Table of Contents

Table of Contents ................................................................. 2
Welcome .................................................................................. 7

Contact Information ..................................................................... 8
  MCNA Member Hotline .............................................................. 8
  MCNA Automated Eligibility Verification .................................... 8
  MCNA Provider Hotline .............................................................. 8
  MCNA Credentialing ................................................................. 8
  MCNA Utilization Management (Pre-Authorizations) ..................... 8
  MCNA Provider Portal Helpdesk ............................................... 8
  MCNA Fraud, Waste & Abuse and Compliance Hotlines ............... 8
  MCNA Corporate Headquarters ................................................ 9
  Arkansas Medicaid Administrative Hearing Requests .................. 9
  Arkansas Medicaid ................................................................. 9
  Arkansas Medicaid Health Care Fraud or Abuse ........................... 9

Revision History ......................................................................... 10

Program Overview ....................................................................... 14

Criteria for Network Participation .............................................. 15
  Applicability ........................................................................... 15
  On-Site Office Survey .............................................................. 15
  Credentialing/Re-Credentialing .................................................. 16
  Credentialing Committee Appeals .............................................. 17
  Practice Requirements ............................................................ 17
  Sterilization and Infection Control ............................................. 18
  Medical Emergencies ................................................................ 19

Provider Roles and Responsibilities ............................................ 20
  Provider Rights ....................................................................... 20
  Primary Care Dentist (PCD) Role and Responsibilities .................. 20
  Specialist Role and Responsibilities .......................................... 21
  Medically Necessary Services .................................................. 21
  Preventive Treatment ................................................................ 22

Access Requirements .................................................................. 24
  Availability and Accessibility .................................................... 24
  Missed Appointments ................................................................ 24
  After Hours Standards ............................................................ 24
  Appointments and Access to Care (Therapeutic/Diagnostic and Urgent Care Dental Services) ...... 24
  Suspected Child or Adult Abuse or Neglect ................................. 25
  Dental Records Standards ....................................................... 25
  Access to Dental Records ......................................................... 27
Appeal Rights........................................................................................................... 47
Laws that Govern Fraud and Abuse ......................................................................... 47
Do You Want to Report Waste, Abuse, or Fraud? .................................................. 48

Provider Grievance Process .................................................................................. 50

Utilization Management ......................................................................................... 52
Decision Making Criteria ......................................................................................... 52
Peer-to-Peer Availability ......................................................................................... 53
Clinical Practice Guidelines ..................................................................................... 53
Clinical Decisions ..................................................................................................... 53
Medical-Necessity Denials ....................................................................................... 53

Quality Improvement .............................................................................................. 54
Quality Improvement Program .............................................................................. 54
Your Role in Quality ................................................................................................. 54
Quality Enhancement Programs (Focus Studies) ..................................................... 55
Quality Review of Key Clinical and Service Indicators .......................................... 55
Corrective Action ..................................................................................................... 55
Member Satisfaction Surveys .................................................................................. 56
Provider Satisfaction Surveys .................................................................................. 56
Member Records - Chart Reviews ........................................................................... 56

Member Services .................................................................................................... 57
Discrimination ........................................................................................................... 57
Confidentiality Policy ............................................................................................... 57
Informed Consent Requirements ............................................................................. 57
Cultural Competence ............................................................................................... 58
Reading/Grade Level Consideration ...................................................................... 58
Availability and Coordination of Linguistic Services .............................................. 58
Role of Provider’s Bilingual Staff ........................................................................... 59
Appointment Attendance Concerns ....................................................................... 59
Case Management .................................................................................................... 59

Member Eligibility, Enrollment, disenrollment, and Value-Added Services .......... 60
Arkansas Medicaid Dental Medicaid Program ......................................................... 60
Eligibility .................................................................................................................... 60
MCNA ID Cards ....................................................................................................... 60
Value-Added Services (VAS) .................................................................................. 61

Member Rights and Responsibilities ..................................................................... 62

Member Outreach ................................................................................................... 64

Member Grievance and Appeal Processes .............................................................. 65
What is a Grievance? ................................................................................................. 65
Member Grievance Process ....................................................................................... 65
What is an Informal Reconsideration? .................................................................... 66
Member Informal Reconsideration Process ................................................................. 66
What is a Member Appeal? ......................................................................................... 66
Member Appeal Process ............................................................................................. 67
Member Expedited Appeals ......................................................................................... 67
Member Request for an Administrative Hearing ......................................................... 68

**Member Request for an Administrative Hearing Form** ........................................... 69

**Arkansas Children’s Covered Services** ................................................................ 70
  Initial Dental Screening and Annual Recall Visits ...................................................... 70
  Diagnostic Services .................................................................................................. 71
  Radiographic Images ................................................................................................ 72
  Preventive Services .................................................................................................. 76
  Restorative Services ................................................................................................ 81
  Crowns .................................................................................................................... 85
  Endodontic Therapy Services .................................................................................... 88
  Periodontal Services ................................................................................................. 91
  Removable Prosthodontics ....................................................................................... 93
  Fixed Prosthodontics ............................................................................................... 97
  Oral and Maxillofacial Surgery Services .................................................................. 98
  Orthodontic Services ............................................................................................... 103
  Transfer Cases ........................................................................................................ 106
  HLD Scoring guidelines ........................................................................................... 108
  Adjunctive General Services ................................................................................... 117

**Arkansas Adult Covered Services** ....................................................................... 123
  Initial Dental Screening and Annual Recall Visits .................................................. 123
  Diagnostic Services ................................................................................................ 124
  Radiographic Images ............................................................................................... 125
  Preventive Services ................................................................................................ 128
  Restorative Services ............................................................................................... 130
  Crowns .................................................................................................................... 134
  Periodontal Services ............................................................................................... 135
  Removable Prosthodontics ...................................................................................... 137
  Fixed Prosthodontics ............................................................................................... 142
  Oral and Maxillofacial Surgery Services ................................................................ 143
  Adjunctive General Services ................................................................................. 147

**Department of Human Services Non-Covered Services** ..................................... 149

**Dental Guidelines** ............................................................................................... 150
  Guidelines for Oral Surgery .................................................................................... 150
  Guidelines for Endodontics ..................................................................................... 151
  Guidelines for Non-Intravenous and IV Sedation .................................................... 152
  Guidelines for Crowns ............................................................................................ 153
Welcome

Dear MCNA Provider:

Managed Care of North America (MCNA) would like to take this opportunity to welcome you and your staff as part of our national network of dental providers. We are pleased that you have chosen to participate with us. Throughout your ongoing relationship with MCNA this Provider Manual will give you useful information concerning the MCNA plans in which you have chosen to participate.

MCNA was founded by a group of dentists with extensive backgrounds in the field of dental care and dental plan operations. MCNA’s goal is to provide quality dental services to members and providers. MCNA recognizes the vital role the dental office plays in a successful dental plan. The purpose of this Provider Manual is to provide you with an explanation of MCNA’s administrative policies and procedures, provisions, and the role you play as a dentist.

When communicating with our network providers, we make every effort to be clear and concise. Our expectation is to answer questions promptly when they arise. We strive to provide accurate and effective information that allows you and your dental team to understand which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered and what to expect from MCNA.

MCNA may make additions, deletions, or changes to the policies and procedures described in this Provider Manual at any time and will give providers at least 30 days-notice before implementation. As a participating provider, your agreement requires you to comply with MCNA policies and procedures including those contained in this manual.

If you require assistance or information that is not included within this manual, please contact our Provider Hotline at 1-844-343-6262.

We will communicate changes in MCNA’s policies and procedures as well as state and federal laws to you through the dissemination of provider bulletins.

Again, we welcome you and your staff to the growing list of MCNA providers. We look forward to a successful relationship with you and your practice.

Sincerely,

MCNA Provider Relations Department

For the latest version of this manual in digital form, please access the MCNA Provider Portal at:

http://portal.mcna.net

or visit:

http://manuals.mcna.net/arkansas

to download a PDF version directly.
Contact Information

For the quickest service, please use the contact information listed below. Please note that calls may be recorded for quality assurance purposes.

MCNA Member Hotline
Member Services Representatives are available from 7 a.m. – 7 p.m. CST, Monday – Friday, excluding national holidays.

Main: 1-844-341-MCNA (1-844-341-6262)
TDD/TTY: 1-800-285-1131

MCNA Automated Eligibility Verification
Our Automated Member Eligibility Hotline is available 24 hours a day, 7 days a week.

Main: 1-844-341-MCNA (1-844-341-6262) option 8
Online: http://portal.mcna.net

MCNA Provider Hotline
Provider Services Representatives are available from 7 a.m. – 7 p.m. CST, Monday – Friday, excluding national holidays.

Main: 1-844-343-MCNA (1-844-343-6262)
eFax: 1-877-563-8560

MCNA Credentialing
Main: 1-844-343-MCNA (1-844-343-6262)
Main Fax: 1-954-730-7131

MCNA Utilization Management (Pre-Authorizations)
Main: 1-844-343-MCNA (1-844-343-6262)
eFax: 1-954-628-3331 (Not for pre-authorization submissions.)
Email: um_ar@mcna.net
(For questions and status updates only, not for pre-authorization/referral submissions.)

MCNA Provider Portal Helpdesk

MCNA Fraud, Waste & Abuse and Compliance Hotlines
Fraud, Waste, and Abuse: 1-855-FWA-MCNA (1-855-392-6262)
Compliance: 1-855-683-MCNA (1-855-683-6262)
MCNA Corporate Headquarters
When sending mail to a specific department, please address it to the attention of that department.

Main: 1-800-494-MCNA (1-800-494-6262)
Main Fax: 1-954-730-7875
Online: http://www.mcna.net
Mailing Address: MCNA Dental
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

Arkansas Medicaid Administrative Hearing Requests
For Administrative Hearing requests.

Phone: 1-501-682-8622
Fax: 1-501-404-4628
Mailing Address: DHS Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437
Web: http://humanservices.arkansas.gov

Arkansas Medicaid
For general Medicaid, Eligibility, ID card and benefits questions.

Main: 1-800-482-8988
Online: https://www.medicaid.state.ar.us/Provider/Provider.aspx

Mailing Address: Arkansas Division of Medical Services
Department of Human Services
Donaghey Plaza South
P. O. Box 1437, Slot S401
Little Rock, Arkansas 72203-1437

Arkansas Medicaid Health Care Fraud or Abuse

Main: 1-501-682-8349
Hotline: 1-855-527-6644
Online: https://omig.arkansas.gov

Mailing Address: Office of the Medicaid Inspector General
323 Center Street, Suite 1200
Little Rock, Arkansas 72201
## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Revision Information</th>
</tr>
</thead>
</table>
| 1.8     | 8/1/2019 | - Added narrative for post-authorization option  
- Clarify D0140 language and benefit (children’s plan & adult’s plan)  
- Revise D0240 claim requirements (children’s plan)  
- Revise D0272/0274 benefit limits for children’s plan  
- Revise children’s plan prophylactic benefit  
- Allow D1206/D1208 on same DOS as any covered D4XXX service (children’s plan & adult’s plan)  
- Clarification of smoking cessation requirements (children’s plan & adult’s plan) (D1320 & D9920)  
- Revised coverage for restorations to the same and other surfaces on the same tooth by the same provider, office, group or by a different provider, office or group (children’s plan & adult’s plan)  
- Allow amalgam restorations on anterior teeth in some cases  
- Remove requirement for a post-op x-ray/photo for SSCs D2930/D2931 (children’s plan & adult’s plan)  
- Add partial coverage in the event that a crown cannot be delivered after the process has started due to loss of eligibility, if a member moves, or due to loss of contact with the member or the member’s refusal to return to complete the service (children’s plan)  
- Allow prior-authorization of D4341/D4355 for adults at the provider’s option instead of requiring post-payment review  
- Revise partial dentures qualifier for adults to match the children’s program qualifier  
- Revise our requirement for x-rays with D7111  
- Clarify language on D7241 for children; pre-authorization vs pre-payment review  
- Allow pre-authorization on 7xxx series codes for adults (adult’s plan) with the exception of D7241  
- Clarify ortho claims process in the event of loss of member eligibility  
- Revise D8xxx habit appliance-related benefit rules  
- Clarify payment policy on ortho records when services are not approved or provided  
- Revise MCNA Request for Orthodontic Treatment HLD Scoring Form  
- Clarify ortho transfer policy  
- Remove CHIP copay on certain ortho services  
- Clarify requirement to use ADA nomenclature on claims  
- Clarify prior authorization process when an office transfers ownership  |
| 1.7     | 03/2019  | - Revised fees for select CDT codes (full and partial dentures) in the Adult Plan (ages 21+):  
  - D5110, D5120, D5211, D5212, D5225, D5226 |
### 1.6 12/2018
- Added reference to AR Pregnant women’s benefit.
- Standardized 175-day limit for children’s preventive services.
- Clarified allowed usage for D0150.
- Clarified required documentation for D0240.
- Added D0274 as a billable code.
- Deleted D1515, D1525 & added D1516, D1517, D1526, D1527 to reflect 2019 CDT code set changes.
- Added D2740 as a billable code for children.
- Revised limits for D2752 to match AR FFS dental benefit.
- Revised prior authorization requirement for D2931
- Noted coverage for pre-op x-ray on the DOS of Endodontic service.
- Revised D4341 & D4355 to allow other services to be performed on the same DOS to match AR FFS program.
- Clarified provider’s responsibility to cover a 1-year warranty on dentures.
- Added new dentures codes: D5225, D5226, D5421, D5422, D5740, & D5741.
- Removed pre-authorization and anesthesia record submission requirements for oral surgeons when two (2) or less units of general anesthesia (D9222, D9223) are administered.

### 1.5 09/2018
- Updated information about the recredentialing process.
- Updated language for both Children and Adult plans on the following codes: D7140, D0220, D0230, D0240, D0250, and D0272.
- Updated reimbursement process for comprehensive orthodontic services.

### 1.4 06/2018
- Updated Forms section.

### 1.3 03/2018
- Added D5511 & D5512 (Repairs to Partial Dentures) for both Children and Adult plans.
- Removed referrals to specialist process
- Updated language for both Children and Adult plans on the following codes: D0140, D0210, D0220, D0230, D0240, D0250, D0330, D1320, and D9920
- Added back pre-authorization requirement for D1515.
- Added back pre-authorization for D2950
- Added language under D9222 and D9223
- Corrected last bullet language under the Guidelines for Oral Surgery

### Updates to the Children’s Plan:
- Removed requirements for submission of x-rays when a restoration or pulpotomy is performed during the exfoliation period on a primary tooth
- Added missing TID requirement to rationale for partial denture codes rationale requirement for D5211 and D5212
<table>
<thead>
<tr>
<th>1.2</th>
<th>01/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added Forms section, and the following:</td>
<td></td>
</tr>
</tbody>
</table>

**Updates to the Adult Plan:**
- Added missing TID requirement to rationale for partial denture codes rationale requirement for D5211 and D5212
- Removed D7250 from the $500 annual limit
- Updated D7473 from (1) to (2) units per lifetime
- Removed D7250 from the $500 annual limit
- Updated D7473 from (1) to (2) units per lifetime

**Updates to the Children’s Plan:**
- Added referrals to specialist process
- Removed rationale requirement for D0140
- Added benefit limits to D0190
- Removed TID requirement for D0220 and D0230
- Removed arch requirement for D0240 and for dentures
- Updated information about crown services
- Added benefit limits for D2934
- Removed pre-authorization requirements for denture repairs and relines
- Updated required TID numbers for D2330-D2335
- Updated language for D9248

**Updates to the Adult Plan:**
- Removed rationale requirement for D0140
- Removed TID requirement for D0220 and D0230
- Corrected frequency for D1110 and D1120
- Updated required TID numbers for D2330-D2335
- Updated information about crown services
- Added language for D4346 and updated language for D4910
- Updated language and removed pre-authorization requirement for D4341
- Added pre-authorization requirement for D5110 and D5120
- Updated information about dentures (Complete and Partial)
- Removed rationale for D5410 and D5411
- Removed pre-authorization requirement for D5640 and D5650
- Added rationale for D5730 and D5731
- Removed pre-authorization requirement for D6930
- Removed pre-authorization requirement for D7210-D7510

| 1.1  | 01/2018 | Added D0150, D1550, D2391-D2394, D2934, D2950, D4355, D5611, D5612, D7283, D8010-D8040, D8050-D8060 for children. Added D0150, D2391-D2394 for adults. Effective 1/1/2018 the following codes were replaced and/or changed:
- D5610 was replaced with D5611 and D5612
- D5620 was replaced with D5621 and D5622
- Added D9222 for the first 15 minutes of sedation |

| 1.0  | 12/2017 | Initial version. |
Program Overview

Dental programs are governed by regulations found in the Code of Federal Regulations 42CFR 440.40 and 42CFR 440.50, and 42CFR 440.100 that describe the services available through the Arkansas Medicaid Dental Program. The Arkansas Medicaid Dental Program covers dental services for members under the age of 21 (ARKids A and ARKids B) and also has limited coverage for members age 21 and older.
Criteria for Network Participation

All contracted providers must enroll with Arkansas Medicaid as an approved service provider. The Dentist Participation Criteria lists a variety of requirements that a participating provider must meet. These requirements include standards regarding the physical attributes of the dental office, practice coverage, member access, office procedures, member dental records, insurance and professional qualifications, and staff work history. The criteria are used in our credentialing and re-credentialing process and a full listing is attached to our current Provider Agreement.

Applicability

The participation criteria apply to each new applicant for participation in MCNA’s network, and to all providers currently participating. They shall be enforced by MCNA as required by the Arkansas Medicaid Dental Program. Any provider applying to join MCNA’s network must be licensed and must adhere to the Arkansas State Board of Dental Examiners requirements concerning the delivery of dental services.

An applicant who was not previously enrolled with Arkansas Medicaid must satisfactorily document evidence meeting MCNA’s credentialing criteria and must be approved for participation by the Credentialing Committee prior to being able to be compensated for services provided to MCNA members. A provider’s effective date in MCNA’s network is determined based on applicable CMS and AR Medicaid guidelines. In order to qualify for payment, dates of service must be after the provider’s effective date in MCNA’s network.

