

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Provider Operations

4 (Amendment)

5 907 KAR 1:026. Dental services.

6 RELATES TO: KRS 205.520, 205.8451, 42 U.S.C. 1396a-d

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C.

8 1396a-d, Pub.L. 109-171

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services, has the responsibility to administer the
11 Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation,
12 to comply with any requirement that may be imposed or opportunity presented by
13 federal law for the provision of medical assistance to Kentucky's indigent citizenry. This
14 administrative regulation establishes the provisions relating to dental services.

15 Section 1. Definitions. (1) "Comprehensive orthodontic" means a medically necessary
16 dental service for treatment of a dentofacial malocclusion which requires the application
17 of braces for correction.

18 (2) "Current Dental Terminology" or "CDT" means a publication by the American
19 Dental Association of codes used to report dental procedures or services.

20 (3) "Debridement" means a procedure that is performed:

1 (a) For removing thick or dense deposits on the teeth which is required if tooth
2 structures are so deeply covered with plaque and calculus that a dentist or staff cannot
3 check for decay, infections, or gum disease; and

4 (b) Separately from a regular cleaning and is usually a preliminary or first treatment
5 when an individual has developed very heavy plaque or calculus.

6 (4) "Department" means the Department for Medicaid Services or its designee.

7 (5) "Disabling malocclusion" means that a patient has a condition that meets the
8 criteria established in Section 13(7) of this administrative regulation.

9 (6) "Direct practitioner contact" means the billing dentist or oral surgeon is physically
10 present with and evaluates, examines, treats, or diagnoses the recipient.

11 (7) "Incidental" means that a medical procedure is performed at the same time as a
12 primary procedure and:

13 (a) Requires little additional practitioner resources; or

14 (b) Is clinically integral to the performance of the primary procedure.

15 (8) "Integral" means that a medical procedure represents a component of a more
16 complex procedure performed at the same time.

17 (9) "Medically necessary" or "medical necessity" means that a covered benefit is
18 determined to be needed in accordance with 907 KAR 3:130.

19 (10) "Mutually exclusive" means that two (2) procedures:

20 (a) Are not reasonably performed in conjunction with one another during the same
21 patient encounter on the same date of service;

22 (b) Represent two (2) methods of performing the same procedure;

23 (c) Represent medically impossible or improbable use of CDT codes; or

1 (d) Are described in CDT as inappropriate coding of procedure combinations.

2 (11) "Other licensed medical professional" means a health care provider other than a
3 dentist who has been approved to practice a medical specialty by the appropriate
4 licensure board.

5 (12) "Prepayment review" or "PPR" means a departmental review of a claim to
6 determine if the requirements of this administrative regulation have been met prior to
7 authorizing payment.

8 (13) "Prior authorization" or "PA" means approval which a provider shall obtain from
9 the department before being reimbursed for a covered service.

10 (14) "Provider" is defined in KRS 205.8451(7).

11 (15) "Recipient" is defined in KRS 205.8451(9).

12 (16) "Resident" is defined in 42 C.F.R. 415.152.

13 (17) "Timely filing" means receipt of a claim by Medicaid:

14 (a) Within twelve (12) months of the date the service was provided;

15 (b) Within twelve (12) months of the date retroactive eligibility was established; or

16 (c) Within six (6) months of the Medicare adjudication date if the service was billed to
17 Medicare.

18 Section 2. Conditions of Participation. (1) A participating provider shall be licensed as
19 a provider in the state in which the practice is located.

20 (2) A participating provider shall comply with the terms and conditions established in
21 the following administrative regulations:

22 (a) 907 KAR 1:005[~~;- Nonduplication of payments~~];

23 (b) 907 KAR 1:671[~~;- Conditions of Medicaid provider participation, withholding~~

1 ~~overpayments, administrative appeal process, and sanctions]; and~~

2 (c) 907 KAR 1:672[; ~~Provider enrollment, disclosure, and documentation for Medicaid~~
3 ~~participation].~~

4 (3) A participating provider shall comply with the requirements to maintain the
5 confidentiality of personal medical records pursuant to 42 U.S.C. 1320d and 45 C.F.R.
6 Parts 160 and 164.

