Dental Services

Revised: January 16, 2024

Overview

The Minnesota Health Care Programs (MHCP) Dental program provides medically necessary, cost-effective oral health care to MHCP members. This care meets specific limits outlined in state statutes and rules; and has been adopted by the Minnesota Department of Human Services (DHS) and explained in the MHCP Provider Manual. Services provided must be medically necessary and meet dental community standards of care. Providers must follow federal and state regulations and Minnesota Board of Dentistry requirements for documentation, infection control, and patient care.

Before beginning a dental service or procedure, providers need to verify member eligibility and available services in MN–ITS. The MN–ITS (271) eligibility response identifies some of the dental benefits limits to the extent that fee-for-service (FFS) claims have been processed for payment. Providers must contact the MHCP Provider Resource Center to verify if claims have been processed for payment for other limited services not displayed on the (271) eligibility response. This is not a guarantee that your service will be covered as the information is based on claims that have completed the adjudication process.

Eligible Providers

The following providers can bill for dental services:

- Endodontists
- General dentists
- Oral and maxillofacial surgeons
- Orthodontists
- Pedodontists or pediatric dentists
- Periodontists
- Prosthodontists

Providers eligible to deliver and bill for limited dental services include:

- Allied Oral Health Professionals:
  - Advanced Dental Therapists
  - Dental Therapists
  - Collaborative Practice Dental Hygienists
- Non-Dental Health Providers:
  - Community Health Workers (CHW)
  - Head Start agencies
  - Nurse practitioners
  - Physicians
  - Physician assistants
  - Public health nurses
  - Women, Infant, & Children (WIC) programs

Locum Tenens Dentist

MHCP recognizes that some dentists retain a substitute dentist to take over their professional practices while they are absent for reasons such as illness, vacations, continuing medical education, and pregnancy. MHCP recognizes locum tenens arrangements and pays FFS for the services provided by the substitute dentist. Refer to Locum Tenens Physicians for more information.

Volunteer Dentist

MHCP recognizes providers who wish to deliver services to MHCP members at no cost. Volunteer dentists should not provide services to MHCP members outside of the volunteer dentist agreement and cannot receive payments for their services rendered. Volunteer dentists must complete the Volunteer Dentists Provider Agreement (DHS-4611B) (PDF), enroll with MHCP as a non pay-to provider, and perform services in an MHCP-enrolled practice.

Eligible Members

MHCP Members - Medical Assistance (MA) and MinnesotaCare

Verify MHCP eligibility before providing services. Programs and coverage may change and not all programs cover dental services. Determine eligibility for dental services using the member's major program code and the dental coverage information on the MHCP Benefits at-a-glance.

Members with major program HH should refer to Program HH (HIV/AIDS) Covered Services.

Members enrolled in a Managed Care Organization (MCO) should contact the MCO for information about dental coverage limitations.

Covered Services

Please refer to these subsections for service details:

- Dental Benefits
  Also see the MHCP Fee Schedule for a current list of all MHCP covered codes.
- Critical Access Dental Payment Program (CADPP)
- Influenza Vaccines Administered by a Dentist
- Community Health Worker Patient Education

DO NOT REMOVE the red text at the beginning of this document. It is there for the licensing agreement.

Alveoloplasty or Gingivectomy

Alveoloplasty and gingivectomy are dental surgical procedures that are considered covered services and do not require a denial from Medicare before billing MHCP.

MHCP allows billing for the following CPT codes for these services. Specify each quadrant:

- 41820: Gingivectomy, excision gingivia
- 41828: Excision of hyperplastic alveolar mucosa
- 41872: Gingivoplasty
- 41874: Alveoloplasty

COVID-19 Testing by Dentists

Refer to the American Dental Association Guidance on COVID-19. Dentists who administer COVID-19 or other microbe testing must be enrolled with Clinical Laboratory Improvement Amendments (CLIA). Any dental practice that performs tests on human tissue (including saliva, plaque, blood or hard or soft tissue) must comply with CLIA regulations. Dentists wishing to obtain CLIA enrollment should contact:

Minnesota Department of Health
CLIA Program
P.O. Box 64900
St Paul, MN 55164-0900
Phone: 651-201-4120
Email: health.clia@state.mn.us

Enrolled Dentists Ordering and Administering COVID-19 Testing

MHCP will only reimburse dentists enrolled with CLIA (Clinical Laboratory Improvement Amendments) for administering COVID-19 tests. Eligible dental providers should use the following procedure code on claims for administering COVID-19 tests to members:

- D0604 Antigen testing for a public health-related pathogen, including coronavirus
- D0605 Antibody testing for a public health-related pathogen, including coronavirus
- D0606 Molecular testing for a public health-related pathogen, including coronavirus

Refer to the ADA's COVID-19 and Lab Testing Requirements Toolkit for additional information.

