CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Physician and Special Services

(Amended After Comments)

907 KAR 1:026. Dental services.

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

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a-d, Public Law 109-171 [~~EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions relating to dental services including new limit provisions as authorized by Public Law 109-171.

Section 1. Definitions.

(1) "Comprehensive orthodontic" means a medically-necessary dental service for treatment of a dentofacial malocclusion which requires application of braces for

correction.

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

(3) “Debridement” means a procedure for removing thick or dense deposits on the teeth which is required when tooth structures are so deeply covered with plaque and calculus that a dentist or staff cannot check for decay, infections and gum disease. A debridement is not the same as a regular cleaning and is usually a preliminary or first treatment when an individual has developed very heavy plaque and or calculus.

(4) "Department" means the Department for Medicaid Services or its designated agent.

(5) "Disabling malocclusion" means that a patient:

(a) Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors;

(b) Has a true anterior open bite that does not include:

1. One (1) or two (2) teeth slightly out of occlusion; or

2. Where the incisors have not fully erupted;

(c) Demonstrates a significant antero-posterior discrepancy (Class II or III malocclusion that is comparable to at least one (1) full tooth Class II or III, dental or skeletal);

(d) Has an anterior crossbite that involves:

1. More than two (2) teeth in crossbite

2. Obvious gingival stripping; or

3. Recession related to the crossbite;

(e) Demonstrates handicapping posterior transverse discrepancies which may include several teeth, one (1) of which shall be a molar and is handicapping in a function fashion as follows:

1. Functional shift;

2. Facial asymmetry;

3. Complete buccal or lingual crossbite; or

4. Speech concern;

(f) Has a significant posterior open bite that does not involve:

1. Partially erupted teeth; or

2. One (1) or two (2) teeth slightly out of occlusion;

(g) Except for third molars, has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention;

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

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

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

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

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

(6) [~~(4)~~] "Direct practitioner contact" means the billing dentist or oral surgeon is

physically present with and evaluates, examines, treats, or diagnoses the recipient.

(7) [~~(5)~~] "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires little additional practitioner resources; or

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

(8) [~~(6)~~] "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

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

(10) [~~(8)~~] "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with each other during the same patient encounter on the same date of service;

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

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

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

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

(12) [~~(10)~~] "Prepayment review" or "PPR" means a departmental review process of a claim to determine if Medicaid requirements have been met prior to authorizing payment.

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

(14) [~~(12)~~] "Provider" is defined in KRS 205.8451(7).

(15) [~~(13)~~] "Recipient" is defined in KRS 205.8451(9).

(16) [~~(14)~~] "Resident" is defined in 42 C.F.R. 415.152.

Section 2. Conditions of Participation.

(1) A participating provider shall be licensed in the state in which the practice is located.

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

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671; Conditions of Medicaid provider participation, withholding overpayments, administrative appeals process, and sanctions; and

(c) 907 KAR 1:672; Provider enrollment, disclosure, and documentation for Medicaid participation.

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

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

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

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

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

1. Being:

a. Incidental;

b. Integral; or

c. Mutually exclusive;

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

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

4. Failure to meet timely filing requirements in accordance with 42 C.F.R. 447.45.

Section 3. Record Maintenance.

(1) A provider shall maintain comprehensive legible medical records which substantiate the services billed.

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

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

(a) Recipient's name;

(b) Service date; and

(c) Provider's name.

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

(a) Diagnosis;

(b) Treatment plan;

(c) Treatment and follow-up; and

(d) Medical necessity.

(5) Medical records, including x-rays, shall be maintained in accordance with 907 KAR 1:672, Section 4(3) and (4).

Section 4. General Coverage Requirements.

