907 KAR 1:026. Dental services.

RELATES TO: KRS 205.520, 205.6451, 42 U.S.C. 1396a-d
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3); 42 U.S.C. 1396a-d, Pub.L. 109-171
NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to dental services.

Section 1. Definitions. (1) "Comprehensive orthodontic" means a medically necessary dental service for treatment of a dentofacial malocclusion which requires the application of braces for correction.
(2) "Current Dental Terminology" or "CDT" means a publication by the American Dental Association of codes used to report dental procedures or services.
(3) "Debridement" means a procedure that is performed:
(a) For removing thick or dense deposits on the teeth which is required if tooth structures are so deeply covered with plaque and calculus that a dentist or staff cannot check for decay, infections, or gum disease; and
(b) Separately from a regular cleaning and is usually a preliminary or first treatment when an individual has developed very heavy plaque or calculus.
(4) "Department" means the Department for Medicaid Services or its designee.
(5) "Direct practitioner contact" means the billing dentist or oral surgeon is physically present with and evaluates, examines, treats, or diagnoses the recipient.
(6) "Disabling malocclusion" means that a patient has a condition that meets the criteria established in Section 13(7) of this administrative regulation.
(7) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:
(a) Requires little additional practitioner resources; or
(b) Is clinically integral to the performance of the primary procedure.
(8) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.
(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(10) "Mutually exclusive" means that two (2) procedures:
(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;
(b) Represent two (2) methods of performing the same procedure;
(c) Represent medically impossible or improbable use of CDT codes; or
(d) Are described in CDT as inappropriate coding of procedure combinations.
(11) "Other licensed medical professional" means a health care provider other than a dentist who has been approved to practice a medical specialty by the appropriate licensure board.
(12) "Prepayment review" or "PPR" means a programmatic review of a claim to determine if the requirements of this administrative regulation have been met prior to authorizing payment.
(13) "Prior authorization" or "PA" means approval which a provider shall obtain from the department before being reimbursed for a covered service.
(14) "Provider" is defined in KRS 205.8451(7).
(15) "Recipient" is defined in KRS 205.8451(9).
(16) "Resident" is defined in 42 C.F.R. 415.152.
(17) "Timely filing" means receipt of a claim by Medicaid:
(a) Within twelve (12) months of the date the service was provided;
(b) Within twelve (12) months of the date retroactive eligibility was established; or
(c) Within (6) months of the Medicare adjudication date if the service was billed to Medicare.

Section 2. Conditions of Participation. (1) A participating provider shall be licensed as a provider in the state in which the practice is located.
(2) A participating provider shall comply with the terms and conditions established in the following administrative regulations:
(a) 907 KAR 1:005;
(b) 907 KAR 1:671; and
(c) 907 KAR 1:672.
(3) A participating provider shall comply with the requirements to maintain the confidentiality of personal medical records pursuant to 42 U.S.C. 1320d and 45 C.F.R. Parts 160 and 164.
(4) A participating provider shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of the decision prior to the delivery of service. If the provider accepts the recipient, the provider:
(a) Shall bill Medicaid rather than the recipient for a covered service;
(b) May bill the recipient for a service not covered by Kentucky Medicaid, if the provider informed the recipient of noncoverage prior to providing the service; and
(c) Shall not bill the recipient for a service that is denied by the department for:
1. Being:
a. Incidental;
b. Integral; or
c. Mutually exclusive;
2. Incorrect billing procedures, including incorrect bundling of procedures;
3. Failure to obtain prior authorization for the service; or
4. Failure to meet timely filing requirements.

Section 3. Record Maintenance. (1) A provider shall maintain comprehensive legible medical records which substantiate the services billed.
(2) A medical record shall be signed by the provider and dated to reflect the date of service.
(3) An X-ray shall be of diagnostic quality and shall include the:
(a) Recipient's name;
(b) Service date; and
(c) Provider's name.
(4) A treatment regimen shall be documented to include:
(a) Diagnosis;
(b) Treatment plan;
(c) Treatment and follow-up; and
(d) Medical necessity.
(5) Medical records, including X-rays, shall be maintained in accordance with 907 KAR 1:672, Section 4(3) and (4).

