Section 25 DENTAL SERVICES AND REIMBURSEMENT METHODOLOGY Established: 9/1/86
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The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.

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25.01 DEFINITIONS

25.01-1 **Board** means the Maine Board of Dental Practice established in Title 5, section 12004-A, subsection 10.

25.01-2 **Dental Extern** means a student in a doctoral dentistry program participating in an externship.

25.01-3 **Dental Hygienist** means a person who holds a valid license as a dental hygienist issued by the Board.

25.01-4 **Dental Resident** means any person with a resident dentist license, as defined in 32 M.R.S. §18302.

25.05-5 **Dental Services** means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of their profession, including treatment of the teeth and associated structures of the oral cavity and disease, injury, or impairment that may affect the oral or general health of the MaineCare member.

25.01-6 **Dental Therapist** means a person who holds a valid license as a dental hygienist issued by the Board and is authorized to practice dental therapy under 32 MRS Chapter 143.

25.01-7 **Dentist** means a person who holds a valid dentist license issued by the Board.

25.01-8 **Dentistry** means the scope of practice for a dentist as described in 32 MRS §18371(1).

25.01-9 **Denture** means any removable full or partial upper or lower prosthetic dental appliance to be worn in the human mouth to replace any missing natural teeth.

25.01-10 **Denturist** means a person who holds a valid denturist license issued by the Board.

25.01-11 **Independent Practice Dental Hygienist** means a person who holds a valid license as a dental hygienist issued by the Board and who is authorized to practice independent dental hygiene.

25.01-12 **Teledentistry**, as it pertains to the delivery of oral health care services, means the use of interactive, real-time visual, audio or other electronic media for the purposes of education, assessment, examination, diagnosis, treatment planning, consultation and directing the delivery of treatment by individuals licensed under 32 MRS Chapter 143 (Dental Professions) and includes synchronous encounters, asynchronous encounters, remote patient monitoring, and mobile oral health care in accordance with practice guidelines specified in rules adopted by the Board.

25.02 ELIGIBILITY FOR CARE

Individuals must meet the eligibility and residency requirements set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

25.03 COVERED SERVICES

The Maine Department of Health and Human Services (Department) will reimburse for the below covered services when medically necessary and appropriately delivered by a rendering provider working within their scope of practice. Some covered services require prior authorization (PA), have age limits, and/or have additional requirements. Providers shall retain in the member's record a narrative of medical necessity, appropriate pre-operative radiographs, and any other documentation that supports medical necessity for each service delivered. Unless otherwise specified, all services are reimbursable once the entirety of the service is delivered.

Miscellaneous Dental Services that do not have an assigned Common Dental Terminology (CDT) code are covered with a Department-approved PA.

25.03-1 **Diagnostic Services**

A. **Oral Evaluations**

1. Comprehensive oral evaluations are covered once per member per three (3) years per service location. Comprehensive limited oral evaluations may be provided to new patients or established patients who have had a significant change in health conditions or other unusual circumstances.

2. Periodic oral evaluations are covered twice per member per year. Any comprehensive oral evaluations that a member receives shall count towards this limit.

3. Limited oral evaluations, detailed and extensive oral evaluations, and re-evaluations have a combined limit of once per member per service location per date of service. This means a member may receive one of these types of evaluations at each eligible service location in a single day, as necessary for referrals.

4. Comprehensive periodontal evaluations are covered twice per member per year.

5. Oral evaluations for a member under three (3) years of age, which include counseling with the primary caregiver, are covered twice per year.

6. Screening of a patient is covered once per member per service location per date of service. Screenings include state and federally mandated screenings that determine if a member needs to be seen by a dentist for a diagnosis and typically include a brief oral examination.

25.03 COVERED SERVICES (cont.)

B. **Radiographs**

Reimbursement for radiographic and arthrogram services includes interpretation of the image(s). When possible, referring providers shall send relevant radiographs to the provider accepting the member to reduce the need for additional radiographs.

1. An intraoral, complete series of radiographic images, consisting of at least fourteen (14) periapical and posterior bitewing images, and a panoramic radiograph have a combined limit of one (1) per member per three (3) years. Providers may submit a PA to cover an additional instance for orthognathic surgery or orthodontic treatment planning.

2. Intraoral periapical radiographs are covered once per member per service location per date of service, but no more than twelve (12) per year.