7 (4) A participating provider shall have the freedom to choose whether to accept an
8 eligible Medicaid recipient and shall notify the recipient of the decision prior to the
9 delivery of service. If the provider accepts the recipient, the provider:

10 (a) Shall bill Medicaid rather than the recipient for a covered service;

11 (b) May bill the recipient for a service not covered by Kentucky Medicaid, if the
12 provider informed the recipient of noncoverage prior to providing the service; and

13 (c) Shall not bill the recipient for a service that is denied by the department for:

14 1. Being:

15 a. Incidental;

16 b. Integral; or

17 c. Mutually exclusive;

18 2. Incorrect billing procedures, including incorrect bundling of procedures;

19 3. Failure to obtain prior authorization for the service; or

20 4. Failure to meet timely filing requirements.

21 Section 3. Record Maintenance. (1) A provider shall maintain comprehensive legible
22 medical records which substantiate the services billed.

23 (2) A medical record shall be signed by the provider and dated to reflect the date of

1 service.

2 (3) An X-ray shall be of diagnostic quality and shall include the:

3 (a) Recipient's name;

4 (b) Service date; and

5 (c) Provider's name.

6 (4) A treatment regimen shall be documented to include:

7 (a) Diagnosis;

8 (b) Treatment plan;

9 (c) Treatment and follow-up; and

10 (d) Medical necessity.

11 (5) Medical records, including x-rays, shall be maintained in accordance with 907

12 KAR 1:672, Section 4(3) and (4).

13 Section 4. General Coverage Requirements. (1) A covered service shall be:

14 (a) Medically necessary;

15 (b) Except as provided in subsection (2) of this section, furnished to a recipient

16 through direct practitioner contact; and

17 (c) Unless a recipient's provider demonstrates that dental services in excess of the

18 following service limitations are medically necessary, limited to:

19 1. Two (2) prophylaxis per twelve (12) month period for a recipient under age twenty-
20 one (21);

21 2. One (1) dental visit per month per provider for a recipient age twenty-one (21)
22 years and over; and

23 3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one

1 (21) years and over.

2 (2) A covered service provided by an individual who meets the definition of other
3 licensed medical professional shall be covered if the:

4 (a) Individual is employed by the supervising oral surgeon, dentist, or dental group;

5 (b) Individual is licensed in the state of practice; and

6 (c) Supervising provider has direct practitioner contact with the recipient, except for a
7 service provided by a dental hygienist if the dental hygienist provides the service under
8 general supervision of a practitioner in accordance with KRS 313.310.

9 (3)(a) A medical resident may provide services if provided under the direction of a
10 program participating teaching physician in accordance with 42 C.F.R. 415.170,
11 415.172, and 415.174.

12 (b) A dental resident, student, or dental hygiene student may provide services under
13 the direction of a program participating provider in or affiliated with an American Dental
14 Association accredited institution.

15 (4) Coverage shall be limited to services identified in 907 KAR 1:626, Section 3, in
16 the following CDT categories:

17 (a) Diagnostic;

18 (b) Preventive;

19 (c) Restorative;

20 (d) Endodontics;

21 (e) Periodontics;

22 (f) Removable prosthodontics;

23 (g) Maxillofacial prosthetics;

1 (h) Oral and maxillofacial surgery;

2 (i) Orthodontics; or

3 (j) Adjunctive general services.

4 Section 5. Diagnostic Service Coverage Limitations. (1)(a) Except as provided in
5 paragraph (b) of this subsection, coverage for a comprehensive oral evaluation shall be
6 limited to one (1) per twelve (12) month period, per recipient, per provider.

7 (b) The department shall cover a second comprehensive oral evaluation if the
8 evaluation is provided in conjunction with a prophylaxis to an individual under twenty-
9 one (21) years of age.

10 (c) A comprehensive oral evaluation shall not be covered in conjunction with the
11 following:

12 1. A limited oral evaluation for trauma related injuries;

13 2. Space maintainers;

14 3. Root canal therapy;

15 4. Denture relining;

16 5. Transitional appliances;

17 6. A prosthodontic service;

18 7. Temporomandibular joint therapy;

19 8. An orthodontic service;

20 9. Palliative treatment; or

21 10. A hospital call.

22 (2)(a) Coverage for a limited oral evaluation shall:

23 1. Be limited to a trauma related injury or acute infection;

1 2. Be limited to one (1) per date of service, per recipient, per provider; and

2 3. Require a prepayment review.