The following additional requirements for continued participation in MCNA’s network apply to all participating providers:

- All MCNA participating providers in a group practice must meet MCNA credentialing criteria. If one or more of the providers in the group fail to meet the criteria, the entire group cannot participate.
- All MCNA participating providers must be credentialed, execute a Provider Agreement, and agree to provide all services to Arkansas Medicaid Dental Program members as set forth by the Arkansas Medicaid Dental Program. Providers who offer only diagnostic and preventive services do not meet the necessary criteria for participation.
- All MCNA participating providers must apply for re-credentialing every three (3) years.

On-Site Office Survey

On-site office surveys are conducted on an ongoing basis for participating offices. All participating providers within MCNA’s network are required to participate in an on-site office survey. These surveys focus on essential areas of office management and dental care delivery. During the survey, which may or may not be scheduled in advance, the following areas are evaluated:

- **General Information** – the name of the practice, address, name of principal owner and all associates, license numbers, staffing information, office hours, list of languages other than English spoken or signed in the office, availability of appointments, method of providing 24-hour coverage (e.g., answering machine or answering services), and the name of the covering dentist when a provider is unavailable (e.g., office closed or provider on vacation).
- **Practice History** – information regarding malpractice suits, settlements, and disciplinary actions, if applicable.
- **Office Profile** – overview of services routinely performed.
- **Office Information** – description of location, accessibility (including handicap accessibility), interior office and the reception area, operatories and lab, type of infection control, general equipment, and radiographic equipment.
- **Risk Management** – review of personal protective equipment (e.g., gloves, masks, equipment to handle waste disposal, equipment and methods to handle sterilization and disinfection), training programs for staff, radiographic procedures and safety, occupational hazard control regarding amalgam, nitrous oxide, and hazardous chemicals, and medical emergency preparedness training and equipment.
- **Recall System** – review of procedures for assuring members are scheduled for recall examinations and follow-up treatment.
- **Provider Credentials** – verification that all MCNA participating dental providers in a group practice are credentialled by MCNA.

**Credentialing/Re-Credentialing**

Credentialing is the review of qualifications and other relevant information pertaining to a dental care professional who seeks acceptance into MCNA’s provider network. Our Credentialing Program follows the recommended CMS categories, which include:

- **Initial Credentialing** – written application, verification of information from primary and secondary sources, confirmation of eligibility for payment under Medicaid and site visits, as appropriate.
- **Monitoring** – monitoring of lists of practitioners who have been sanctioned and/or had grievances filed against them, and of practitioners who opt-out of accepting federal reimbursement from Medicaid. Monitoring is conducted on a regular basis between credentialing and re-credentialing cycles.
- **Re-credentialing** – re-evaluation of provider’s credentials at least once every three (3) years through a process that updates the information obtained during initial credentialing. Re-credentialing considers performance indicators such as those collected through the Quality Improvement (QI) Program, the Utilization Management system, the Grievance system, member satisfaction surveys, and other activities of the organization. In addition, MCNA confirms that each Network Provider meets all criteria required for Arkansas Medicaid enrollment.

Following initial credentialing with MCNA, we will no longer send out re-credentialing letters from the Credentialing Committee to our network providers who are approved during their re-credentialing cycles. If you have any questions regarding re-credentialing with MCNA, please call our Provider Hotline at 1-844-343-6262 (7 a.m. to 7 p.m., central time, Monday through Friday).

Additionally, MCNA will:

- Verify licenses through the appropriate licensing agency
- Review state and federal sanction activity including Medicare/Medicaid services (Attorney General and State Medicaid Agencies)
- Review monthly reports released by the Attorney General and local Medicaid Agencies for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

All providers are required to complete the Dental Credentialing Form and Dental Re-Credentialing form.

MCNA’s Credentialing Program establishes the selection criteria for qualification as a participating provider. The criteria are reviewed and approved by the Credentialing Committee. The full set of criteria is clearly outlined by the credentialing application.
Additionally, current copies of the following documents must be attached to an application for initial credentialing as well as for re-credentialing. These documents are required as components of the selection criteria and will be verified through primary and secondary sources.

- Dental License
- National Provider Identifier (NPI)
- Controlled Substance Registration Certificate from the Drug Enforcement Agency (DEA)
- Professional Liability Insurance Face Sheet
- Work History
- Board Certificate or Evidence of Adequate Training
- Completed W-9 Form
- Signed Provider Agreement/Contract
- Signed Provider Application

It is the provider’s responsibility to submit any renewal certification documentation or changes in information to MCNA within 10 business days of any change. MCNA encourages all eligible providers to seek applicable Board Certification.

MCNA will send a letter to a provider with a license nearing expiration, according to the most current information received from the provider.

**Credentialing Committee Appeals**

In the event an applicant is credentialed with restrictions or denied, the Credentialing Committee offers an opportunity to appeal. An appeal must be requested in writing and must be reviewed by the committee within 30 days of the date the committee gave notice of its decision.

A copy of MCNA’s credentialing policies can be obtained by contacting the Credentialing Department.

**Practice Requirements**

Each dentist’s office must:

- Have a sign containing the names of all dentists practicing at the office that is visible at all times the office is open.
- Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
- Be accessible to all members in all areas, including but not limited to, the entrance, parking, and bathroom facilities.
- Have offices that are clean, presentable, and professional in appearance.
- Be a non-smoking office and have a no-smoking sign prominently displayed in the waiting room.
- Have clean and properly equipped non-staff toilet and hand-washing facilities.
- Have a waiting room that will accommodate at least four (4) members.
- Have treatment rooms that are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
- Have at least one (1) staff person (in addition to the provider) on duty during normal office hours.
• Provide a copy of current licenses and certificates for all providers, dental hygienists, and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement Agency, and State Controlled Drug Substance licenses and certification (where applicable).

• Keep a file and make available to MCNA any state-required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.

• Have appropriate, safe x-ray equipment. Radiation protection devices including, but not limited to, lead aprons which shall be available and used according to professionally recognized guidelines, such as Food and Drug Administration guidelines. Signs warning pregnant women of potential exposure must be prominently displayed.

• Use gloves, disposable needles and appropriate sterilization procedures for instruments. All staff shall maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state, and local laws and regulations including, but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (ADA) and state and local societies.

• Comply with all applicable federal, state, and local laws and regulations regarding the handling of sharp and environmental waste, including the disposal of waste and solutions.

• Make appointments in an appointment book or the electronic equivalent accepted by MCNA. Appointments should be made in a manner that will prevent undue member waiting time and in compliance with the access criteria listed in this manual.

• Have documented emergency procedures, including procedures addressing treatment, evacuation, and transportation plans to provide for the safety of members.

• Upon request, provide members with the MCNA Member Hotline number to receive a copy of their rights and responsibilities as listed in the Member Handbook.

• Provide translation assistance services to any member whose native language is other than English.

• Have a functional recall system in place to notify members of the need to schedule dental appointments. The recall system must meet the following requirements for all enrolled members:
  1. The system must include either written or verbal notification
  2. The system must have procedures for scheduling and notifying members of routine checkups, follow-up appointments, and cleaning appointments
  3. The system must have procedures for the follow-up and rescheduling of missed appointments

MCNA encourages its providers to attempt to decrease the number of “no shows.” Provider offices should contact the member prior to a scheduled appointment either by voice, text, mail or email to remind them of the time and place of the appointment. Follow-up communication should be provided to encourage the member to reschedule the appointment in the event the appointment is missed.

Sterilization and Infection Control
Members and all office staff must be protected from infectious and environmental contaminants. The following OSHA requirements must be met, without exception:

• All personnel should wash with anti-bacterial soap before all oral procedures.
• Dental gloves, facemask, and eye protection should be worn.
• All debris should be removed from instruments before sterilization.
• All instruments and equipment that cannot be sterilized, including operating light chair switches, hand pieces, cabinet working surfaces, and water/air syringes and their tips, should be disinfected, using approved techniques, after each use.
• ADA-approved sterilization solutions should be utilized.
• All equipment should be monitored using process indicators with each load and spore testing on a weekly basis. A record of this activity should be maintained and available upon request.
• Handling of all environmental waste, including the disposal of waste and solutions, must be completed in compliance with all applicable federal, state, and local laws and regulations.

Medical Emergencies
All office staff shall be prepared to deal with any medical emergency through the implementation of the following guidelines:

• The provider and at least one other staff member must be currently certified in CPR procedures.
• The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. All emergency numbers must be posted.
• Members with medical risk shall be identified in advance.
• All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff, and stethoscope.
Provider Roles and Responsibilities

Provider Rights
Each MCNA contracted provider that furnishes services to MCNA members shall be assured of the following rights:

1. A dental provider, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
   1. Member health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   2. Any information the member needs in order to decide between all relevant treatment options
   3. The risks, benefits, and consequences of treatment or non-treatment
   4. Member right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

2. The right to receive information on the Complaints, Grievances, Appeals and Administrative Hearing procedures.

3. The right to access MCNA’s policies and procedures covering the authorization of services.

4. The right to be notified of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested

5. The right to challenge, at the request of an Arkansas Medicaid Dental member and on their behalf, the denial of coverage of, or payment for, medical assistance.

6. The right to be free from discrimination with regard to MCNA’s provider selection policies and procedures based on a provider’s service to high-risk populations or specialization in conditions that require costly treatment.

7. The right to be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

Primary Care Dentist (PCD) Role and Responsibilities
Arkansas defines a Primary Care Dentist as the dentist who is the principal Dental Services provider for a member and responsible for coordinating and integrating the member's dental services. Establishment of a member’s Primary Care Dentist begins no later than six (6) months of age and includes referrals to dental specialists for members when appropriate.

Arkansas defines primary dental services as dental services and laboratory services customarily furnished by or through a Primary Care Dentist for the evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures. Primary dental services should be delivered through direct service to the member when possible or through the appropriate referral to specialists and/or ancillary providers.

MCNA must develop a network of Primary Care Dentists consisting of general or pediatric dentists that practice in solo or group practices. Primary Care Dentists may also practice in a clinic (Federally Qualified Health Centers or Rural Health Care Clinics). They provide preventive care to members and complete referrals for specialty care as needed. When an ARKids member or an adult member does not select a Primary Care Dentist, DentalTrac™ will
auto-assign to a Primary Care Dentist (general dentist or pediatric specialist) based on the following considerations:

- Providers who are not in good standing are not considered during the auto-assignment methodology.
- MCNA strives to keep families together. If a member of a family is assigned to a PCD, other members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family member from being assigned, we will assign that family member to another PCD in the same office that meets the age restrictions if possible.
- If there is historical claims data that identifies a dentist that performed dental services on the member, we will assign the member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the member.
- For each member that needs to be auto-assigned to a PCD, we will generate a pool of participating PCDs that meet the age restrictions of the member who are located near the member’s residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan. Once a pool of providers is generated, members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence in order to equalize the patient load amongst providers within such radius.

Arkansas Medicaid Dental program participating providers must offer the same services to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, participating providers have the responsibility to develop a provider-member relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member and provider and is a critical tool for achieving positive oral health outcomes.

Primary Care Dentists must assess the dental needs of members for referral to specialty care providers and complete referrals as needed. Primary Care Dentists are responsible for coordinating care with specialty providers after referral.

**Specialist Role and Responsibilities**

The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Pediatric Dentist, Periodontist, and Prosthodontist) is to provide covered services to members for medically necessary treatment. Once treatment is complete, the specialist discharges the member back to their Primary Care Dentist for follow-up. MCNA allows Pediatric Dentists to serve as Primary Care Dentists for our pediatric members.

**Medically Necessary Services**

Medically necessary services are those healthcare services that are delivered in accordance with generally accepted, evidence-based medical standards, or are considered by most dentists (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction.
- Those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the member.
Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. They may be neither more nor less than what the member requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.”

**Preventive Treatment**

Arkansas Medicaid Dental Program members should be encouraged to return for a recall visit as frequently as indicated by their individual oral health status and within plan time parameters. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride, if indicated
- Sealant application, if indicated

Please refer to the American Academy of Pediatric Dentistry’s recommendations for treatment of pediatric patients by age below for further guidance.
Arkansas Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

http://www.aapd.org/assets/1/7/Periodicity-AAPDSchedule.pdf

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

<table>
<thead>
<tr>
<th>Age</th>
<th>6 to 12 Months</th>
<th>12 to 24 Months</th>
<th>2 to 6 Years</th>
<th>6 to 12 Years</th>
<th>12 Years and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral examination</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assess oral growth and development</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Caries-risk assessment</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Radiographic assessment</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Fluoride supplementation</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Oral hygiene counseling</td>
<td>Parent</td>
<td>Parent</td>
<td>Patient/parent</td>
<td>Patient/parent</td>
<td>Patient</td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Injury prevention counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for nonnutritive habits</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Counseling for intraoral/interoral piercing</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 18 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk, then with sports and routine playing, including the importance of mouth guards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as trigeminal biting, clenching, or bruxism.
Access Requirements

Availability and Accessibility
Providers must provide the same availability to MCNA members as is done for all other patients as stated in the MCNA Provider Agreement.

Appropriate access to care is an essential part of MCNA's Quality Improvement Program. Access to care is monitored by the Provider Relations Department. Periodically, a written inquiry or phone call may be generated by a Provider Relations Representative to obtain information concerning the next available appointment.

Any dental provider who serves MCNA members, including a provider who delivers services at locations other than his or her physical office location such as school based or mobile dental services, shall demonstrate to the satisfaction of MCNA that he or she has the requisite skill and facilities to deliver comprehensive care to MCNA members. Comprehensive care means that the provider or group must provide all of the covered restorative and therapeutic services described in this Provider Manual. Programs that are sealant only or preventive only will not be permitted.

Providers should be familiar with additional Arkansas State Board of Dental Examiners requirements concerning the delivery of dental services in locations other than private offices.

Missed Appointments
Providers cannot charge members for missed or failed appointments. For assistance with members who routinely break appointments, please use the Member Outreach Form located at the end of this manual.

After Hours Standards
When a provider’s office is closed the office should have an answering service or answering machine that offers the following information:

- Instructions for contacting someone who can render clinical decisions or someone who can reach a dentist for clinical decisions
- Instructions for emergency services (including directing the member to dial 9-1-1 if necessary)
- List of the office hours
- Instructions for the caller to leave a message so that someone can return their call

The answering service or machine must also offer all of the information listed above in any additional languages based on cultural population.

Appointments and Access to Care (Therapeutic/Diagnostic and Urgent Care Dental Services)
The Provider Agreement outlines appointment availability standards. These standards are monitored through the Quality Improvement Program:

- **Urgent care** – defined as dental care that is necessary due to a dental condition, which, after applying the prevailing dental standards of judgment and practice within the community, would require immediate dental intervention. Conditions needing urgent dental care include, but are not limited to, significant oral
or dental pain, suspected or obvious infection, or oral or dental trauma. It must be provided within 48 hours of request. Urgent care with MCNA in-network providers does not require pre-authorization.

- **Non-urgent, specialty care** – must be provided within 60 calendar days of authorization.
- **Therapeutic and diagnostic care** – must be provided within 14 calendar days of request.
- **Emergent care** – must be provided within 24 hours and does not require an appointment or pre-authorization.

Primary Care Dentists **must** make referrals for specialty care on a timely basis, based on the urgency of the member’s dental condition, but no later than 30 calendar days.

### Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations. Abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is also an act of omission.

If suspected cases are discovered, a verbal report should immediately be made by telephone or other means to law enforcement. Reports of suspected cases of abuse or neglect can also be made by calling the MCNA Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262).

### Dental Records Standards

State law and Medicaid regulations require that all services provided under the Arkansas Medicaid Dental Program are documented. **Services not adequately documented are considered not to have been delivered.** Providers are required to maintain radiographs and treatment records that should reflect all procedures performed during all appointments. MCNA dentists must ensure that dental records are maintained for each member enrolled. The record shall include the quality, quantity, appropriateness, and timeliness of services performed as described by the remainder of this section of the manual.

All documentation, radiographs, and/or records must be maintained for at least seven (7) years after the last good, service, or supply has been provided to a member or an authorized agent of the state or federal government, or any of its authorized agents, unless those records are subject to review, audit, investigations, or subject to an administrative or judicial action brought by or on behalf of the state or federal government. It is strongly suggested that the provider maintain records for at least seven (7) years as the program allows for the provision of prosthetics once every seven (7) years. Failure to produce these records upon demand for the Medicaid program or MCNA will result in sanctions against the provider.

Records must include a detailed charting of the oral condition that is updated on each visit and a chronological (dated) narrative account of each appointment indicating what services were provided or what conditions were present during those visits. Providers should also include in the member’s treatment record copies of all pre-authorization requests (including any attachments), all pre-authorization letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, treatment consent forms, and sedation logs are examples of additional supporting documentation.

A checklist of codes and services billed is insufficient documentation. The claim forms or copies of the claim forms submitted for reimbursement are not considered sufficient to document the delivery of services; however, these items must also be maintained in the member’s treatment record.
The following dental record standards must be followed for each member’s record as appropriate.

Providers shall ensure dental records are:

- Safeguarded against loss, destruction, or unauthorized use and are maintained, in an organized fashion, for all members evaluated or treated, and are accessible for review and audit.
- Readily available for review and provide dental and other clinical data required for Quality and Utilization Management review.