3. Intraoral occlusal radiographs are covered for members under twenty-one (21) and limited to one per member per three years.

4. Single bitewing radiographs are covered once per member per date of service per service location. Sets of two (2) or more bitewing radiographs and extra-oral posterior radiographs have a combined limit of two (2) per member per year. Extra-oral posterior radiographs are covered for Members under twenty-one (21) when the Member has a clinical intolerance of the sensor, and providers must document the intolerance in the member’s record. Extra-oral posterior radiographs may not be delivered on the same date of service as a panoramic radiograph.

5. Temporomandibular joint arthrograms and other temporomandibular joint radiographs require PA.

6. A 2D cephalometric radiograph is covered for members under twenty-one (21) when medically necessary as part of an orthodontic, trauma, or orthognathic treatment plan.

7. An extra-oral 2D projection radiograph is covered for members under twenty-one (21) and adults with an intellectual or developmental disability when medically necessary as part of an orthognathic or orthodontic treatment plan

8. Sialography requires PA.

C. **Pulp vitality tests** are covered once per member per date of service, but are not covered on the same date of service as a comprehensive or periodic oral evaluation.

D. **Teledentistry.** Providers may deliver diagnostic services via telehealth in accordance with Chapter I, Section 4, of the MaineCare Benefits Manual (MBM) and current Board rules

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25.03 COVERED SERVICES (cont.)

and guidance. When delivering services via telehealth, providers shall bill for the underlying service and include, for tracking purposes only, the appropriate teledentistry CDT code that indicates a synchronous real-time encounter or an asynchronous encounter in which information is stored and forwarded to the dentist for subsequent review.

E. **Caries risk assessments** and documentation with a finding of low, moderate, or high risk may be reported at a $0 rate for tracking purposes only.

F. **Diagnostic casts** are covered once per lifetime for members under twenty-one (21) when delivered as part of orthodontic treatment planning.

25.03-2 **Preventive Services**

A. **Prophylaxis** is covered twice per member per year (periodontal maintenance and scaling in presence of gingival inflammation are included in this limit). This service shall include the removal of plaque, calculus, and stains and may include oral hygiene instructions. Prophylaxis is not covered when billed on the same date of service as any periodontal procedure code. A “toothbrush prophylaxis” is not recognized as a covered service and cannot be billed as prophylaxis.

Providers may provide one (1) additional prophylaxis treatment per member per year if the member meets one or more of the following criteria:

1. Has a history of restorative or periodontal treatment; or

2. Presents with demonstrable caries and has a history of dental plaque and enamel demineralization.

B. **Topical fluoride** is covered four (4) times per year for members under twenty-one (21) and twice per year for members twenty-one (21) and over.

C. **Sealants** are covered once per eligible tooth per three (3) years for members under twenty-one (21). Eligible teeth include premolars and primary and permanent first and second molars. Once sealants are placed, providers are responsible for the maintenance of the sealants for three (3) years.

D. **Space Maintainers**

Space maintainer services are covered for members under age twenty-one (21).

1. Bilateral space maintainers are covered twice per arch per lifetime.

2. Unilateral and distal shoe space maintainers have a combined limit of twice per quadrant per lifetime.

25.03 COVERED SERVICES (cont.)

3. Space maintainer re-cement or re-bond is covered once per space maintainer per six months, but is not reimbursable to the provider or service location that delivered the space maintainer within six (6) months of placement.

4. Removal of fixed bilateral maxillary and mandibular space maintainers are each covered once per space maintainer, but is not covered when performed by the provider or service location that delivered the space maintainer.

E. **Oral hygiene instruction** is covered three (3) times per year for members under age twenty-one (21). Oral hygiene instruction is not covered on the same day that prophylaxis is delivered. Oral hygiene instruction shall include instructions for dental care at home and hands-on training in tooth brushing and flossing technique.

F. **Tobacco cessation counseling** and **counseling for control and prevention of adverse health effects associated with substance use** have a combined limit of twice per member per year.

Tobacco cessation counseling shall be provided in the form of brief individualized behavioral therapy. Providers shall educate members about the risks of smoking and the benefits of quitting and assess the member's willingness and readiness to quit. Providers shall identify barriers to cessation, provide support, and use techniques to enhance motivation for each member. Providers may also use pharmacotherapy for tobacco cessation for those members for whom it is clinically appropriate and who are assessed as willing and ready to quit or in the process of quitting.

