Appendix C

Comparison of State Medicaid Manuals to Core Components

Comparison of State Medicaid Manuals ○ Core Components

Service Specific Information Specific services or children under 21	ADA procedure code	CA	MI[1]	MS[2]	NV	NY	OH	TX[3]
Does the manual specify the following to be performed during the initial visit?:								
• a patient history (info given by parent or responsible person) to include: medical history; dental history; and past fluoride exposure		Y	Y	NS	NS	Y	Y	×S
• clinical charting of existing conditions of the oral and facial structures		Y	Y	NS	NS	Y	Y	NS
• formulation and presentation (to child and parent) of an organized plan or approach to treatment		NS	Y	NS	NS	Y	Y	Y
• that first dental visit should be performed by, at least, age three[a]		NS	NS	NS	NS	Y4	Y	Y5
New patients: initial oral exam incl appropriate radiographic survey	00110 Initial oral examination	Y6	Y7	Y8	Y9	Y	Y10	Y11
Oral exam, at least annually	00120 Periodic oral examination	N12	Y13	Y14	Y15	Y	Y16	N17
Prophylaxis, at least annually	01110 Prophylaxis-adult	Y20	Y22	N	-	T	T	T26
	00120 Prophylaxis-child	Y21	Y22	Y23	Y24	Y25	Y26	Y27
Topical fluoride application, at least annually	01203 Topical application of fluoride (excl prophylaxis)-child	Y28	Y29	Y30	Y3	Y	Y32	N33
	01204 Topical application of fluoride (excl prophylaxis)-adult	Y34	N	-	-	Y	-	"
Counseling on oral hygiene, diet (reductions in cariogenic food), and risk management; should be directed to the parent as well as the child	01310 Dietary planning for the control of dental caries	NS	NS	NS	NS	NS	-	NS
	01330 Oral hygiene instruction	NS	N36	NS	NS	NS	-	NS
Sealants	01351 Sealant-per tooth	NS	NS	T37	T38	T	T39	NS
Maintenance of space: at least for posterior primary teeth lost prematurely	01510 Space maintainer-fixed-unilateral	Y40	Y41	Y42	Y43	Y	Y	Y44
	01515 Space maintainer-fixed-bilateral	"	"	Y	"	Y	Y	Y45
	01520 Space maintainer-removable-unilateral	"	"	-	"	-	Y	-
	01525 Space maintainer-removable-bilateral	"	"	Y	"	-	Y	-
	01550 Recementation of space maintainer	"	"	Y	"	Y	-	Y
Specific services for children under 21	ADA procedure code	CA	MI	MS	NV	NY	OH	TX
Radiographs (for primary, transitional and permanent dentition):	00210 Intraoral-complete series (incl bitewings)	Y46	Y47	Y48	Y49	Y	Y50	Y5
• for patients with caries or in a high risk[b] group: posterior bitewings every 6-12 months;	00220 Intraoral-periapical -first film	Y52	Y53	Y54	"	Y	Y	Y55
	00230 Intraoral-periapical -each additional film	"	"	"	"	Y	Y	"
• for patients with no caries and not in a high risk group: posterior bitewings 12-24 months for children and 24-36 months for adults;	00240 Intraoral-occlusal film	Y	"		"	Y	Y	Y
	00250 Extraoral-first film	Y	"			Y	Y56	