Sleep Apnea Appliances

For MHCP members who cannot tolerate a continuous positive airway pressure (CPAP) machine, a physician may prescribe an oral appliance. MHCP considers the oral appliance as Durable Medical Equipment. Dentists assure the proper fit of the appliance. Most appliances require that a dentist take necessary impressions and a bite registration.

For an appliance to be covered, it must meet the following criteria (A-D):

A. A face-to-face evaluation by a physician prior to a sleep test to assess the client for obstructive sleep apnea testing.
B. The sleep test must meet **one** of the following three criteria (1, 2, or 3):
    1. The apnea-hypoxia index (AHI) or Respiratory Disturbance Index (RDI) is between 15 and 29 events per hour.
    2. The AHI or RDI is between 5 and 14 events per hour with documentation of one of the following (a or b):
        a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia.

   b. Hypertension, ischemic heart disease, or history of stroke.
3. The AHI or the RDI is greater than 30 and meets either of the following (a or b):
   a. The member is not able to tolerate a positive airway pressure device.
   b. The treating physician determines that the use of a positive airway pressure device is contraindicated.

C. A physician must order the device following review of the report of the sleep test (the physician who provides the order for the oral appliance could be different from the one who performed the clinical evaluation in criterion A).
D. A dentist provides and bills for the device.

A custom fabricated oral appliance (E0486) must additionally meet all of the following criteria:

- Have a fixed mechanical hinge (defined as a mechanical joint containing an inseparable pivot point) at the sides, front or palate.
- Interlocking flanges, tongue and groove mechanisms, hook-and-loop or hook-and-eye clasps, elastic straps or bands do not meet this requirement.
- Be able to protrude the member's mandible (jawbone) beyond the front teeth when adjusted to maximum protrusion.
- Incorporate a mechanism that allows the mandible to be easily advanced by the member in increments of one millimeter or less.
- Retain the adjustment setting when removed from the mouth.
- Maintain the adjusted mouth position during sleep.
- Remain fixed in place during sleep to prevent dislodging the device.
- Require no return dental visits beyond the initial 90-day fitting and adjustment period to perform ongoing modification and adjustments to maintain effectiveness.

Items that require repeated adjustments and modification beyond the initial 90-day fitting and adjustment period to maintain fit or effectiveness are not eligible for classification as durable medical equipment. MHCP considers these items dental therapies, which are not eligible for reimbursement.

Teledentistry Services

Teledentistry is the delivery of dental care services or consultations while the patient is at an originating site and the dentist is at a distant site. MHCP allows payment for teledentistry services. Refer to Telehealth Services for more information. Reimbursement for teledentistry is the same as face-to-face encounters. The distant site can bill for the services provided by a licensed dentist. Affiliate practice or originator within Minnesota Board of Dentistry defined scope of practice must be present at originating site.

Eligible Providers

- Dentist
- Advanced dental therapists
- Dental therapists
- Dental hygienists
- Licensed dental assistants
- Other licensed health care professionals

List of Teledentistry Services

Enrolled providers must self-attest that they meet all of the conditions of the MHCP telemedicine policy, prior to delivering services, by completing the Telehealth Provider Assurance Statement (DHS-

6806) (PDF). MHCP allows the following CDT codes for these diagnostic services when performed through teledentistry services:

- D0120: Periodic oral evaluation—established patient
- D0140: Limited oral exam
- D0145: Oral evaluation for a patient under 3 years of age
- D0150: Comprehensive oral evaluation—new or established patient
- D0210: Intraoral—complete series of radiographic images
- D0220: Intraoral—periapical first radiographic image
- D0230: Intraoral—periapical each additional radiographic image
- D0270: Bitewing—single radiographic image
- D0272: Bitewings—two radiographic images
- D0274: Bitewings—four radiographic images
- D0240: Intraoral—occlusal radiographic image
- D0330: Panoramic radiographic image
- D9310: Medical Dental Consultation

Limitations

- MHCP will pay for only one reading or interpretation of diagnostic tests such as X-rays, lab tests and diagnostic assessment.
- Payment is not available to providers for sending materials.
- Out-of-state coverage policy applies to services provided via teledentistry services
- Consultations performed by providers who are not located in Minnesota and contiguous counties require authorization prior to the service being provided.