Counseling for control and prevention of adverse health effects associated with substance use shall include education about the adverse oral, behavioral, and systemic health effects associated with high-risk substance use and administration routes, including ingesting, injecting, inhaling, and vaping.

G. **Medicament application** is covered twice per tooth per year for members with a documented history of high caries. Medicament applications are not covered on teeth that have received a restorative service in the last twelve (12) months.

H. **Preventive resin restorations** (PRRs) are covered once per eligible tooth per three years for members with a moderate to high caries risk when an active cavitated lesion in a pit or fissure does not extend into the dentin. Eligible teeth include premolars and permanent first and second molars. A PRR includes placement of a sealant in any radiating non-carious fissures or pits, and providers are responsible for the maintenance of sealants placed as part of PRRs for three (3) years from the date of placement.

I. **Nutritional counseling for control of dental disease** is covered once per member per year when delivered in addition to another covered service. Nutritional counseling

25.03 COVERED SERVICES (cont.)

includes review of current dietary habits, including consumption of cariogenic foods, counsel on food selection, and recommendations for diet changes.

25.03-3 Restorative Services

A. **Restorations** are covered once per tooth surface per year. Restorations are billable when the preparation and filling material extend into the dentin.

1. Providers shall bill the appropriate code that represents the number of tooth surfaces on which the provider performed restorations for each tooth. Providers shall not bill for multiple, separate restorations when performed on the same tooth. For example, two single-surface restorations delivered on different surfaces on the same tooth on the same day shall be coded as one two-surface restoration.

2. Reimbursement for restorations includes tooth preparation, bases, liners, adhesives, etching, polishing, adjustments, caries detection agents, and all other affiliated materials and processes.

3. Reinforcing pins are separately reimbursable.

B. **Crowns** are covered if the member has one of the following:

1. Permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis;
2. Presence of vertical root fracture (not craze lines) demonstrated through intraoral photos; or
3. Root canal treated tooth where a lesser restoration will not suffice.

Crowns are not covered if:

i. A lesser means of restoration is possible;
ii. Tooth has a subosseous and/or furcation decay;
iii. Tooth has advanced or active periodontal disease:
iv. Tooth is a primary tooth;
v. Tooth is not in occlusion (natural or denture) or will not be used as an abutment for removable partial denture; or
vi. Crown is part of a plan to alter vertical dimension.

Crowns are covered once per tooth per five (5) years. Prefabricated crowns are covered once per tooth per two (2) years. Resin-based composite crowns are covered for anterior teeth once per tooth per three (3) years. Crowns only require PA for members twenty-one (21) and over. Crowns do not require PA for members under twenty-one (21).

25.03 COVERED SERVICES (cont.)

Re-cement or re-bond of a crown is covered once per tooth per year, but is not covered for a provider that delivered the crown within six (6) months of placement. Crown repairs necessitated by restorative material failure are covered once per tooth per five (5) years.

C. **Protective restorations** are covered once per tooth per year, but cannot be billed on the same date as a restorative or endodontic service.

D. **Core buildup and prefabricated post and core in addition to a crown** have a combined limit of once per tooth per five (5) years. Re-cement or re-bond of a post and core are each covered once per tooth per year.

E. **Pin Retention** is covered once per tooth per two (2) years, but is not covered on the same date of service as core buildup and prefabricated post and core in addition to a crown.

25.03-4 Endodontic Services

A. **Pulp Caps.** Direct and indirect pulp caps are each covered once per tooth per three (3) years.

B. **Pulpotomy.** Therapeutic pulpotomy is covered once per tooth per lifetime. Partial pulpotomy for apexogensis is covered once per permanent tooth per lifetime. Pulpotomies shall not be billed as part of endodontic therapy and shall not be billed on the same date of service as pulpal or endodontic therapy conducted on the same tooth.

C. **Pulpal debridement** is covered once per tooth per lifetime on an emergency basis to relieve acute pain prior to endodontic therapy. Pulpal debridement is not covered on the same service date as endodontic therapy conducted on the same tooth and is not reimbursable to providers providing scheduled endodontic therapy on the same tooth.

D. **Pulpal therapy** is covered once per primary tooth per lifetime when all pulpal tissue is removed and resorbable filling material is placed. Pulpal therapy is not reimbursable on the same service date as a pulpotomy or endodontic therapy for the same tooth.