MCNA shall ensure each member’s dental record includes, minimally, the following:

- All pages contain member name and/or member ID.
- Biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
- Documentation of the member’s race and primary language.
- Documentation of vital signs (blood pressure and pulse) if member is 13 years of age or older.
- All necessary forms completed, signed, and present in the record. This includes procedure/treatment consent, incident reports, pre-authorization, member outreach, non-covered services, and criteria for dental therapy under General Anesthesia forms.
- Current medical and dental history (including illness, medical conditions, psychological health, and substance abuse documentation) beginning with, at a minimum, the first member visit to the dental office.
- Documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
- Identification and history of nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
- Documentation of medication list and/or prescribed therapies including medication strength, directions, dose, and the amount and number of refills given.
- Progress notes, lab results, and imaging studies.
- Documentation of written denials for service and the reason for those denials.
- Documentation of imaging reports, initialed by the provider to indicate they have been reviewed.
- Documentation of allergies (e.g., medications or latex) and all known adverse reactions. If no allergies are known, “NKA” or “NKDA” is clearly indicated.
- Documentation of advance directives, as appropriate.
- Indication of the chief complaint or purpose of each visit, objective findings, diagnosis, and proposed treatment.
- The record is legible, accurate, and maintained in detail. (Staff can read the record)
- All entries dated and signed by the provider who rendered services, including credentials (DDS, DMD, RDH).
- Documentation of all dental examinations.
- Documentation of emergency and/or after-hours encounters, as well as follow-up for emergency services.
- Documentation of working diagnosis consistent with clinical findings and treatment plan.
- Documentation of schedule for return visit(s) following the AAPD Periodicity Schedule.
- Documentation that unresolved problems from previous visits achieve resolution. This includes diagnostic tests, referral forms and the outcomes of referrals.
- Evidence of appropriateness and timeliness of care.
- Documentation of outcomes of studies and evidence that they were appropriately ordered.
• Documentation of any known member comments/dissatisfaction.
• Documentation of service site.
• Documentation of each visit, which must include:
  1. Date and beginning/ending times of service
  2. Chief complaint or purpose of the visit
  3. Diagnoses or dental impression
  4. Objective findings
  5. Member assessment findings
  6. Studies ordered and results of those studies (e.g. laboratory, x-ray)
  7. Medications prescribed
  8. Health education provided
  9. Name and credentials of the provider rendering services (e.g., DDS) and the signature or initials of that provider (initials of providers must be identified with correlating signatures)

Access to Dental Records
As an MCNA participating provider, you are required to ensure that an accurate and complete member dental record is established and maintained. On-site access to these dental records must be made available to MCNA’s authorized personnel, its designated representatives, review organizations, and government agencies during regular business hours. If requested, you must provide MCNA with member dental records according to timelines, definitions, formats, and instructions specified by MCNA.

A request from MCNA may be for any information required under the Provider Agreement including, but not limited to, dental records, reports, and other information related to the performance of your obligations under the agreement. You are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider Agreement and any records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- MCNA-authorized personnel
- State of Arkansas and/or federal regulatory agencies
- DHS-authorized personnel

You must also provide access to the location or office where such records, books, documents, and papers are maintained, along with the furnishings, equipment, and other conveniences necessary to fulfill any of the following described purposes within reasonable comfort:

- Audits and investigations
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose MCNA deems necessary for contract enforcement or to perform our regulatory functions.

Transfer of Dental Records
MCNA recommends that your office request that all new members authorize the release of their dental records to you from the practitioner(s) who treated them prior to visiting your office.
There will be no charge for the copying of charts and/or radiographs subject to Arkansas requirements and MCNA policies. All copies must be provided to the MCNA member within five (5) days of their request per MCNA’s Provider Agreement.

**The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)**

As a health care provider, your office is a covered entity as defined under HIPAA. Your office is required to comply with all aspects of the HIPAA regulations and rules that are in effect or that will go into effect as indicated in the final publications of HIPAA rules.

MCNA is a covered entity and has taken the required steps to become compliant with all aspects of the HIPAA rules and regulations. The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form of media, whether electronic, paper, or verbal. The Privacy Rule calls this information protected health information (PHI), and the requirements apply to both electronic medical records and paper medical records.

Individually identifiable health information is information, including demographic data that relates to:

- The individual’s past, present, or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual

This is any information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information (IIHI) includes many common identifiers (e.g., name, address, birth date, Social Security number).

A central component of the Privacy Rule is the principle of “minimum necessary” use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances:

- Disclosure to or a request by a healthcare provider for treatment
- Disclosure to an individual who is the subject of the information, or the individual’s personal representative
- Use or disclosure made pursuant to an authorization
- Disclosure to DHS for complaint investigation, compliance review, or enforcement
- Use or disclosure that is required by law
- Use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules
Because dental records are legal documents, providers should be familiar with additional Arkansas State Board of Dental Examiners requirements in the area of record keeping and of delivery of dental services in locations other than private offices.

**Provider Information Updates**

It is important to keep MCNA informed of all information updates for your office. Providers are required to submit in writing the following information and provider changes to both MCNA and DHS:

- Immediate notification of changes in license status, board actions, practice address or name, DBA name, and tax ID
- Immediate notification of the decision to remove a treating dentist from practice
- Notification as soon as known to the practice (a minimum of three (3) to four (4) weeks) prior to the addition of a new treating dentist (All dentists must be credentialed with MCNA prior to treating MCNA members)
- Notification 90 days prior to termination of participating provider from MCNA network to allow for continuity of care coordination

Please send updated provider information to MCNA at this address:

**MCNA Dental**
Attn: Provider Enrollment
P.O. Box 29008
San Antonio, Texas 78229

**Phone:** 1-844-343-6262

**Termination of Dental Contract**

MCNA may terminate a provider from the network for any misrepresentation(s) made on his/her credentialing application. Causes for termination with a 90-day notice include, but are not limited to:

- Failure to meet participating criteria
- Failure to provide requested dental records

Causes for immediate termination include, but are not limited to:

- Expulsion from, discipline by, or being barred from participation in any state Medicaid program
- Loss or suspension of the provider’s professional liability coverage
- Failure to satisfy any or all of the credentialing requirements of MCNA
- Failure to cooperate with or abide by MCNA’s Quality Improvement Program
- Commission of one or more acts of fraud in connection with the provision of dental services
- Conduct injurious to MCNA’s business reputation

Providers who wish to terminate participation with MCNA must provide a 90-day notice of termination in writing mailed with a certified return receipt that includes the final termination date.
When a provider’s pending termination is identified, we will contact all members currently assigned to that provider and assist them with finding a new dentist (general dentist or pediatric specialist) based on the following considerations:

- A participating dental provider within the same group practice and at the same office location, if possible
- A participating dental provider closest to the member’s geographic location
Verification of Eligibility

Member eligibility varies by day. Therefore, each participating provider is responsible for verifying member eligibility with MCNA before providing services.

Eligibility can be verified 24 hours a day, 7 days a week via the following methods:

- Electronically through MCNA’s online Provider Portal
- By calling the MCNA Provider Hotline at 1-844-343-6262, option 8
- By calling the MCNA Member Hotline at 1-844-341-6262

You should verify member eligibility before providing any services. MCNA strongly recommends using our Provider Portal to easily and quickly verify all member eligibility. Access your Provider Portal account at http://portal.mcna.net.

Please note that due to possible retroactive eligibility status changes, the information provided does not guarantee payment.
Copayments

Medicaid and ARKids First-A
There are no copayments or cost sharing requirements for the Medicaid Program.

ARKids First-B (CHIP)
Members may have responsibility for a copayment per dental visit based on the CHIP Cost Sharing Requirements that are effective on their date of treatment. Federal law prohibits charging premiums, deductibles, coinsurance, copayments or any other cost sharing to CHIP members that are Native Americans or Alaskan Natives.

Benefit Limits

Adult Members 21 and older have an annual benefit limit of up to $500 a year for limited dental care, from January 1 to December 31.
Referrals

Second Opinion
The provider should discuss all aspects of a member’s treatment plan with the member and parent/guardian prior to beginning treatment. Second-opinion provider visits are covered services, subject to all other benefit coverages and limitations. A referral from the initial provider is not required in order for a member to obtain a second opinion. The member must tell the provider it is for a second opinion.

If no appropriate provider is available within the network to provide the second opinion, the member should be encouraged to call our Member Hotline for assistance.

Out-of-Network Referrals

General Dental Care
If there are no contracted MCNA network general dentists or pediatric dentists available to treat MCNA members within a geographic area, MCNA will process an out-of-network referral. We will initiate the process with select dentists in the area and advise them of the guidelines for payment. All out-of-network treatment must be pre-authorized unless for emergency treatment services.

Specialty Care
If a required service is not available within the MCNA provider network, the member’s dentist may request an out-of-network referral. However, the provider must obtain a pre-authorization from the MCNA Utilization Management Department. They will provide the necessary guidance on a case-by-case basis to ensure that all necessary pre-authorizations and agreements are provided and successfully complete the process.

Reimbursements made for the examination, prophylaxis, bitewing radiographs, and/or fluoride to providers who routinely refer members for restorative, surgical, and other treatment services are subject to recoupment. Please contact MCNA’s Utilization Management Department if you have questions.
Pre-Authorization of Care

We recommend using our Provider Portal (http://portal.mcna.net) to easily and quickly submit your pre-authorization requests. Pre-authorization requests will be processed by MCNA within the shorter of two (2) business days after receiving the required documentation or seven (7) calendar days from the date of request. Urgent/expedited pre-authorization requests will be processed within 72 hours of receipt by MCNA.

MCNA's utilization management criteria incorporate components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed. Pre-authorization requests are reviewed against MCNA-approved criteria.

MCNA uses EPSDT medical necessity criteria in accordance with the periodicity standards of the AAPD in order to meet the EPSDT standard for Medicaid members under the age of 21. We ensure that all medically necessary dental services that are administered by or under the direct supervision of a licensed dentist are provided to children who are eligible for EPSDT services.

Failure to submit a request for pre-authorization and supporting documentation will result in non-payment to the provider for services that require pre-authorization. Per the Dental Provider Agreement, the provider must hold MCNA, the member, and the state harmless if coverage is denied for failure to obtain pre-authorization, whether before or after service is rendered.

In addition to submitting pre-authorization requests electronically through the MCNA Provider Portal, providers may submit them through Change Healthcare (formerly EMDEON) using the MCNA Payor ID 65030 or by mail.

Providers may send a completed paper ADA Claim Form (2012 or newer) to:

MCNA Dental
Attn: UM Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

Approved pre-authorization requests to include pre-authorizations for orthodontic treatment are valid for 180 days from the date of approval. If orthodontic treatment does not begin within the valid 180-day period of the approved pre-authorization, the case must be resubmitted. Once a determination is made, the authorization is immediately available to view on the Provider Portal. MCNA's Utilization Management Department staff will mail the authorization letter to those providers not utilizing the Provider Portal within one business day. Members also receive a copy of this notice.

All approvals will be assigned an authorization number for the service. This number must be submitted with the claim after services are rendered. After the provider receives approval of a pre-authorization request, they are required to contact the member to let them know of the approval and schedule the authorized services.

Please note, MCNA does not accept faxed pre-authorization requests. MCNA will not return x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.
Pre- and Post-Authorizations

Requests for pre-authorization can be submitted electronically using MCNA’s Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the required information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are clinically contraindicated or unobtainable, the reason must be stated in the “Remarks” section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member’s record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA’s Utilization Management department.

For ease of billing it is preferable to group services requiring authorization on a single form so that only one pre-authorization request need be issued per member.

Arkansas Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided in the grid below. The need for pre-authorization is noted in the grid column labeled “Benefit Limits” for all covered procedure codes.

A provider may choose to submit a post-authorization (Orthodontic services cannot be post-authorized) request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims for services that require pre-authorization submitted without a pre-authorization noted in Box 2 of the claim form or without the narrative and documentation required for post-authorization review will be denied. Pre-authorizations are valid for 180 days. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.

It is the provider’s responsibility to utilize the appropriate procedure code in a pre-authorization request. The pre-authorization approval of a requested service does not constitute approval of the fee indicated by the provider.

When requesting a pre-authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for the clinical reviewer making a decision about the case to fully understand the general dental health and condition of the member for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the member’s name and Medicaid ID number as well as the provider’s name and Medicaid ID number.

A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member’s treatment record.

In general, an approved prior authorization will be honored for 180 days for the requesting provider at any MCNA-enrolled facility the provider is linked to or by any provider at the facility originating the prior authorization request. In the event a facility changes ownership and a new facility ID is issued, the new facility may apply for a new prior
authorization or may file a claim with a narrative describing the ownership change and referencing the existing, approved prior authorization number.

**Emergency Treatment Authorization**

MCNA ensures that members have access to emergency care without pre-authorization and to services and treatment as provided through the State agreement and defined in other state and federal regulations. MCNA ensures that members have the right to access emergency dental care services, consistent with the need for such services.

Should you need to refer a member on an emergency basis please contact MCNA’s Provider Hotline at 1-844-343-6262 if you need assistance with coordination of the member’s care.

Authorization prior to emergency treatment may not be possible. In such instances, the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for pre-authorization. Claims submitted without this documentation will be denied. All submissions are evaluated for medical necessity and compliance with plan rules.

To submit the required documentation with a claim using MCNA’s Provider Portal, please indicate in the “office remarks” section that the service was provided on an emergency basis and pre-authorization does not apply. If submitting the claim on a paper ADA claim form, please indicate this information in Box 35.

**Urgent Treatment Authorization**

The state of Arkansas defines Urgent Care as dental services that do not constitute emergency care but that are needed to treat pain. MCNA ensures that members have access to urgent care with in-network providers without pre-authorization, and to services and treatment as provided through the State agreement and defined in other state and federal regulations. MCNA ensures that members have the right to access urgent dental care services, consistent with the need for such services.

Should you need to refer a member on an urgent basis please contact MCNA’s Provider Hotline at 1-844-343-6262 if you need assistance with coordination of the member’s care.

Authorization prior to urgent treatment may not be possible. In such instances, the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for pre-authorization. Please include a detailed narrative/rationale. Claims submitted without this documentation will be denied. All submissions are evaluated for medical necessity and compliance with plan rules.

To submit the required documentation with a claim using MCNA’s Provider Portal, please indicate in the “office remarks” section that the service was provided on an urgent basis and pre-authorization does not apply. If submitting the claim on a paper ADA claim form, please indicate this information in Box 35.
Covered Services

Children’s Medicaid and CHIP plus EPSDT Dental Covered Services Overview

- Preventive
- Diagnostic
- Restorative services (fillings and crowns)
- Endodontic services
- Periodontal services (treatment of gums)
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontic services – based on necessity
- Adjunctive general services

Adult’s 21 and older Medicaid Dental Covered Services Overview

- Preventive
- Diagnostic
- Restorative services (fillings and crowns)
- Periodontal services (treatment of gums)
- Prosthodontics
- Oral and maxillofacial surgery

Continuity of Care

When a Member Moves Out of Service Area
Members who move out of the service area are responsible for obtaining a copy of their dental records from their current dentist to provide to their new dentist. Participating dentists must furnish members with copies of their records, including x-rays, free of charge.

When a Member Has Pre-Existing Conditions
MCNA does not have a pre-existing condition limitation. Regardless of any pre-existing conditions or diagnosis, members are eligible for all covered services on the effective date of their enrollment in the Arkansas Medicaid Dental program.

When a Member is in Active Treatment
Medicaid members will be pre-authorized to continue treatment by an out-of-network provider during the course of “active treatment” at the time of enrollment until one (1) of the following conditions occurs, whichever comes first:

- The member’s records, clinical information, and care can be transferred to an in-network provider
- The member is disenrolled
- The course of “active treatment” is completed
- A period of 90 days has passed
- A period of nine (9) months for members who, at the time of enrollment with MCNA, have been diagnosed with and were receiving treatment for a terminal illness and remains enrolled with the Contractor
- The prior authorization for the services being received expires
Non-Capitated Services
The following services will continue to be provided by the Medicaid medical health plan:

- Outpatient office fees for dental services
- Transportation

Emergency Dental Services
Arkansas Medicaid defines emergency dental services as dental services that are medically necessary to treat an acute disorder of oral health that requires dental and/or medical attention, including broken, loose, or avulsed teeth caused by traumas; infections and inflammations of the soft tissues of the mouth; and complications of oral surgery, such as dry tooth socket.

Emergency or palliative dental care services include the following:

- Procedures used to control bleeding
- Procedures used to relieve pain
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen
- Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth
Claims Administration

Claim Submission
MCNA requires all dental providers to identify a place of treatment (service) on the 2012 (or newer) American Dental Association (ADA) Claim Form.

Picking and Choosing Services
Providers must bill MCNA for all covered services performed on any eligible member whom the provider has accepted as a Medicaid patient. This policy prohibits MCNA providers from "picking and choosing" the services for which they agree to accept reimbursement from MCNA. Providers must accept MCNA reimbursement as payment in full for all services covered by MCNA.

Submitting Claims to MCNA
Providers may submit a claim to MCNA using any of the following three (3) methods:

- Electronically through MCNA’s Provider Portal
- Electronically through a clearinghouse (MCNA Payor ID: 65030)
- Using a paper ADA Claim Form (2012 or newer) sent via United States Postal Service. ADA Claim Forms can be obtained from various vendors.

Please note, MCNA does not accept faxed or handwritten claims.

Claims Payment
Claims are paid by MCNA. Please see the Covered Services and Clinical Guidelines sections of this manual for a list of all covered benefits. For any claims questions please contact our Provider Hotline at 1-844-343-6262.

Claims will be denied if the member is not eligible on the date of service. However, MCNA will reprocess 100% of claims denied due to member ineligibility upon receipt of retroactive eligibility verification from DHS showing the member as eligible on the date of service.

Providers have 365 calendar days from the date of service (DOS) to submit a claim. If your claim is not received within 365 calendar days from the date of service, it will be denied for late submission. The following are exceptions to the standard 365-calendar day timely filing submission requirement:

- If a provider files a claim erroneously with DHS or with the wrong plan within the 365-day submission requirement and produces documentation of that, MCNA must honor the initial filing date as notification of the claim and process it without denying for untimely submission. The provider must submit the claim in question to MCNA within 365 calendar days from the date of notification by the wrong plan. If the 365-day time frame cannot be met, the provider may file a grievance within 30 calendar days of the date of notification by DHS or the wrong plan. The grievance submission must include the claim, all supporting documentation, and the dated documentation from DHS or the wrong plan showing the reason for the inability to meet the 365-day time frame.
- If a claim was unable to be submitted within 365 calendar days of the date of service due to an issue with the provider’s clearinghouse, the provider must submit the claim and the supporting documentation from the clearinghouse within 365 days of the date of notification by the clearinghouse. If the 365-day time
frame cannot be met, the provider may submit a grievance within 30 calendar days of the date of notification from the clearinghouse. The grievance submission must include the claim, all supporting documentation, and the dated documentation from the clearinghouse showing the reason for the inability to meet the 365-day time frame.

- If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, MCNA may receive and process claims upon review of substantiating documentation that justifies the late submittal of a claim.
- Claims for members who have both Medicare and Medicaid coverage fall under Medicare timely filing requirements. These claims must be submitted to MCNA within 365 days from the date on the Medicare Explanation of Medicare Benefits (EOMB).
- Claims for retroactive Medicaid members must be filed within 365 days from the date of eligibility determination.
- Provider-requested adjustments and voids of claims must be filed within 365 days from the date of payment.

Dental services must not be separated or performed on different dates of service solely to enhance reimbursement.