3 (b) A limited oral evaluation shall not be covered in conjunction with another service

4 except for:

5 1. A periapical x-ray;

6 2. Bitewing x-rays;

7 3. A panoramic x-ray;

8 4. Resin, anterior;

9 5. A simple or surgical extraction;

10 6. Surgical removal of a residual tooth root;

11 7. Removal of a foreign body;

12 8. Suture of a recent small wound;

13 9. Intravenous sedation; or

14 10. Incision and drainage of infection.

15 (3)(a) Except as provided in paragraph (b) of this subsection, the following limitations

16 shall apply to coverage of a radiograph service:

17 1. Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per

18 recipient, per provider;

19 2. Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per

20 recipient, per provider;

21 3. An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month

22 period, per recipient, per provider;

23 4. Periapical and bitewing x-rays shall not be covered in the same twelve (12) month

1 period as an intraoral complete x-ray series per recipient, per provider;

2 5. A panoramic film shall:

3 a. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider;

4 and

5 b. Require prior authorization in accordance with Section 15(2) and (3) of this

6 administrative regulation for a recipient under age six (6);

7 6. A cephalometric film shall be limited to one (1) per twenty-four (24) month period,

8 per recipient, per provider; or

9 7. Cephalometric and panoramic x-rays shall not be covered in conjunction with a

10 comprehensive orthodontic consultation.

11 (b) The limits established in paragraph (a) of this subsection shall not apply to:

12 1. An x-ray necessary for a root canal or oral surgical procedure; or

13 2. An x-ray that exceeds the established service limitations and is determined by the

14 department to be medically necessary.

15 Section 6. Preventive Service Coverage Limitations. (1)(a) Coverage of a prophylaxis

16 shall be limited to:

17 1. For an individual twenty-one (21) years of age and over, one (1) per twelve (12)

18 month period, per recipient; and

19 2. For an individual under twenty-one (21) years of age, two (2) per twelve (12)

20 month period, per recipient.

21 (b) A prophylaxis shall not be covered in conjunction with periodontal scaling or root

22 planing.

23 (2)(a) Coverage of a sealant shall be limited to:

- 1 1. A recipient age five (5) through twenty (20) years;
- 2 2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime
- 3 limit of three (3) sealants per tooth, per recipient; and
- 4 3. An occlusal surface that is noncarious.

5 (b) A sealant shall not be covered in conjunction with a restorative procedure for the
6 same tooth on the same date of service.

7 (3)(a) Coverage of a space maintainer shall:

- 8 1. Be limited to a recipient under age twenty-one (21); and
- 9 2. Require the following:
 - 10 a. Fabrication;
 - 11 b. Insertion;
 - 12 c. Follow-up visits;
 - 13 d. Adjustments; and
 - 14 e. Documentation in the recipient's medical record to:
 - 15 (i) Substantiate the use for maintenance of existing intertooth space; and
 - 16 (ii) Support the diagnosis and a plan of treatment that includes follow-up visits.
- 17 (b) The date of service for a space maintainer shall be considered to be the date the
18 appliance is placed on the recipient.
- 19 (c) Coverage of a space maintainer, an appliance therapy specified in the CDT
20 orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12)
21 month period, per recipient.

22 Section 7. Restorative Service Coverage Limitations. (1) A four (4) or more surface
23 resin-based anterior composite procedure shall not be covered if performed for the

1 purpose of cosmetic bonding or veneering.

2 (2) Coverage of a prefabricated crown shall be:

3 (a) Limited to a recipient under age twenty-one (21); and

4 (b) Inclusive of any procedure performed for restoration of the same tooth.

5 (3) Coverage of a pin retention procedure shall be limited to:

6 (a) A permanent molar;

7 (b) One (1) per tooth, per date of service, per recipient; and

8 (c) Two (2) per permanent molar, per recipient.

9 (4) Coverage of a restorative procedure performed in conjunction with a pin retention
10 procedure shall be limited to one (1) of the following:

11 (a) An amalgam, three (3) or more surfaces;

12 (b) A permanent prefabricated resin crown; or

13 (c) A prefabricated stainless steel crown.

14 Section 8. Endodontic Service Coverage Limitations. (1) Coverage of the following
15 endodontic procedures shall be limited to a recipient under age twenty-one (21):

16 (a) A pulp cap direct;

17 (b) Therapeutic pulpotomy; or

18 (c) Root canal therapy.

19 (2) A therapeutic pulpotomy shall not be covered if performed in conjunction with root
20 canal therapy.

