THSteps Therapeutic Dental Benefits to Change for Texas Medicaid July 1, 2017

Information posted May 17, 2017

Note: *Texas Medicaid managed care organizations (MCOs) must provide all medically necessary, Medicaid-covered services to eligible clients. Administrative procedures such as prior authorization, pre-certification, referrals, and claims/encounter data filing may differ from traditional Medicaid (fee-for-service) and from MCO to MCO. Providers should contact the client's specific MCO for details.*

Effective for dates of service on or after July 1, 2017, Texas Health Steps (THSteps) therapeutic dental benefits will change for Texas Medicaid.

Overview of Benefit Changes

Major changes to the therapeutic dental policy include the following:

- New requirements for dental therapy under general anesthesia
- Prior authorization criteria for periodontal scaling and root planing
- New procedure code limitations
- Clarification of units for time-based procedure codes

Dental Therapy under General Anesthesia

For clients who are six years of age or younger, the following will apply:

- All Level 4 sedation/general anesthesia services provided by a dentist (procedure code D9223) must be prior authorized.
- Any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) to be provided in conjunction with dental therapeutic services (procedure code 00170 with EP modifier) must be prior authorized.
- The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization from TMHP and is responsible for providing the anesthesia prior authorization information to the anesthesiology provider.

Prior Authorization Criteria

Requests for prior authorization must include, but are not limited to, the following client-specific documents and information:

- A completed Criteria for Dental Therapy Under General Anesthesia form
- A completed THSteps Dental Mandatory Prior Authorization Request Form
- Location where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- Narrative unique to the client, detailing reasons for the proposed level of anesthesia (indicate procedure code D9223 or 00170). The narrative must include history of prior treatment, failed attempts at other levels of sedation, behavior in the dental

chair, proposed restorative treatment (tooth ID and surfaces), emergent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).

- Diagnostic quality radiographs or photographs
    - When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For these special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP Dental Director.

The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Note: *In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP Dental Director.*

A copy of the Criteria for Dental Therapy under General Anesthesia form must be maintained in the client's dental record. The client's dental record must be available for review by representatives of the Health and Human Services Commission (HHSC) or its designee.

Procedure Code Updates

Procedure code 00170 with modifier EP, and procedure code D9223, will be limited to once per six calendar months, any provider.

The following payable provider types will be added for procedure code 00170 with modifier EP, and procedure code D9223:

Procedure Code	Place of Service	Provider Types
00170 with modifier EP	Office	Physician providers
D9223	Inpatient hospital, outpatient hospital	Federally qualified health center, Texas Health Steps dental, orthodontist, and oral maxillofacial surgeon providers

Prior Authorization for Periodontal Scaling and Root Planing

Procedure codes D4341 and D4342 will require prior authorization. Current periodontal charting, a current set of full mouth radiographs, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.

Procedure Code Limitations

Procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure code, any provider.

Periodontal scaling and root planing (procedure codes D4341 and D4342) will be denied when submitted for the same date of service as other D4000 series codes, except D4341 and D4342, any provider.

Full mouth debridement (procedure code D4355) will be denied when submitted for the same date of service as the following procedure codes, any provider:

Procedure Codes						
D4210	D4211	D4230	D4231	D4240	D4241	D4245
D4249	D4260	D4261	D4266	D4267	D4270	D4273
D4274	D4275	D4276	D4277	D4278	D4283	D4285
D4320	D4321	D4381	D4910	D4920	D4999	

Dental hospital calls (procedure code D9420) are currently limited to twice per rolling year, per client, any provider. Procedure code D9248 will be denied when submitted for the same date of service as procedure code D9420, any provider.

Time-Based Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

Note: *All levels of sedation must have clinical documentation and a narrative in the client's dental record to support the necessity of the service. Documentation must*

include the sedation record that indicates sedation start and end times in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines. The client's dental record must be available for review by representatives of HHSC or its designee.

For more information, call the TMHP Contact Center at 1-800-925-9126.