In order to ensure the prompt payment of claims, MCNA is required to adjudicate a paper clean claim within 30 calendar days of receipt and an electronic claim within 14 calendar days of receipt. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the state’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

All claims should be submitted to MCNA via the Provider Portal or on an ADA Claim Form (2012 or newer). The claim must include all of the following information to be considered a clean claim:

- Member name
- Member identification number
- Member and/or guardian signature (or signature on file)
- Member date of birth
- Description of services rendered
- Provider NPI number (included with all claim submissions regardless of format)
- Provider name, state license number, and signature (included with electronic or online submissions)
- Provider address, phone number, and office ID number (included with electronic or online submissions)
- Proper CDT coding with tooth numbers, surfaces, quadrants, and arch, when applicable
- ADA-approved nomenclature must be utilized on all claims requiring specification of tooth, tooth surface, quadrant or arch (see table below)
- Full mouth x-ray series, bitewings, and/or periapical x-rays, rationale, photos, sedation time records, or other documentation, when required

Remittance Advice (RA) documents will be available in the MCNA Provider Portal for all offices.
ADA Guide to Dental Procedures Reported with Area of the Oral Cavity or Tooth Anatomy (or Both)

Version 1 - January 2018

ADA Dental Claim Data Content Recommendation - Reporting Area of the Oral Cavity and Tooth Anatomy by CDT Code

Dental procedure codes, listed in numeric order, are as published in CDT 2018 (© American Dental Association)

This recommendation:


2) Is applicable to both the ADA Dental Claim Form (© 2012) and the HIPAA standard electronic dental claim transaction (0370 v5010)

Notes:

a) For reference the Area of the Oral Cavity and the Tooth Anatomy code sets used on 0370 and ADA Claim Form follow:

<table>
<thead>
<tr>
<th>Area of the Oral Cavity</th>
<th>Tooth Anatomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>entire oral cavity</td>
<td>entire oral cavity</td>
</tr>
<tr>
<td>upper right quadrant</td>
<td>upper right quadrant</td>
</tr>
<tr>
<td>maxillary arch</td>
<td>maxillary arch</td>
</tr>
<tr>
<td>upper left quadrant</td>
<td>upper left quadrant</td>
</tr>
<tr>
<td>mandibular arch</td>
<td>mandibular arch</td>
</tr>
<tr>
<td>lower left quadrant</td>
<td>lower left quadrant</td>
</tr>
<tr>
<td>lower right quadrant</td>
<td>lower right quadrant</td>
</tr>
</tbody>
</table>

b) "X" in columns titled "XR" = ADA does not recommend reporting any Area of the Oral Cavity or Tooth Anatomy information for that row's CDT code

c) "Y" in other columns under "Area of the Oral Cavity" or "Tooth Anatomy" = ADA recommends reporting the indicated information for that row's CDT code

Version History:

<table>
<thead>
<tr>
<th>Number</th>
<th>Remarks / Change Summary</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initial publication</td>
<td>Jan 2018</td>
</tr>
</tbody>
</table>
## Example of a Clean Claim

### ADA American Dental Association* Dental Claim Form

**HEADER INFORMATION**
1. **Type of Transaction** (Mark all applicable boxes):  
   - [X] Statement of Actual Services  
   - [ ] Request for Predetermination/Preauthorization  
   - [ ] EPSDT/Fetus/Infant

2. **Predetermination/Preauthorization Number**

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**
3. **Company/Plan Name**, **Address**, **City, State, Zip Code**  
   - **MCNA Dental**  
   - **200 West Cypress Creek Road, Suite #500**  
   - **Fort Lauderdale, Florida 33309**

**OTHER COVERAGE** (Mark applicable box and complete items 5-11. If frames, leave blank.)
4. **Dental?**  
   - [ ] Yes  
   - [ ] No
5. **Name of Payor/Subscriber in #4 (last, first, middle initial, suffix)**

**PATIENT INFORMATION**
6. **Date of Birth (MM/DD/YYYY)**  
7. **Gender**  
8. **relationship to Payor/Subscriber in #4 Above**
   - [X] Self  
   - [ ] Spouse  
   - [ ] Dependent Child  
   - [ ] Other
9. **Plan/Group Number**
10. **Name (last, first, middle initial, suffix), Address, City, State, Zip Code**
11. **Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**

**RECORD OF SERVICES PROVIDED**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2018</td>
<td>JP</td>
<td>D0150</td>
<td>1</td>
<td>Comprehensive Oral Evaluation</td>
<td>$30.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**AUTHORIZATIONS**

**ANCILLARY CLAIM/TREATMENT INFORMATION**

- **Place of Treatment**
  - [X] Dental Office  
  - [ ] Hospital  
  - [ ] Other
- **Diagnosis Code(s) (Use ‘A’ for Primary Diagnosis)**
  - ICD-9 [ ] A
  - ICD-10 [ ] B
  - Diagnosis Code(s) [ ] C

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/insurer)

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

**AUTHORIZATIONS**

- **Acceptance of Assignment**
  - [X] Yes  
  - [ ] No
- **Signature on File**
  - **Patient/Provider Signature**
  - **Date**

- **Signature on File**
  - **Provider Signature**
  - **Date**

**Address, City, State, Zip Code**

**License Number**

**NPI**

©2013 American Dental Association

To order call 800.947.4746 or go online at adabcatalog.org
Electronic Submission of Claims via MCNA’s Provider Portal

MCNA’s Provider Portal (http://portal.mcna.net) allows participating providers to easily submit claims to us and track their status. Submitting claims electronically using the Provider Portal is always free.

You have the ability to attach scanned x-rays, periodontal charting, and other documents to your claims. MCNA contracts with NEA FastAttach to allow for the electronic submission of x-rays. For those offices unable to work with digital copies of x-rays, a completed ADA Claim Form (2012 or newer) along with the x-ray(s) must be sent to MCNA at the address listed in the Paper Claim Submission via Mail section below.

Electronic Submission via Clearinghouse and Billing Intermediaries

Providers may submit electronic claims through clearinghouses, which transmit claims to CHANGE HEALTHCARE (Formerly Emdeon/WEBMD). MCNA’s Payor ID code is 65030. MCNA contracts with NEA FastAttach for the electronic submission of digital attachments.

Providers who use a billing intermediary for claims preparation and submission must notify MCNA of their billing arrangements in writing. If a billing intermediary changes or ceases to exist, you must also notify MCNA in writing. A billing intermediary is not considered to be a provider’s salaried employee. A billing intermediary is an individual, partnership, or corporation contracted with the provider to bill on their behalf.

Paper Claim Submission via Mail

Paper claims must be typed or printed and submitted on the ADA Claim form (2012 or newer). Providers can download this form from our Provider Portal (http://portal.mcna.net) and print it.

Paper claims may be submitted by mail to:

MCNA Dental
Attn: Claims Department
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, Florida 33309

It is important to affix sufficient postage when mailing in bulk as MCNA does not accept postage due mail. Insufficient postage will result in the mail being returned to sender and a delay in processing your claim.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

Direct Deposit and Electronic Funds Transfer (EFT)

MCNA offers direct deposit to your bank account. To participate in direct deposit, you must complete, sign, and return the Direct Deposit EFT Form, which you can download from our website (www.mcnaar.net). Please fax or mail the completed form to MCNA’s Credentialing Department.

MCNA Processing of Deficient Claims

Providers have a total of 365 calendar days from the date of service to submit a claim. If a claim is not received by MCNA within this 365-day time frame it will be denied.
MCNA may also deny your claim as deficient if it does not include all supporting documentation, such as x-rays or narrative, when required. When this occurs, the Explanation of Payment/Remittance Advice will state the reason for the denial. For example, a procedure that has been denied might be listed with reason code 48, which states “please submit x-ray(s) and narrative with this request.”

MCNA sends a notification within two (2) business days of receipt of an electronic claim and within five (5) days of receipt of a paper claim to inform providers that a determination for the claim has been made. Active Provider Portal users are notified via a portal alert. To view why a claim is considered non-clean, providers can log in to the Provider Portal and click on “Non-Clean Claim Notices.” Providers who do not use their Provider Portal accounts receive a letter in the mail with the same information.

Additional information may be required for a non-clean claim to be processed. The provider must send in the required information within 30 calendar days from the date of the deficient denial determination. MCNA considers the official submission date of a corrected claim to be the date that a provider electronically transfers any required additional information and documentation. If a provider mails the information, the official submission date is the date MCNA receives it.

**Reconsiderations**

Reconsideration requests must be filed within 90 calendar days of the claim determination. Requests for MCNA’s reconsideration of a claim may be filed when a claim has been denied for anything other than medical necessity or benefit coverage including, but not limited to, the following examples:

- Timely filing
- Duplicate
- Member and provider eligibility
- Incorrect fee applied

Any supporting documentation should be included with the reconsideration request. Providers may submit their request in writing by using the Provider Reconsideration and Appeal Request form or online using MCNA’s Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on support and downloads to access the Online Reconsideration/Appeal link. Please complete the electronic form titled, “Provider Reconsideration and Appeal Request” including all information needed to evaluate your request.

**Appeals**

Appeals must be filed within 90 calendar days of the initial claim determination. Appeals may be filed when a claim has been denied for determinations related to medical necessity and benefit coverage. Any requested or supporting information such as x-rays or rationale should be included with the appeal submission.

Providers may submit an appeal online through MCNA’s Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on “Support and Downloads” to access the Online Reconsideration/Appeal link. Please include all information needed to evaluate your request. If your original ADA claim form was completed incorrectly, you must submit a corrected ADA claim form with your appeal.

Providers may also mail an appeal to MCNA’s Grievances and Appeals Department.
The timeframes for resolving most grievances and appeals are:
- Expedited – within 24 hours or next business day
- Non-emergency clinical – within 5 business days
- Non-clinical – within 30 business days

**Coordination of Benefits**

It is the provider’s responsibility to determine if members have other dental insurance. When other insurance exists and MCNA is the secondary insurer, a copy of the primary insurance Remittance Advice (RA) or Explanation of Payment (EOP) must be submitted with all claims for services rendered to the member. These claims may be filed electronically if an electronic copy of the RA or EOP is attached. MCNA will deem a claim paid in full when the primary insurance payment meets or exceeds MCNA’s reimbursement rates.

**Third Party Liability**

Medicaid is the payor of last resort with the exception of members who are covered by Tribal Benefits through Indian Health Services. Providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. A third-party insurance carrier is an individual or company who is responsible for the payment of medical or dental services. Examples of third parties are Medicare, private health insurance, automobile insurance, and other liability carriers. When billing MCNA after payment consideration from a third party (except Medicare), a Remittance Advice (RA) or an Explanation of Payment (EOP) from the primary insurance carrier must be attached. The six-digit state-assigned carrier code for the primary insurance and the amount paid by the primary insurance carrier (including zero [$0] payment) must be entered in the appropriate places on the claim form. If the third-party coverage is found to be erroneous, providers may submit a corrected claim to MCNA. In situations where third-party benefits exist, the time frame for filing a claim with MCNA begins on the date that the third-party carrier resolves the claim.

**Non-Covered Services**

MCNA will not pay a provider for non-covered services. According to the MCNA Provider Agreement, the provider will hold harmless members, the plan, MCNA, and the State for payment of non-covered dental services.

No additional charges may be assessed to covered MCNA members. The MCNA Provider Agreement states that the only circumstance in which a provider may bill for non-covered services is when a member has signed a form or letter of understanding agreeing to the fees.

The following services are considered non-covered services:

- Services that are not medically necessary to the member’s dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Plaque control
- Certain types of x-rays
- Routine post-operative services - these services are covered as part of the fee for initial treatment provided
- Treatment of incipient or non-caries lesions (other than covered sealants and fluoride)
• Services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan
• Dental expenses related to any dental services:
  o Started after the member’s coverage ended
  o Received before the member became eligible for these services
• Prescriptions or drugs
• Administration of in-office pre-medication

Patient Financial Responsibility Form
MCNA only reimburses for services that are medically necessary or benefits of special preventive and screening programs, such as the EPSDT program. The provider may bill a member only if a specific service or item is provided at the member’s request.

The provider must obtain and keep a written Patient Financial Responsibility Form that is signed by the member and/or responsible party on the date of service prior to the services being rendered. It must be filled out completely with the following information:

• A statement that the member is financially responsible for the described services
• A complete description of the dental services to be rendered. A statement that the neither the plan, MCNA, nor the State will be responsible for payment of the described dental services.

Balance Billing
MCNA network providers may not bill or otherwise attempt to recover from members the difference between the agreed upon contract allowable rate for a service and the provider’s billed charge(s). This practice is called balance billing and is not permitted under your MCNA Provider Agreement.

Fraud Reporting
Providers are expected to bill only for medically necessary covered services delivered to members in accordance with MCNA’s policies and procedures. MCNA and the appropriate governmental agencies actively investigate all suspected cases of fraud and abuse. In our commitment to prevent fraud and abuse in the Medicaid Program, MCNA has implemented an integrity component as a part of our Compliance Program. We monitor and maintain integrity through the following activities:

• Prevention of duplicate payments
• Post-payment utilization review to detect fraud and abuse
• Internal controls to ensure payments are not issued to providers that are excluded or sanctioned under Medicare/Medicaid
• Review of alleged illegal, unethical, or unprofessional behavior
• Profiling of providers to identify over or under utilization of services
• Completion of investigations and audits

All program integrity activities are coordinated with MCNA’s Compliance Department and our Special Investigation Unit (SIU) as needed.
Program Integrity

Providers are not allowed to provide services to a member beyond the intent of Medicaid guidelines, limitations, and/or policies for the purpose of maximizing payments. If this practice is detected, the provider may be subject to sanctions. Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid-established guidelines, limitations, and/or policies are not exceeded. Providers not participating in the MCNA network may not use the name and/or provider number of a participating provider in order to bill Medicaid for services rendered.

MCNA is committed to controlling fraud, waste, and abuse in the Arkansas Medicaid Dental Program. Our efforts include vigilant monitoring, investigation, enforcement, training, and communication. MCNA monitors the appropriateness and quality of services provided to our members and verifies services billed by dental providers through pre- and post-payment reviews. These reviews help us to prevent or recover overpayments paid to providers. An overpayment includes any amount not authorized to be paid by state and federal programs, whether paid as a result of inaccurate or improper claims submissions, unacceptable practices, fraud, abuse, or a mistake.

When an overpayment is identified, MCNA begins payment recovery efforts. Providers will be given the opportunity to submit a refund or payment plan within a specified time period. If you fail to submit a refund within the specified time period, the overpayment amount will be automatically deducted from future RAs. Additionally, MCNA will pursue all remedies up to and including the termination of your participation in our network. If you wish to report fraud, please see the contact information for MCNA and DHS’s Medicaid Program Integrity Unit located at the front of the manual.

Appeal Rights

MCNA affords to any provider or person against whom it enforces payment recoupment requests a right to appeal this action by requesting an informal review. A request for an informal review must be received in writing within 30 calendar days of the date you receive a recoupment notice. Appeals should be mailed to MCNA to the attention of “Corporate Investigations.”

Along with your appeal, you may submit any documentary evidence that addresses whether the recoupment is warranted and any related issues. MCNA will consider your appeal and your evidence carefully. You will be contacted after that consideration is completed and a decision about your case is made.

Please contact MCNA’s Provider Hotline if you have questions.

Laws that Govern Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These acts outline the civil penalties and damages that are allowed to be brought against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U.S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes this program. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.
“Knowingly” is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance or in reckless disregard of the truth or falsity of the claim.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this act:

- Billing for services not rendered
- Billing for services that are not medically necessary
- Billing for services that are not documented
- Up coding
- Participation in kickbacks

Penalties in addition to amount of damages may range from $5,500 to $11,000 per false claim, plus three (3) times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

**Do You Want to Report Waste, Abuse, or Fraud?**

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Arkansas Medicaid Dental services that were not necessary or not actually provided
- Making false statements about a medical condition in order to get medical treatment
- Letting someone else use a MCNA ID card
- Using another person’s MCNA ID card
- Making false statements about the amount of money or resources in order to get benefits

**To report waste, abuse, or fraud, choose one of the following:**

- Call the Medicaid Fraud and Patient Abuse Unit of the Attorney General’s Office at (501) 682-2007, toll free at 1-800-482-8982 or the Hotline at 1-855-527-6644
- To report fraud, you can visit https://www.arkansasag.gov/forms/medicaid-fraud-reporting/ or you can send an email to oag@arkansasag.gov
- To report fraud via mail, send the information to the Office of the Medicaid Inspector General, 323 Center Street, Suite 1200, Little Rock, Arkansas 72201
- To file a Medicaid Provider Fraud Self Disclosure, you must submit it in writing to the Office of the Medicaid Inspector General, P.O Box 1437, Slot S-414, Little Rock, AR 72203-1437. Submissions by telecopier, facsimile or other electronic media may not be considered. The Arkansas Medicaid Inspector General Self-Disclosure Protocol 2013 may be found by going to http://omig.arkansas.gov/providers and clicking on “Self Disclosure Protocol”
- To report abuse visit https://www.arkansasag.gov/forms/medicaid-fraud-reporting/
- Call the MCNA Fraud, Waste, and Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262)

**To report waste, abuse or fraud, gather as much information as possible:**

When reporting about a provider (a doctor, dentist, counselor, etc.) include:
• Name, address, and phone number of provider.
• Name and address of the office (hospital, nursing home, home health agency, etc.)
• Medicaid number of the provider and office, if you have it
• Type of provider (doctor, dentist, therapist, pharmacist, etc.)
• Names and phone numbers of other witnesses who can help in the investigation
• Date(s) of event(s)
• Summary of what happened

When reporting about someone who gets benefits, include:

• The person’s name
• The person’s date of birth, Social Security Number, or case number, if you have it
• The city where the person lives
• Specific details about the suspected waste, abuse or fraud
Provider Grievance Process

MCNA makes every effort to provide the highest quality of service to our members and providers. We understand there are times when issues or concerns need to be discussed, and our Provider Services team is ready to help. Please contact the Provider Hotline at 1-844-343-6262.

Arkansas Providers may submit a complaint (grievance) to MCNA within 30 calendar days of a notice of action, receipt of a Remittance Advice (RA) or the date of incident. Grievances filed on behalf of a member have no filing time limit. Arkansas Medicaid grievances are defined as an expression of dissatisfaction, from or on behalf of a member or provider, about any action taken by MCNA or provider, other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. The meaning of “grievance” includes a member's right to dispute an extension of time proposed by MCNA to make an authorization decision.

