

DEPARTMENT OF HEALTH AND SOCIAL SERVICES



CHANGES TO REGULATIONS

7 AAC 43. MEDICAL ASSISTANCE. ADULT DENTAL COVERAGE



FILED REGULATIONS

Effective March 29, 2007

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Title 7. Health and Social Services.

Chapter 43. Medical Assistance.

7 AAC 43.600(a) is amended to read:

(a) Medicaid will pay for routine dental services for recipients under [AGE] 21 **years of age**. [MEDICAID PAYMENT FOR RECIPIENTS AGE 21 OR OLDER IS LIMITED TO DENTAL SERVICES FOR THE IMMEDIATE RELIEF OF PAIN AND ACUTE INFECTION.]

(Eff. 8/18/79, Register 71; am 6/30/84, Register 90; am 7/1/86, Register 99; am 9/1/94, Register 131; am 10/12/97, Register 144; am 3/29/2007, Register 181)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.620 is repealed and readopted to read:

7 AAC 43.620. Excluded dental services for recipients under 21 years of age. The department will not pay for the following dental services for recipients under 21 years of age:

- (1) treatment for conditions of the temporomandibular joint;
- (2) final restorations in resin or amalgam for more than five surfaces;
- (3) indirect pulp capping. (Eff. 7/1/86, Register 99; am 9/1/94, Register 131; am 2/1/97, Register 141; am 10/12/97, Register 144; am 6/26/98, Register 146; am 3/29/2007, Register 181)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43 is amended by adding a new section to Article 12 to read:

7 AAC 43.625. Dental services for adults. (a) The department will pay for recipients 21 years of age or older for dental services for the immediate relief of pain and acute infection, except as specifically excluded under (c) of this section. Payment for services covered under this subsection does not reduce the recipient's annual limit under (b) of this section. The services covered under this subsection include

- (1) minimal services for the immediate relief of pain and acute infection;
- (2) general anesthesia and sedation; and
- (3) diagnostic examination or radiographs necessary for emergency dental care.

(b) The department will pay for dental claims under this section that are applied toward a recipient's annual limit for service dates from July 1 to June 30 of that year. On July 1 of each year, a recipient's annual limit returns to the maximum limit permitted under this section.

Beginning April 1, 2007, the department will pay, up to an annual limit of \$1,150 per recipient 21 years of age or older, for the following dental services:

- (1) diagnostic examination or radiographs necessary for routine dental care;
- (2) preventative care, including
 - (A) prophylaxis, including necessary scaling, polishing, and instructions;
 - (B) topical fluoride application; and

(C) an anterior removable space maintainer;

(3) restorative care, including amalgams, resins, stainless steel crowns, and full crowns for restoration of decayed or fractured teeth; temporary restorations, cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately;

(4) endodontics, with the following limitations:

(A) palliative and sedative treatments may not exceed two times per tooth before a definitive treatment;

(B) pulp capping must be necessary for a direct pulp cap of an exposed pulp of a permanent tooth;

(C) root canal therapy must include tooth preparation, filling of the root canal, and follow-up;

(D) a separate claim may be made for pin retention and restoration, not to exceed five surfaces per tooth;

(5) periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess;

(6) prosthodontics, including complete or partial dentures and denture repair or relines; the department will pay for replacement of complete or partial dentures only once per five calendar years;

(7) oral surgery; local anesthesia, materials, and routine post-operative care are considered components of a complete surgical procedure and may not be billed separately;

(8) professional consultation, if medically necessary or as requested by the department.

(c) The department will not pay for the following dental services provided to a recipient 21 years of age or older:

- (1) panoramic radiograph more than once in a calendar year;
- (2) final restorations in amalgam or resin for more than five surfaces;
- (3) dental sealants;
- (4) restoration of etched enamel or deep grooves without dentin involvement;
- (5) inlays, overlays, or three-fourth crowns;
- (6) endodontic apical surgery or retrograde fillings;
- (7) periodontal surgery;
- (8) implant or implant-related dental services;
- (9) orthodontic services.

(d) Notwithstanding 7 AAC 43.050, for services provided under (b) of this section a provider may bill a recipient for the difference between the full reimbursement and the amount remaining in the recipient's annual limit if the annual limit would provide less than the full reimbursement for the service.

(e) A provider shall inform a recipient in advance of the recipient's obligation to pay for a service if the recipient's annual limit has already been reached or if the amount due will cause the recipient's annual limit to be exceeded. The provider shall document in the recipient's records that the recipient was provided that information and agreed to pay for any balance above the annual limit for the service provided.

(f) The department will not pay a provider for a recipient's missed appointment. If the provider has a policy to charge patients for missed appointments, the provider may charge the recipient. However, the recipient is responsible for payment.

(g) A dental service provided when a recipient's annual limit has been reached is considered a non-Medicaid service. The recipient is responsible for the full amount due for the service. The department will not provide reimbursement if the recipient's annual limit has been reached.

(h) For a recipient 21 years of age or older, dental services must have prior authorization from the department. The department will assist a provider and recipient to the extent possible in monitoring the recipient's annual limit. However, the department will not assume financial responsibility for services provided that exceed the recipient's annual limit. When requesting prior authorization, a provider must include, on a form provided by the department, the

- (1) name of the recipient to whom dental services were provided;
- (2) type of dental services provided; and
- (3) charge for the services provided. (Eff. 3/29/2007, Register 181)

Register 181, April 2007

HEALTH AND SOCIAL SERVICES

Authority: AS 47.05.010 AS 47.07.040 AS 47.07.067
AS 47.07.030