• individualized radiographic • xamination for periodontal disease and a growth and development assessment	00260	Extraoral-each additional fi m	"	"			Y	"	-
	00270	Bitewings-single film	Y[57]	"		"	Y	Y[58]	-
	00272	Bitewings-two films	"	"	Y	"	Y	"	Y
	00274	Bitewings-four films	"	"		"	Y	Y	-
	00275	Bitewings-each additional fi m	"	"				Y	-
	00290	Posterior-anterior or latera skull and facial bone survecfilm				"	Y[59]	-	-
	00315	Sialography					Y	-	-
	00320	Temporomandibular joint arthrogram, incl injection					Y	-	-
	00321	Other temporomandibular joint films, by report			Y	"	Y	Y[60]	-
	00330	Panoramic film	Y[61]	Y[62]	Y[63]	Y[64]	Y	Y[65]	Y[66]
	00340	Cephalometric film		Y[67]		Y[68]	Y	Y[69]	
Restoration of carious lesions (primary and permanent) with silver amalgam, plastic materials, composite resin restoration, and stainless steel crowns (on primary teeth)[c]	02110-02161	Amalgam restorations (incl polishing)	Y	Y	Y[70]	Y	Y	Y	Y
	02330-02387	Filled or unfilled resin restorations	Y[71]	Y[72]	Y[73]	Y[74]	Y[75]	Y[76]	Y[77]
	02930	Prefabricated stainless steel crown -primary tooth	Y	Y[78]	Y	Y	Y	Y	Y
Pulp therapy (primary and permanent teeth) and root canal filling	03110	Direct pulp cap	Y[79]	Y	-	Y	N	-[80]	
	03120	Indirect pulp cap	"	N	-	Y	N	-	
	03220	Pulpotomy	Y[81]	Y[82]	Y[83]	Y	Y	Y	Y[84]
	03310	One canal (excl final restoration)	Y[85]	Y[86]	Y[87]	Y[88]	Y	Y[89]	Y[90]
	03320	Two canals (excl final restoration)	"	"	"	"	Y	"	"
	03330	Three canals (excl final restoration)	"	"	"	"	Y[91]	"	"
	03340	Four or more canals (excl final restoration)	"	"	"	"	"	"	-
Scaling and curettage and/or root planing	04341	Periodontal scaling and root planing -per quadrant	N[92]	Y[93]	N	N	Y	N[94]	N[95]
	04220	Gingival curettage, by report	"	"	N[96]	Y[97]	N[98]	N[99]	N
Removable prosthesis: at least when mastication function is impaired or existing prosthesis is unserviceable, incl repair and rebasing of the prosthesis	?		Y[100]	Y[101]	Y[102]	Y[103]	Y[104]	Y[105]	Y[106]
Orthodontic treatment: at least when medically necessary to correct handicapping malocclusion	?		Y[107]	Y[108]	Y[109]	Y[110]	Y[111]	Y[112]	Y[113]
Specific services for children under 21	ADA procedure code		CA	MI	MS	NV	NY	OH	TX
Emergency Services									
appropriate methods for control and relief of pain and procedures necessary to control bleeding and eliminate acute infection	00911	Palliative (emergency) treatment dental pain-minor procedures	-	-	-	-	Y[114]	-	Y
	00130	Emergency oral examination	-[115]	Y[116]	Y[117]	Y[118]	-	-[119]	-[120]
• operative procedures to prevent pulpal death and imminent loss of teeth									
• treatment of injuries to teeth or supporting structures									
• palliative therapy for periocoronitis with impacted teeth									

Additional procedures suggested by core component reviewers:								
Oral Surgery								
Extractions-includes local anesthesia and routine postoperative care:								
07110	Single tooth	Y	Y	Y	Y	Y	Y	Y
07120	Each additional tooth	Y	Y[121]	Y	Y	Y	Y	Y
07130	Root removal-exposed roots	Y[122]	Y[123]	N	-	Y	Y	-
Other surgical procedures:								
07285	Biopsy of oral tissue-hard	Y[124]	Y[125]	Y	Y[126]	Y	Y	N
07286	Biopsy of oral tissue-soft	"	"	Y	"	Y	Y	N

[a]Many reviewers indicated that a first visit by age 1 is more appropriate than by age 3.
[b]Those at high risk include those demonstrating: high level of caries experience, history of recurrent caries, poor quality existing restoration, poor oral hygiene, inadequate fluoride exposure, prolonged nursing, diet with high sucrose, poor family dental health, developmental enamel defects, developmental disability, xerostomia, genetic abnormality of teeth, many multisurface restorations, chemo/radiation therapy.
[c]Silicate cement restorations, which are specifically included in the HCFA Guidelines, are excluded from this core component list because most reviewers indicated that silicate cement restorations have been replaced by newer materials. Also, many reviewers suggested that stainless steel crowns for permanent teeth should be included in a list of basic dental services.
Y = Yes
N = No
NS = Not specified in the manual; the service is not specifically covered or not covered.
- = No mark would apply (e.g., the particular service was included in a previous code, or there is no code that specifically describes that particular service).
" = Refer to the preceding service

SOURCE: Compiled from State Medicaid manuals by the Office of Technology Assessment, 1990.