Provider grievances may be reported to the MCNA Provider Hotline by calling 1-844-343-6262. Providers may also submit grievances directly to their Provider Relations Representative verbally or in writing via mail to the address below or via email to ArkansasPR@mcna.net. Grievances about decisions that are not a unique function of MCNA should be made directly to DHS.

If you would like to file a grievance (complaint) in writing with MCNA, please send it to the following address:

MCNA Dental  
Attention: Provider Grievances – Provider Relations  
P.O. Box 29008  
San Antonio, Texas 78229

Upon receipt of a grievance, the Provider Relations Department will send a written acknowledgment of the grievance to the provider or their representative within 10 calendar days. Provider Relations will then review the issue and forward it to or solicit the assistance of the appropriate MCNA department(s). We will investigate and resolve the grievance within 30 calendar days from the date we receive it. Providers may consolidate grievances of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or claims included in the bundled grievance. When submitting a consolidated complaint, please include all applicable patients and/or claims and denote that the complaint is a consolidated grievance in the submission.

The timeframes for resolving most grievances and appeals are:

- Expedited – within 24 hours or next business day
- Non-emergency clinical – within 5 business days
- Non-clinical – within 30 business days
Upon resolution of the grievance, the Provider Relations Department will inform the provider in writing of the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 calendar days, the Provider Relations Department will inform the provider in writing of the need for an extension. Should a provider (or their representative) wish to present their case in person, they may contact the Provider Hotline at 1-844-343-6262. Concerns related to medical necessity are not addressed through the grievance system. They can be submitted through the appeal system on behalf of a member, or the provider can utilize MCNA's peer-to-peer process to speak with one of our licensed dentists. You can find more information about our peer-to-peer process in the Utilization Management section of this manual. Instructions for filing an appeal on behalf of a member can be found in the Member Grievances and Appeals process section.

After a provider has exhausted MCNA’s internal complaint process, if the provider is dissatisfied with the resolution they may file a complaint directly with DHS using the contact information provided below.

**Arkansas Medicaid Administrative Hearing Requests**

**Mailing Address:**
DHS Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

**Phone:**
1-501-682-8622

**Fax:**
1-501-404-4628

**Website:**
http://humanservices.arkansas.gov
Utilization Management

Utilization Management (UM) is the process of evaluating the necessity and efficiency of health care services and affecting member care decisions through assessments of the appropriateness of care. MCNA’s UM Department helps to assure prompt delivery of medically appropriate dental care services to all members and subsequently monitors the quality of care.

All participating providers are required to obtain pre-authorization from MCNA’s UM Department. The UM Department is available Monday through Friday, 8 a.m. to 4 p.m., CST, except on weekends and designated holidays. All requests for the authorization of services may be received during these hours of operation.

MCNA provides an opportunity for the provider to discuss a decision with the dentist who reviewed the case or the Dental Director, to ask clinical questions about a UM issue, or to seek information from a clinical reviewer about the clinical aspects of the UM process and the authorization of care. If you contact us after business hours or on a holiday, you may leave a message and a representative will return the call the next business day to schedule your peer-to-peer discussion.

MCNA will not enter into any contractual arrangement that rewards clinical reviewers or any other individuals who may conduct utilization review activities for issuing denial of coverage of a service, or any other financial incentives for utilization decision-making. MCNA’s UM Department ensures that quality of care will not be affected by financial- and reimbursement-related processes and decisions.

MCNA adheres strictly to the following:

- Compensation for utilization management activities is not structured to provide inappropriate incentives for denials, limitations, or discontinuation of authorization of services.
- Compensation programs for MCNA, consultants, dental directors, or staff who make clinical determinations do not include any incentives for denial of medically necessary services.
- Continuous monitoring of the potential effects of any incentive plan on access and/or quality of care is a standard procedure within the UM process.

Decision Making Criteria

MCNA’s Utilization Management criteria use components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA’s criteria are changed and enhanced as needed. For all children under 21, MCNA adheres to all federal EPSDT requirements found in 42 CFR 441.50-441.62.

The procedure codes used by MCNA are described in the American Dental Association’s Code Manual. Requirements for documentation of these codes are determined by community-accepted dental standards for authorization, such as treatment plans, narratives, radiographs, and periodontal charting.

These criteria are annually reviewed and approved by MCNA’s Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

We appreciate your input regarding the criteria used for decision-making. Please contact the Provider Hotline to comment or make suggestions. MCNA also complies with the Center for Medicare and Medicaid Services (CMS)
national coverage decisions and written decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

**Peer-to-Peer Availability**

MCNA offers the availability of peer-to-peer consultations with our Dental Director and clinical reviewers. These licensed general dentists, pediatric dentists, and specialty dental providers (e.g., orthodontists and oral surgeons) make all clinical determinations. The peer-to-peer process enables participating providers to discuss cases and clinical issues, including medical necessity denials, with MCNA clinical reviewers.

To request a peer-to-peer discussion, please contact your Provider Relations Representative or call the Provider Hotline.

**Clinical Practice Guidelines**

The Clinical Practice Guidelines are based on the enrolled membership and dictate the provision of dental care services to members with acute, chronic, and complex conditions to assist providers and members in making appropriate dental care decisions to improve quality of care. These guidelines are developed based on the following criteria:

- Reasonable, sound, scientific medical evidence
- Prevalence of dental conditions
- Extent of variation present in current clinical practice patterns
- Magnitude of quality of care issues based on existing patterns of clinical practice
- Ability to impact practice patterns
- Consideration of the needs of the members
- Strength of evidence to support best clinical practice management strategies
- Ability to achieve consensus on optional strategy

**Clinical Decisions**

A pre-authorization request for a service may be denied for failure to meet Clinical Practice Guidelines, clinical criteria, protocols, dental policies, or for failure to follow administrative procedures outlined in your Provider Agreement or this Provider Manual. All pre-authorization request approvals and denials are available through MCNA’s Provider Portal. Providers who do not have access to the Provider Portal will receive their determinations via mail.

**Medical-Necessity Denials**

Utilization Management uses dental policies, protocols, and industry standard guidelines to render review decisions. Licensed dentists and specialty dentists serve as clinical reviewers for the plan. All adverse benefit determinations are issued by an Arkansas licensed dentist and approved by the Dental Director. All clinical requests are reviewed by an MCNA clinical reviewer who is available to discuss any decision rendered with the attending dental provider through our peer-to-peer process.
Quality Improvement

Quality Improvement Program
The goal of the MCNA Quality Improvement (QI) Program is to ensure that each member has affordable and convenient access to quality dental care delivered in a timely manner by a network of credentialed providers.

The Board of Directors of MCNA is responsible for establishing the priorities of the QI Program based on the recommendations of the MCNA Dental Management Committee.

The Quality Improvement Committee oversees the QI Program to ensure that the performance of all quality improvement functions is timely, consistent, and effective. This committee reports to the Board of Directors and carries out the following responsibilities:

- Oversees the implementation of the QI Program throughout MCNA’s operational departments
- Establishes a method to measure and quantify improvements in dental care delivery to MCNA members resulting from QI initiatives
- Reviews and makes recommendations, which are identified through the QI process, for approval of all new and revised policies, procedures, and MCNA benefit designs
- Ensures that adequate resources are allocated toward the achievement of MCNA’s QI Program goals
- Oversees the management of all aspects of MCNA’s operations to make sure they are consistent with the goals and objectives of the QI Program
- Monitors the progress of all MCNA-initiated corrective action plans
- Monitors the integration, coordination, and supervision of Risk Management Program activities through the formal reporting of those activities
- Demonstrates compliance with regulatory requirements and delegation standards
- Assesses and confirms that quality care and services are being appropriately delivered to MCNA members
- Reports quarterly to the Board of Directors the status of MCNA QI Program

A copy of the QI Program is available to all participating providers upon request. Please contact the Provider Hotline.

Your Role in Quality
Every MCNA network provider is a recipient in the Quality Improvement (QI) Program through his or her contractual agreement with MCNA. You may be asked to serve on any of the committees that are part of the QI Program or contribute to the development of audits, Clinical Practice Guidelines, member education programs, or other projects. Participation on a committee is voluntary and encouraged.

You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form, which is located in Forms section of this manual. This can be submitted to MCNA via fax, email, or regular mail. The MCNA Dental Director might contact your office about an incident report. Please keep a copy of any incident report you file with MCNA in the appropriate member’s dental record.
Quality Enhancement Programs (Focus Studies)

MCNA monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, MCNA will perform one (1) or more state-approved PIPs per year. The PIP(s) will focus on both clinical and non-clinical areas.

Quality Review of Key Clinical and Service Indicators

One of MCNA’s Quality Improvement (QI) Program objectives is to perform a quality review of key clinical and service indicators through analysis of member and provider data to assess and improve member and provider satisfaction rates. These clinical and service indicators include reviews of:

- Member and provider grievances about care or service
- Sentinel events (defined as any event involving member care that warrants further investigation for quality of care concerns)
- National Committee for Quality Assurance’s (NCQA’s) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of Clinical Practice Guidelines
- Application of appropriate dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member pre-authorizations requests and referrals

In order to support the quality review activities of our QI Program, your office is required to make available upon a request from an MCNA representative the dental records of any MCNA member in your care.

Corrective Action

When Quality Improvement (QI) Program identifies specific cases of substandard quality of care during its review process, a letter requesting corrective action will be mailed to the treating provider. There are many forms of corrective action that may be recommended. Some examples of corrective action include:

- A Quality Correction Letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days (the severity of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Special pre-authorization/claims review
- Post-treatment reviews of members by a licensed dentist who serves as an MCNA Clinical Reviewer
- Requirement for the provider to attend training sessions or participate in continuing education programs
- Restriction on the acceptance of new members until the provider becomes compliant with all standards of care for a specified amount of time
- Recoupment of sums paid where billing discrepancies are found during reviews
- Restriction on a provider’s authorized scope of services.
- Referral of a case to the state Board of Dental Examiners and/or the Department of Justice, Attorney General’s Office, and/or Office of Inspector General of the State
- Termination of the Provider Agreement
Where corrective action is recommended, our priority is to work with the provider to improve performance and compliance with all MCNA policies and procedures defined in the Provider Agreement and this Provider Manual. MCNA is willing to provide support for a provider who shows sincere intent to correct deficiencies.

**Member Satisfaction Surveys**

The Member Satisfaction Survey is a tool that assists MCNA in rating the member's experience with network providers and with MCNA. The survey addresses key member issues such as level of satisfaction with MCNA, access to care, referral for specialty services, utilization, care received, and interaction with dental office staff. The survey is conducted on a quarterly basis. This information is used to develop and implement strategies to improve care and service to our members. Providers may be contacted to assist MCNA in developing improvement strategies.

**Provider Satisfaction Surveys**

MCNA will assess its contracted providers’ satisfaction with MCNA. This activity shall include, but not be limited to, analyses of provider satisfaction with the following operational aspects conducted through outbound call campaigns or during a site visit:

- MCNA’s response time to provider inquiries and complaints
- MCNA communications
- Claims payment process
- Authorization and referral process
- MCNA availability and effectiveness

We will use the results of our provider satisfaction surveys and any state-approved, contracted independent surveys to develop and implement plan-wide activities designed to improve provider satisfaction.

MCNA will make aggregate survey results available to providers and members upon request.

**Member Records - Chart Reviews**

As specified in MCNA’s Provider Agreement, we are authorized to conduct reviews of member records. These treatment records are chosen randomly for periodic chart review. The chart review includes assessment of the following member elements:

- Record of medical history, dental history, and existing dental conditions
- Radiograph evaluation and diagnostic material used
- Treatment plan and timeliness of treatment plan
- Actual care delivered in relation to proposed treatment plan
- Recall protocol and utilization analysis of actual care delivered
- A signed Patient Consent Form

A chart review offers an insight into the provider’s practice patterns and allows MCNA to identify deficiencies and suggest areas of improvement. The on-site review is a component of our Quality Improvement (QI) Program; all data is collected and entered into a QI database. This data allows MCNA to perform analysis of utilization and general network and practice patterns, contributing to valuable feedback and information for network dental offices. This information will also be used as part of the re-credentialing process.
Member Services

Discrimination
Providers may choose whether to accept a member as a Medicaid patient. Providers are not required to accept every Medicaid member requiring treatment; however, providers must be consistent in this practice and not discriminate against a Medicaid member based on the member’s race, religion, national origin, color, or impairment.

Providers must not differentiate or discriminate in the treatment of any member because of the member’s race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

Confidentiality Policy
MCNA follows all HIPAA requirements. We require our contracted providers to also adhere to HIPAA requirements. The Provider Agreement requires that all providers maintain member information in a current, detailed, organized, and comprehensive manner, and in accordance with customary dental practices, and applicable state and federal laws and accreditation standards. Providers must have policies and procedures to implement HIPAA confidentiality requirements. In addition to complying with customary dental practices, applicable state and federal law, and accreditation standards, these policies and procedures should include, but are not limited to, protection of member confidentiality under the following circumstances:

- The release of information, using a release form, at the request of a member and in response to a legal request for information
- The storage of and restricted access to dental records in secured files
- The education of employees regarding the confidentiality of member records and other member information

Informed Consent Requirements
Providers must understand and comply with applicable legal requirements regarding informed consent from members, as well as adhere to the policies of the dental community in which they practice. The provider must give MCNA members adequate information and be reasonably sure the member has understood it before proceeding with any proposed treatment. Consent documents should be in writing and signed by the member and/or responsible party.

The provider must obtain and maintain a specific written informed consent form signed by the member, or the responsible party if the member is a minor or has been adjudicated incompetent, prior to the utilization of a papoose board as part of the member’s treatment.

Such consent is required for the utilization of a papoose board and is strongly encouraged for all treatment plans and procedures where a reasonable possibility of complications from the proposed treatment or a procedure exists. Consent should disclose all risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given prior to the services being rendered and must not have been revoked. Members or their responsible parties who can give written informed consent must receive information about the dental
diagnoses, scope of proposed treatment, including risks and alternatives, anticipated results, and the need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. As a provider, you may consider seeking advice from an attorney to ensure the informed consent meets all applicable legal requirements.

MCNA urges all providers to comply with the AAPD’s 2013 “Guideline on Protective Stabilization for Pediatric Dental Patients.” You can find the guideline online at the AAPD’s website (www.aapd.org).

**Cultural Competence**

We facilitate access to dental services for non-English speaking members. MCNA’s member population is culturally and linguistically diverse, and we recognize that this diversity sometimes serves as a barrier to members, affecting their willingness to access all available services. Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected.

MCNA has adopted the CLAS recommendations (www.minorityhealth.hhs.gov) as a guideline in the development of our Cultural Competency Program. MCNA encourages contracted providers to address the care and service provided to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language, and abilities.

We want to ensure that we, along with our network providers, are meeting the communication needs of members with limited English proficiency. MCNA’s Quality Improvement department monitors and evaluates the level of cultural competency throughout our network through dental services provided by our providers. MCNA encourages employees and network providers to utilize their own diverse cultural backgrounds to enhance our program and the services provided to our members.

Please contact the Provider Hotline to request a copy of our Cultural Competency Program.

**Reading/Grade Level Consideration**

All member materials produced by MCNA are written for ease of understanding and typically target a sixth-grade reading level to promote enhanced communication between the Medicaid population, providers, and MCNA. Our goal is to create plain and clearly understandable member communications.

**Availability and Coordination of Linguistic Services**

MCNA does not require members to provide their own interpreter when utilizing the services available to them through MCNA. We will ensure that dental care services are presented in a culturally and linguistically appropriate manner utilizing the member’s primary spoken or signed language:

- Interpreter services are available through MCNA at no charge when accessing dental care. Please have the member contact the MCNA Member Hotline at 1-844-341-6262 for interpreter assistance.
- Member refusal of interpreter services must be documented.
- Friends and family are only used as an interpreter when specifically requested by the member. A Minor may not be used as an interpreter.
- Member may request face-to-face or telephone interpreter services to discuss complex dental information and treatment options.
• Informative documents must be translated into and available in threshold languages.
• Member has the right to file a complaint if linguistic needs are not met.
• Dental provider offices are informed of the availability of the TTY contact number (1-800-285-1131) for members with hearing impairment.

**Role of Provider’s Bilingual Staff**

The role of the bilingual staff in the office is to assist members to access and receive dental services and to understand the instructions they receive from the person speaking to them. If the member speaks a language not spoken by an office staff person, the telephone interpreter service should be utilized.

It is the responsibility of the provider’s office to notify MCNA in writing within 30 days of a change in the linguistic capacity of the office that may affect the provider’s ability to provide dental services.

To get a free copy of MCNA Cultural Competency Program, contact MCNA’s Member Hotline.

**Appointment Attendance Concerns**

We track the appointment attendance history of members who are consistent “no shows” to their scheduled dental appointments. If you are treating an MCNA member who has a history of being a no show at your office, please download the Member Outreach Form from the Provider Portal and submit it to us. This form can also be found in the Forms section located at the end of this Provider Manual.

**Case Management**

MCNA has dedicated Case Managers to assist members with special health care needs by coordinating dental care with their general or pediatric dentist, dental specialists, and Medicaid Case Manager, as applicable.

Members or providers may contact Case Management to initiate the assessment process for members with conditions that are medically compromising or are otherwise physically or mentally disabled. Our Case Managers will act as a liaison between the member and provider in all aspects of arranging care, including coordinating travel arrangements, communication services, facilitating treatment pre-authorization, and assisting with scheduling follow-up while the member is in active care. Please call the Provider Hotline at 1-844-343-6262 or send an email to casemanagement@mcna.net to refer a member to MCNA’s Case Management Program.
Member Eligibility, Enrollment, Disenrollment, and Value-Added Services

Arkansas Medicaid Dental Medicaid Program
MCNA does not perform enrollment functions for Arkansas Medicaid Dental recipients. All eligibility information provided by MCNA is the information that we have received from the Arkansas Department of Human Services (DHS) or its designee. The effective date of enrollment will be 12:01am of the first calendar day of the month of Medicaid eligibility.

Eligibility
The goals of the Arkansas Medicaid Dental program are to provide medically necessary dental services for children, pregnant women and adults. Arkansas Medicaid Dental considers a recipient to be an adult beginning with the day after his or her twenty-first birthday. A recipient is considered a child through the end of the day before his or her twenty-first birthday.