21 (3)(a) Coverage of root canal therapy shall require:

22 1. Treatment of the entire tooth;

23 2. Completion of the therapy; and

1 3. An x-ray taken before and after completion of the therapy.

2 (b) The following root canal therapy shall not be covered:

3 1. The Sargenti method of root canal treatment; or

4 2. A root canal on one (1) root of a molar.

5 Section 9. Periodontic Service Coverage Limitations. (1) Coverage of a gingivectomy

6 or gingivoplasty procedure shall require prepayment review and shall be limited to:

7 (a) A recipient with gingival overgrowth due to a:

8 1. Congenital condition;

9 2. Hereditary condition; or

10 3. Drug-induced condition; and

11 (b) One (1) per tooth or per quadrant, per provider, per recipient per twelve (12)

12 month period.

13 1. Coverage of a quadrant procedure shall require a minimum of a three (3) tooth

14 area within the same quadrant.

15 2. Coverage of a per-tooth procedure shall be limited to no more than two (2) teeth

16 within the same quadrant.

17 (2) Coverage of a gingivectomy or gingivoplasty procedure shall require

18 documentation in the recipient's medical record that includes:

19 (a) Pocket-depth measurements;

20 (b) A history of nonsurgical services; and

21 (c) Prognosis.

22 (3) Coverage for a periodontal scaling and root planing procedure shall:

23 (a) Not exceed one (1) per quadrant, per twelve (12) months, per recipient, per

1 provider;

2 (b) Require prior authorization in accordance with Section 15(2) and (4) of this
3 administrative regulation; and

4 (c) Require documentation to include:

5 1. A periapical film or bitewing x-ray; and

6 2. Periodontal charting of preoperative pocket depths.

7 (4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth
8 area within the same quadrant.

9 (5) Periodontal scaling and root planing shall not be covered if performed in
10 conjunction with dental prophylaxis.

11 (6)(a) A full mouth debridement shall only be covered for a pregnant woman.

12 (b) Only one (1) full mouth debridement per pregnancy shall be covered.

13 Section 10. Prosthodontic Service Coverage Limitations. (1) A removable
14 prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).

15 (2) A denture repair in the following categories shall not exceed three (3) repairs per
16 twelve (12) month period, per recipient:

17 (a) Repair resin denture base; or

18 (b) Repair cast framework.

19 (3) Coverage for the following services shall not exceed one (1) per twelve (12)
20 month period, per recipient:

21 (a) Replacement of a broken tooth on a denture;

22 (b) Laboratory relining of:

23 1. Maxillary dentures; or

- 1 2. Mandibular dentures;
- 2 (c) An interim maxillary partial denture; or
- 3 (d) An interim mandibular partial denture.
- 4 (4) An interim maxillary or mandibular partial denture shall be limited to use:
- 5 (a) During a transition period from a primary dentition to a permanent dentition;
- 6 (b) For space maintenance or space management; or
- 7 (c) As interceptive or preventive orthodontics.

8 Section 11. Maxillofacial Prosthetic Service Coverage Limitations. The following
9 services shall be covered if provided by a board certified prosthodontist:

- 10 (1) A nasal prosthesis;
- 11 (2) An auricular prosthesis;
- 12 (3) A facial prosthesis;
- 13 (4) A mandibular resection prosthesis;
- 14 (5) A pediatric speech aid;
- 15 (6) An adult speech aid;
- 16 (7) A palatal augmentation prosthesis;
- 17 (8) A palatal lift prosthesis;
- 18 (9) An oral surgical splint; or
- 19 (10) An unspecified maxillofacial prosthetic.

20 Section 12. Oral and Maxillofacial Service Coverage Limitations. (1) The simple use
21 of a dental elevator shall not constitute a surgical extraction.

22 (2) Root removal shall not be covered on the same date of service as the extraction
23 of the same tooth.

- 1 (3) Coverage of surgical access of an unerupted tooth shall:
- 2 (a) Be limited to exposure of the tooth for orthodontic treatment; and
- 3 (b) Require prepayment review.
- 4 (4) Coverage of alveoplasty shall:
- 5 (a) Be limited to one (1) per quadrant, per lifetime, per recipient; and
- 6 (b) Require a minimum of a three (3) tooth area within the same quadrant.
- 7 (5) An occlusal orthotic device shall:
- 8 (a) Be covered for temporomandibular joint therapy;
- 9 (b) Require prior authorization in accordance with Section 15(2) and (5) of this
- 10 administrative regulation;
- 11 (c) Be limited to a recipient under age twenty-one (21); and
- 12 (d) Be limited to one (1) per lifetime, per recipient.
- 13 (6) Frenulectomy shall be limited to one (1) per date of service.
- 14 (7) Coverage shall be limited to one (1) per lifetime, per recipient, for removal of the
- 15 following:
- 16 (a) Torus palatinus (maxillary arch);
- 17 (b) Torus mandibularis (lower left quadrant); or
- 18 (c) Torus mandibularis (lower right quadrant).
- 19 (8) Except as specified in subsection (9) [~~(8)~~] of this section, a service provided by an
- 20 oral surgeon shall be covered in accordance with 907 KAR 3:005[~~, Physicians'~~
- 21 ~~services~~].
- 22 (9) [~~(8)~~] If performed by an oral surgeon, coverage of a service identified in CDT shall
- 23 be limited to:

- 1 (a) Extractions;
- 2 (b) Impactions; and
- 3 (c) Surgical access of an unerupted tooth.

4 Section 13. Orthodontic Service Coverage Limitations. (1) Coverage of an
5 orthodontic service shall:

- 6 (a) Be limited to a recipient under age twenty-one (21); and
- 7 (b) Require prior authorization.

8 (2) The combination of space maintainers and appliance therapy shall be limited to
9 two (2) per twelve (12) month period, per recipient.

10 (3) Space maintainers and appliance therapy shall not be covered in conjunction with
11 comprehensive orthodontics.

12 (4) The department shall only cover new orthodontic brackets or appliances.

13 (5) An appliance for minor tooth guidance shall not be covered for the control of
14 harmful habits.

15 (6) In addition to the limitations specified in subsection (1) of this section, a
16 comprehensive orthodontic service shall:

17 (a) Require a referral by a dentist; and

18 (b) Be limited to:

19 1. The correction of a disabling malocclusion; or

20 2. Transitional or full permanent dentition unless for treatment of a cleft palate or
21 severe facial anomaly.

22 (7) A disabling malocclusion shall exist if a patient:

23 (a) Has a deep impinging overbite that shows palatal impingement of the majority of

- 1 the lower incisors;
- 2 (b) Has a true anterior open bite that does not include:
- 3 1. One (1) or two (2) teeth slightly out of occlusion; or
- 4 2. Where the incisors have not fully erupted;
- 5 (c) Demonstrates a significant antero-posterior discrepancy (Class II or III
- 6 malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or
- 7 skeletal);
- 8 (d) Has an anterior crossbite that involves:
- 9 1. More than two (2) teeth in crossbite;
- 10 2. Obvious gingival stripping; or
- 11 3. Recession related to the crossbite;
- 12 (e) Demonstrates handicapping posterior transverse discrepancies which:
- 13 1. May include several teeth, one (1) of which shall be a molar; and
- 14 2. Is handicapping in a function fashion as follows:
- 15 a. Functional shift;
- 16 b. Facial asymmetry;
- 17 c. Complete buccal or lingual crossbite; or
- 18 d. Speech concern;
- 19 (f) Has a significant posterior open bite that does not involve:
- 20 1. Partially erupted teeth; or
- 21 2. One (1) or two (2) teeth slightly out of occlusion;
- 22 (g) Except for third molars, has impacted teeth that will not erupt into the arches
- 23 without orthodontic or surgical intervention;

1 (h) Has extreme overjet in excess of eight (8) to nine (9) millimeters and one (1) of
2 the skeletal conditions specified in paragraphs (a) through (g) of this subsection;

3 (i) Has trauma or injury resulting in severe misalignment of the teeth or alveolar
4 structures, and does not include simple loss of teeth with no other affects;

5 (j) Has a congenital or developmental disorder giving rise to a handicapping
6 malocclusion;

7 (k) Has a significant facial discrepancy requiring a combined orthodontic and
8 orthognathic surgery treatment approach; or

9 (l) Has developmental anodontia in which several congenitally missing teeth result in
10 a handicapping malocclusion or arch deformation.

11 (8) Coverage of comprehensive orthodontic treatment shall not be inclusive of
12 orthognathic surgery.