E. **Endodontic therapy** is covered once per permanent tooth per lifetime when there is a favorable prognosis for the remaining dentition. Reimbursement for endodontic therapy includes pulpectomy and all appointments and intra-operative radiographs necessary to complete treatment. Reimbursement for endodontic therapy does not include diagnostic evaluation and other necessary radiographs. The closure of an endodontic access hole is reported as a separate procedure. Endodontic therapy is not covered on a tooth that has received a pulpotomy in the last six (6) months.

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25.03 COVERED SERVICES (cont.)

Retreatment of previous endodontic therapy is covered once per permanent tooth per lifetime but is not reimbursable to the provider or service location that performed the endodontic therapy within two (2) years of the original service date.

F. **Apexification/Recalcification.** The initial visit, interim medication replacement, and final visit for apexification/recalcification are each covered once per permanent tooth per lifetime for members under twenty-one (21).

G. **Apicoectomy** is covered once per permanent tooth per lifetime when it is impossible to do conventional endodontic therapy because the canal(s) cannot be negotiated or endodontic therapy was unsuccessful.

25.03-5 **Periodontic Services**

A. **Gingivectomy or Gingivoplasty, gingival flap procedure, and osseous surgery** require PA and have a combined limit of once per quadrant per three (3) years. Gingivectomy is not covered for cosmetic or esthetic purposes and is not allowed if done solely to allow access for a restorative procedure.

B. **Apically positioned flap** requires PA and is covered once per quadrant, per three years.

C. **Bone replacement grafts** require PA and are covered once per tooth per lifetime.

D. **Pedicle soft tissue grafts** and **free soft tissue grafts** require PA and are covered once per tooth per lifetime for members under twenty-one (21).

E. **Periodontal scaling and root planing** (SRP) is covered when the member has:

1. Generalized pocket depths of 4mm or greater as evidenced by charting or visible demonstrable bone loss; and

2. Calculus visible on interproximal surfaces as evidenced by radiographs.

The first unit of SRP delivered to each quadrant does not require PA. The second unit and any additional units of SRP delivered to each quadrant requires PA. Scaling and root planing shall not be billed on the same date of service as prophylaxis for the same member.

F. **Full mouth debridement** to enable a comprehensive oral evaluation and diagnosis on a subsequent visit is covered once per member per year.

G. **Periodontal maintenance**, **scaling in the presence of generalized moderate or severe gingival inflammation after an oral evaluation**, and prophylaxis (see Section 25.03-2(A)) have a combined limit of twice per member per year. Periodontal maintenance is

25.03 COVERED SERVICES (cont.)

covered following scaling and root planing or periodontal surgery and includes the removal of bacterial plaque and calculus, site specific scaling and root planing where appropriate, and polishing the teeth.

25.03-6 **Prosthodontic Services**

A. **Dentures.** When clinically appropriate, maxillary and mandibular dentures are each covered once per member per five years, starting from the date of the first denture delivery. These dentures include complete, partial, and immediate dentures. Maxillary and mandibular immediate dentures each have an additional limit of once per member per lifetime and are covered when delivered within six (6) months of teeth extraction.

Dentures require PA, and reimbursement for dentures includes the initial six (6) months of routine post-delivery care, including adjustments, relines, rebases, and repairs. Replacement dentures require PA and are covered when they are no longer sufficiently functional and there is not a cost-efficient way to repair them.

B. **Denture-related services.** The following denture-related services are covered, except when billed by the service location that delivered the denture within six (6) months from the denture delivery date.

1. **Adjustments** are covered twice per denture per year.

2. **Repairs** are covered once per denture per year.

3. **Replacing a missing or broken tooth** is covered twice per member per year.

4. **Repair or replacement of a broken clasp** is covered twice per member per year.

5. **Adding a tooth to an existing partial denture** is covered twice per member per year.

6. **Adding a clasp to an existing partial denture** is covered twice per member per year.

7. **Rebases and relines** have a combined limit of once per denture per three years.

C. **Fixed Prosthodontics**

The following fixed prosthodontic services require PA and are covered for members under age twenty-one (21). Reimbursement for fixed prosthodontic services includes all necessary post-delivery adjustments for six (6) months and routine temporary prosthetics.