To be eligible for Arkansas Medicaid Dental, members must be in one (1) of the following categories:
- A child under the age of 21
- An adult age 21 or older
- A pregnant woman who does not otherwise qualify for Medicaid coverage

They must also meet all of the following eligibility criteria:
- Be a citizen or legal immigrant
- Be a resident of the State of Arkansas
- Maintain a household income that is less than the program income limits for their household size
- Have resources that do not exceed the program resource limits

Special Benefit for Pregnant Women
The Arkansas Department of Human Services offers a “pregnant women’s” benefit that provides limited Medicaid benefits for pregnant Arkansas citizens of any age who are not otherwise covered Medicaid beneficiaries. Eligible beneficiaries are entitled to Arkansas Medicaid adult dental benefits regardless of the age of the beneficiary.

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

MCNA ID Cards
MCNA strongly recommends all provider offices require each member to present their MCNA identification card and confirm eligibility at each appointment. You may quickly and easily complete eligibility verification by utilizing our Provider Portal (http://portal.mcna.net) or by calling our Member Hotline at 1-844-341-6262.

MCNA advises that you keep a copy of each member’s ID card on file in the member’s dental record.
Value-Added Services (VAS)
Value-added services are extra services MCNA offers to members. Our value added benefits are focused on promoting proper oral hygiene, ensuring access to care, and improving health outcomes. In addition to the standard Medicaid services, MCNA members can also receive:

Bright Beginnings
The Bright Beginnings program is designed to provide outreach to mothers about available benefits and educate them about the importance of seeking routine preventive dental care for their child before their first birthday. Upon enrollment, members will receive educational materials and a free dental kit that includes:

- Toothbrush
- Toothpaste
- Floss
- Oral health education materials

Walmart Gift Card
Upon enrollment, each household of MCNA Dental members will receive one $10.00 Walmart Gift Card along with a mailer that encourages the receipt of timely dental checkups. The Gift Card can only be used to buy dental products such as toothpaste, toothbrushes, mouthwash, and dental floss.

Caries Risk Assessment
When a general dentist or pediatric dentist sees a member for their comprehensive oral exam (D0150) or periodic exam (D0120 or D0145) in accordance with plan requirements, MCNA will reimburse the provider for the completion of a caries risk assessment. The provider must include the appropriate CDT code indicating the risk level on their claim with the examination:

- D0601 (low risk)
- D0602 (moderate risk)
- D0603 (high risk)

The reimbursement rate for these codes will be $5.00 for each service rendered during the member’s examination, not to exceed one per member per six (6) months.

Translation Assistance
MCNA offers interpreter services through our language line at no additional cost. MCNA will provide translation assistance as needed to ensure that members and providers are able to communicate about dental treatment needs without language barriers.

Providers may contact Member Hotline at 1-844-341-6262 for assistance in meeting the language needs of the member.
Member Rights and Responsibilities

Members are informed of their rights and responsibilities in the MCNA Member Handbook. MCNA providers are also expected to respect and honor members’ rights.

Member Rights as written in the MCNA Member Handbook

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and the right to express preferences about future treatment decisions.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.
- You have the right to be able to request a copy of your medical records (one copy free of charge) and request that they be amended or corrected.
- You have the right to receive healthcare services that are easy to access. These services should be comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service. They should be sufficient in amount, duration, and scope to reasonable be expected to achieve their purpose.
- You have the right to receive services that are appropriate and are not denied or reduced because of diagnosis, type of illness, or dental condition.
- You have the right to receive all information, like enrollment notices, informational materials, instructional materials, and available treatment options and alternatives in a way that is easy to understand.
- You have the right to receive assistance from the Arkansas Department of Human Services in understanding the requirements and benefits of MCNA.
- You have the right to receive oral interpretation services for free and in all non-English languages, not just those that are the most common.
- You have the right to be notified that interpretation services are available and how to access those services.
- You have the right to receive information on MCNA’s services, to include, but not be limited to:
  - Benefits covered
  - The way to use benefits, including any authorization requirements
  - Service area
  - Names, locations, telephone numbers of, and non-English language spoken by current network providers, like Primary Care Dentists, specialists, Federally Qualified Health Centers, Rural Health Clinics, and hospitals.
  - Any restrictions on your freedom of choice among network providers
  - Providers who are not accepting new patients
  - Benefits not offered by MCNA that are available to you and how to obtain them, including transportation
- You have the right to receive a complete description of disenrollment rights at least once a year.
- You have the right to receive notice of any major changes in core benefits and services at least 30 days before the intended effective date of the change.
- You have the right to receive information on grievance, appeal, and Administrative Hearing procedures.
- You have the right to receive detailed information on emergency and after-hours coverage, to include, but not be limited to:
  - What constitutes an emergency medical condition and emergency services, and post-stabilization services.
o That emergency services do not require prior authorization.
o The process and procedures for getting emergency services.
o The locations of any emergency rooms and other places where MCNA has contracted to furnish emergency dental services and post-stabilization services.
o The right to use any hospital or other setting for emergency care.
o The rules about post-stabilization services after emergency care.

- You have the right to receive MCNA’s policy on referrals for specialty care and other benefits not provided by your Primary Care Dentist.
- You have the right to have your privacy protected according to legal privacy requirements.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Arkansas Department of Human Services.

**Member Responsibilities as written in the MCNA Member Handbook**
You and MCNA both have an interest in seeing your dental health improve. You can help by assuming these responsibilities:

- Present your MCNA member ID card when getting services from your dentist.
- Be familiar with MCNA’s procedures to the best of your ability.
- Call or contact MCNA to obtain information and have questions answered.
- Let the dentist know any reasons your treatment cannot be followed as soon as possible.
- Live a healthy lifestyle and avoid behavior that can hurt your health.
- Follow the grievance process that MCNA provides for you if you have a disagreement with a dentist.
- Use the preventive dental services that are a part of your benefits.
- Be respectful of the dentist and their staff.
- Be respectful of the rights of other patients.
- Follow the dentist’s rules and regulations about patient care and conduct while at the dental office.
- Provide the dentist and their office staff with true and complete information so they can give you proper care.
- Obtain services from only in-network Primary Care Dentists or specialists, except if you have a dental emergency.
- Ask the dentist questions about his or her instructions.
- Ask the dentist about the care you receive.
- Understand your dental problems and work with your dentist to decide treatment goals.
- Make good decisions about your dental health and avoid things that can damage it.
- Follow the plan of treatment for dental care agreed upon by you and your dentist and/or their staff.
- Make sure that payments for non-covered dental services are fulfilled as soon as possible.
- Report unexpected changes in your dental condition to your dentist.
- Keep all appointments and arrive on time. If you are unable to do so for any reason, call your dentist’s office as soon as you can.

If you think you have been treated unfairly or discriminated against, please call MCNA’s Member Hotline at 1-844-341-6262. You can also file your complaint via email at MemberHotlineAR@mcna.net.
Member Outreach

MCNA provides an Enrollment Packet for each head of household where at least one member of the family is enrolled in a dental plan under Arkansas Medicaid Dental. The packet includes helpful information such as MCNA’s Provider Directory to help members choose a dentist near their home. It also informs members about how they can search for a dentist online or receive assistance in finding one by using MCNA’s toll-free Member Hotline.

Our Bright Beginnings Program highlights our commitment to expecting and new mothers with young children enrolled in Arkansas Medicaid Dental. Bright Beginnings is designed to provide face-to-face as well as telephonic outreach to mothers about available benefits and the importance of seeking routine preventive dental care for their child before their first birthday.

The program also includes a community outreach component where our Member Advocate Outreach Specialists (MAOS) visit local community agencies and group homes for teen and single mothers. We encourage you to remind expectant mothers about this program and have them contact our Member Hotline at 1-844-341-6262.

Our MAOS partner with local school districts to organize and participate in community health fairs as well as provide oral health presentations in schools for students, faculty, staff and parents. They utilize age-appropriate activities to engage children in learning about proper oral health.

MCNA provides education materials in English, Marshallese and Spanish to our members throughout the year. We produce a member-focused newsletter to keep members up to date with the latest program information, remind them about existing benefits, and to provide helpful oral health and hygiene tips.

MCNA’s Provider Outreach Form allows providers to inform MCNA when a member is behind in routine dental checkups, a chronic no-show for confirmed appointments, non-compliant with treatment plan, non-compliant with office policies and/or displays unacceptable behavior in office, requires education regarding referral use, requires transfer from office/office panel, or requires follow-up with a MCNA representative after being referred for services, or is a pregnant woman. Once a provider completes this form, it can be mailed or faxed to MCNA.

Upon receipt, MCNA’s Care Connections Team (CCT) processes each form and attempts to reach out to the member regarding the reason the provider sent the form. If the member requires assistance finding a provider or scheduling an appointment, the CCT representative conducts a three-way call with the provider’s office and the member to schedule the member with an appointment. When the provider indicates that the member is an expecting mother, the CCT will reach out to the member. If a provider indicates that a member has special needs that member’s information will be forwarded to our Case Management Department to see if they may benefit from our Case Management services.
Member Grievance and Appeal Processes

Member grievances may be filed verbally or in writing. A verbally filed appeal must be followed by a written, signed appeal. At no time will a member be discriminated against because he or she has filed an appeal. All information contained within a grievance or appeal and anything that comes to light throughout the grievance and appeal process is kept strictly confidential. A provider acting on behalf of a member or a member’s representative may submit grievances and appeals on behalf of members with their written consent. All non-expedited appeals submitted by a provider on behalf of a member or by a member’s representative must be submitted in writing with a signed copy of the member consent form.

The timeframes for resolving most grievances and appeals are:

- Expedited – within 24 hours or next business day
- Non-emergency clinical – within 5 business days
- Non-clinical – within 30 business days

If you would like to file a grievance or appeal on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at beginning of this manual.

The member may request an Administrative Hearing within 120 calendar days from the date of the last decision notification by MCNA. MCNA will cooperate with any decision the State makes.

What is a Grievance?

A member grievance is any dissatisfaction expressed by a member or a person acting on behalf of the member, either verbally or in writing, to MCNA concerning any aspect of MCNA’s operation. This includes, but is not limited to, dissatisfaction with MCNA’s administration or the way a service is provided and the right to dispute an extension of time proposed by MCNA to make an authorization decision. A grievance does not include a request for review of an action or a decision by MCNA related to covered services or services provided, misinformation that is resolved promptly by supplying the appropriate information, or clearing up a misunderstanding to the satisfaction of the member.

Member Grievance Process

Members have the right to file a grievance. Grievances can be filed verbally, in writing, or in person. A provider may file a grievance on a member’s behalf. Grievances filed by a provider on a member’s behalf require the member’s written consent.

MCNA will acknowledge receipt of a grievance in writing within 10 business days. MCNA will resolve and provide written resolution of all member grievances within 30 business days from the date the grievance is received.

If you would like to file a grievance on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at beginning of this manual.

At no time will a member be discriminated against because he or she has filed a grievance. We always respect our members’ privacy. Anything said or written will be kept confidential.
What is an Informal Reconsideration?
A member has the right to request an informal reconsideration. An informal request is request for review of a service authorization because MCNA did not approve a service request or approved a reduced amount of the services requested. MCNA will take no more than one (1) business day from the date we receive the request to make a decision about it.

Member Informal Reconsideration Process
MCNA will notify the member and requesting provider of a decision about the request for a covered service through a Notice of Action Letter. If the member, member’s representative, or provider disagrees with our decision, he or she can request an informal reconsideration. Informal reconsiderations filed by a provider on behalf of a member or a member’s representative require the member’s written consent.

An informal reconsideration may be filed verbally or in writing within 30 calendar days of the date when the member receives the Notice of Action Letter. If there is an oral request, a written notice must be received from the member or the member’s representative unless they request an expedited resolution. The MCNA Clinical Reviewer who made the original decision will meet with the member or their dentist within one (1) business day after receiving the request. We will our decision at the end of the meeting. Then we will send the member or the member’s representative a letter about our decision within 30 business days of receipt of the informal reconsideration request.

If you would like to request an informal reconsideration on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at beginning of this manual.

What is a Member Appeal?
A member has the right to file an appeal. An appeal is a request for review of an adverse benefit determination. An adverse benefit determination is defined as the denial or limited authorization of a requested service, including:

- The denial or limited authorization of a requested covered service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered service
- The reduction, suspension, or termination of a previously authorized covered service, including but not limited to the down-coding of prior authorization services
- The denial, in whole or in part, of payment for a covered service
- The failure to provide covered services in a timely manner
- MCNA’s failure to act within the timeframes provided under State and federal law regarding the standard disposition of grievances and standard disposition and resolution of appeals
- The denial of a request to dispute financial liability, including cost sharing, copayments, and member financial liabilities
- Any other occurrence which meets the definition of an “Adverse Decision” under §20-77-1701 of the Arkansas Medicaid Fairness Act
**Member Appeal Process**

MCNA will notify the member and requesting provider of a decision about the request for a covered service through a Notice of Action Letter. If the member, member’s representative, or provider disagrees with our decision, he or she can file an appeal. Appeals filed by a provider on behalf of a member or a member’s representative require the member’s written consent.

An appeal may be filed verbally or in writing within 60 calendar days of the date when the member receives the Notice of Action Letter. If there is an oral request, a written notice must be received from the member or the member’s representative unless they request an expedited resolution. We will acknowledge receipt of a member appeal in writing within five (5) calendar days from the date we receive it. We will notify the member or the member’s representative of our decision in writing within five (5) business days of receipt.

MCNA or the member can request a 14-calendar day extension if there is a need for additional information and the delay is in the member’s best interest. If an extension is needed by MCNA, we will notify the member in writing of the reason within two (2) calendar days and notify them of their right to file a grievance if they disagree with the reason for the extension.

The member’s benefits will not end while we review the appeal unless the member is taken out of Arkansas Medicaid Dental. If the member is currently receiving authorized services that are now denied and the member wishes to continue to get these services, the member must file the appeal on or before the latter of (1) 10 days following MCNA’s mailing of the Notice of Action, or (2) the intended effective date of the proposed action.

The written appeal must clearly state that the member wishes to continue getting the services. Services may be continued until the appeal decision is made. If, however, the appeal decision agrees with MCNA’s denial, the member may have to pay for the services.

If you would like to file an appeal on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at beginning of this manual. The member has the right to request an Administrative Hearing if they are not satisfied with the resolution provided by MCNA’s appeal process. To request an Administrative Hearing please contact the MCNA Member Services Department by telephone or in writing.

**Member Expedited Appeals**

If the member’s appeal is about care that is medically necessary and needed soon, a dental professional who has the relevant clinical experience and who did not render the original denial decision will review the appeal on an expedited basis. You may file an expedited review request verbally or in writing and you must include the member’s written consent.

An expedited review process is available for a member appeal that is for pre-service medical necessity. This expedited review process may take place when MCNA determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function.

MCNA will make a decision about an expedited review request as expeditiously as the member’s health requires but no later than within 24 hours of receipt or by the close of the next business day after we receive it. If MCNA
denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeal process and be resolved in 30 business days.

MCNA will contact the member by telephone to inform them of the decision to deny the expedited request. We will send a written notice indicating our denial of the request within two (2) calendar days.

**Member Request for an Administrative Hearing**

If a member is not happy with MCNA’s decision about an appeal, they have the right to ask for an Administrative Hearing within 120 calendar days of the date of MCNA’s Notice of Appeal Resolution. A provider may also request an Administrative Hearing on behalf of the member.

To request an Administrative Hearing on behalf of a member, you must first have the member complete and sign a one-page form, which you can request by calling the Provider Hotline or download from our website (www.mcnaar.net). This form is located in this manual and will serve as the member’s authorization for you to request an Administrative Hearing for the member.

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf.

To request an Administrative Hearing, call or write to the MCNA Member Services Department. You can find the appropriate phone numbers and mailing address in the Contact Information section located at beginning of this manual. Alternatively, you can request a hearing by sending a letter to:

**Hearings Coordinator**
**DHS Office of Appeals and Hearings**
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

**Website:** [http://humanservices.arkansas.gov](http://humanservices.arkansas.gov)

A member’s benefits will not end during the Administrative Hearing unless they are taken out of Arkansas Medicaid Dental. If the member chooses to receive the services that were denied before the hearing process is complete, the member will have to pay for the services if the final decision is that MCNA does not have to cover them.
Member Request for an Administrative Hearing Form

[Recipient Name]
[Street Address]
[City, State & Zip Code]

I want to appeal the decision MCNA made on my case because: __________________________
______________________________________________________________

Date: ______________ Signature: ________________________________
Recipient/Representative: _______________________________________
Your address if different from the address shown above: __________________

Telephone No: __________________________
Social Security Number: ________________________________
Email address: ________________________________
Name, Address and Phone number of your Authorized Representative at the Hearing, if any:
______________________________________________

Mail this complete form to:

DHS Office of Appeals and Hearings
P.O. Box 1437, Slot N401
Little Rock, AR 72203-1437

The postmark showing the date you mailed your appeal will be the date of your appeal request.

After you ask for an Administrative Hearing, the DHS will send you a Notice by mail of the date, time and location of your Administrative Hearing.

*** DON’T FORGET TO INCLUDE THE NOTICE OF ADVERSE ACTION LETTER WITH THIS FORM***
Arkansas Children's Covered Services

Benefit Limits Key

A = Age range limitations
TID = Tooth ID

Initial Dental Screening and Annual Recall Visits

For children under the age of 21 with MCNA in accordance with the EPSDT program: Dental care is covered for children with Medicaid, ARKids First-A (Medicaid Title XIX funded) and ARKids First-B (CHIP Title XXI funded). This includes orthodontic care such as braces, if needed for medical reasons. All orthodontic care must be approved by Medicaid before treatment. If you have ARKids First-B (CHIP Title XXI funded), you will need to pay a co-payment.

The dental visit, which includes the initial dental screening (oral evaluation) and annual recall visit (periodic oral evaluation), must include (but is not limited to) the following diagnostic and preventive services:

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required), and necessary diagnostic or vitality tests (considered part of the examination)
- Bitewing radiographic images
- Prophylaxis, including oral hygiene instructions
- Topical fluoride application
- Sealants

This visit should also include either the initial preparation or the updating of the member’s dental record, as appropriate. It should also include the development of a current treatment plan and the completion of reporting forms. The member may have only one (1) of a comprehensive oral examination (D0150), a periodic oral examination (D0120), or an oral evaluation for a patient under three (3) years of age (D0145) in 175 days period subject to other benefit limits. Prophylaxis (D1110 or D1120) and topical application of fluoride (D1206 or D1208) are both limited to once per 175 days.
Diagnostic Services

Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for recipients.

