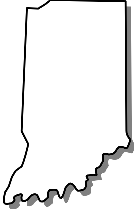


PROVIDER BULLETIN

BT200311 FEBRUARY 7, 2003

To: All Dentists and Dental Clinics

Subject: Delayed Implementation of the $600 Dental Cap

Overview

This bulletin notifies providers that the Office of Medicaid Policy and Planning (OMPP) has delayed implementation of the $600 dental cap until March 1, 2003. This bulletin includes clarification of information in the Indiana Health Coverage Programs (IHCP) provider bulletin BT200302, dated January 15, 2003.

From March 1, 2003, through December 31, 2003, the IHCP only pays up to $600 for dental care to members who are 21 years old or older. In 2004, and the years after, the cap will start on January 1 each year. This bulletin notifies IHCP providers of the changes in dental services under *405 IAC 5-14* regarding the dental cap implementation. Effective March 1, 2003, the IHCP will limit dental services to $600 per calendar year, per member. Services provided prior to March 1, 2003, do not count toward the $600 cap for calendar year 2003.

In addition to the implementation of a dental cap, IHCP provider bulletin *BT200302* provided a 45-day notice that claims for *D4341 – Periodontal root planing and scaling* require supporting documentation. Claims that do not include attachments with supporting documentation will deny.

Dental Cap

Effective March 1, 2003, a $600 cap on dental services per calendar year, per member, for members 21 years old and older will be implemented. This includes members who will reach 21 years old in 2003, and new members who are 21 years old or older on the date the member becomes eligible for dental services. When a member reaches 21 years old, services provided on or after that date are included in the $600 cap. For years 2004 and beyond, the calendar year for the $600 cap will start on January 1 and end on December 31. Dental services provided in a hospital will not apply to the cap. If the place of service is not indicated on the claim form, the service will be captured as delivered in a dental office.

The tables in IHCP provider bulletin *BT200302*, dated January 15, 2003, identify codes for services that are included in the $600 dental cap when provided as a dental office service on or after March 1, 2003, and codes that are not included in the cap. *BT200302* is available at www.indianamedicaid.com, or by request from Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Dental services included in the dental cap are considered noncovered when the dental cap is reached for that calendar year. If additional dental services are needed beyond the $600 of dental services

covered under the dental cap for that calendar year, providers can hold members responsible for the additional payment and claims should not be filed with the IHCP. The following guidelines must be met for IHCP providers to hold a member responsible for payment.

- The service rendered must be determined to be noncovered by the IHCP.
- The member has exceeded the program limitations for a particular service.
- The member must understand before receiving the service that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service knowing that the IHCP will not cover the service.

Providers can use a consent form for adult dental services that specifies a member has only $600 of dental services and that all dental services are noncovered when the $600 dental cap is exhausted. The member should acknowledge this understanding and the responsibility for all services agreed to when the cap is exhausted and reimbursement is not available from the IHCP.

Providers can bill the usual and customary charge to the member for any services provided after the cap has been exhausted. However, if a service is partially paid by the IHCP because of the cap limit, the member can only be billed for the difference between what the IHCP would have reimbursed to the provider and what the IHCP actually paid.

Providers must verify member eligibility prior to delivering services. The Eligibility Verification System (EVS) for the automated voice-response system (AVR) and Web interChange will confirm if a member has reached the dental cap. Audit *6236 – Dental services are limited to $600 per member 21 years old and older* identifies whether a member has met his or her cap. To inquire about eligibility via AVR, providers must use the billing provider number for the dental office.

To verify how much of the dental cap has been met, providers should call Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. Dentists should remember the information provided by Customer Assistance only reflects services paid up to the point in time of the call. The IHCP does not reserve services for a provider or guarantee payment of services.

D4341 - Periodontal Scaling and Root Planing

Effective March 1, 2003, IHCP providers submitting claims for *D4341 – Periodontal scaling and root planing*, must submit supporting documentation as to the medical necessity of providing this service. Documentation must show that the member has periodontal disease by showing pocket markings, or evidence of attachment loss, and that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or micro-organisms. Radiographs documenting the periodontal disease are not required with the claim submission, but must be part of the medical record and maintained in the dentist's office.