Temporomandibular Joint Disorder (TMD)

MHCP considers treatment for TMD a medical service when the underlying pain and dysfunction is caused by:

- Pain-related TMD, which includes myalgia, myofascial pain, arthralgia, arthritis or headache that is attributed to TMD or
- Temporomandibular joint (TMJ) intra-articular disorders, including disk displacement with and without reduction, degenerative joint disease, osteoarthritis or subluxation.

Prior authorization is required if service is rendered by a dentist. Use the TMD Treatment Authorization Form (DHS-6119) (PDF).

Use this CPT code to bill for this service: 41899: Unlisted procedure, dentoalveolar structures.

Dental Periodicity Schedule

As required by the Centers for Medicare & Medicaid Services (CMS), the Minnesota Child and Teen Checkups (C&TC) Schedule of Age-Related Dental Standards (DHS-5544) (PDF) was developed. Both primary care and dental providers must use this schedule, which is in keeping with recommendations of the American Academy of Pediatric Dentistry.

Noncovered Services

A provider may seek payment from the MHCP member for services only when the provider, prior to delivering the service, reviews and discusses all other available covered alternatives with the member and obtains a signed release of liability using Advance Recipient Notice of Non-covered Service/Item (DHS-3640) (PDF).

The following services are not covered because they are included in other procedure fees and are not payable separately or billable to the member. This is not an all-inclusive list.

- Barriers
- Disposable equipment or supplies
- Drapes
- Eye protection
- Fluoride trays or rinses
- Gauze or sterile packing
- Gloves
- Infection control procedures
- MinnesotaCare tax
- Needles
- Periodontal charting (separate from codes D0150 or D0180)
- Prescriptions dispensed in the office
- Prosthetic cleaning
- Pulp caps (direct D3110 and indirect D3120)
- Sterilization solutions or equipment
- Surgical supplies
- Suture material
- Syringes
- Treatment deemed to be cosmetic or for aesthetic reasons

Authorization Requirements

Follow the guidelines outlined in the Authorization section of the MHCP Provider Manual. The medical review agent must receive all required documentation to complete the review. Verify the member is eligible for FFS and that the service requires authorization before submitting the authorization request to the medical review agent. Refer to MHCP FFS dental authorization charts below for procedure-specific documentation requirements:

- Authorization Tables for Dental
- Program HH Dental Authorization Requirement Chart

Do not submit authorization requests for services that do not require authorization or are noncovered services; they incur unnecessary costs and MHCP will not approve them. For services that do require authorization, do not send authorization requests to MHCP. They will not be forwarded to the medical review agent and will delay the authorization process.

Sleep Apnea Appliances

Medical authorizations are always required for sleep apnea appliances.

Billing

Follow these billing requirements:

- Report accurate and complete information on all electronic claims.
- Enter the valid tooth surface, tooth number or oral cavity indicator when applicable.
- Use your valid NPI number as the billing provider.
- Use 837D to submit professional dental services claims with CDT codes.
- Use 837P when billing CPT procedure codes for medical or technical services.
- Use a principal diagnosis (ICD code) when using CPT codes.
- Outpatient facilities must use CPT or CDT codes on the 837I, as well as adhere to the following:

- Report each service on a separate service line.
- Report dental codes that require tooth numbers or oral cavity designations with supporting clinical documentation including tooth numbers or oral cavity designations for the service(s) provided.
- Include an Electronic Claim Attachment number and type on your claim.
- Fax the AUC Uniform Cover Sheet for Health Care Claim Attachments with supporting documentation.
- All state-owned and operated dental clinics must bill all claims directly to MHCP.

Dental Procedures Billed on an Institutional Claim

Dental providers must make a contractual arrangement with the hospital to be reimbursed for providing dental services. Bill medical services provided using the 837I claim and report each individual dental service on a separate line. Providers must submit claims with a claim attachment number and claim attachment type code to list tooth numbers or oral cavity designations for each dental procedure code. Dental CDT procedure codes allow reimbursement for a unit count of one.

Dental Procedures Reported with CPT Coding

Dentists and board-eligible and board-certified oral and maxillofacial surgeons must use the Physician's Current Procedural Terminology (CPT) procedure codes when billing complex oral surgery to MHCP. To receive reimbursement for CPT procedure codes, you must be individually enrolled with MHCP. Providers must document any service or procedure in the member's medical record. Bill medical services provided by a dentist using current CPT procedure codes on the 837P.

Dentists using CPT procedure codes and coding must select the code for the procedure or service that most accurately identifies the service performed. You must also list any additional procedures performed or pertinent special services. When necessary, list any modifying or extenuating circumstances.