Examinations

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnostic Service</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation - established patient</td>
<td>A 0-20. One (1) per 175 days. Only one (1) D0120, D0145 or D0150 per 175 days per member.</td>
<td>$26.60 ARKids-B no copay</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>A 0-20. Limited to one (1) service per day by the same provider, facility or group. Not reimbursable on the same day as D0120 by the same provider, facility or group. Not payable for follow-up care. D0140 by the same provider, facility or group within 30 days of a D0120, D0140, D0145, or D0150 will require a rationale. Not payable with dentures, orthodontics or other services paid as all-inclusive procedures.</td>
<td>$34.20 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver</td>
<td>A 0-35 months. One (1) of D0120, D0145 or D0150 per 175 days per member.</td>
<td>$26.60 ARKids-B no copay</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation - new or established patient</td>
<td>A 0-20. One (1) per three (3) years per member. Only one (1) D0120, D0145 or D0150 per 175 days per member. D0140 must be utilized when performing a comprehensive problem-focused comprehensive exam.</td>
<td>$34.20 ARKids-B no copay</td>
</tr>
<tr>
<td>D0190</td>
<td>Screening of a patient</td>
<td>A 0-20. Two (2) times in a 12-month period per member. Only covered if no other dental service is billed on the same day or within 6 months. No copay required.</td>
<td>$7.98</td>
</tr>
</tbody>
</table>
Radiographic Images

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if MCNA determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within a 45-day period will be limited to the allowance for a full mouth series (intraoral complete series).

Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for recipients.

MCNA utilizes the guidelines published by the U.S. Department of Health and Human Services Center for Devices and Radiological Health. Please consult the following benefit tables for benefit limitations.

In order for MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and/or oral/facial images that are not of good diagnostic quality will be denied.

All radiographs must be of good diagnostic quality, properly mounted, dated, and identified with the member’s name, date of birth, indication of tooth ID, and labeled as left or right. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. The reason must be documented in the member’s record and be in accordance with the accepted standard of care.

### Radiographs/Diagnostic Imaging (Including Interpretation)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims submitted by the same provider, facility, or group for any combination of covered intra-oral or extra-oral radiographs, including periapicals, bitewings and panoramic images within a 45-day period that exceed the maximum allowed fee for a D0210 full mouth series will be combined and an alternative benefit of a D0210 full mouth series will be applied.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Requirements when submitting x-ray(s):
- Must be of diagnostic quality
- Must be marked right and left, and tooth ID included
- Must be mounted properly
- Must include the patient’s name and date of birth
- Must include the date x-rays were taken

Only one full mouth series or one panoramic x-ray is available per member every five (5) years by the same provider, facility, or group.

Bitewings are limited to a maximum of one set per date of service.

MCNA encourages the use of digital images. Please be aware that MCNA will not return hardcopy x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D0210</strong></td>
<td>Intraoral - complete series of radiographic images</td>
<td>A 0-20. One (1) D0210 or D0330 per five (5) years per member by the same provider, facility, or group. Not allowed as an emergency service. Additional service allowed with prior authorization with rationale for oral surgery or orthodontics. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
</tr>
<tr>
<td><strong>D0220</strong></td>
<td>Intraoral - periapical first radiographic image</td>
<td>A 0-20. Limited to once (1) per date of service per member by the same provider, facility, or group. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210. Not payable if billed in conjunction with any 3000 series code, except D3220.</td>
</tr>
<tr>
<td><strong>D0230</strong></td>
<td>Intraoral - periapical each additional radiographic image</td>
<td>A 0-20. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210. Not payable if billed in conjunction with any 3000 series code except D3220.</td>
</tr>
<tr>
<td><strong>D0240</strong></td>
<td>Intraoral - occlusal film</td>
<td>A 0-20. Limited to two (2) services in a six-month period per member by the same provider, facility, or group. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Coverage</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - 2d projection radiographic image created using a stationary radiation source, and detector</td>
<td>A 0-20. Limited to two (2) services in a six-month period per member by the same provider, facility, or group. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210. Requires pre-authorization with narrative explaining medical necessity.</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two (2) radiographic images</td>
<td>A 0-20. One (1) set of D0272 or D0274 images per 175 days, per member. The total cost of bitewings and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four (4) radiographic images</td>
<td>A 0-20. One (1) set of D0272 or D0274 images per 175 days, per member. The total cost of bitewings and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
<td>A 0-20. One (1) D0210 or D0330 per five (5) years per member by the same provider, facility, or group. Covered more frequently if necessary with a rationale for treatment in the event of an orthodontic or oral surgery service. This will be allowed subject to post authorization or prepayment review. In the event of an emergency, this can also be allowed with third molar involvement or trauma, also subject to prepayment review.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D0340</td>
<td>Cephalometric radiographic image</td>
<td>A 0-20. Covered if the member will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria. Requires pre-authorization with narrative explaining medical necessity.</td>
</tr>
<tr>
<td>D0350</td>
<td>2D oral/facial photographic image obtained intra-orally or extra-orally</td>
<td>A 0-20. Requires pre-authorization with narrative explaining medical necessity.</td>
</tr>
</tbody>
</table>

### Diagnostic Casts

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>A 0-20. Covered if the member will qualify for Medicaid coverage of treatment as outlined in the Orthodontic coverage criteria. Requires pre-authorization with narrative explaining medical necessity.</td>
<td>$47.50 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

### Caries Risk Assessment Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0601</td>
<td>Caries risk assessment and documentation, with a finding of low risk</td>
<td>A 0-20. Once every 175 days when billed with a valid exam code (D0120, D0150, or D0145) on the same date of service.</td>
<td>$5.00</td>
</tr>
<tr>
<td>D0602</td>
<td>Caries risk assessment and documentation, with a finding of moderate risk</td>
<td>A 0-20. Once every 175 days when billed with a valid exam code (D0120, D0150, or D0145) on the same date of service.</td>
<td>$5.00</td>
</tr>
<tr>
<td>D0603</td>
<td>Caries risk assessment and documentation, with a finding of high risk</td>
<td>A 0-20. Once every 175 days when billed with a valid exam code (D0120, D0150, or D0145) on the same date of service.</td>
<td>$5.00</td>
</tr>
</tbody>
</table>
## Preventive Services
Preventive services include prophylaxis, topical fluoride treatments, sealants and space maintainers.

### Dental Prophylaxis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis – adult</td>
<td>A 10-20. One (1) D1110 or D1120 per 175 days per member. Includes scaling and</td>
<td>$48.45</td>
</tr>
<tr>
<td></td>
<td></td>
<td>polishing procedure to remove coronal plaque, calculus, and stains.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the member’s dentition is primary, D1120 should be used. If the dentition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is transitional/adult, D1110 should be used.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If billed on the same DOS as any 4000-series code, this procedure code will be</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>denied.</td>
<td></td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis – child</td>
<td>A 0-13. One (1) D1110 or D1120 per 175 days per member. Includes scaling and</td>
<td>$36.10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>polishing procedure to remove coronal plaque, calculus, and stains.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the member’s dentition is primary, D1120 should be used. If the dentition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is transitional/adult, D1110 should be used.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If billed on the same DOS as any 4000-series code, this procedure code will be</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>denied.</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish</td>
<td>A 0-20. One (1) D1206 or D1208 per 175 days.</td>
<td>$19.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride excluding</td>
<td>A 0-20. One (1) D1206 or D1208 per 175 days.</td>
<td>$19.95</td>
</tr>
<tr>
<td></td>
<td>varnish (prophylaxis not included)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Preventive Services
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Payment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1320</strong></td>
<td>Tobacco counseling for the control and prevention of oral disease</td>
<td>A 5-20. Two (2) sessions per year. The provider must document that the member is an active tobacco user in the member’s medical record. The provider must deliver 8 to 15 minutes of tobacco prevention/cessation-specific counseling; A shorter, unscripted statement that tobacco products are bad and the member should not start/quit smoking is not sufficient. Providers are encouraged to develop an outline or specific script to follow to ensure the counseling session meets minimum requirements for payment. The provider must actively refer the member to the AR Department of Health tobacco cessation program. Referral to a tobacco cessation program without 8 to 15 minutes of tobacco prevention/cessation-specific counseling is not sufficient. The provider must document the delivery of the tobacco prevention/cessation-specific counseling and the referral in the member’s medical record.</td>
</tr>
<tr>
<td><strong>D1351</strong></td>
<td>Dental sealant per tooth</td>
<td>A 5-20. One (1) per lifetime per tooth. Limited to 1st and 2nd permanent molars only. Sealants are not covered when placed over restorations. Teeth must be free of proximal caries and free of restorations on the surface to be sealed. This benefit will always include the occlusal surface. Additional surfaces will not have an additional reimbursement. Requires indication of TID 2, 3, 14, 15, 18, 19, 30 or 31.</td>
</tr>
</tbody>
</table>
## Space Maintenance (Passive Appliances)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Space maintainers</td>
<td>A 0-20. One (1) D1510 per year per member, per quadrant. Requires pre-authorization with an indication of quadrant, or TID.</td>
<td>$171.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer. Limited to fixed appliances, including unilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed space maintainers are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (or teeth). Removable maxillary anterior or active space maintainers are not provided. Requires pre-authorization with an indication of quadrant, or TID and an x-ray. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed unilateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Coverage Details</td>
<td>Fee</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>D1516</td>
<td>Space maintainer - fixed – bilateral, maxillary</td>
<td>A 0-20. One (1) D1516 or D1526 per year per member per arch. Requires pre-authorization with an indication of quadrant or TID and an x-ray. The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer. Limited to fixed appliances, including bilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed space maintainers are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (or teeth). Removable maxillary anterior or active space maintainers are not provided. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$256.50 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D1517</td>
<td>Space maintainer - fixed – bilateral, mandibular</td>
<td>A 0-20. One (1) D1517 or D1527 per year per member per arch. Requires pre-authorization with an indication of quadrant or TID and an x-ray. The billing provider is responsible for replacement and recementation within the first six (6) months after placement of the space maintainer. Limited to fixed appliances, including bilateral, that are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed space maintainers are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (or teeth). Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$256.50 ARKids-B $10 copay</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Eligibility</td>
<td>Price</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>D1526</td>
<td>Space maintainer – removable – bilateral, maxillary</td>
<td>A 0-20. One (1) D1526 or D1516 per year per member per arch. Requires pre-authorization with an indication of quadrant, or TID and an x-ray. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$266.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D1527</td>
<td>Space maintainer – removable – bilateral, mandibular</td>
<td>A 0-20. One (1) D1527 or D1517 per year per member per arch. Requires pre-authorization with an indication of quadrant, or TID and an x-ray. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$266.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cement or re-bond space maintainer</td>
<td>A 0-20. One (1) D1550 per year per member. Requires indication of quadrant 10, 20, 30, or 40 (unilateral) or arch 01 or 02 (bilateral). Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$37.05 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer – fixed unilateral</td>
<td>A 0-20. One (1) D1575 per year per member, per quadrant or arch. Requires pre-authorization with an indication quadrant or TID and x-ray. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$171.95 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
Restorative Services

Reimbursement for each covered service includes tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia. Operative dentistry fees include local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

Generally, once a particular restoration is placed on a tooth, a similar restoration will not be covered for at least 24 months, unless there is recurrent decay or material failure.

All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration.

Restorative procedures should be billed on the date the final restoration is completed.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is disallowed.

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider/office/group is responsible for the replacement of the original restoration within the first 24 months after initial placement. Duplicate surfaces are not payable on the same tooth in a 24-month period by same provider/office/group. All restored surfaces on a single tooth shall be considered connected. A restoration to the same tooth surface within 24 months of a previous restoration by a different provider/office/group will require an x-ray for payment and the original restoration will be reviewed for possible recoupment.

The fee for any additional restorative service(s) to other surfaces on the same tooth by the same provider/office/group within 24 months will be paid at the one surface rate. An x-ray is required for permanent teeth. Any additional restorative service(s) to other surfaces on the same tooth by the same provider/office/group within 6 months will also require a narrative.

A restoration to other surfaces on the same tooth within 24 months of a previous restoration by a different provider/office/group will require an x-ray for payment and the original restoration will be reviewed for possible recoupment.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161) or resin-based composite, four (4) or more surfaces or involving incisal angle, anterior (D2335).
All restoration placement must extend through the enamel and into dentin to ensure a successful long-term outcome. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal-occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.

If two (2) or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

### Amalgam Restorations (Including Polishing)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one (1) surface - primary or permanent</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surface with claim submission. Allowed every 24 months. Amalgam restorations are permitted on anterior teeth if clinically appropriate with a rationale.</td>
<td>$65.55 ARKids-B $10 copay</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two (2) surfaces - primary or permanent</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three (3) surfaces - primary or permanent</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four (4) or more surfaces - permanent</td>
<td>A 0-20. This procedure is reimbursable for tooth 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
</tbody>
</table>

Resin-Based Composite Restorations – Direct

Resin restoration includes composites or glass ionomer.

Duplicate surfaces are not payable on the same tooth in resin-based restorations in a 24-month period by the same provider, office, or group. The maximum allowable fee for any combination of amalgam and resin surfaces is the fee for a four or more surface restoration.

The original billing provider/office/group is responsible for the replacement of the original restoration within the first 24 months after initial placement. Duplicate surfaces are not payable on the same tooth in a 24-month period by same provider/office/group. All restored surfaces on a single tooth shall be considered connected. A restoration to the same tooth surface within 24 months of a previous restoration by a different provider/office/group will require an x-ray for payment and the original restoration will be reviewed for possible recoupment.

The fee for any additional restorative service(s) to other surfaces on the same tooth by the same provider/office/group within 24 months will be paid at the one surface rate. An x-ray is required for permanent teeth. Any additional restorative service(s) to other surfaces on the same tooth by the same provider/office/group within 6 months will also require a narrative.

A restoration to other surfaces on the same tooth within 24 months of a previous restoration by a different provider/office/group will require an x-ray for payment and the original restoration will be reviewed for possible recoupment.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2330</td>
<td>Resin-based composite - one (1) surface, anterior</td>
<td>A 0-20. This procedure is reimbursable for tooth C-H, M-R, 6-11, and 22-27. Requires TID and surface with claim submission. Allowed every 24 months.</td>
<td>$76.95 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two (2) surfaces, anterior</td>
<td>A 0-20. This procedure is reimbursable for tooth C-H, M-R, 6-11, and 22-27. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$95.95 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three (3) surfaces, anterior</td>
<td>A 0-20. This procedure is reimbursable for tooth C-H, M-R, 6-11, and 22-27. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$114.95 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four (4) or more surfaces or involving incisal angle, anterior</td>
<td>A 0-20. Requires pre-authorization and x-rays. This procedure is reimbursable for tooth C-H, M-R, 6-11, and 22-27. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$144.40 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite – one (1) surface, posterior</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surface with claim submission.</td>
<td>$65.55 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite – two (2) surfaces, posterior</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$80.75 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite – three (3) surfaces, posterior</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$94.05 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite – four (4) or more surfaces, posterior</td>
<td>A 0-20. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$114.95 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
Crowns

Crown services require radiographic images that depict the pre- and post-treatment condition. The documentation supporting the need for crown services must be available for review by MCNA upon request.

### Other Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Procedure codes D2710, D2740, D2752, D2930, D2931, and D2934 represent final restorations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Please refer to each specific CDT code in this section for prior authorization and documentation requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc., must be radiographically evident and/or documented in the member's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by MCNA upon request.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a crown is placed on a tooth that received a restoration within the past 12 months by the same provider, facility, or group, the fee for the crown will be reduced by the fee paid for the prior restoration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In the event, a covered crown service is started but not completed due to the member’s loss of eligibility, the provider may submit a claim for services performed and lab bills incurred prior to the member’s loss of eligibility. A narrative and copies of lab bills should be submitted with a D9999 claim. Not applicable with D2930, D2931, or D2934 codes. Any approved payment will be manually priced by the MCNA dental director.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In the event, a covered crown service is started but not completed due to loss of contact with the member or the member’s refusal to return to complete the service, the provider may submit a claim for services performed and lab bills incurred prior to the member’s loss of contact with the provider. A narrative and copies of lab bills should be submitted with a D9999 claim. Required documentation includes evidence the member will not be returning or a copy of a referral to MCNA member outreach and member outreach has been unsuccessful in making contact with the member for a minimum of 30 days. Not applicable with D2930, D2931, or D2934 codes. Any approved payment will be manually priced by the MCNA dental director.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2710</td>
<td>Crown - resin-based composite (indirect)</td>
<td>A 0-13. One (1) D2710, D2740, or D2752 per 84 months, per member, per tooth.</td>
<td>$371.45 ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-authorization, TID 6-11, 22-27, and pre-operative x-rays. Claim submission requires a post-operative x-ray with TID.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Description</td>
<td>Coverage</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown – porcelain/ceramic</td>
<td>A 14-20. One (1) D2710, D2740 or D2752 per 84 months, per member, per tooth. Only approved in unusual cases, including cases involving trauma or where there is no other clinically acceptable alternative. Requires pre-authorization, TID 6-11, 22-27, and pre-operative x-ray. Claim submission requires a post-operative x-ray with TID. Eligible for post authorization (Refer to Pre-Authorization of Care section).</td>
<td>$610.85 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused noble metal</td>
<td>A 14-20. One (1) D2710, D2740, or D2752 per 84 months, per member, per tooth. Only approved in unusual cases, including cases involving trauma or where there is no other clinically acceptable alternative. Requires pre-authorization TID 6-11, 22-27, and pre-operative x-ray. Claim submission requires a post-operative x-ray with TID. Eligible for post authorization (Refer to Pre-Authorization of Care section).</td>
<td>$610.85 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
<td>A 0-20. Not payable for the initial six (6) months after crown placement, then limited to one (1) per tooth every six (6) months. Not allowed within six (6) months of D2710, D2752, D2920, D2930, or D2931. The billing provider, office, or group is responsible for recementation within the first six (6) months after placement of the crown. Requires TID 1-32, A-T.</td>
<td>$43.70 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>A 0-20. One (1) D2930 or D2934 per 24 months, per member, per tooth. Requires TID A-T. Requires x-ray for teeth within shed range or over-retained.</td>
<td>$140.60 ARKids-B $10 copay</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Eligibility</td>
<td>Cost</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>A 0-20. One (1) D2931 per 24 months, per member, per tooth. Prior authorization with x-ray required for TIDs 1,16, 17, 32. Prior authorization allowed with x-ray for all other TIDs. Pre-operative x-rays must be retained in patient record and available for inspection on request for all TIDs. Eligible for post authorization (Refer to Pre-Authorization of Care section). $158.65 ARKids-B $10 copay</td>
<td></td>
</tr>
<tr>
<td>D2934</td>
<td>Prefabricated esthetic coated stainless steel crown – primary tooth</td>
<td>A 0-20. One (1) D2934 per 24 months per member, per tooth. Requires TID A-T. Requires x-ray for teeth within shed range or over-retained. $140.60 ARKids-B $10 copay</td>
<td></td>
</tr>
<tr>
<td>D2950</td>
<td>Core build-up, including any pins</td>
<td>A 0-20. Limited to traumatic conditions. Requires pre-authorization with x-ray, narrative, and TID. Eligible for post authorization (Refer to Pre-Authorization of Care section). $125.40 ARKids-B $10 copay</td>
<td></td>
</tr>
</tbody>
</table>
Endodontic Therapy Services

Complete root canal therapy includes pulpectomy and radiographs performed pre-, intra-, and post-operatively, local anesthesia, all appointments necessary to complete treatment, temporary fillings, and filling and obturation of canals.