25.03 COVERED SERVICES (cont.)

1. **Pontics (Bridges)** are covered once per arch per five (5) years for permanent anterior teeth.

2. **Retainer crowns and wings** are covered twice per arch per five (5) years for teeth five (5) through twelve (12) and twenty-one (21) though twenty-eight (28).

Re-cement or re-bond of fixed partial dentures is covered twice per member per year. Fixed partial denture repairs necessitated by restorative material failure require PA and are covered twice per member per three (3) years.

25.03-7 **Oral and Maxillofacial Surgery Services**

A. **Alveoloplasty** in conjunction with extractions is covered once per quadrant per lifetime. Alveoloplasty not in conjunction with extractions is covered once per quadrant per lifetime.

B. **Appliance removal** is covered when the provider removing the appliance did not place the appliance.

C. **Autogenous grafting** is covered with a PA.

D. **Bone replacement graft for ridge preservation** is covered with a PA.

E. **Buccal and labial frenectomies** are covered three (3) time per lifetime for members under twenty-one (21).

F. **Closure of salivary fistula** is covered with PA

G. **Coronectomy**

H. **Destruction of lesion**

I. **Excisions** of benign and malignant lesions and malignant tumors are covered. Providers must include a pathology report indicating a malignancy in the member's record when providing and billing for an excision of a malignant lesion or tumor.

J. **Excision of hyperplastic tissue**

K. **Excision of pericoronal gingiva**

L. **Exposure of an uninterrupted tooth** is covered for members under twenty-one (21) as part of an orthodontic plan of care. This service is not covered on the same service date as an extraction or removal for the same tooth.

25.03 COVERED SERVICES (cont.)

M. **Extractions** of coronal remnants, erupted teeth, and exposed roots are covered. Prophylactic extraction of asymptomatic teeth or teeth free from pathology is not covered, unless the extraction is part of a medically necessary treatment plan or comprehensive replacement plan.

N. **Frenuloplasty** is covered once per lifetime for members under twenty-one (21).

O. **Incision and drainage of abscess** is not reimbursable for the same site on the same date of service as an extraction.

P. **Incisional biopsy of oral tissue**

Q. **Lingual frenectomy** is covered once per lifetime for members under twenty-one (21).

R. **Maxillary sinusotomy** for removal of tooth fragment or foreign body.

S. **Non-surgical sialolithotomy**

T. **Occlusal orthotic device** is covered with a PA. Reimbursement for occlusal orthotic devices include the fabrication, placement, and follow-up adjustments.

U. **Oroantral fistula closure**

V. **Partial ostrectomy/sequestrectomy** for removal of non-vital bone

W. **Placement of device to facilitate eruption of impacted tooth** is covered once per tooth per lifetime for members under 21 as part of an orthodontic plan of care.

X. **Primary closure of a sinus perforation**

Y. **Removal of benign cysts and tumors, lateral exostosis, torus palatinus and mandibularis, and foreign bodies**

Z. **Removal of impacted teeth and residual tooth roots** are covered. Prophylactic removal of asymptomatic teeth or teeth free from pathology is not covered, unless the extraction is part of a medically necessary treatment plan or comprehensive replacement plan. Removal of residual tooth roots is not covered on the same service date as an extraction or removal for the same tooth unless provided by a different provider.

AA. **Surgical repositioning of teeth** requires a PA.

BB. **Surgical reduction of fibrous tuberosity** is covered twice per arch per lifetime.

25.03 COVERED SERVICES (cont.)

CC. **Sutures** are covered without limitations. Providers shall bill for one of the appropriate CDT suture codes per date of service, regardless if the provider sutures multiple lacerations. Sutures are not covered for the routine closure of a surgical incision.

DD. **Tooth reimplantation and/or stabilization** of accidentally evulsed or displaced tooth

EE. **Transseptal fiberotomy/supracrestal fiberotomy** requires a PA.

25.03-8 **Orthodontic Services**

A. **Comprehensive and Limited Orthodontic Treatment**

Comprehensive and limited orthodontic treatment require PA and are each covered once per lifetime for members under age twenty-one (21). The one-time reimbursement for each treatment is inclusive of the appliance, brackets, bands, arch wires, ligatures, elastics, headgear, placement and removal of the appliance, repairs, adjustments, one retainer per treated arch, retainer checkups, all visits for the entire duration of the active treatment period, and all other associated services and supplies.