Footnotes:

1 Michigan requires prior authorization for all *treatment* plans for beneficiaries under 21 which require more than S200 of dental services (according to the dentist's usual end customary fee). Also all authorized work must be provided wi thin 6 months.

2 In Mississippi, beneficiaries under 21 are ● tigible for ● maximum of S2S0 in dental services (exclusive of ● xtractiooa). Recipients over 18 are responsible for a S2.00 copayment per visit.

3 In Texas, EPSDT recipients are ● tigible for dental services once in ● 12-month period, whichit character i zed as the 12 month period fol Lowing the last paid date of service. Those requi ring additional services must obtain an Exception to Periodic ty. Any treatment plan requi ring more than S300 of dental services must receive prior author i zat i on.

4 NY: Specified in Part S08 of the Chi ld/TeenHealth Plen regulations, 18 NYCRR S08.

5 TX: An Exception to Periodici ty Form needs to be obtained by the dentist in waler to provide s(rvi ces to children under 3.

6 CA: u/o radiographs; one ● xam per beneficiary per provider.

7 MI: Not including radiographs, which are billed separately.

8 MS: May be claimed on the first visit for EPSD' pat ients under 21 and is 1 imi ted to one per fiscal year. Ooes not inc ude radi ographs, but other procedures are ● (lowed in conjunct i on.

9 NV: Al lowed once per beneficiary per provider, ● xcludi ng radiographs.

10 OH: The ini tialoral● xam does not specifically include radiographs. Radiographs are billable separately.

11 TX: Initi al● xam may only be bi[ledwhen no radiographs ● re taken.

12 CA: Only developmentally disabled children may receive ● periodic ● xax, according to the manual.

13 MI : Covered service once ● very 6 months.

14 MS: The periodic ● xmn is limi ted to recipients under 21 who have space maintainers. Al lowed once per year and includes prophylaxis and fluoride treatment. The clinical oral ● xam for other EPSDT recipients is described and referred to above in the initial oral ● xrrn.

15 NV: A periodic oral ● xam is allowed ● very 12 months for all children under 21.

16 OH: Periodic oral ● xams are allowed once ● very 6 months.

17 TX: There is no procedure code or payment specifically for a periodic ● x m. However, a patient must wait 12 months after services outlined in a treatment plan have been performed before ● new treatment plan for routine services cm be authorized. Prior authorization is required for a treatment plan requiring over $300 of services or if MY procedures in the treatment plan require prior authorization.

18 CA: Annually for beneficiaries 13 and over.

19 MI: Adults are defined as those aged 14 and older. Beneficiaries tinder 21 but ● t ● ast 14 may receive prophylaxis no more than once in a 6-month period.

20 TX: Prophylaxis for recipients 13-20 may be provided once every 12 months, and may or may not include fluoride. Procedure intended for periodontal cases only.

21 CA: Annually for beneficiaries 12 and under.

22 MI: Beneficiaries under 14 may receive prophylaxis once in a 6-month period.

23 MS: Prophylaxis is allowed for all recipients under 21 once per 12 month period.

24 NV: Prophylaxis is covered for children 10 through 20 years once ● very 12 months; prophylaxis and f uoride treatment is allowed for children 9 and under once ● very 6 months.

25 NY: 'Child" is defined as beneficiaries under age 21.

26 OH: Prophylaxis is allowed for recipients through age 20 once ● very 6 months.

27 TX: Prophylaxis for recipients 3-12 may be provided once ● very 12 months, includes subgingival scaling, and may or may not include fluoride.

28 CA: In addition to prophylaxis, for beneficiaries 5 and under.

29 MI: Fluoride treatment is a benefit only for recipients under 18, must be preceded by a complete oral prophylaxis, and may be provided only once in a 12-month period.

30 MS: Topical application of fluoride includes prophylaxis, allowed once per year for EPSDT recipients.

31 NV: Children up to 9 may receive fluoride treatments (including prophylaxis) ● very 6 months; chi ldren 10 through 20 may receive fluoride treatments (exclusive of prophylaxis) once ● very year.

32 OH: Fluoride treatment, following complete prophylaxis, is allowed once ● very 6 months for beneficiaries under 21.

33 TX: Fluoride treatment is included in the fee for prophylaxis, although its provision is not required and it may not be billed for separately.

34 CA: In addition to prophylaxis, for beneficiaries 6 through 17.

35 OH: Although not specified in the manual, an Ohio State Medicaid official noted that both dietary planning for control of dental caries and oral hygiene instruction should be included as part of the periodic ● xm and prophylaxis procedures.

36 HI: Not a covered service since 1981.

37 MS: Covered for recipients under 21 for newly ● rupted first and second permanent molars or for first and second premolars. Prior approval is required for primary teeth.

38 NV: Children 6-20 are allowed one sealant per primary tooth.

39 OH: Sea[ants ● re permitted on permanent first molars for recipients under age 9 and on permanent second molars for recip mts under age 15. Only one application of sealant per tooth per lifetime is allowed.

40 CA: Space maintainers are allowed "where there {s sufficient room for an unerupted permanent tooth to ● rtqx normally." t is not covered to hold space for missing permanent teeth.

41 MI: Space maintenance requires prior authorization, and is limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth.

42 MS: Space maintenance is provided for deciduous or permanent dentition.

43 NV: Prior authorization required -- not a routinely ● vai(able benefit.

44 TX: Limited to loss of primary second molar.

45 TX: Allowable only for the loss of two or more primary molars in a single ● rch, one of which must be a primary second molar.

46 CA: For beneficiaries 13 ● nd over, ● complete series once ● very 3 years.
For beneficiaries under 13, fever intraoral radiographs comprise a complete series and may be allowed "commensurate with signs, symptoms, and age of the Patient" (although Sec. 51307(d)(11) specifically denies" full mouth radiograph coverage for beneficiaries 12 and under).

47 MI: Complete mouth survey ● benefit only once every 3 years.

48 MS: Allowable only once ● very 2 years. Should include 10 to 14 intraoral films and bitewings.

49 NV: Medicaid acceptable x-rays are not to be taken with ● xcessive frequency.

50 OH: A complete series will consist of ● minimum of 12 or more films and is allowed only once ● very 3 years, unless prior authorized.

51 TX: Allowable once every 3 years by the same dentist.

52 CA: A total of 11 films are ● iicwed in ● series.

53 MI: Recall radiographs are covered only once ● very 6 months, and ● re limited to bitewings and necessary periapical radiographs.

54 MS: Only 7 intraoral films are covered per claim.

55 TX: Not to ● xceed payment for full mouth series.

56 OH: Extraoral film is allowed as an adjunct to complex treatment.

57 CA: Supplementary bitewings are a benefit no more than once ● very 6 months Single radiographs are a benefit when necessary to a maximum of 11 films.

58 OH: Bitewing radiographs, in combination or alone, are allowed at 6 month ntervals.

59 NY: Three films minimum.

60 OH: Prior authorization is required.

61 CA: Allowed as part of full mouth series, with periapical radiographs of anterior teeth and at least 2 bitewings, once every 3 years for beneficiaries 13 and over. Panographic radiographs ● lorw are ● limited benefit.

62 MI: Require prior authorization when they ● re the only type of radiograph taken, which is allowed under limited c rcumstances.