Claims submitted for dates of service on or after March 1, 2003, that do not include the required supporting documentation for periodontal scaling and root planing will deny. Dentists should be aware that *D4341* is limited to four quadrants per lifetime for members 21 years old and older who are not institutionalized. The audit that limits root planing and scaling for noninstitutionalized members is *6223*. Providers can check audit limitations to determine if the member has received all four units. Institutionalized members are restricted to four quadrants every two years. Audit *6221* is the audit that limits institutionalized members to four units every two years. Providers can check these audits by using Provider Electronic Solutions, the Web interChange, OMNI, or the automated voice response.

Note: Audit 6236 *for the dental cap is not printed on OMNI.*

General Information

Qualified Medicare beneficiaries (QMBs) are eligible for Medicare covered services only. Federal law requires that state programs pay Medicare premiums, coinsurance, and deductibles for certain elderly and disabled people. For QMBs, Traditional Medicaid pays Medicare deductibles, coinsurance, and the Part B premium. Therefore, only services covered by Medicare are reimbursable by the IHCP. Eligibility must be verified at the time of each appointment. If the information about the member's eligibility indicates the member is QMB **only**, the member is responsible for paying for services not covered by Medicare, such as dental care. If the member is QMB **also**, the member has a spenddown and is eligible for IHCP covered services when that spenddown is met.

Undocumented aliens, Package E members, are eligible for emergency services only. Package E members who seek dental services that are non-emergencies are responsible for payment of these services.

Electronic claims will be rejected if there are too many detail lines of service on the claim. Please restrict the number of detail lines on each electronic claim to 18 lines.

When prior authorization (PA) of a dental service is approved, such as for adult dentures and partials, the PA belongs to the IHCP member, not the dental provider. If necessary, dental providers can refer IHCP members to another provider for completion of approved services.

Concerns about mobile dentists operating in your area can be referred to the Health Professions Bureau, (Attn: Indiana State Board Of Dentistry), 402 W. Washington St., Room W041, Indianapolis, IN 46204; e-mail: hpb7@hpb.state.in.us or phone at (317) 234-2057.

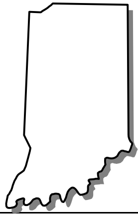
Health Care Excel (HCE) was recently contacted by dental providers whose patients encountered problems obtaining prescriptions written by some providers. The following information clarifies this process for dental provider:

- Members in the Restricted Card Program (RCP) who are locked-in can self-refer for dental services unless they have shown a pattern of misuse in this area. When a member seeks dental services, the dental provider is responsible for verifying the member's eligibility prior to providing services. If there is the notation that the member is *locked-in* and the dental provider anticipates writing a prescription, the dental provider must contact the primary lock-in physician to obtain a referral. A copy of that referral must be faxed to HCE at (317) 347-4535 – Attention: Restricted Card Program.
- If the dental provider does not know the identity of the primary lock-in physician, or if there are other questions about RCP issues, the provider should call HCE at (317) 347-4527 in the Indianapolis area or 1-800-457-4515, select the option for the RCP.

Additional Information

Direct questions about the information in this bulletin, or beginning March 1, 2003, direct questions about the amount a member has used toward the dental cap, to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Enclosed for your information is a copy of the IHCP member bulletin, *BT200310*, being mailed to members explaining the delay of implementing the dental cap in English and Spanish.



MEMBER BULLETIN

BT200310 FEBRUARY 7, 2003

To: **Indiana Health Coverage Programs Members**

Subject: **Dental Limit of $600 for Members 21 Years of Age and Older**

Overview

The effective date of the dental cap has been changed. The new date is March 1, 2003.

Beginning March 1, 2003, the Indiana Health Coverage Programs (IHCP) will only pay up to $600 this year (March through December) for your dental care if you are 21 years of age or older. If you are younger than 21 years old, the $600 per year limit does not apply. In 2004 and the years after, the cap will start on January 1 each year. If you are 21 years of age or older and you need more dental care after the IHCP has already paid $600, you will have to pay for anymore dental services you get. If you do have to pay, your dentist may work with you on a payment plan. To find out how much the IHCP has already paid for your dental care call (317) 713-9627 in the Indianapolis local area or 1-800-457-4584.

You should get all services from the same dentist because the dentist can help plan your dental care.