1. Orthodontic treatment must begin within twelve (12) months after the Department approves a PA. Providers must submit a new PA to the Department if treatment does not start within twelve (12) months of the original authorization. If the member becomes ineligible twelve (12) months after the original authorization, a subsequent PA will not be granted.

   Providers shall submit the Supplemental Orthodontia PA Form from the HealthPAS Portal for authorization of limited orthodontic treatment. Limited orthodontics does not require the submission of a Handicapping Labiolingual Deviation (HLD) Index Report. Authorization for limited orthodontic treatment is not considered approval for comprehensive orthodontics in a two-phase plan.

   Providers shall submit the HLD Index Report and Orthodontics PA Sheet and the Supplemental Orthodontia PA Form from the HealthPAS Portal for authorization of comprehensive orthodontic treatment. Providers requesting approval for comprehensive orthodontic treatment after a period of limited orthodontic treatment should indicate the last date of active treatment on the HLD Index Report and Orthodontics PA Sheet.

2. Once treatment has begun, the provider may bill and receive an all-inclusive payment for the orthodontic services. Reimbursement for orthodontic treatment is not available after the member's twenty-first (21st) birthday unless treatment has begun prior to the member's twenty-first (21st) birthday and prior authorization was

25.03 COVERED SERVICES (cont.)

granted. Treatment will be considered to have begun with the extraction of teeth for orthodontic purposes or the placement of a major orthodontic appliance, such as fixed orthodontic brackets, palatal expanders, or other functional appliances requiring active management.

When the Department reimburses a provider for orthodontic treatment at the beginning of such services, the provider must continue to deliver orthodontic treatment even if the member becomes ineligible for MaineCare. The member must continue to meet the residency requirements in the MaineCare Eligibility Manual. If treatment is stopped or suspended or the patient moves or is dismissed from a practice, the provider must notify the Office of MaineCare Services (OMS). OMS will pro-rate, on a case-by-case basis, the amount the provider will be required to reimburse the Department based on the start date of the orthodontia treatment and the actual services and visits that have been completed.

3. The Department will cover the completion of orthodontic treatment for Members under active orthodontic treatment that started prior to the member's enrollment. Providers shall request a PA for the number of medically necessary periodic orthodontic treatment visits to complete the orthodontic treatment.

4. If less than twelve (12) months have elapsed between the last treatment of limited orthodontics and the commencement of an approved comprehensive plan, the reimbursement received for the limited orthodontic treatment will be deducted from the reimbursement for the comprehensive plan. In the event that twelve (12) months or more have elapsed between the two approved plans, the provider will be fully reimbursed for the comprehensive treatment plan.

B. **Pre-orthodontic treatment examinations** to monitor growth and development are covered once per six (6) months for members under twenty-one (21).

C. **Removable and fixed appliance therapy** require PA and are each covered once per lifetime for members under twenty-one (21).

D. **Periodic orthodontic treatment visits** require PA and are covered after an active limited or comprehensive orthodontic treatment period has concluded or for treatment visits for members whose limited or comprehensive orthodontic treatment plan began with a provider or service location that is not able to complete the active treatment plan.

E. **Repair of an orthodontic appliance** requires PA and is covered once per arch per year, but is not covered for the provider or service location that placed the appliance or brackets.

25.03 COVERED SERVICES (cont.)

F. **Re-cement or re-bond of a fixed retainer** requires PA and is covered twice per maxillary and mandibular retainer per lifetime, but is not covered for the provider or service location that placed the retainer within six (6) months of placement.

G. **Replacement of a lost or broken retainer** is covered twice per maxillary and mandibular retainer per lifetime. Reimbursement for replacement of a lost or broken retainer is inclusive of retainer check-ups.

H. **Removal of fixed orthodontic appliance** is covered for medically necessary reasons other than completion of orthodontic treatment. This service is not covered for the provider or service location who placed the appliance.

25.03-9 **Adjunctive Services**

A. **Sedation** is covered when the member has one or more qualifying conditions including, but not limited to, the following:

1. Documented local anesthesia toxicity or failure;
2. Severe cognitive impairment or developmental disability;
3. Severe physical disability;
4. Uncontrolled behavior management problem;
5. Extensive or complicated surgical procedures;
6. Documented medical complications; or
7. Acute infections.

