Effective:	*1/1/2021*
Last Approved:	*2/18/2021*
Last Revised:	*2/18/2021*
Next Review:	*2/18/2022*

Medicaid Adult Dental Benefit

Applicable Lines of Business:

Commercial - Health Maintenance Organization (HMO), Preferred Provider Option (PPO) and Point of Service (POS)

Medicare Advantage - SecureCare HMO (includes the Dual Eligible Special Needs Plan [DSNP]) and SecureChoice PPO)

✓ WV Medicaid (Temporary Assistance for Needy Families [TANF], Expansion [WV Health Bridge] and Supplemental Security Income [SSI] populations)

Self-Funded/Administrative Services Only (ASO)

West Virginia Children's Health Insurance Program (WVCHIP)

West Virginia Public Insurance Agency (WV PEIA)

Applicable Claim Type:

- ✓ Dental
- Facility
- Pharmacy
- Professional

Definitions:

Term	Definition
Bureau for Medical Services (BMS)	BMS is the designated single state agency responsible for the administration of the State of West Virginia's Medicaid program.
Claim Adjustment Reason Code (CARC)	A code used in billing to communicate a change or an adjustment in payment. A CARC code may be an informational code or may be an encompassing denial code.
Pre-Treatment Estimate (PTE)	A written estimate of benefits that may be available under a member's plan for proposed dental treatment. The dentist submits the proposed dental treatment to the

	payer in advance of providing the treatment.

Policy Purpose:

The purpose of this policy is to address general payment guidelines related to dental benefits available to West Virginia Medicaid members over the age of 21.

Policy Description:

Effective January 1, 2021, The Health Plan (THP) is administering the adult preventative and restorative dental benefit for our Medicaid members over the age of 21.

This new benefit has a $1,000 limit per calendar year.

Prior authorization is not required for the new $1,000 preventive and restorative adult dental benefit for WV Medicaid members.

THP does not currently require providers to be contracted to administer this benefit.

However, providers contracted with THP have the following benefits:

- Listed in the Medicaid provider directory
- Access to member benefits
- Ability to view claims status
- Access to news and training materials
- Ability to view payment vouchers
- Receive announcements on up-to-date information and changes that are available only to contracted providers

To become an enrolled provider, visit healthplan.org/providers/overview/join-our-network.

WV Medicaid Reimbursement Guidelines:

Dental providers are reimbursed at the current WV Medicaid dental fee schedule which is located on the Bureau for Medical Services' (BMS) website.

Remaining balances at the end of the year **CANNOT** be carried over to the following year.

Services classified as cosmetic in nature are not covered.

Any remaining balance over $1,000 will be the responsibility of the member.

Dental providers may direct bill the member, at the Medicaid fee schedule, for any outstanding balance.

The comprehensive codes set and service limitations can be found in the Oral Health section of BMS' Provider Manual located on BMS' website.

Skygen, Inc. will continue to administer the dental benefits for THP's WV Medicaid children's population.

Billing Information and Guidelines:

THP is requiring providers to contact the Customer Service Department at 1.888.613.8385 prior to rendering any Medicaid adult dental service.

THP will provide an estimate of the current available fund balance for each member to allow the provider to

estimate what
the potential member responsibility is for the service.

The conveyance of available funds is a point-in-time estimate and not a guarantee of THP payment, as it does not account for outstanding claims that have not yet been submitted/processed.

A pre-treatment estimate (PTE) is not required.

If a PTE is submitted, the eligible codes and billed amounts are required to be provided.

The PTE will not be processed If these items are not submitted together.

The PTE may take up to 30 days for processing and generating returned results.

There is no member cost-sharing (such as a copay) for the adult WV Medicaid population.

Claims specific to this benefit and the adult emergent dental benefit should be sent to **THP** for processing.

Please submit **original** American Dental Association (ADA) claim forms to the mailing address or through the electronic payer listed below for the adult dental benefit.

THP will not accept hand-written claims.

NOTE: Claims with supporting documentation require postal mailing.

When submitting imaging, please send copies of current, diagnostic images. **Images will not be returned.**

Mailing address for paper claims, PTE and supporting documentation submission:

The Health Plan
1110 Main Street
Wheeling, WV 26003

Electronic claim submission:

Submit electronic claims through Emdeon - Clearinghouse Payer ID #34150.

Denial codes for exhausted member benefit:

A claim received after the adult member has exhausted their $1,000 yearly dental benefit will have denial code:

- "B" (maximum dental benefit exhausted) displayed on paper payment vouchers OR
- Claim Adjustment Reason Code (CARC): 119 (benefit maximum for this time period or occurrence has been reached) displayed on 835 electronic remittances:

More billing information may be found in The Health Plan's Provider Manual located at healthplan.org "For Providers," "Resources."

References and Research Materials:

West Virginia Medicaid Adult Dental Program Memo. WV Department of Health and Human Resources. Available at: https://dhhr.wv.gov/bms/News/Pages/Attention-Adult-Dental-Program-Providers!-.aspx

Oral Health Services, Provider Manual Chapter 505. West Virginia Department of Health and Human Resources Bureau for Medical Services. Available at: https://dhhr.wv.gov/bms/Pages/Chapter-505-Dental-Services-.aspx

Medicaid Dental Fee Schedule. West Virginia Department of Health and Human Resources Bureau for Medical Services. Available at: https://dhhr.wv.gov/bms/FEES/Pages/Dental-Fee-Schedule.aspx

Disclaimer:

This policy is intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry standard claims editing logic, benefit design and other factors are considered in developing payment policies. This policy is intended to serve as a guideline only and does not constitute medical advice, any guarantee of payment, plan pre-authorization, an explanation of benefits, or a contract. This policy does not govern whether a specific procedure is covered under any specific member plan or policy, nor is it intended to address every claim situation. The determination that any service, procedure, item, etc., is covered under a member's benefit plan shall not be construed as a determination that a provider will be reimbursed for services provided. Individual claims may be affected by other factors, including but not necessarily limited to state and federal laws and regulations, legislative mandates, provider contract terms, and THP's professional judgement. Reimbursement for any services shall be subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Unless otherwise noted within the policy, THP's policies apply to both participating and non-participating providers and facilities. THP reserves the right to review and revise these policies periodically as it deems necessary in its discretion, and it is subject to change or termination at any time by THP. THP has full and final discretionary authority for its interpretation and application. Accordingly, THP may use reasonable discretion in interpreting and applying this policy to health care services provided in any particular case.

All revision dates: 2/18/2021