(1) A covered service shall be:

(a) Medically necessary; [~~and~~]

(b) Except as provided in subsection (2) of this section, furnished to a recipient through direct practitioner contact; and

(c) Unless a recipient's provider demonstrates that dental services in excess of the following service limitations are medically necessary, limited to:

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

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

3. One (1) prophylaxis per twelve (12) month period for a recipient age twenty-one (21) years and over.

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

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

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

(c)1. Supervising provider has direct practitioner contact with the recipient, except for a service provided by a dental hygienist in accordance with KRS 313.310.

2. A dental hygienist may provide a service without direct practitioner contact if the dental hygienist provides the service under general supervision of a practitioner in accordance with KRS 313.310.

(3)(a) A medical resident may provide services if provided under the direction of a

program participating teaching physician in accordance with 42 C.F.R. 415.170, 415.172, and 415.174; or

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

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

(a) Diagnostic;

(b) Preventive;

(c) Restorative;

(d) Endodontics;

(e) Periodontics;

(f) Removable prosthodontics;

(g) Maxillofacial prosthetics;

(h) Oral and maxillofacial surgery;

(i) Orthodontics; or

(J) Adjunctive general services.

Section 5. Diagnostic Service Coverage Limitations.

(1)(a) Coverage for a comprehensive oral evaluation shall be limited to one (1) per twelve (12) month period, per recipient, per provider. An exception shall apply and the department shall cover a second comprehensive oral evaluation if provided in conjunction with a prophylaxis to an individual under twenty-one (21) years of age; and

(b) A comprehensive oral evaluation shall not be covered in conjunction with the

following:

1. A limited oral evaluation for trauma related injuries;

2. Space maintainers;

3. Root canal therapy;

4. Denture relining;

5. Transitional appliances;

6. A prosthodontic service;

7. Temporomandibular joint therapy;

8. An orthodontic service;

9. Palliative treatment; or

10. A hospital call.

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

1. Be limited to a trauma related injury <u>or acute infection</u>;

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

3. Require a prepayment review; and

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

1. A periapical x-ray;

2. Bitewing x-rays;

3. A panoramic x-ray;

4. Resin, anterior;

5. A simple <u>or surgical</u> extraction;

6. Surgical removal of a residual tooth root;

7. Removal of a foreign body;

8. Suture of a recent small wound; [~~or~~]

9. Intravenous sedation; or

10. Incision and drainage of infection.

(3) An x-ray necessary for a root canal or oral surgical procedure, or an x-ray that exceeds the following service limitation and is determined to be medically necessary by the department, shall not be subject to the following: [~~limitations shall apply to coverage of a radiograph service:~~]

(a) Bitewing x-rays shall be limited to four (4) per twelve (12) month period, per recipient, per provider[~~, per provider~~];

(b) Periapical x-rays shall be limited to fourteen (14) per twelve (12) month period, per recipient, per provider[~~, per provider~~];

(c) An intraoral complete x-ray series shall be limited to one (1) per twelve (12) month period, per recipient, per provider[~~, per provider~~];

(d) Periapical and bitewing x-rays shall not be covered in the same twelve (12) month period as an intraoral complete x-ray series per recipient, per provider[~~, per provider~~];

(e) A panoramic film shall:

1. Be limited to one (1) per twenty-four (24) month period, per recipient, per provider [~~, per provider~~]; and

2. Require prior authorization in accordance with Section 15(2) and (3) of this administrative regulation for a recipient under age six (6);

(f) A cephalometric film shall be limited to one (1) per twenty-four (24) month period, per recipient, per provider[~~, per provider~~]; or

(g) Cephalometric and panoramic x-rays shall not be covered in conjunction with a comprehensive orthodontic consultation.

Section 6. Preventive Service Coverage Limitations.

(1)(a) Coverage of a prophylaxis shall be limited to:

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

2. For an individual under twenty-one (21) years of age, two (2) per twelve (12) month period, per recipient; and

(b) A prophylaxis shall not be covered in conjunction with periodontal scaling and root planing.

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

1. A recipient age five (5) through twenty (20) years;

2. Each six (6) and twelve (12) year molar once every four (4) years with a lifetime limit of three (3) sealants per tooth, per recipient; and

3. An occlusal surface that is noncarious; and

(b) A sealant shall not be covered in conjunction with a restorative procedure for the same tooth on the same date of service[~~; and~~

~~(c) A provider shall be responsible for maintaining a sealant for four (4) years at no additional expense to the recipient or the department~~].

(3)(a) Coverage of a space maintainer shall be limited to a recipient under age twenty-one (21); and

(b) Require the following:

1. Fabrication;

2. Insertion;

3. Follow-up visits;

4. Adjustments; and

5. Documentation in the recipient's medical record to:

a. Substantiate the use for maintenance of existing intertooth space; and

b. Support the diagnosis and a plan of treatment that includes follow-up visits.

(c) The date of service for a space maintainer shall be considered to be the date the appliance is placed on the recipient.

(d) Coverage of a space maintainer, an appliance therapy specified in the CDT orthodontic category, or a combination thereof shall not exceed two (2) per twelve (12) month period, per recipient.

<u>(4)(a) A full mouth debridement shall only be covered for a pregnant woman; and</u>

<u>(b) Only one (1) full mouth debridement per pregnancy shall be covered.</u>

Section 7. Restorative Service Coverage Limitations.

(1) A four (4) or more surface resin-based anterior composite procedure shall not be covered if performed for the purpose of cosmetic bonding or veneering.

(2) Coverage of a prefabricated crown shall be:

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

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

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

(a) A permanent molar;

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

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

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

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

(b) A permanent prefabricated resin crown; or

(c) A prefabricated stainless steel crown.

Section 8. Endodontic Service Coverage Limitations.

(1) Coverage of the following endodontic procedures shall be limited to a recipient under age twenty-one (21):

(a) A pulp cap direct;

(b) Therapeutic pulpotomy; or

(c) Root canal therapy.

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

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

1. Treatment of the entire tooth;

2. Completion of the therapy; and

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

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

1. The Sargenti method of root canal treatment; or

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

Section 9. Periodontic Service Coverage Limitations.

(1) Coverage of a gingivectomy or gingivoplasty procedure shall require prepayment review and shall be limited to:

(a) A recipient with gigival overgrowth due to a:

1. Congenital condition;

2. Hereditary condition; or

3. Drug-induced condition; and

(b) One (1) per tooth or per quadrant, per provider, per twelve (12) month period.

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

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

(2) Coverage of a gingivectomy or gingivoplasty procedure shall require documentation in the recipient's medical record that includes:

(a) Pocket-depth measurements;

(b) A history of nonsurgical services; and

(c) Prognosis.

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

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

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

(c) Require documentation to include:

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

2. Periodontal charting of preoperative pocket depths.

(4) Coverage of a quadrant procedure shall require a minimum of a three (3) tooth

area within the same quadrant.

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

Section 10. Prosthodontic Service Coverage Limitations.

(1) A removable prosthodontic or denture repair shall be limited to a recipient under age twenty-one (21).

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

(a) Repair resin denture base; and

(b) Repair cast framework.

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

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

(b) Laboratory relining of:

1. Maxillary dentures; or

2. Mandibular dentures;

(c) An interim maxillary partial denture; or

(d) An interim mandibular partial denture.

(4) An interim maxillary or mandibular partial denture shall be limited to use:

(a) During a transition period from a primary dentition to a permanent dentition;

(b) For space maintenance or space management; or

(c) As interceptive or preventive orthodontics.

Section 11. Maxillofacial Prosthetic Service Coverage Limitations. The following

services shall be covered if provided by a board certified prosthodontist:

(1) A nasal prosthesis;

(2) An auricular prosthesis;

(3) A facial prosthesis;

(4) A mandibular resection prosthesis;

(5) A pediatric speech aid;

(6) An adult speech aid;

(7) A palatal augmentation prosthesis;

(8) A palatal lift prosthesis;

(9) An oral surgical splint; or

(10) An unspecified maxillofacial prosthetic.

Section 12. Oral and Maxillofacial Service Coverage Limitations.

(1) The simple use of a dental elevator shall not constitute a surgical extraction.

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

(3) Coverage of surgical access of an unerupted tooth shall:

(a) Be limited to exposure of the tooth for orthodontic treatment; and

(b) Require prepayment review.

(4) Coverage of alveoplasty shall:

(a) Be limited to one (1) per quadrant, per lifetime, per recipient; and

(b) Require a minimum of a three (3) tooth area within the same quadrant.

(5) An occlusal orthotic device shall:

(a) Be covered for tempormandibular joint therapy;

(b) Require prior authorization in accordance with Section 15(2) and (5) of this administrative regulation;

(c) Be limited to a recipient under age twenty-one (21); and

(d) Be limited to one (1) per lifetime, per recipient.

(6) Frenulectomy shall be limited to one (1) per date of service.

(7) Except as specified in subsection (8) of this section, a service provided by an oral surgeon shall be covered in accordance with 907 KAR 3:005, Physicians' services.

(8) If performed by an oral surgeon, coverage of a service identified in CDT shall be limited to:

(a) Extractions;

(b) Impactions; and

(c) Surgical access of an unerupted tooth.

Section 13. Orthodontic Service Coverage Limitations.

(1) Coverage of an orthodontic service shall:

(a) Be limited to a recipient under age twenty-one (21); and

(b) Require prior authorization.

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

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

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

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

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

(a) Require a referral by a dentist; and

(b) Be limited to:

1. The correction of a disabling malocclusion; or

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

(7) Coverage of comprehensive orthodontic treatment shall not be inclusive of orthognathic surgery.

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

(a) A referral form, if applicable; and

(b) A letter detailing:

1. Treatment provided, including dates of service;

2. Current treatment status of the patient; and

3. Charges for treatment provided.

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

(a) Is transferred to another provider; or

(b) Began prior to Medicaid eligibility.

Section 14. Adjunctive General Service Coverage Limitations.

(1)(a) Coverage of palliative treatment for dental pain shall be limited to one (1) per

date of service, per recipient, per provider.

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

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

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

1. Limited oral evaluation;

2. Comprehensive oral evaluation; or

3. Treatment of dental pain.

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

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

Section 15. Prior Authorization.

(1) Prior authorization shall be required for the following:

(a) A panoramic film for a recipient under age six (6);

(b) Periodontal scaling and root planing;

(c) An occlusal orthotic device;

(d) A preorthodontic treatment visit;

(e) Removable appliance therapy;

(f) Fixed appliance therapy; or

(g) A comprehensive orthodontic service.

(2) A provider shall request prior authorization by submitting the following information to the department:

(a) A MAP-9, Prior Authorization for Health Services;

(b) Additional forms or information as specified in subsections (3) through (7) of this section; and

(c) Additional information required to establish medical necessity if requested by the department.

(3) A request for prior authorization of a panoramic film shall include a letter of medical necessity.

(4) A request for prior authorization of periodontal scaling and root planing shall include periodontal charting of preoperative pocket depths.

(5) A request for prior authorization of an occlusal orthotic device shall include a MAP 306, Temporomandibular Joint (TMJ) Assessment Form.

(6) A request for prior authorization of removable and fixed appliance therapy shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) Panoramic film or intraoral complete series; and

(c) Dental models.

(7) A request for prior authorization for comprehensive orthodontic services shall include:

(a) A MAP 396, Kentucky Medicaid Program Orthodontic Evaluation Form;

(b) A MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement;

(c) Cephalometric x-rays with tracing;

(d) A panoramic x-ray;

(e) Intraoral and extraoral facial frontal and profile pictures;

(f) Occluded and trimmed dental models;

(g) An oral surgeon's pretreatment work up notes if orthognathic surgery is required;

(h) After six (6) monthly visits are completed, but not later than twelve (12) months after the banding date of service:

1. A MAP 559, Six (6) Month Orthodontic Progress Report; and

2. An additional MAP 9, Prior Authorization for Health Services; and

(i) Within three (3) months following completion of the comprehensive orthodontic treatment:

1. Beginning and final records; and

2. A MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission.

(8) Upon receipt and review of materials required in subsection (7)(a) through (g) of this section, the department may request a second opinion from another provider regarding the proposed comprehensive orthodontic treatment.

(9) If a service that requires prior authorization is provided before the prior authorization is received, the provider shall assume the financial risk that the prior authorization may not be subsequently approved.

(10) Prior authorization shall not be a guarantee of recipient eligibility. Eligibility verification shall be the responsibility of the provider.

(11) Upon review and determination by the department that removing prior authorization shall be in the best interest of Medicaid recipients, the prior authorization requirement for a specific covered benefit shall be discontinued, at which time the covered benefit shall be available to all recipients without prior authorization.

Section 16. Appeal Rights.

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

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

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

Section 17. Incorporation by Reference.

(1) The following material is incorporated by reference:

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

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

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

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

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

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

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:026
(Amended After Comments)

Reviewed:

_____	_____
Date	Glenn Jennings, Commissioner Department for Medicaid Services
_____	_____
Date	Mike Burnside, Undersecretary Administrative and Fiscal Affairs

APPROVED:

_____	_____
Date	Mark D. Birdwhistell, Secretary Cabinet for Health and Family Services

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: Stuart Owen or Stephanie Brammer-Barnes (502-564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes standards for the provision and receipt of dental services under the Medicaid program.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws that require the provision of dental services to Kentucky's indigent citizenry.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation fulfills the requirements of KRS 194A.050(1) related to the execution of policies to establish and direct health programs mandated by federal law.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides the necessary criteria for the provision of medically necessary dental services to Medicaid recipients.

(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 enables the Department for Medicaid Services to establish limitations on dental services in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). The amendment defines the term "disabling malocclusion", a condition for which corrective treatment is covered; establishes limitations on dental services by limiting the number of dental cleanings covered per year as well as number of visits per month; allows services provided by a dental hygienist in accordance with KRS 313.310 and delivered under the general supervision of a practitioner to be covered; permits coverage for services delivered by a dental resident, student, or dental hygiene student under the direction of a participating provider in an American Dental Association-accredited institution; exempts x-rays necessary for a root canal or oral surgical procedure from the limit on the number of covered x-rays; and establishes coverage of full mouth debridements for pregnant women. These actions are being taken in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by

the Centers for Medicare and Medicaid Services, established via *KyHealth Choices* are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. The amended after comments regulation clarifies that individuals age twenty-one (21) and over are subject to a soft limit of one (1) dental visit per month per provider. The amended after comments regulation further clarifies that two comprehensive oral evaluations during a twelve (12) month period may be covered for members under twenty-one (21) years of age if the second comprehensive oral evaluation is provided in conjunction with a prophylaxis. The amended after comments regulation also clarifies that a limited oral evaluation will be covered in cases of acute infection, adds "surgical extraction" and "incision and drainage of infection" to the list of services for which a limited oral evaluation may be covered if provided in conjunction with either of these services, and restores the original regulatory language of Section 5(3) to reflect that the limitation on the number of x-rays shall be per recipient, per provider.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to maintain the financial viability of the Medicaid program and is enacted in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages, already approved by the Centers for Medicare and Medicaid Services, established via *KyHealth Choices* are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. The amended after comments regulation is necessary to further clarify the Department's coverage criteria for dental services.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment and the amended after comments regulation establishes limitations on dental services as authorized by the Deficit Reduction Act of 2005 and the Centers for Medicare and Medicaid Services and in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages established via *KyHealth Choices* are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices

is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. This amendment further conforms with the state Dental Practice Act by allowing dental hygienists to apply sealants or provide other services in accordance with KRS 313.310 while being under the general supervision, rather than direct supervision, of a dentist.