Sedation does not require PA unless the member does not meet any of the above criteria. Deep sedation is covered for ninety (90) minutes per member per date of service. Intravenous moderate sedation is covered for one hundred thirty-five (135) minutes per member per date of service. Non-intravenous conscious sedation is covered once per member per date of service without regard to length of administration.

B. **Nitrous oxide** is covered once per member per date of service without regard to length of administration.

C. **Consultation.** A professional consultation is covered four (4) times per member per year. A consultation includes an oral evaluation and is reimbursable to the consulting doctor who gives their opinion or advice when requested by a dentist, physician, or other appropriate source. Consultations are not covered for a treatment plan presentation.

D. **House/Extended care facility call** is covered once per member per date of service. Providers may report this service in addition to other services delivered during the visit.

25.03 COVERED SERVICES (cont.)

E. **House or Ambulatory Surgical Center Call** is covered once per member per date of service. Providers may report this service in addition to other services delivered during the visit.

F. **Behavior management** is covered three (3) times per member per year per service location when the behavior of the member delays or prevents a covered service from being delivered. Providers shall retain a description of the behavior that delayed or prevented a covered service from being delivered in the member's record. Behavior management shall be reported in fifteen- (15) minute increments.

G. **Occlusal guards** are covered once per arch per two (2) years to minimize the effects of bruxism or other occlusal factors. Occlusal guards do not include any type of sleep apnea, snoring, or temporomandibular appliances.

H. **Dental case management** is covered twice per member, per service location, per year when the provider expends additional time and resources to provide experience or expertise beyond that possessed by the member to coordinate oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. Dental case management is not covered for the normal efforts a provider makes when referring a patient to another healthcare professional or coordinating treatment.

I. **Fluoride gel carriers** are covered once per member per year.

25.04 NON-COVERED SERVICES

A. The Department does not cover any service that is not described in Section 25.03 or that does not have an approved PA if required.

B. The Department does not cover services that are delivered for cosmetic or aesthetic purposes.

C. The Department does not reimburse for missed appointments but they may be reported using the appropriate CDT code for tracking purposes once per member per missed appointment. A member cannot be billed for a missed appointment even if the member was notified in advance there would be a charge.

D. Dental-related services not covered in this Section of the MBM may be covered in other Sections. These include, but are not limited to, some oral and maxillofacial surgery and maxillofacial prosthetic services.

The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.

25.05 POLICIES AND PROCEDURES

25.05-1 Prior Authorization

Providers shall use the appropriate PA criteria sheet on the Department's HealthPAS Portal when requesting PA. If a covered service does not have a unique criteria sheet with specific criteria, providers shall use the Supplemental Dental Services PA Form and include a narrative of medical necessity, appropriate radiographs, and any other documentation that demonstrates medical necessity. The Department may use PA criteria that are industry recognized criteria from a national company under contract. In cases where criteria are not met, providers may submit additional supporting evidence such as medical documentation to demonstrate that the requested service is medically necessary. Providers may submit a PA to exceed the limit for a covered service, and the Department will approve the PA if it determines exceeding the limit is medically necessary. The Department may request additional documentation before approving a PA if the documentation provided is insufficient.

25.05-2 Provider Requirements

Providers of covered services described in Section 25.03 shall be appropriately licensed by the Board, abide by the Board's rules, and meet requirements and only deliver services in accordance with their scope of practice as defined in 32 M.R.S. Chapter 143.

Covered services rendered by Dental Residents and Dental Externs shall be reimbursed to entities enrolled as MaineCare providers employing or sponsoring Dental Residents and Dental Externs.

25.05-3 Timeframe Limits for Covered Services

"Year," in the context of covered service limits, means "calendar year" when the limit is defined on a "per year" basis. For covered service limits that are defined on a multi-year basis, each "year" means a rolling 365-day period or the 365 days following the date of the delivery of the first covered service subject to the limit. For example, a "two per three years" limit means a member cannot receive more than two of the specified services in any given 1,095-day period.

25.06 REIMBURSEMENT METHODOLOGY

Specific reimbursement rates are listed on the dental fee schedule, which is posted on the Department's website in accordance with 22 MRSA §3173-J(7). Reimbursement for covered services may be inclusive of, but is not limited to, local anesthesia, sutures, materials, supplies, and routine postoperative care.