Section 4. General Coverage Requirements. (1) A covered service shall be:
(a) Medically necessary;
(b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and
(c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:
1. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-one (21);
2. One (1) dental visit per month per provider for a recipient age twenty-one (21) years and over; and
3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.
(2) A covered service provided by an individual who meets the definition of other licensed medical professional shall be covered if the:
(a) Individual is employed by the supervising oral surgeon, dentist, or dental group;
(b) Individual is licensed in the state of practice; and
(c) Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist if the dental hygienist provides the service under general supervision of a practitioner in accordance with KRS 313.310.
(3)(a) A medical resident may provide services if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174.
(b) A dental resident, student, or dental hygiene student may provide services under the direction of a program participating provider in or affiliated with an American Dental Association accredited institution.
(4) Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in the following CDT categories:
(a) Diagnostic;
(b) Preventive;
(c) Restorative;
(d) Endodontics;
(e) Periodontics;
(f) Removable prosthodontics;
(g) Maxillofacial prosthetics;
(h) Oral and maxillofacial surgery;
(i) Orthodontics; or
(j) Adjunctive general services.

Section 5. Diagnostic Service Coverage Limitations. (1)(a) Except as provided in paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider.
(b) The department shall cover a second comprehensive oral evaluation if the evaluation is provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age.
(c) A comprehensive oral evaluation shall not be covered in conjunction with the following:
1. A limited oral evaluation for trauma related injuries;
2. Space maintainers;
3. Root canal therapy;
4. Denture relining;
5. Transitional appliances;
6. A prosthodontic service;
7. Temporomandibular joint therapy;
8. An orthodontic service;
9. Palliative treatment; or
10. A hospital call.
(2)(a) Coverage for a limited oral evaluation shall:
1. Be limited to a trauma related injury or acute infection;
2. Be limited to one (1) per date of service, per recipient, per provider; and
3. Require a prepayment review.
(b) A limited oral evaluation shall not be covered in conjunction with another service except for:
1. A periapical X-ray;
2. Bitewing X-rays;
3. A panoramic X-ray;
4. Resin, anterior;
5. A simple or surgical extraction;
6. Surgical removal of a residual tooth root;
7. Removal of a foreign body;
8. Suture of a recent small wound;
9. Intravenous sedation; or
10. Incision and drainage of infection.
(3)(a) Except as provided in paragraph (b) of this subsection, the following limitations shall apply to coverage of a radiograph service:
1. Bitewing X-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider;
2. Periapical X-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider;
3. An intraoral complete X-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider;
4. Periapical and bitewing X-rays shall not be covered in the same twelve (12) month period as an intraoral complete X-ray series per recipient, per provider;
5. A panoramic film shall:
a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider; and
b. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);
6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider; or
7. Cephalometric and panoramic X-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.
(b) The limits established in paragraph (a) of this subsection shall not apply to:
1. An X-ray necessary for a root canal or oral surgical procedure; or
2. An X-ray that exceeds the established service limitations and is determined by the department to be medically necessary.

Section 6. Preventive Service Coverage Limitations. (1)(a) Coverage of a prophylaxis shall be limited to:
1. For an individual twenty-one (21) years of age and over, one (1) per twelve (12) month period, per recipient; and
2. For an individual under twenty-one (21) years of age, two (2) per twelve (12) month period, per recipient.
(b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root planing.
(2)(a) Coverage of a sealant shall be limited to:
1. A recipient age five (5) through twenty (20) years;
2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and
3. An occlusal surface that is nonocarious.
(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same date of service.
(3)(a) Coverage of a space maintainer shall:
1. Be limited to a recipient under age twenty-one (21); and
2. Require the following:
a. Fabrication;
b. Insertion;
c. Follow-up visits;
d. Adjustments; and
e. Documentation in the recipient's medical record to:
(i) Substantiate the use for maintenance of existing intertooth space; and
(ii) Support the diagnosis and a plan of treatment that includes follow-up visits.
(b) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.
(c) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12) month period, per recipient.