(d) How the amendment will assist in the effective administration of the statutes: This amendment and the amended after comments regulation establishes limitations on dental services as authorized by the Deficit Reduction Act of 2005 and the Centers for Medicare and Medicaid Services and in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program. The benefit packages established via *KyHealth Choices* are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs. This amendment further conforms with the state Dental Practice Act by allowing dental hygienists to apply sealants or provide other services in accordance with KRS 313.310 while being under the general supervision, rather than direct supervision, of a dentist.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This amendment will affect all Medicaid recipients who are subject to the new service limitations as well as dental providers enrolled in the Medicaid program.

(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: The above groups will be subject to new service limitations required by *KyHealth Choices* in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program which tailors benefit packages to individual needs and circumstances. The benefit packages established via *KyHealth Choices* are comprehensive choices, family choices, global choices and optimum choices. Comprehensive choices is designed for individuals with nursing

facility level of care needs, family choices is designed for children, global choices is the basic coverage plan and optimum choices is designed for individuals with intermediate care facility for individuals with mental retardation or developmental disabilities level of care needs.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Regulated entities will not be expected to incur additional costs in order to comply with this administrative regulation. However, regulated entities will be subject to service limitations required by *KyHealth Choices*, Medicaid's transformation initiative approved on May 3, 2006, by the Centers for Medicare and Medicaid Services (CMS) under the provisions of the Deficit Reduction Act of 2005 (DRA).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The service limitations on dental services are authorized by the DRA and CMS in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). 907 KAR 1:900E transforms the Kentucky Medicaid program into a program that tailors benefit packages to individual needs and circumstances and is necessary to maintain the viability of the Medicaid Program.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) anticipates a potential maximum savings of approximately $12.4 million ($8.47 million federal funds; $3.93 million state funds) annually as a result of this amendment; however, the savings are indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.

(b) On a continuing basis: DMS anticipates a potential maximum savings of approximately $12.4 million ($8.47 million federal funds; $3.93 million state funds) annually as a result of this amendment; however, the savings are indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.

(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 the Social Security Act, Title XIX and matching funds of 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: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish

or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

This administrative regulation includes tiering, by age, in order to assist transforming the Medicaid program into one tailored to individual medical needs and circumstances in conjunction with 907 KAR 1:900E (*KyHealth Choices* Benefit Packages). The transformed program provides innovative opportunities to Medicaid and Kentucky Children's Health Insurance Program (KCHIP) beneficiaries which will promote healthy lifestyles, personal accountability and responsible program governance for a healthier Commonwealth.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Reg NO: 907 KAR 1:026 Contact Person: Stuart Owen or Stephanie Brammer-Barnes (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 all Medicaid recipients who are subject to the new service limitations, as well as dental providers enrolled in the Medicaid program. This amendment will also affect the Medicaid program administered by the Cabinet for Health and Family Services.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Because this amendment and amended after comments regulation enables the Department for Medicaid Services to establish limitations on dental services in conjunction with 907 KAR 1:900E(KyHealth Choices Benefits Packages), this amendment is authorized by the Deficit Reduction Act of 2005 (Public Law No. 109-171).

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? This amendment will not generate any additional revenue for state or local governments during the first year of implementation.

   (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? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

   (c) How much will it cost to administer this program for the first year? Implementation of this amendment will not result in any additional costs during the first year. However, DMS anticipates a potential maximum savings of approximately $12.4 million ($8.47 million federal funds; $3.93 million state

funds) annually as a result of this amendment. The exact savings are indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.

(d) How much will it cost to administer this program for subsequent years?
Implementation of this amendment will not result in any additional costs during subsequent years of implementation. However, DMS anticipates a potential maximum savings of approximately $12.4 million ($8.47 million federal funds; $3.93 million state funds) annually as a result of this amendment. The exact savings are indeterminable given that the limits are soft (may be overridden) and utilization cannot be accurately predicted at this time.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.