Reimbursement rates are based on the following methodology:

The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.

25.06 REIMBURSEMENT METHODOLOGY (cont.)

A. **Benchmarks**

The Department calculates reimbursement rates for covered CDT codes using either the Commercial Median Benchmark or the All-States Medicaid Average Benchmark.

1. The **Commercial Median Benchmark** for each CDT code is the median of Maine commercial payer dental claim allowed amounts when the claim is paid as primary with an allowed amount greater than zero (0) based on data from the Maine Health Data Organization's All Payer Claims Database. The Commercial Median Benchmark rate for a CDT code must have equal to or greater than one-hundred (100) claims billed in the source data used to set the benchmarks in order for the Department to consider it reliable. Benchmarks are updated every two (2) years utilizing claims from the most recent Maine state fiscal year.

2. The **Medicaid State Average Benchmark** (Medicaid Benchmark) is the average of all other states' Medicaid rates for a CDT code, where rates are available and reliable. The Department excludes any rates as unreliable in the determination of the Medicaid Benchmark when they represent outliers in comparison to the other state rates, or when there is excessive variation across all state rates available. If a Medicaid agency uses different child and adult rates, the Department uses the average of the rates. Benchmarks are updated every two (2) years utilizing the most current rates available as of the time of the rate schedule update.

B. **Determination of Benchmark and Percent of Benchmark**

The Department determines which Benchmark and percent of Benchmark to use in setting rates using the following methodology:

1. The Department sets rates for diagnostic, endodontic, periodontic, preventive, and limited orthodontic treatment services based on 67% of the Commercial Median Benchmark or 133% of the Medicaid State Average Benchmark, if the Commercial Median Benchmark rate is unavailable or unreliable as defined in Section 25.06(A)(1).

2. The Department sets rates for adjunctive, oral and maxillofacial surgery, orthodontics (except for limited orthodontic treatment), prosthodontics, and restorative services based on 50% of the Commercial Median Benchmark, or 100% of the Medicaid State Average Benchmark if the Commercial Median Benchmark rate is unavailable or unreliable as defined in Section 25.06(A)(1).

3. Temporary Exceptions: The following methodologies will be in effect through June 30, 2024.

   a. The methodology set forth in B.1 will also apply to codes for extraction of an erupted or exposed root; and

   b. The Department will default codes for medicament application to 133% of the Medicaid State Average Benchmark.

The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions.

25.03 REIMBURSEMENT METHODOLOGY (cont.)

C. **Adaptation of Methodology for Related Codes**

In alignment with common practice by commercial payers and other state Medicaid agencies, for codes in the same series and/or for the same service, differentiated only by time increment for the code or age of patient, etc., the methodology outlined above applies to the base service; other CDT codes are set in relation to the base service proportional to the amount of time or factor of difficulty of the related service.

1. Orthodontic Treatment: For limited and comprehensive orthodontic treatment, after calculation of the initial rates by code in alignment with the methodology above, the Department then sets the final MaineCare rates at the adolescent dentition rate for the codes in the same series (limited and orthodontic).

   In order to identify claims that reflect a bundled rate for orthodontic treatment, the Department only includes claims that are paid as primary and that have a rate greater than $300 and $1000 for limited and comprehensive orthodontic treatment codes, respectively. The Department excludes claims when the code was billed more than once per person.

2. Sedation: The Department sets rates for deep and intravenous moderate sedation service codes at 50% of the Commercial Median Benchmark for the CDT code that represents the first fifteen (15) minutes of deep sedation.

D. **Inflation Adjustment**

The Department applies an inflation adjustment to all rates based on the Consumer Price Index (CPI) for dental services in U.S. city average, all urban consumers, seasonally adjusted (CUSR0000SEMC02) to adjust rates to the current year.

25.07 BILLING INSTRUCTIONS

Providers that attest to and bill for services under Section 25, Dental Services, shall not bill claims containing Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes for covered services described in Section 25.03.

If a provider that attests to Section 25 provides a service that is within their scope of practice that is not covered under Section 25.03, but is covered under another Section of the MBM, the provider must comply with the relevant Section of the MBM which authorizes coverage of that service and may bill for the service using the appropriate CPT or HCPCS code(s).

Providers shall bill in accordance with the Department's current billing instructions. Billing instructions are available upon request or from the Department's website at: https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx.