



CHAPTER 505 DENTAL, ORTHODONTICS, AND ORAL HEALTH SERVICES

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BACKGROUND

General dentists, specialty dentists and dual degree practitioners who possess a dental, and medical (MD) or osteopathic (DO) license may provide a variety of covered dental services in accordance with their license and the [West Virginia State Code Chapter 30, Article 4 and Article 4A](#). Coverage decisions are based upon the member's age, medical necessity, and the member's need. Services may be provided in a practitioner's office, ambulatory surgical center, and outpatient or inpatient hospital setting. Please refer to [Chapter 522 Federally Qualified Health Center \(FQHC\) and Rural Health Clinic \(RHC\)](#) for additional information on provision of dental services within the FQHC or RHC.

POLICY

505.1 COVERED SERVICES

Enrolled children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Dental periodic screenings are based on the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Prior authorization may be required for specific services and when service limits are exceeded.

Covered dental services for enrolled adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Prior authorization may be required for specific services and when service limits are exceeded. An oral evaluation for limited fractures, pain, or infection is covered.

Orthodontic services for children up to 21 years of age must be medically necessary and requires prior authorization before services are provided. Clinical documentation to include a treatment plan of care, radiograph results, and photographs must be available to the Utilization Management Contractor (UMC) for prior authorization review and final determination of approval. One treatment of comprehensive orthodontia procedure codes (D8070, D8080, or D8090) per lifetime per member is covered. If more than one comprehensive orthodontic procedure code is billed, the claim will deny.

Orthognathic surgical procedures with orthodontic treatment is covered even if the member exceeds the 21 years of age restriction AND the needed surgery is documented in the original orthodontic plan of care and request. Orthodontic services require prior authorization from the UMC regardless of primary insurance.

505.2 PRACTITIONER ENROLLMENT AND PARTICIPATION REQUIREMENTS

West Virginia Medicaid recognizes Doctor of Dental Surgery (DDS), Doctor of Dental Medicine (DDM), and Doctor of Oral Maxillofacial Surgery (OMS) as eligible practitioners to provide general dental, orthodontic and oral and maxillofacial surgery services to enrolled Medicaid members.

Refer to [Chapter 300, Provider Participation Requirements](#) for additional information.



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505.3 DENTAL HYGIENIST/DENTAL ASSISTANT

Licensed practitioners may assign intra-oral tasks to employed dental hygienists or dental assistants. Refer to [West Virginia State Code §30-4-11](#) for dental hygienists and dental assistants scope of practice. Dental hygienists and dental assistants are not eligible to enroll individually as a Medicaid provider or receive direct reimbursement for services rendered. Services are to be billed under the dentist's national provider identifier (NPI). Please refer to [Chapter 522 Federally Qualified Health Center \(FQHC\) and Rural Health Clinic \(RHC\)](#) for additional information on provision of dental services within the FQHC or RHC by the dental hygienist/dental assistant.

505.4 ANESTHESIA

Anesthesia in the form of general anesthesia, conscious sedation, or anxiolysis is covered when basic behavior guidance techniques have not been successful or for members who cannot cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability. In addition, it may be required for members where the use of sedation may protect the developing psyche and/or reduce medical risk.

No dentist may induce central nervous system anesthesia without first having obtained an anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners or from the State Board of Dental Examiners in the state in which they practice for the level of anesthesia being used. Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately.

505.5 INFANT AND CHILD ORAL HEALTH FLUORIDE VARNISH PROGRAM FOR PRIMARY CARE PRACTITIONERS

The Bureau for Medical Services (BMS) reimburses enrolled primary care providers for fluoride varnish to children ages six months to 36 months (three years). The application of the fluoride should include communication with and counseling of the child's caregiver, including a referral to a dentist.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- Pediatricians
- General and Family Practice Doctors
- Nurse Practitioners
- Physician Assistants (in FQHC settings only)

Providers must have completed an approved BMS' certified training course.

Reimbursement for Fluoride Varnish

BMS allows coverage of two fluoride varnish applications per calendar year. The first application must be provided and billed in conjunction with a comprehensive well child exam. The second fluoride varnish application may be reimbursed during a subsequent visit. Billing of both CPT and CDT procedure codes on the same day of service, for the same member and the same procedure is prohibited and monies will be recouped by BMS. Note: CPT codes must be billed on a CMS-1500 claim

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form or an 837 electronic claim format with the medical provider number. CDT codes must be billed on the current American Dental Association (ADA) claim form or an 837 electronic format with the dental provider number.

505.6 EARLY PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services. Based on medical necessity, prior authorization is required when service limits are exceeded.

Dental screenings are covered to any child under the age of 21 years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Refer to www.aapd.org for the American Academy of Pediatrics Dental (AAPD) periodicity schedule.

Refer to <http://www.dhhr.wv.gov/healthcheck> for detailed information regarding EPSDT.

