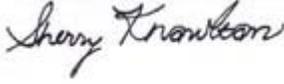


	MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE	
	SUBJECT Dental Services for Adults	BY  Sherry Knowlton Deputy Secretary for Medical Assistance Programs
NUMBER:	03-93-04, 1149-93-01	
ISSUE DATE:	July 9, 1993	
EFFECTIVE DATE:	July 1, 1993	

PURPOSE:

The purpose of this bulletin is to:

1. notify providers that effective July 1, 1993, the Department is reinstating medically necessary dental services for adults age 21 and over, with new limits, as a result of the Stipulation of Settlement entered in Felix v. Casey;
2. inform providers that the terms of the Felix v. Casey Interim Agreement remain in effect through June 30, 1993;
3. inform providers that they can resubmit requests for prior authorization that were previously denied because the service was not compensable, if the service has not already been provided, and
4. provide revised Medical Assistance Program Fee Schedule pages which include one new procedure code for adult oral examinations, the new limits to existing procedure codes for adults, fees, and prior authorization requirements.

NOTE: This bulletin references, obsoletes and replaces the following Medical Assistance (MA) Bulletins effective July 1, 1993:

Dental Service Limits, MA Bulletin Number 03-92-07

Interim Agreement Felix et. al. v. Casey et. al., MA Bulletin Number 1101-93-02.

Procedures for Dental Services Begin Prior to January 1, 1993, MA Bulletin Number 03-93-02.

SCOPE:

This bulletin applies to all dentists enrolled in the Medical Assistance Program.

BACKGROUND:

On January 1, 1993, the Department limited dental services for all adult categorically needy (blue card) and State Blind Pension (pink card) recipients to surgical procedures and emergency services. Emergency services were defined as palliative treatment (pain relief) and diagnostics (x-rays), restorations (fillings) and/or extractions relative to the need for palliative treatment.

Categorically needy (blue card) and medically needy (green card) recipients under 21 years of age were not affected by these changes and remained eligible for all medically necessary dental services.

A class action lawsuit, Felix v. Casey, was filed in Federal District Court in Philadelphia challenging the dental service limits. The plaintiffs and the Department signed an interim agreement effective January 7, 1993, which revised the definition of emergency services, expanded the list of compensable procedures when provided as emergency services, and provided for coverage of dentures and crowns under certain conditions.

DISCUSSION:

The terms of Felix v. Casey Interim Agreement remain in effect through June 30, 1993.

On July 1, 1993, the Department will reinstate medically necessary dental services for all adult blue card (HealthCare Benefit Packages II, III, VI, and VIII) and pink card (HealthCare Benefit Package VII) recipients. Adult green card (HealthCare Benefit Packages IV and V) recipients are not eligible for dental services except when provided in an inpatient or an ambulatory surgical center/short procedure unit setting. Some services have new limits and conditions for payment.

After July 1, 1993, providers can resubmit requests for prior authorization that were previously denied because the service was not compensable, if the service has not already been provided. Post approval will not be granted for any services rendered between January 1, 1993, and June 30, 1993, that were noncompensable during that time period.

Attached is a revised Medical Assistance Program Fee Schedule which includes one new procedure code, the new limits to existing procedure codes for adults, fees, and prior authorization requirements. A summary of the changes which affect all adults age 21 and over is as follows:

1. Clinical Oral Examination

Type Service OE, Procedure Code X0110, Adult Oral Examination (age 21 and over), is limited to one per 365 days. Fee is \$12.00.

2. Dental Prophylaxis

Type Service OE, Procedure Code D1110, Prophylaxis – Adult (Age 21 and over) is limited to one per 365 days. Fee is \$17.00.