If you need help finding a dentist, and you are in the Hoosier Healthwise program, call 1-800-889-9949. If you are not enrolled in the Hoosier Healthwise program, call the Family Helpline at 1-800-433-0746 to find a dentist. If you need dentures or partials, some dentists may refer you to another dentist.

Reminder: Be sure to keep your appointments or call within 24 hours to reschedule appointments because most dentists will not see patients who do not show up for their appointments and do not call to cancel.

Call 713-9627 (if you live in Indianapolis) or 1-800-457-4584 (if you live outside Indianapolis) if you have any questions about this message.

The following is a list of some of the services the IHCP will pay for up to the $600 limit:

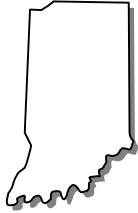
Dental Services Included in the $600 Limit	
An oral examination	Stainless steel crowns
X-rays	Dentures
Teeth cleaning	Partial dentures
Fillings	Repair to dentures or partial dentures

The following services are still covered and do not count in the $600 limit per year:

Dental Services Not Included in the $600 Limit	
Tooth or teeth extractions	Intravenous sedation for oral surgery
Other oral surgical procedures	Two services for treatment of the gums

Additional Information

Your dentist can explain services that count toward the $600 limit or services that do not count in the $600 per year limit. If you need a lot of dental care, please talk to your dentist so he or she can work with you to plan for the $600 the IHCP will pay.



BOLETÍN PARA LOS MIEMBROS

BT200310 FEBRUARY 7, 2003

Para: **Miembros De Los Programas De Salud Cubiertos De Indiana**

Tema: **Limite Dental de $600 para miembros de 21 Años y Mayores**

Resumen:

Comenzando el primero de Marzo del 2003, Los Programas de Salud de Indiana (IHCP) pagarán un limite de $600 para este año (de Marzo a Diciembre) para el cuidado dental de personas de 21 años o mayores. Si usted es menor de 21 años no se aplica el limite de $600. En 2004 el limite de $600 comenzará el primero de Enero de cada año. Si usted tiene 21 años o es mayor de esa edad y necesita mas trabajo dental después de que IHCP ha pagado los $600, usted tendrá que pagar por los servicios adicionales que necesite. Si tiene que pagar, su dentista puede que haga arreglos con usted para un plan de pago. Para saber cuanto ya ha pagado IHCP por su cuidado dental llame al (317) 713-9627 en la area local de Indianápolis o al 1-800-457-4584.

Usted deberá obtener todos los servicios del mismo dentista, de esa manera el le puede organizar su plan dental.

Si necesita ayuda para encontrar un dentista, y usted pertenece al programa Hoosier Healthwise, llame al 1-800-889-9949. Si no es miembro de Hoosier Healthwise, llame a la Línea de Ayuda de la Familia al 1-800-433-0746 para encontrar un dentista. Si necesita dentadura postiza, parcíales o otros servicios que su dentista no provee, su dentista lo puede referir a otro dentista que se especiliza en el cuidado que necesite.

Recuerde: Asegúrese de cumplir su citas o llame antes de las 24 horas para cancelar y hacer la cita de nuevo porque la mayoria de los dentistas no atenderan a pacientes quienes no van a su cita y no llaman para cancelar.

Si tiene alguna pregunta acerca de este mensaje y vive in Indianápolis llame al 713-9627, si vive fuera de Indianápolis llame al 1-800-457-4584.

La siguiente es una lista de algunos de los servicios que IHCP pagará hasta el limite de $600:

Servicios Dentales Incluidos en el limite de $600	
Examen oral	Coronas de acero inoxidable
Rayos-X	Dentaduras postizas
Limpieza dental	Dentaduras parciales
Empastes	Reparación de dentaduras postizas o parciales

Los siguientes servicios seguirán siendo cubiertos y no están incluidos en el limite annual de $600:

Servicios Dentales No Incluidos en el Limite de $600	
Extracciones dentales	Sedantes intravenosos para cirugía oral
Otros procedimientos quirúgicos	Dos servicios para el tratamiento de encías

Información Adicional

Su dentista le puede explicar los servicios incluidos o excluidos del limite de $600 annual. Si usted necesita bastante trabajo dental, por favor hable con su dentista para que le ayude a arreglar un plan con los $600 que pagará el IHCP.