Medicare Coverage and Other Insurance Billing

If the provider is enrolled with Medicare (including Federally Qualified Health Centers), send the bill to Medicare first when billing CPT or CDT codes. Medical Assistance is the payer of last resort. If a provider is not enrolled with Medicare but is enrolled with MHCP, submit the claim to DHS along with an attachment stating that the provider is not enrolled in Medicare and the reason for the CPT or CDT code being performed. The claim will automatically be suspended and reviewed for payment.

Sleep Apnea Appliances

Billing process and required documentation:

- Use the Professional 837P claim.
- Complete and fax the AUC claims attachment cover sheet and include the following:
  - Copy of the lab slip with fee included.
  - Cost of materials including those used to fabricate the impression and bite registration.
- Submit a 278 medical authorization request in MN–ITS.
- Use the appropriate International Classification of Diseases (ICD) diagnosis code.
- Indicate the appropriate HCPCS code (E0485 or E0486) for the appliance.
- Copy of the sleep study results and interpretation by a physician.
- Documentation of a trial of a CPAP machine.

Billing for Teledentistry Services

Use the CDT code that describes the services rendered with place of service (POS) 02, certifying that you are rendering services to a patient located in an eligible originating site via an interactive audio and visual telecommunications system.

Documentation requirements

As a condition of payment, each occurrence of services must include maintaining the following documentation in the member's health record:

- The type of service provided.
- The time the service began and the time the service ended.
- A description of the provider's basis for determining that Services is an appropriate and effective means for delivering service to the member.
- The mode of transmission of the telehealth service.
- The location of the originating and distant site.

Third-Party Liability (TPL) or Other Insurance

MHCP considers TPL or other insurance as primary coverage to dental care services. MHCP will not consider a request for authorization of a service or item for a member with TPL or other insurance coverage unless the provider has made a good faith effort to receive authorization or payment from the primary payer(s).

Authorization is not required if a TPL payer has made payment that is equal to or greater than 60 percent of the MHCP maximum allowed amount for the service or item.

Medical necessity review

If there is concern about TPL ending before treatment is complete, submit a prior authorization request to the medical review agent and include a note indicating the request is for medical necessity review.

If the medical necessity review is:

- Approved: the provider should bill MHCP as a secondary payer with TPL as the primary, and MHCP as the primary payer after TPL ends.
- Denied: providers may obtain a signed Advance Recipient Notice of Noncovered Service/Item (DHS-3640) (PDF) and receive payment from the member for the service or cost sharing. If the member chooses not to sign the Advance Recipient Notice, the provider must not bill the member or MHCP for any service cost.

Retroactive authorization

If service has begun without an MHCP medical necessity determination and TPL coverage ends, MHCP will pay for the remainder of service only if the applicable authorization criteria would have been met when begun. Contact the medical review agent to submit a request for retroactive authorization review.

If the retroactive authorization review is:

- Approved: the provider should bill MHCP as the primary payer after the last TPL payment made.
- Denied: the provider must not bill the member or MHCP for any service cost.

Legal References

Minnesota Rules, 9505.0270 (Dental Services)
Minnesota Rules, 9505.0445 (Payment Rates)

Minnesota Statutes, 62J.50-62J.61 (Minnesota Health Care Administrative Simplification Act)
Minnesota Statutes, 150A.05, subdivision 1a (Practice of dental hygienists)
Minnesota Statutes, 150A.10, subdivision 1a (Collaborative practice dental hygienists in community settings)
Minnesota Statutes, 150A.22 (Donated Dental Services)
Minnesota Statutes, 150A.105 (Dental Therapist)
Minnesota Statutes, 150A.105, subdivisions 4c and 4d (Dental therapist allowed dental services)
Minnesota Statutes, 150A.106 (Advanced Dental Therapist)
Minnesota Statutes, 152.01, subdivision 10 (Narcotic drug)
Minnesota Statutes, 256B.0625, subdivision 3b (Telehealth services)
Minnesota Statutes, 256B.0625, subdivision 9 (Covered services; Dental services)
Minnesota Statutes, 256B.0625, subdivision 59 (Services provided by advanced dental therapists and dental therapists)
Minnesota Statutes, 256B.76, subdivision 2 (Dental reimbursement)
Minnesota Statutes, 256B.76, subdivision 4 (c) (Critical access dental providers)
Minnesota Statutes, 256L.03, subdivisions 1 and 5 (MinnesotaCare covered services; Cost-sharing)
Minnesota Statutes, 256L.11, subdivision 7 (Critical access dental providers, MinnesotaCare)