505.7 RESIDENTIAL SERVICES

Any service required in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or Psychiatric Residential Treatment Facility (PRTF) by the member is reimbursed as an all-inclusive rate. However, if the ICF/IID or PRTF does not provide the required service(s) on-site, such as dental services, a written agreement between the ICF/IID or PRTF and an outside source must be developed and implemented to provide these services. The ICF/IID or PRTF is responsible for reimbursement of dental services to the provider. Services provided by outside source(s) are included in the ICF/IID or PRTF rate and must not be billed separately. Refer to [Chapter 511, Intermediate Care Facility for Individuals with Intellectual Disabilities](#) or [Chapter 531, Psychiatric Residential Treatment Facilities](#) for more information.

Dental services required in a Nursing Facility by the member must meet the requirements of this Chapter. Please refer to [Chapter 514, Nursing Facility Services](#).

505.8 PRIOR AUTHORIZATION

Medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry, the American Academy of Pediatrics (AAP), the American Dental Association (ADA), research-based, nationally accredited medical appropriateness criteria OR other appropriate criteria approved by BMS. Prior authorization requests are available for electronic or paper submittal at the BMS' Utilization Management Contractor (UMC) website <https://providerportal.apshealthcare.com>. Prior authorization does not guarantee approval or payment.

If a Current Dental Terminology (CDT) code requires prior authorization, the service requires prior authorization regardless of place of service. All inpatient hospitalizations require prior authorization (PA) by BMS' Utilization Management Contractor (UMC). Inpatient hospitalization shall not be reimbursed



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when the service could be provided in an outpatient setting. Requests for prior authorization do not guarantee approval or payment.

Refer to [Appendix 505A - Covered Dental, Orthodontic, and Oral Health Services - Children Up to Age 21 Years](#) and [Appendix 505B - Covered Dental, Orthodontic, and Oral Health Services - Adults Over 21 Years of Age](#) for the list of covered services, specific procedure codes requiring prior authorization, and service limits.

Retrospective authorization is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive West Virginia Medicaid eligibility.

Refer to [Chapter 100, General Administration and Information](#) for additional information.

505.9 BILLING AND REIMBURSEMENT

Dual degree practitioners such as an MD or DO with DDS/OMS license may bill Current Procedural Terminology (CPT) procedure codes or Current Dental Terminology (CDT) procedure codes for dental/oral maxillofacial facial services within their scope of practice. These practitioners are assigned both a medical and dental provider numbers.

Reimbursement for general and specialty dental services is based on:

- American Dental Association Survey of Dental Fees for Southern Atlantic Regional Norms
- American Society of Anesthesiology guidelines
- Lesser of the established fees or the provider's usual customary charge to the general public
- Unaltered cost invoice.

For reimbursement of Fluoride Varnish refer to [Section 505.5](#) of this Chapter.

Refer to [Chapter 100, General Administration and Information](#) and [Chapter 600, Reimbursement Methodologies](#) for additional information.

505.10 DOCUMENTATION REQUIREMENTS

Documentation requirements for Dental Services include, but are not limited to:

- A referral for treatment
- The primary diagnosis and appropriate CDT code for service to be provided
- A treatment plan (Orthodontics)
- Radiographs
- Photos, when appropriate
- Dental molds, when appropriate
- Documentation to justify medical necessity
- Copy of Prior Authorization Request Form, when applicable

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- Copy of ADA claim form submitted for payment consideration, when appropriate.

In addition to documentation requirements in [Chapter 100 General Administration and Information](#) and [Chapter 300 Provider Participation Requirements](#)

505.11 NON-COVERED SERVICES

Non-Covered services include, but are not limited to:

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services for which prior authorization has been denied or not obtained
- Dental services for the convenience of the member, the member's caretaker or the provider of service
- Procedures for cosmetic purposes
- Temporomandibular Joint (TMJ) for adults
- Anesthesia services when solely for the convenience of the member, the member's caretaker or the provider of services
- Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately
- Dental services for residents of an ICF/IID or PRTF
- Dental services for participants enrolled in the Division of Rehabilitation Services or when services are covered under a Workers Compensation plan
- Dental services provided by providers not enrolled with West Virginia Medicaid
- Use of an unlisted code when a national CDT code is available
- Unbundled CDT codes

Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abscess: An acute or chronic localized inflammation, probably with a collection of pus, associated with tissue destruction and frequently, swelling; usually secondary to infection.

Bicuspid: A premolar tooth; a tooth with two cusps.

Bitewing radiograph: An interproximal radiographic view of the coronal portion of the tooth/teeth

Complete series: An entire set of intra-oral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

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Comprehensive Orthodontic Treatment: A phrase indicating multiple phases of treatment provided at different stages of dentofacial development.

Crown:

- An abutment (artificial crown serving for the retention or support of a dental prosthesis);
- Anatomical (that portion of tooth normally covered by, and including, enamel);
- Artificial (restoration covering or replacing the major part, or the whole of the clinical crown of a tooth); and,
- Clinical (that portion of a tooth not covered by tissues).

Current Dental Terminology (CDT): A listing of procedure codes and descriptive terms published by the American Dental Association (ADA) for reporting dental services and procedures.

Current Procedural Terminology (CPT): A listing of descriptive terms and identifying codes developed by the American Medical Association (AMA) for reporting practitioner services and procedures to medical plans and Medicare

Cuspid: A single cusped tooth located between the incisors and bicuspid.

Dental Assistant: An individual qualified by education, training, and experience who assists a dentist in the delivery of patient care in accordance with delegated procedures or who may perform intra-oral tasks in the dental office. No occupational title other than dental assistant shall be used to describe this individual.

Dental Auxiliary Personnel: Dental hygienists and dental assistants who assist the dentist in the provision of oral health care services to patients.

Dental Hygienist: A person licensed by the West Virginia Board of Dental Examiners who provides preventive oral health care services to patients in the dental office and in a public health setting. No occupational title other than dental hygienist may be used to describe this individual. State dental regulations determine dental hygienist duties.

Dentition: The teeth in the dental arch:

- Adolescent (refers to the stage of permanent dentition prior to cessation of growth)
- Deciduous (refers to the deciduous or primary teeth in the dental arch)
- Permanent (adult, refers to the permanent teeth in the dental arch)
- Transitional (refers to a mixed dentition; begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous teeth).

Dentures: An artificial substitute for some or all of the natural teeth and adjacent tissues.

- Complete – a prosthetic for the edentulous maxillary or mandibular arch, replacing the full dentition.
- Fixed partial – a prosthetic replacement of one or more missing teeth cemented or otherwise attached to the abutment teeth.
- Removable partial – a removable prosthetic device that replaces missing teeth.

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Direct Supervision: Supervision of dental auxiliary personnel provided by a licensed dentist who is physically present in the dental office or treatment facility when procedures are being performed.

Emergent Oral Health Procedures: Covered services provided as quickly as the situation warrants necessary to relieve pain, eliminate infection, or reduce fractures.

Endodontist: A dental specialist who limits his/her practice to treating disease and injuries of the pulp and associated periradicular conditions.

Extraction: The process or act of removing a tooth or tooth parts.

Fracture: The breaking of a part, especially of a bony structure; breaking of a tooth

General Dentist: A dentist who is not considered a specialist and can perform examinations, evaluations, diagnosing of diseases, disorder and conditions of the oral cavity, maxillofacial area and adjacent and associated structures. They can treat diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures, fabricate, repair and alter dental prosthesis, administer anesthesia in accordance with [West Virginia Code Chapter 30, Article 4a](#), and prescribe drugs necessary for dentistry.

General Supervision: A dentist is not required to be in the office or treatment facility when procedures are being performed by the auxiliary dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the treatment provided by the dental auxiliary personnel.

Impacted tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

Malocclusion: Improper alignment of biting or chewing surfaces of upper and lower teeth:

- **Class I malocclusion** – The relationship of the first molars is normal and the upper and lower jaws are in a normal relationship to each other, but the other teeth are crowded, irregularly spaced, or overlapped
- **Class II malocclusion** – The lower first molar is distally positioned relative to the upper first molar
- **Class III malocclusion** – The lower molar mesially positioned relative to the upper molar.

Molar: Teeth posterior to the premolars (bicuspid) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

Mountain Health Trust: The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

Occlusion: Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

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Oral and Maxillofacial Surgeon: A dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

Orthodontist: A dental specialist whose practice is limited to the interception and treatment of malocclusion and other neuromuscular and skeletal abnormalities of the teeth and their surrounding structures.

Orthognathic: The functional relationship of maxilla and mandible.

Pediatric Dentist (Pedodontist—old terminology): A dental specialist whose practice is limited to treatment of children from birth through adolescence (including those with special health care needs, at any age), providing primary and comprehensive preventive and therapeutic oral healthcare.

Periapical: The area surrounding the end of the tooth root.

Periodontist: A dental specialist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.

Preventive dentistry: The aspects of dentistry concerned with promoting good dental care and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Primary: A current term used to describe the older verbiage of deciduous or baby teeth.

Primary Care Provider (PCP): A practitioner associated with the medical home that is the primary contact for provision and coordination of a member's health care services or needs.

Primary Dentition: The teeth that erupt first and are usually replaced by the permanent teeth (baby teeth).

Prosthodontist: A dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Quadrant: One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.

Radiograph: An image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation

Root canal: The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

Sealant: A resinous material designed to be applied to the occlusal surfaces of posterior teeth to prevent occlusal caries.

Space maintainer: A passive appliance, usually cemented in place that holds teeth in position.

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Specialty: The practice of a certain branch of dentistry.

Supernumerary teeth: extra erupted or unerupted teeth that resemble teeth of normal shape.

Symptomatic impacted tooth: Pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Transitional Dentition: Begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous (baby) teeth.

REFERENCES

West Virginia State Plan references audiology, hearing aid, speech, and language services at sections [3.1-A\(10\)](#), [3.1-B\(10\)](#), [supplement 2 to attachments 3.1-A and 3.1-B\(10\) Dental Services and \(5\) Medical and Surgical Services Provided by a Dentist](#) and reimbursement at [4.19-B\(10\)](#).

[American Dental Association](#)

[West Virginia Dental Association](#)

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Dental, Orthodontics, and Oral Health Services		6/1/2016