3. Crowns

- Crowns must be prior authorized.
- Radiological films for proposed crowns of abutment teeth must have acceptable views of adjacent and opposing teeth.
- Teeth must have pathological destruction by caries or trauma, and must involve:
 - Four or more surfaces and two or more cusps for molars;
 - Four or more surfaces and at least 50% of the incisal edge for anterior teeth; or
 - Three or more surfaces and one cusp for bicuspid.
- A request for a crown following a root canal must meet the following conditions:
 - a one month period of time must elapse between the date the root canal is completed and the date that the request for a crown is submitted;
 - a periapical film must be taken and submitted to show the root and crown of the natural tooth;
 - the tooth must be filled within two millimeters of the radiological apex, unless there is curvature or calcification of the canal that limits the ability to fill to the radiological apex;
 - the root canal filling material cannot be filled beyond the radiological apex;
 - the root canal filling must be properly condensed/obturated.
- To be approved, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- Crowns will not be covered in the following situations:
 - Where lesser means of restoration is possible;

- Teeth with subosseous and/or furcation carious involvement;
- Teeth with advanced periodontal disease;
- Third molar (unless it is an abutment tooth);
- Primary teeth if the radiograph indicates imminent exfoliation;
- Crown coverage is limited to one crown per tooth for six years;
- Crown coverage is limited to four per calendar year per recipient with no more than two crowns per arch.
- The dentist should impress upon the patient the importance of taking care of a crown. Crowns that are dislodged, broken, or lost are not sufficient justification for replacement.
- There is no coverage for restorations, procedures, or applications done to alter vertical dimension. Payment for these noncompensable services are the responsibility of the patient. Such procedures include, but are not limited to those done primarily for replacement of tooth structure lost by attrition, realignment of teeth, splinting, equilibration, full mouth rehabilitation, and treatment of Temporal Mandibular Joint Syndrome.

4. Root Canal Therapy

- Payment for root canals requires post-op review and pre-and post-op radiographs, with the following criteria:
 - a periapical film must be taken and submitted to show the root and crown of the natural tooth (pre- & post-op);
 - the tooth must be filled within two millimeters of the radiological apex (unless there is a curvature or calcification of the canal that limits the ability to fill to the radiological apex);
 - the root canal filling material cannot be filled beyond the radiological apex;
 - the root canal filling must be properly condensed/obtured.
- Root canals are not covered in the following situations:
 - Intentional (elective) endodontics;
 - Third molar (unless it is an abutment tooth);
 - Teeth with advanced periodontal disease;
 - Teeth with subosseous and/or furcation carious involvement;
 - Teeth which cannot be restored with conventional methods (i.e., amalgam, composite or crowns);
 - Teeth which have received prior endodontic treatment.

5. Complete Dentures

- Full dentures are limited to one denture per arch, regardless of procedure code, every seven years.

6. Partial Dentures

- A partial denture must include two or more anterior teeth or four or more posterior teeth, excluding third molars, which are anatomically correct (natural size, shape and color) and are limited to one per arch, regardless of procedure code, every seven years.

7. Denture Relines

- Relining of a denture, either full or partial, is limited to one per arch, every two years, regardless of procedure code.

8. All other Dental Procedures for Adults on the MA Program Fee Schedule

- Reinstated with no changes for adults.

Dental Prior Authorization Procedures

Crowns and Dentures – The procedures to request prior authorization of crowns and dentures are located in the Dental Services Handbook, Section VIII, Dental Prior Authorization. All regulations and guidelines included in Section VIII of the handbook and this bulletin must be met for prior approval of crowns and dentures for adults.

Post-Op Review for Payment for Root Canals – The provider should follow the standard procedures for completion and submission of a Dental Prior Authorization Request (MA 98) in order to request post-op review for payment for root canals for adults. All regulations and guidelines in Section VIII of the Dental Services Handbook and this bulletin must be met for post-op review of root canals.

The Dental Prior Authorization Request (MA 98), with required radiographs for prior authorization of crowns and dentures and post-op review of root canals, should be submitted to the following box number as detailed in the Prior Authorization Section of the Dental Services Handbook:

Provider Type 03 - P.O. Box 8187
Provider Type 27 - P.O. Box 8186

NEXT STEP:

Please replace your Medical Assistance Program Fee Schedule pages with the attached updated pages which reflect the change affecting all adults age 21 and over, effective July 1, 1993.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Division of Outpatient Programs
P.O. Box 8046
Harrisburg, Pennsylvania 17105

1-800-537-8862

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.