13 (9) If comprehensive orthodontic treatment is discontinued prior to completion, the
14 provider shall submit to the department:

15 (a) A referral form, if applicable; and

16 (b) A letter detailing:

17 1. Treatment provided, including dates of service;

18 2. Current treatment status of the patient; and

19 3. Charges for treatment provided.

20 (10) Remaining portions of comprehensive orthodontic treatment may be authorized
21 for prorated coverage upon submission of the prior authorization requirements specified
22 in Section 15(2) and (7) of this administrative regulation if treatment:

23 (a) Is transferred to another provider; or

1 (b) Began prior to Medicaid eligibility.

2 Section 14. Adjunctive General Service Coverage Limitations. (1)(a) Coverage of
3 palliative treatment for dental pain shall be limited to one (1) per date of service, per
4 recipient, per provider.

5 (b) Palliative treatment for dental pain shall not be covered in conjunction with
6 another service except radiographs.

7 (2)(a) Coverage of a hospital call shall be limited to one (1) per date of service, per
8 recipient, per provider.

9 (b) A hospital call shall not be covered in conjunction with:

- 10 1. Limited oral evaluation;
- 11 2. Comprehensive oral evaluation; or
- 12 3. Treatment of dental pain.

13 (3)(a) Coverage of intravenous sedation shall be limited to a recipient under age
14 twenty-one (21).

15 (b) Intravenous sedation shall not be covered for local anesthesia or nitrous oxide.

16 Section 15. Prior Authorization. (1) Prior authorization shall be required for the
17 following:

- 18 (a) A panoramic film for a recipient under age six (6);
- 19 (b) Periodontal scaling and root planing;
- 20 (c) An occlusal orthotic device;
- 21 (d) A preorthodontic treatment visit;
- 22 (e) Removable appliance therapy;
- 23 (f) Fixed appliance therapy; or

- 1 (g) A comprehensive orthodontic service.
- 2 (2) A provider shall request prior authorization by submitting the following information
3 to the department:
- 4 (a) A MAP-9, Prior Authorization for Health Services;
- 5 (b) Additional forms or information as specified in subsections (3) through (7) of this
6 section; and
- 7 (c) Additional information required to establish medical necessity if requested by the
8 department.
- 9 (3) A request for prior authorization of a panoramic film shall include a letter of
10 medical necessity.
- 11 (4) A request for prior authorization of periodontal scaling and root planing shall
12 include periodontal charting of preoperative pocket depths.
- 13 (5) A request for prior authorization of an occlusal orthotic device shall include a MAP
14 306, Temporomandibular Joint (TMJ) Assessment Form.
- 15 (6) A request for prior authorization of removable and fixed appliance therapy shall
16 include:
- 17 (a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;
- 18 (b) Panoramic film or intraoral complete series; and
- 19 (c) Dental models.
- 20 (7) A request for prior authorization for comprehensive orthodontic services shall
21 include:
- 22 (a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;
- 23 (b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;

- 1 (c) Cephalometric x-rays with tracing;
- 2 (d) A panoramic x-ray;
- 3 (e) Intraoral and extraoral facial frontal and profile pictures;
- 4 (f) Occluded and trimmed dental models;
- 5 (g) An oral surgeon's pretreatment work up notes if orthognathic surgery is required;
- 6 (h) After six (6) monthly visits are completed, but not later than twelve (12) months
- 7 after the banding date of service:
- 8 1. A MAP 559, Six (6) Month Orthodontic Progress Report; and
- 9 2. An additional MAP 9, Prior Authorization for Health Services; and
- 10 (i) Within three (3) months following completion of the comprehensive orthodontic
- 11 treatment:
- 12 1. Beginning and final records; and
- 13 2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.
- 14 (8) Upon receipt and review of the materials required in subsection (7)(a) through (g)
- 15 of this section, the department may request a second opinion from another provider
- 16 regarding the proposed comprehensive orthodontic treatment.
- 17 (9) If a service that requires prior authorization is provided before the prior
- 18 authorization is received, the provider shall assume the financial risk that the prior
- 19 authorization may not be subsequently approved.
- 20 (10) Prior authorization shall not be a guarantee of recipient eligibility. Eligibility
- 21 verification shall be the responsibility of the provider.
- 22 (11) Upon review and determination by the department that removing prior
- 23 authorization shall be in the best interest of Medicaid recipients, the prior authorization

1 requirement for a specific covered benefit shall be discontinued, at which time the
2 covered benefit shall be available to all recipients without prior authorization.