Section 7. Restorative Service Coverage Limitations. (1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.
(2) Coverage of a prefabricated crown shall be:
(a) Limited to a recipient under age twenty-one (21); and
(b) Inclusive of any procedure performed for restoration of the same tooth.
(3) Coverage of a pin retention procedure shall be limited to:
(a) A permanent molar;
(b) One (1) per tooth, per date of service, per recipient; and
(c) Two (2) per permanent molar, per recipient.
(4) Coverage of a restorative procedure performed in conjunction with a pin retention procedure shall be limited to one (1) of the following:
(a) An amalgam, three (3) or more surfaces;
(b) A permanent prefabricated resin crown; or
(c) A prefabricated stainless steel crown.

Section 8. Endodontic Service Coverage Limitations. (1) Coverage of the following endodontic procedures shall be limited to a recipient under age twenty-one (21):
(a) A pulp cap direct;
(b) Therapeutic pulpotomy; or
(c) Root canal therapy.
(2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root canal therapy.
(3)(a) Coverage of root canal therapy shall require:
1. Treatment of the entire tooth;
2. Completion of the therapy; and
3. An X-ray taken before and after completion of the therapy.
(b) The following root canal therapy shall not be covered:
1. The Sargenti method of root canal treatment; or
2. A root canal on one (1) root of a molar.

Section 9. Periodontic Service Coverage Limitations. (1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:
(a) A recipient with gingival overgrowth due to a:
1. Congenital condition;
2. Hereditary condition; or
3. Drug-induced condition; and
(b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12) month period.
1. Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
2. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth within the same quadrant.
(2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:
(a) Pocket-depth measurements;
(b) A history of nonsurgical services; and
(c) Prognosis.
(3) Coverage for a periodontal scaling and root planing procedure shall:
(a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per provider;
(b) Require prior authorization in accordance with Section 15(2) and (4) of this administrative regulation; and
(c) Require documentation to include:
1. A periapical film or bitewing X-ray; and
2. Periodontal charting of preoperative pocket depths.
(4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth area within the same quadrant.
(5) Periodontal scaling and root planing shall not be covered if performed in conjunction with dental prophylaxis.
(6)(a) A full mouth debridement shall only be covered for a pregnant woman.
(b) Only one (1) full mouth debridement per pregnancy shall be covered.

Section 10. Prosthodontic Service Coverage Limitations. (1) A removable prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).
(2) A denture repair in the following categories shall not exceed three (3) repairs per twelve (12) month period, per recipient:
(a) Repair resin denture base; or
(b) Repair cast framework.
(3) Coverage for the following services shall not exceed one (1) per twelve (12) month period, per recipient:
(a) Replacement of a broken tooth on a denture;
(b) Laboratory relining of:
1. Maxillary dentures; or
2. Mandibular dentures;
(c) An interim maxillary partial denture; or
(d) An interim mandibular partial denture.
(4) An interim maxillary or mandibular partial denture shall be limited to use:
(a) During a transition period from a primary dentition to a permanent dentition;
(b) For space maintenance or space management; or
(c) As interceptive or preventive orthodontics.

Section 11. Maxillofacial Prosthetic Service Coverage Limitations. The following services shall be covered if provided by a board certified prosthodontist:
(1) A nasal prosthesis;
(2) An auricular prosthesis;
(3) A facial prosthesis;
(4) A mandibular resection prosthesis;
(5) A pediatric speech aid;
(6) An adult speech aid;
(7) A palatal augmentation prosthesis;
(8) A palatal lift prosthesis;
(9) An oral surgical splint; or
(10) An unspecified maxillofacial prosthetic.