63 MS: Not covered in conjunction with full-mouth intraoral series.

64 NV: Panorex or panelipse x-rays require written prior authorization if more frequent than within 90 days.

65 OH: Panoramic radiographs are allowed once every 3 years (and 3 years must ● lapse between panoramic radiographs and complete series of radiographs) and are limited to beneficiaries 6 ● nd older, unless prior authorized.

66 TX: Limited to one during the ages 0-9 and one during the ages 10-20 by the same dentist.

67 MI: Prior authorization required.

68 NV: Medicaid acceptable x-rays are not to be taken with excessive frequency.

69 OH: Prior authorization is required.

70 MS: Amalgam should be used on all teeth distal to cuspids for beneficiaries under 21, primary or permanent.

71 CA: Benefit includes Silicate, Composite, and Plastic restorations, but only on anterior teeth.

72 MI: Benefit includes Silicate, Composite, and Plastic restorations, but only on anterior teeth.

73 MS: Composites may be performed on both anterior and posterior teeth, primary and permanent.

74 NV: Restorations with acrylic/plastic, composite resin, limited to anterior teeth.

75 NY: Although the fee schedule does not specify, corresponding AOA Codes imply that resin restorations are allowed for anterior teeth only.

76 OH: For anterior teeth only.

77 TX: The fee for restoring anterior teeth with resin is higher than for posterior teeth.

78 MI: Preformed stainless steel crowns are authorized only for deciduous teeth and first permanent molars and only for recipients 15 and under. Other crowns are for anterior teeth only and require prior authorization.

79 CA: According to the California manual, pulp capping is covered as part of restorative services, but it is specifically a "not covered" service according to Section 51307(d)(11).

80 OH: Although there is no coda for pulp therapy, an Ohio State Medicaid official noted that these procedures should be included as part of restorative procedures if necessary.

81 CA: Therapeutic pulpotomy for deciduous teeth only. Vital pulpotomy for vital permanent teeth only.

82 MI: A vital pulpotomy is covered for a vital deciduous tooth or a vital permanent tooth with incompletely formal roota, and requires prior authorization.

83 MS: Pulpotomy for primary teeth does not require prior authorization.

84 TX: Therapeutic pulpotomy with base.

8S CA: A limited benefit for posterior and anterior permanent teeth for beneficiaries though age 17.

86 MI: Prior authorization is required for any root canal therapy.

87 MS: Root canals for permanent teeth requires submission of substantiating x-rays.

M NV: Prior authorization required -- not routinely available benefit.

89 OH: Root canal therapy is allowed only on permanent teeth.

90 TX: Root canal payments are limited to four permanent teeth for each recipient and x-rays are required.

91 NY: Prior approval required.

92 CA: Periodontal services are Limited to beneficiaries 18 and over.

93 MI: Requires prior authorization.

94 OH: Although the manual specifically does not cover periodontal seating, an Ohio State Medicaid official noted that the defnition of prophyaxis includes necessary scaling and that periodontal scaling should be provided if necessary. There is no billable code for periodontal scaling.

9S 1X: Although the fee for prophylaxis for recipients 3-12 includes subgingival scaling, neither periodontal scaling and root planing nor gingival curettage ● re specifically covered services.

96 MS: Gingival curettage and gingivectomies will be considered only for patients on Dilantin therapy.

97 NV: Prior authorization required -- not ● routinely ● vailable benefit.

96 NY: However, gingivectomy or gingivoplasty is ● lloud.

W ON: However, gingivectomy or gingivoplasty sometimes (though not usually) allowed and prior authorization is required.

100 CA: Removable prostheses ● re ● benefit with limitations (e.g., only when necessary for the balance of a complete denture) and only once in a 5 year period.

101 MI: A partial denture will be authorized for beneficiaries under 21 only if one or more incisor is missing or fewer than 6 teeth are in occlus on in posterior ● reas. Complete or partial dentures will only be authorized when masticatory deficiencies will impair general health and when ● xisting dentures cannot be made serviceable. Replacement dentures ● re not ● benefit if the original dentures were placed within 5 years.
All dentures require prior authorization.