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

6 (2) An appeal of a department decision regarding Medicaid eligibility of an individual
7 shall be in accordance with 907 KAR 1:560.

8 (3) An appeal of a department decision regarding a Medicaid provider based upon an
9 application of this administrative regulation shall be in accordance with 907 KAR 1:671.

10 Section 17. Incorporation by Reference. (1) The following material is incorporated by
11 reference:

12 (a) "MAP 9, Prior Authorization for Health Services", December 1995 edition;

13 (b) "MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement",
14 December 1995 edition;

15 (c) "MAP 306, Temporomandibular Joint (TMJ) Assessment Form", December 1995
16 edition;

17 (d) "MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form", March
18 2001 edition;

19 (e) "MAP 559, Six (6) Month Orthodontic Progress Report", December 1995 edition;
20 and

21 (f) "MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission",
22 December 1995 edition.

23 (2) This material may be inspected, copied, or obtained, subject to applicable

- 1 copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,
- 2 Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:026

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

A public hearing on this administrative regulation shall, if requested, be held on August 21, 2008, at 9:00 a.m. in the Cabinet for Health and Family Services Health Services Board Room, Second Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by August 14, 2008, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business September 2, 2008. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:026

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Linda Dailey (502) 564-5969 or Cheryl Bentley (502) 564-6204

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes provisions related to dental services provided to Medicaid recipients.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to dental services.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to KRS 194A.050 and other authorizing statutes by establishing provisions related to dental services.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of KRS 194A.050 and other authorizing statutes by establishing provisions related to dental services.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This amendment allows reimbursement for additional dental procedures for Medicaid recipients in both age categories, under and over twenty-one (21) years of age. The following additional dental procedures that will be covered are limited to one (1) per lifetime, per recipient: removal of torus palatinus (maxillary arch), removal of torus mandibularis (lower left quadrant), and removal of torus mandibularis (lower right quadrant).
 - (b) The necessity of the amendment to this administrative regulation: This amendment is necessary to enable dental providers to be reimbursed for the removal of torus palatinus (maxillary arch), torus mandibularis (lower left quadrant), and torus mandibularis (lower right quadrant). A few dentists are performing these procedures free-of-charge because they are necessary and currently Medicaid does not allow reimbursement for these services; however, other dental providers are not performing these procedures due to the lack of reimbursement by Medicaid.
 - (c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by enabling dental providers to be reimbursed for the removal of torus palatinus (maxillary arch), torus mandibularis (lower left quadrant), and torus mandibularis (lower right quadrant).
 - (d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes

by enabling dental providers to be reimbursed for the removal of torus palatinus (maxillary arch), torus mandibularis (lower left quadrant), and torus mandibularis (lower right quadrant).

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect Medicaid dental service recipients and Medicaid dental providers.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
 - (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Dental providers, approved to provide Medicaid services, will be allowed to receive reimbursement for the added procedures and will not have to take any action to comply with the amendment.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). As a result of the amendment, dental providers will be allowed to be reimbursed for additional dental procedures and DMS anticipates that recipients will have more access to these procedures.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: The Department for Medicaid Services (DMS) anticipates the cost will exceed \$38,000 annually because during the past year the cost for the procedures was approximately \$38,000 while the coverage was limited to fewer providers.
 - (b) On a continuing basis: DMS anticipated the cost will exceed \$38,000 based on prior service utilization while providers were more limited.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds from general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding is necessary as a result of the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly

or indirectly increases any fees: This amendment establishes reimbursement fees for dental providers for additional procedures.

- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is not applied as the amendment applies equally to all dental providers.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:026 Contact Person: Linda Dailey (502) 564-5969 or Cheryl Bentley (502) 564-6204

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____

If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect the Department for Medicaid Services but is not expected to affect local government units, parts or divisions.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 194A.030(2), 194A.050(1), 205.520(3), and 42 U.S.C. 1396a-d.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates no revenue will be generated by the amendment.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS anticipates no revenue will be generated by the amendment.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates the cost will exceed \$38,000 annually because during the past year the cost for the procedures was approximately \$38,000 while the coverage was limited to fewer providers.

(d) How much will it cost to administer this program for subsequent years? DMS anticipated the cost will exceed \$38,000 based on prior service utilization while providers were more limited.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to

explain the fiscal impact of the administrative regulation.

Revenues (+/-): .

Expenditures (+/-):