Section 12. Oral and Maxillofacial Service Coverage Limitations. (1) The simple use of a dental elevator shall not constitute a surgical extraction.
(2) Root removal shall not be covered on the same date of service as the extraction of the same tooth.
(3) Coverage of surgical access of an unerupted tooth shall:
(a) Be limited to exposure of the tooth for orthodontic treatment; and
(b) Require prepayment review.
(4) Coverage of alveoplasty shall:
(a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
(b) Require a minimum of a three (3) tooth area within the same quadrant.
(5) An occlusal orthotic device shall:
(a) Be covered for temporomandibular joint therapy;
(b) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;
(c) Be limited to a recipient under age twenty-one (21); and
(d) Be limited to one (1) per lifetime, per recipient.
(6) Frenulectomy shall be limited to one (1) per date of service.
(7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the following:
(a) Torus palatinus (maxillary arch);
(b) Torus mandibularis (lower left quadrant); or
(c) Torus mandibularis (lower right quadrant).
(8) Except as specified in subsection (9) of this section, a service provided by an oral surgeon shall be covered in accordance with 907 KAR 3:005.
(9) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:
(a) Extractions;
(b) Impactions; and
(c) Surgical access of an unerupted tooth.

Section 13. Orthodontic Service Coverage Limitations. (1) Coverage of an orthodontic service shall:
(a) Be limited to a recipient under age twenty-one (21); and
(b) Require prior authorization.
(2) The combination of space maintainers and appliance therapy shall be limited to two (2) per twelve (12) month period, per recipient.
(3) Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.
(4) The department shall only cover new orthodontic brackets or appliances.
(5) An appliance for minor tooth guidance shall not be covered for the control of harmful habits.
(6) In addition to the limitations specified in subsection (1) of this section, a comprehensive orthodontic service shall:
(a) Require a referral by a dentist; and
(b) Be limited to:
1. The correction of a disabling malocclusion; or
2. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.
(7) A disabling malocclusion shall exist if a patient:
(a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;
(b) Has a true anterior open bite that does not include:
1. One (1) or two (2) teeth slightly out of occlusion; or
2. Where the incisors have not fully erupted;
(c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);
(d) Has an anterior crossbite that involves:
1. More than two (2) teeth in crossbite;
2. Obvious gingival stripping; or
3. Recession related to the crossbite;
(e) Demonstrates handicapping posterior transverse discrepancies which:
1. May include several teeth, one (1) of which shall be a molar; and
2. Is handicapping in a function fashion as follows:
a. Functional shift;
b. Facial asymmetry;
c. Complete buccal or lingual crossbite; or
d. Speech concern;
(f) Has a significant posterior open bite that does not involve:
1. Partially erupted teeth; or
2. One (1) or two (2) teeth slightly out of occlusion;
(g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;
(h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of the skeletal conditions specified in paragraphs (a) through (g) of this subsection;
(i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects;
(j) Has a congenital or developmental disorder giving rise to a handicapping malocclusion;
(k) Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach; or
(l) Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation.
(8) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.
(9) If comprehensive orthodontic treatment is discontinued prior to completion, the provider shall submit to the department:
(a) A referral form, if applicable; and
(b) A letter detailing:
1. Treatment provided, including dates of service;
2. Current treatment status of the patient; and
3. Charges for the treatment provided.
(10) Remaining portions of comprehensive orthodontic treatment may be authorized for prorated coverage upon submission of the prior authorization requirements specified in Section 15(2) and (7) of this administrative regulation if treatment:
(a) Is transferred to another provider; or
(b) Began prior to Medicaid eligibility.

