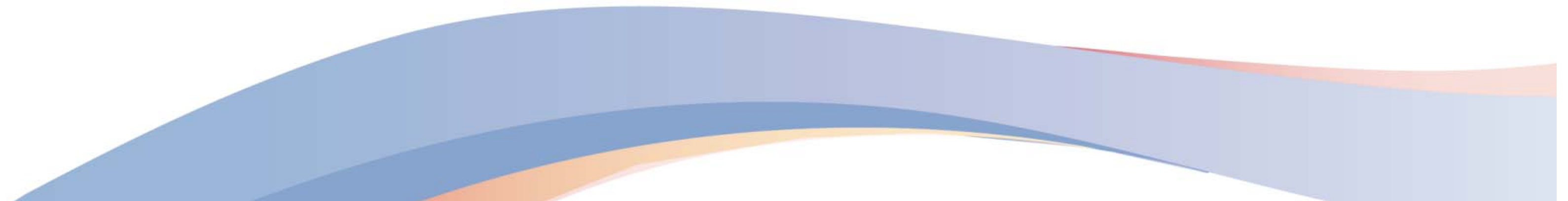
Better Health Care for All Floridians
AHCA.MyFlorida.com



Managed Care Plan Responsibilities

- Managed care plans are required to comply with all current coverage and limitations handbooks.

- Limitations and exclusions imposed by the managed care plan cannot be more stringent than handbooks or fee schedules.



Results

- The Agency currently has approximately 85 related rules

- We identified that the majority would need to be updated

What Has Changed?

- The following changes have been initiated across all coverage and limitations handbooks:
  - We no longer will call them "coverage and limitations handbooks". They are now "coverage policies" or simply "policies"
  - We created a new layout and format, which includes the use of standard language

Services Coverage Template	
1.0 Introduction	1.1 Description 1.1.1 Florida Medicaid Policies 1.1.2 Statewide Medicaid Managed Care Plans 1.2 Legal Authority 1.3 Definitions
2.0 Eligible Recipient	2.1 General Criteria 2.2 Who Can Receive 2.3 Coinsurance, Copayment, or Deductible
3.0 Eligible Provider	3.1 General Criteria 3.2 Who Can Provide
4.0 Coverage Information	4.1 General Criteria 4.2 Specific Criteria

Services Coverage Template	
5.0 Exclusion	5.1 General Non-Covered Criteria 5.2 Specific Non-Covered Criteria
6.0 Documentation	6.1 General Criteria 6.2 Specific Criteria
7.0 Authorization (*Specific for fee-for-service*)	7.1 General Criteria 7.2 Specific Criteria
8.0 Reimbursement (*Specific for fee-for-service*)	8.1 General Criteria 8.2 Claim Type 8.3 Billing Code, Modifier, and Billing Unit 8.4 Rate

What Has Changed?

- Practice standards have been removed
- Policies are not provider specific, but rather procedure/service specific
- Redundant documentation requirements have been removed

What Has Changed?

- We will not recite the **exact same** requirements that are specified in state statute or in federal regulations unless an interpretation is required to implement

Coverage Policy

- Eligible Florida Medicaid recipients
- This policy must be used with Florida Medicaid's general policy, any applicable service-specific, and claim reimbursement policies

General Policies

- Rule Chapter 59G-1

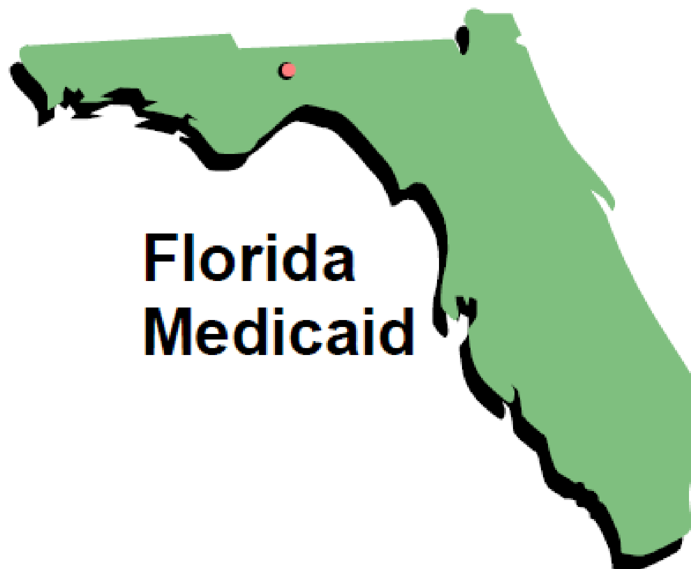
Examples include:

- Definitions
- Provider and Recipient General Requirements
- Copayments and Coinsurance Requirements
- Third Party Liability Payment Requirements
- Authorization Requirements
- Enrollment Requirements
- Recordkeeping and Documentation Requirements
- Fraud and Abuse Requirements

Reimbursement Policies

- Providers will have to comply with reimbursement policies:
  - Fee Schedules
  - General Reimbursement Policies
  - Claims Reimbursement Form Requirements

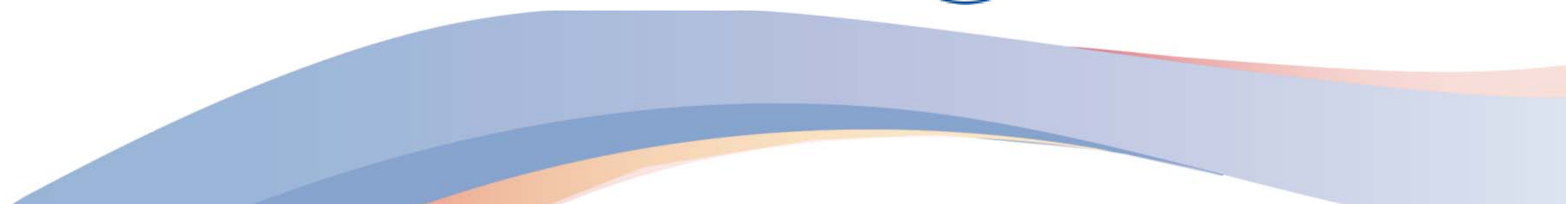
Coverage Policy



Dental Services Coverage Policy

Agency for Health Care Administration

May 2016



Overview

Florida Medicaid
Dental Services Coverage Policy

Table of Contents

1.0 Introduction 1
- 1.1 Description 1
- 1.2 Legal Authority 1
- 1.3 Definitions 1

2.0 Eligible Recipient 2
- 2.1 General Criteria 2
- 2.2 Who Can Receive 2
- 2.3 Coinsurance, Copayment, or Deductible 2

3.0 Eligible Provider 2
- 3.1 General Criteria 2
- 3.2 Who Can Provide 2

4.0 Coverage Information 3
- 4.1 General Criteria 3
- 4.2 Specific Criteria 3
- 4.3 Early and Periodic Screening, Diagnosis, and Treatment 4

5.0 Exclusion 5
- 5.1 General Non-Covered Criteria 5
- 5.2 Specific Non-Covered Criteria 5

6.0 Documentation 5
- 6.1 General Criteria 5
- 6.2 Specific Criteria 5

7.0 Authorization 5
- 7.1 General Criteria 5
- 7.2 Specific Criteria 6

8.0 Reimbursement 6
- 8.1 General Criteria 6
- 8.2 Claim Type 6
- 8.3 Billing Code, Modifier, and Billing Unit 6
- 8.4 Rate 6

Introduction

Legal Authority:

Dental services are authorized by the following:

- Title XIX, section 1905 of the Social Security Act
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.060, F.A.C.

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy. Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.

2.3 Coinsurance, Copayment, or Deductible

Recipients are responsible for a $3.00 copayment for non-emergency dental services, per federally qualified health center visit, per day, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Florida Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Dental interns and dental graduates permitted or temporarily certified to practice in accordance with section 466.025, F.S.

Registered dental hygienists (RDH) may provide services, within their scope of practice, in accordance with Chapter 466, F.S., to recipients in health access settings.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Dental Association Current Dental Terminology Manual, the American Academy of Pediatrics Periodicity Schedule, and the applicable Florida Medicaid fee schedule(s), or as specified in this policy.

*See Dental Services Coverage Policy for complete list

5.0 Exclusions

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non- Covered Criteria

*See Dental Services Coverage Policy for complete list

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

Fee-for-service providers must maintain a record of any behavior management services provided in the recipient file.

7.0 Authorization

7.1 General Criteria

- The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid’s authorization requirements policy.

Authorization Continued

7.2 Specific Criteria

- Providers must obtain authorization from the quality improvement organization for orthodontic and prosthodontic related services when indicated on the applicable Florida Medicaid fee schedule(s).

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Claim Type

- Dental (837D/ADA)
- Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

DISCUSSION