102 MS: Prosthodontics ● re limited to upper and lower removable bridges. Prior approval is required.

103 NV: Prior authorization required -- not ● routinely ● vai1s4(e benefit.

104 NY: Prior authorization is required.

105 ON: All dentures must be prior authorized; partial dentures ● *re* authorized when several teeth ● re missing in the arch and masticatory function s severely impaired. All dentures cannot be replaced or remade within 8 years ● xcept for very unusual circumstances.

106 TX: Partial dentures may be authorized for recipients 9-20 if the recipient has missing anterior teeth or less than 8 occluding posterior teeth Cleft palate and partial anodontia cases (age 3-20)" may be ● xceptai.

107 CA: Orthodontic treatment is limited to beneficiaries with cleft palate deformities who are under case management of the California Children Services Program.

108 MI: Orthodontic procedures are only provided to children medical y ● ligib(e for the Crippled Children Program (Medicaid recipients are already financially ● (igib(e) and require prior authorization.

109 MS: For permanent dentition only, and must receive prior approval.

110 NV: Orthodontic coverage is limited to only those children with the most severe handicapping conditions.

111 NY: Prior approval required.

112 ON: Orthodontic coverage is limited to only those children with the most severe handicapping conditions.

113 TX: Orthodontic coverage is limited but may be authorized for children with the most severe handicapping conditions.

114 NY: The only emergency service listed in the New York program's fee schedule is palliative care; there is no procedure code for an emergency visit nor any specific parameters regarding the provision of emergency services.

115 In California, emergency dental services do not need prior authorization. There is no specific emergency ● xcm procedure code (except in the case of emergency periodontic service); providers should bill for the services rendered. From the ● xanples in the manual, it would appear that the emergency situations covered in California ● re consistent with those specified in this list of core components.

116 In Michigan, one visit is allowed for ● ach specific emergency for all recipients and does not require prior authorization. Some services rendered (such as emergency oral surgery, reduction of dislocations of TMJ, treatment of cellulitis, and single, simple ● xtraction) do not require prior authorization for billing. All other emergency services do require prior authorization, but it may be obtained by phone by the end of the next working day. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not emergency procedures.

117 In Mississippi, emergency dental care is provided to relieve pain and/or infection. Emergency is defined as a condition which requires treatment and there exists pain and/or infection of the dental apparatus and/or contiguous structures which, in the opinion of the dentist, will require ● xtraction of the tooth or teeth. An emergency ● xms is billable only if no other procedures, other than x-rays, are performed that same day.

118 The Nevada program definition of emergency care is quite similar to the elements listed here. Treatment measures include emergency prosthetic repair, replacement of missing teeth in a prosthesis, denture adjustments, routine restorative procedures, endodontics (on anterior teeth only) and extractions. Emergency services need no prior authorization.

119 There are no procedure codes in the Ohio handbook for either palliative emergency care or an emergency ● xam. Indeed, there is no discreet section ● xplaining the policies on emergency services at all in the handbook, although some guidance is provided regarding specific services (e.g., extractions rendering the patient edentulous must be prior approved, ● xcept in absolute emergency). The billing form does offer 'emergency room" as a ocation of service. An Ohio Medicaid official noted that providers should bill for the actual services rendered.

120 There is no procedure coda for an emergency ● xrn. ● tthowh there is one for palliative emergency treatment. Prior authorization is required or emergency dental services payable ● t more than $80, which may be obtained by calling an "800" number. Routine restorative procedures are not considered as emergency procedures. The Texas manual definition of emergency services is similar to the ● lements in this list of core components.

121 M : Extraction of more than one tooth requires prior authorization.

122 CA: Not payable to provider receiving payment for tooth extraction.

123 MI: Requires prior authorization.

124 CA: But not ● benefit in conjunction with ● xtraction.

125 MI: A biopsy performed in conjunction with another surgical procedure is considered part of that surgical procedure.

126 NV: Prior authorization required -- not ● routinely ● vailable benefit.