Section 14. Adjunctive General Service Coverage Limitations. (1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per date of service, per recipient, per provider.
(b) Palliative treatment for dental pain shall not be covered in conjunction with another service except radiographs.
(2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per recipient, per provider.
(b) A hospital call shall not be covered in conjunction with:
1. Limited oral evaluation;
2. Comprehensive oral evaluation; or
3. Treatment of dental pain.
(3)(a) Coverage of intravenous sedation shall be limited to a recipient under age twenty-one (21).
(b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

Section 15. Prior Authorization. (1) Prior authorization shall be required for the following:
(a) A panoramic film for a recipient under age six (6);
(b) Periodontal scaling and root planing;
(c) An occlusal orthotic device;
(d) A preorthodontic treatment visit;
(e) Removable appliance therapy;
(f) Fixed appliance therapy; or
(g) A comprehensive orthodontic service.
(2) A provider shall request prior authorization by submitting the following information to the department:
(a) A MAP-9, Prior Authorization for Health Services;
(b) Additional forms or information as specified in subsections (3) through (7) of this section; and
(c) Additional information required to establish medical necessity if requested by the department.
(3) A request for prior authorization of a panoramic film shall include a letter of medical necessity.
(4) A request for prior authorization of periodontal scaling and root planing shall include periodontal charting of preoperative pocket depths.
(5) A request for prior authorization of an occlusal orthotic device shall include a MAP 396, Temporomandibular Joint (TMJ) Assessment Form.
(6) A request for prior authorization of removable and fixed appliance therapy shall include:
(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;
(b) Panoramic film or intraoral complete series; and
(c) Cephalometrics.
(7) A request for prior authorization for comprehensive orthodontic services shall include:
(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;
(b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;
(c) Cephalometric x-rays with tracing;
(d) A panoramic film;
(e) Intraoral and extraoral facial frontal and profile pictures;
(f) Occluded and trimmed dental models;
(g) An oral surgeon's pretreatment work up notes if orthognathic surgery is required;
(h) After six (6) monthly visits are completed, but not later than twelve (12) months after the banding date of service:
1. A MAP 559, Six (6) Month Orthodontic Progress Report; and
2. An additional MAP 9, Prior Authorization for Health Services; and
(i) Within three (3) months following completion of the comprehensive orthodontic treatment:
1. Beginning and final records; and
2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.
(8) Upon receipt and review of the materials required in subsection (7)(a) through (g) of this section, the department may request a second opinion from another provider regarding the proposed comprehensive orthodontic treatment.
(9) If a service that requires prior authorization is provided before the prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.
(10) Prior authorization shall not be a guarantee of recipient eligibility. Eligibility verification shall be the responsibility of the provider.
(11) Upon review and determination by the department that removing prior authorization shall be in the best interest of Medicaid recipients, the prior authorization requirement for a specific covered benefit shall be discontinued, at which time the covered benefit shall be available to all recipients without prior authorization.

Section 16. Appeal Rights. (1) An appeal of a department decision regarding a Medicaid recipient based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563.
(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.
(3) An appeal of a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671.

Section 17. Incorporation by Reference. (1) The following material is incorporated by reference:
(a) "MAP 9, Prior Authorization for Health Services", December 1995 edition;
(b) "MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement", December 1995 edition;
(c) "MAP 396, Temporomandibular Joint (TMJ) Assessment Form", December 1995 edition;
(d) "MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form", March 2001 edition;
(e) "MAP 559, Six (6) Month Orthodontic Progress Report", December 1995 edition; and
(f) "MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission", December 1995 edition.
(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (Recodified from 904 KAR 1:026, 5-6-96; Am. 14 Ky.R. 663; eff. 10-6-87; 16 Ky.R. 267; eff. 9-20-89; 21 Ky.R. 139; 930; eff. 8-17-94; 23 Ky.R. 3450; 3782; eff. 4-16-97; 25 Ky.R. 654; 1379; eff. 11-18-98; 30 Ky.R. 1630; 1939; eff. 2-16-2004; 33 Ky.R. 582; 1371; 1552; eff. 1-5-2007; 35 Ky.R. 436; 841; eff. 10-31-2008.)