Documentation supporting medical necessity must be kept in the member's record and include the following:

- medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status
- the final size of the file to which the canal was enlarged
- the type of filling material used

Only endodontic treatment completed to an acceptable standard of care will be approved for reimbursement. In cases where a root canal filling does not meet MCNA's general criteria treatment standards, MCNA will require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA’s Clinical Reviewer reviews the circumstances. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Root canal therapy is billable upon completion of the final fill. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g. Sargenti filling material) is not covered.

### Pulpotomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and the application of medicament</td>
<td>A 0-20. One (1) D3220 per lifetime, per member, per tooth. Not to be considered as first step of root canal therapy. Not allowed on same DOS as endodontic therapy. Requires TID A-T. Pre-authorization with x-ray required for TID 1-32 with a narrative explaining medical necessity and an x-ray. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$86.45 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D3221</td>
<td>Pulpal debridement, primary and permanent teeth</td>
<td>A 0-20. One (1) D3221 per lifetime, per member, per tooth.</td>
<td>$92.15 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
### Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3310</td>
<td>Endodontic therapy, anterior tooth (excluding final restorative)</td>
<td>A 6-20. One (1) per lifetime, per member per tooth. If submitted within two (2) years after D3220 on this tooth fee for this service will be reduced by the fee for the D3220. Requires submission of pre- and post-operative x-rays, and TID 6-11, 22-27.</td>
<td>$404.70 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, premolar tooth (excluding final restorative)</td>
<td>A 6-20. One (1) per lifetime per member per tooth. If submitted within two (2) years after D3220 on this tooth fee for this service will be reduced by the fee for the D3220. Requires submission of pre- and post-operative x-rays, and TID 4, 5, 12, 13, 20, 21, 28, or 29.</td>
<td>$474.05 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D3330</td>
<td>Endodontic therapy, molar tooth (excluding final restorative)</td>
<td>A 6-20. One (1) per lifetime per member per tooth. If submitted within two (2) years after D3220 on this tooth fee for this service will be reduced by the fee for the D3220. Not covered for 2nd or 3rd molar unless 1st molar is not present. Not covered for maxillary 1st molar if 2nd molar is unerupted. Requires submission of pre- and post-operative x-rays, and TID 1-3, 14-19, and 30-32.</td>
<td>$599.45 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

Complete endodontic therapy (procedures D3310, D3320 and D3330) includes treatment plan, all appointments necessary to complete treatment, clinical procedures, all intra-operative radiographic images (which must include a post-operative radiograph) and follow-up care. **Diagnostic evaluation and necessary radiographs/diagnostic images can be billed separately.** In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated.

Root canals require submission of pre- and post-operative radiographs with the claim in order to receive reimbursement.

A pre-operative radiograph (D0220) is payable to a General Dentist, Pediatric Dentist, or Endodontist prior to or on the date of endodontic service if required for claim submission. Intra-operative and post-operative radiographs are included in the fee for endodontic services and will not be paid separately. A justification is required if a claim for more than one pre-operative x-ray is submitted.

The date of service on the payment request must reflect the final treatment date. Written documentation must also include the type of filling material used as well as the notation of any complications encountered which may compromise the success of the endodontic treatment.

Not a benefit for third molars.
## Apicoectomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>A 6-20. Only considered for trauma cases. When submitting claims, requires submission of pre- and post-operative x-rays.</td>
<td>$380.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
</tbody>
</table>
Periodontal Services

Designated periodontal services require pre-authorization, x-rays, and rationale with documentation of medical necessity. In most cases, preventive dental procedure codes D1110, D1120, and D1351 submitted for the same DOS as any D4000-series periodontal procedure codes will be denied.

Periodontal services include gingivectomy, periodontal scaling and root planing, full mouth debridement, and unspecified periodontal procedures. Local anesthesia is considered to be part of periodontal procedures. Surgical services include usual post-operative care.

Nonsurgical Periodontal Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing, four (4) or more teeth, per quadrant</td>
<td>A 0-20. One (1) D4341 per 12 months, per member, per quadrant (10, 20, 30, 40). At least 4 mm pocket on four (4) or more affected teeth per quadrant. Periapical x-rays must show subgingival calculus and/or loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes or with D1120 or D1110. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting, narrative explaining medical necessity, and indication of quadrant (10, 20, 30, 40). Eligible for post authorization (Refer to Pre-authorization of Care section)</td>
<td>$142.50 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation</td>
<td>A 0-20. Only one (1) D4346, D1110 or D1120 per member per 175 days. Denied when submitted for the same date of service as any other D4000 series codes.</td>
<td>$48.45 ARKids-B $10 copay</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Reimbursable</td>
<td>Notes</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit</td>
<td>A 0-20</td>
<td>Reimbursable once every 12 months per member. Limited to patients with excessive plaque that prevents the dentist from completing a comprehensive oral evaluation. The D4355 will be denied if billed on the same DOS as any CDT oral evaluation code and/or D1110, D1120 or D4910. D4355 will be denied if provided within 21 days of D4341. Denied when submitted for the same date of service as other D4000 series codes. This procedure will not be reimbursed if payment has previously been made for D1110 or D1120 to the same billing provider, office, or group within a 12-month period. Requires a pre-authorization, x-rays, and rationale. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance procedures</td>
<td>A 0-20</td>
<td>Reimbursable one (1) per year. Must have received D4341 periodontal scaling and root planing. Not payable on the same DOS as D1110 or D1120. The D4910 will be denied if billed for the same DOS as D1110 or D1120. Requires pre-authorization with date of completion of D4341 and periodontal chart. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
</tr>
</tbody>
</table>
Removable Prosthodontics

Medically necessary partial or full mouth dentures and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member’s dental problem. Eligible members have a lifetime limit of one partial and one full denture per arch. A minimum of 24 months must have elapsed after a partial is placed before a full denture benefit will be paid.

Provision for dentures for cosmetic purposes is not a covered service.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Billing for space maintainers fixed and removable prosthetics, is to be on the insertion or cementation date.

Removable prosthodontic services include complete dentures, partial dentures, denture repairs, and denture relines.

Documentation requirements are included to conform to state and federal regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

The provider is required to obtain acceptance of esthetic appearance from the member prior to processing. This acceptance must be documented by the member’s signature in the treatment record.

- The denture should be flasked and processed under heat and pressure in a commercial or dental office laboratory using ADA-certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the member’s dental record.
- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasp must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the member (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and esthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The delivery date of the denture and/or partial dentures is the billing date of service.

All dentures must be covered by a one-year warranty covering manufacturing defect or component failure. Dentures that do not meet acceptable quality, fit and finish standards as determined by MCNA clinical reviewers are subject to recoupment.

The dentist is responsible for all necessary adjustments required during the first six (6) months following delivery. Any exams are inclusive to this process and not reimbursable.
### Complete Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Dentures complete maxillary</td>
<td>A 0-20. One (1) D5110 per lifetime. Requires pre-authorization and pre-operative x-rays and narrative explaining medical necessity. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$807.50 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D5120</td>
<td>Dentures complete mandible</td>
<td>A 0-20. One (1) D5120 per lifetime. Requires pre-authorization and pre-operative x-rays and narrative explaining medical necessity. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$807.50 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

The following codes require pre-authorization and x-rays. The provider must inform the member that relines are not covered within six (6) months of the delivery date of the denture. A minimum of 24 months must elapse between coverage for a partial and coverage for a full denture on the same arch.

### Partial Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
</table>

The following codes require pre-authorization, x-rays, and rationale.

Medicaid may provide a partial denture (D5211, D5212, D5225, D5226) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:

- Missing one (1) or more adjacent maxillary anterior teeth, or
- Missing one (1) or more adjacent mandibular anterior teeth, or
- Missing at least two (2) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or
- Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement).

An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Arkansas Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries-free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of a partial denture.

Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth.
Only permanent teeth are eligible for replacement by a partial denture.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>A 0-20. One (1) D5211 or D5225 per lifetime. Requires pre-authorization including pre-operative x-rays and list of teeth that will be replaced.</td>
<td>$570.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>A 0-20. One (1) D5212 or D5226 per lifetime. Requires pre-authorization including pre-operative x-rays and list of teeth that will be replaced.</td>
<td>$570.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>D5225</td>
<td>Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)</td>
<td>A 0-20. One (1) D5211 or D5225 per lifetime. Requires pre-authorization including pre-operative x-rays and list of teeth that will be replaced.</td>
<td>$570.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>D5226</td>
<td>Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)</td>
<td>A 0-20. One (1) D5212 or D5226 per lifetime. Requires pre-authorization including pre-operative x-rays and list of teeth that will be replaced.</td>
<td>$570.00 ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
</tbody>
</table>

Adjustments to Dentures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture maxillary</td>
<td>A 0-20. Not covered within six (6) months of initial placement. Three (3) per lifetime</td>
<td>$41.80 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture mandibular</td>
<td>A 0-20. Not covered within six (6) months of initial placement. Three (3) per lifetime</td>
<td>$41.80 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture maxillary</td>
<td>A 0-20. Not covered within six (6) months of initial placement. Three (3) per lifetime</td>
<td>$41.80 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
D5422  Adjust partial denture mandibular  A 0-20. Not covered within six (6) months of initial placement. Three (3) per lifetime  $41.80  ARKids-B  $10 copay

## Repairs to Complete and Partial Dentures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular  A 0-20. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$76.95  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary  A 0-20. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.  If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td>$76.95  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular  A 0-20. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.  If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td>$76.95  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary  A 0-20. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.  If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td>$76.95  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5621</td>
<td>Repair cast partial framework, mandibular  A 0-20.</td>
<td>$127.30  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5622</td>
<td>Repair cast partial framework, maxillary  A 0-20.</td>
<td>$127.30  ARKids-B  $10 copay</td>
<td></td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth (each tooth)  A 0-20.  Requires rationale and TID 1-32.</td>
<td>$75.05  ARKids-B  $10 copay</td>
<td></td>
</tr>
</tbody>
</table>
Add tooth to existing partial denture

A 0-20.

Requires rationale and TID 1-32.

$97.85

ARKids-B

$10 copay

### Denture Reline Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>A 0-20. Not covered within six (6) months of initial placement or reline.</td>
<td>$163.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
<td>A 0-20. Not covered within six (6) months of initial placement or reline.</td>
<td>$163.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>A 0-20. Not covered within six (6) months of initial placement.</td>
<td>$259.35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>A 0-20. Not covered within six (6) months of initial placement.</td>
<td>$259.35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
</tbody>
</table>

Allowed if the reline makes the denture serviceable. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. The dentist is responsible for all necessary adjustments for a period of six (6) months.

Not covered within six (6) months of initial placement of dentures. Reimbursement for complete and partial denture relines are allowed only if six (6) months has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within six (6) months after delivery of the reline, the reline fee will be deducted from the new prosthesis fee.

### Fixed Prosthodontics

**Other Fixed Partial Dental**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>A 0-20. Not covered within six (6) months of initial placement. Requires arch 01 or 02 and rationale.</td>
<td>$64.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10 copay</td>
</tr>
</tbody>
</table>
Oral and Maxillofacial Surgery Services

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic teeth is not a covered benefit. Symptomatic conditions include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. Extractions for dentures are a covered benefit.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7111</td>
<td>Extraction coronal remnants - deciduous tooth</td>
<td>A 0-20. Requires TID A-T, AS-TS. All primary teeth within the ADA’s shed age chart or over-retained will require an x-ray with claim submission.</td>
<td>$47.50 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>A 0-20. Requires TID 1-32, 51-82, A-T, AS-TS. TIDs A-T within the normal exfoliation period require submission of an x-ray. All primary teeth within the ADA’s shed age chart or over-retained will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and rationale. TIDs 1, 16, 17, 32 require submission of an x-ray and rationale with claim submission.</td>
<td>$72.20 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

http://www.ada.org/~/media/ADA/Publications/Files/patient_56.ashx
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>A 0-20. Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Requires TID 1-32, 51-82, A-T, AS-TS, pre-authorization with x-rays, and rationale. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$138.70 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
<td>A 0-20. Removal of asymptomatic tooth not covered. Requires TIDs 1-32, 51-82, A-T, AS-TS, pre-authorization with x-rays, and rationale. Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$180.50 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
## D7241
Removal of impacted tooth - completely bony, with unusual surgical complications

A 0-20. Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction.

Removal of asymptomatic tooth not covered.

Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis, which means that providers must submit pre- and post-operative x-rays and detailed rationale on the claim submission outlining the unusual surgical complications.

Requires TID 1-32, 51-82, A-T, AS-TS, with pre- and post-operative x-rays, and rationale.

### Other Surgical Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7270</td>
<td>Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth</td>
<td>A 0-20. This procedure is not reimbursable for periodontal splinting. Includes splinting and/or stabilization.</td>
<td>$211.85 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

Requires pre-authorization, TID, pre- and post-operative x-rays, and rationale.

Eligible for post authorization (Refer to Pre-Authorization of Care section)
<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Description</th>
<th>Modifier</th>
<th>Price</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7280</td>
<td>Exposure of an un-erupted tooth</td>
<td>A 0-20.</td>
<td>$149.15</td>
<td>ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td>Requires TID 1-32, pre-authorization with x-rays, and rationale.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>A 1-20.</td>
<td>$215.65</td>
<td>ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization, x-rays, and rationale.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue - hard (bone, tooth)</td>
<td>A 1-20.</td>
<td>$119.70</td>
<td>ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization, x-rays, and rationale.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7286</td>
<td>Incisional biopsy of oral tissue - soft</td>
<td>A 1-20.</td>
<td>$110.20</td>
<td>ARKids-B $10 copay</td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization, color photograph, and rationale. A pathology report must be available for review on request.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Surgical Incision

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
<td>A 0-20. Not payable on same DOS as D7111, D7140, D7210, D7220, D7230, D7240, D7241, or D7250 for the same tooth per day, per member.</td>
<td>$87.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires preauthorization with a color photo, TIDs 1-32, 51-82, A-T, AS-TS. Not payable for same tooth on the same DOS as the extraction.</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td>$10 copay</td>
</tr>
</tbody>
</table>

## Frenulectomy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7960</td>
<td>Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure</td>
<td>A 0-20. Procedure not recommended until eruption of permanent maxillary canines.</td>
<td>$189.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The frenum may be excised when the tongue has limited mobility, for large diastemas between teeth, or when frenum interferes with a prosthetic appliance, or when it is the etiology of periodontal tissue disease.</td>
<td>ARKids-B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The specific dental reason is required for authorization. If the specific reason is not dental, e.g., if a speech impediment is the reason for the request, then a written statement from a speech pathologist or physician must be submitted.</td>
<td>$10 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-authorization, color photos, and rationale.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
</tbody>
</table>
Orthodontic Services
Medically necessary orthodontic procedures for members aged 20 years and younger, including limited, interceptive and comprehensive treatments, are covered services, but will only be approved for the most severe malocclusions. Assessment of the most severe malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing/impacted teeth, overjet, overbite, openbite and crossbite. Because a case must be severe to be accepted for orthodontic treatment, beneficiaries whose molars and bicuspid are in good occlusion seldom qualify. Crowding or spacing alone does not qualify. Orthodontic services for cosmetic purposes are not covered.

In most cases, Orthodontic services are a once-in-a-lifetime benefit. In addition, the lifetime maximum orthodontic benefit is $4,174.30 for all orthodontic services. A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090) and is not included in the calculation of a member’s lifetime orthodontic benefit dollar limit.

The member must be a good candidate for orthodontic treatment as assessed by the potential provider. The member must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, etc.) must be completed prior to submission of an orthodontic prior authorization request.

Pre-authorization requests must be submitted and approved prior to providing orthodontic services. A provider should not begin orthodontic treatment until the pre-authorization request has been approved.

The following artifacts must be submitted with the request for pre-authorization. MCNA will not return radiographs, study models, or other related artifacts. Please submit duplicate sets of these artifacts when you include them with your preauthorization request. Do not submit originals with your preauthorization request.

- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.
- Completed MCNA Request for Orthodontic Treatment HLD Scoring Form.
- Full mouth diagnostic quality radiographs or a panoramic radiograph.
- Complete set of diagnostic quality color photos.
- Diagnostic quality study models (or OrthoCad equivalent). Please note: instead of submitting physical study models with a prior authorization request, providers are encouraged to submit diagnostic quality digital images of the study model. Five images w/millimeter scale are required: 1) frontal view (with the study model in centric occlusion) 2) right lateral view (with the study model in centric occlusion) 3) left lateral view (with the study model in centric occlusion) 4) occlusal view of the upper arch 5) occlusal view of the lower arch.
- Diagnostic quality Cephalometric radiograph w/millimeter scale.
- Please submit each orthodontic case with all records and documentation in their entirety. If the records and documentation submitted are incomplete, over 6 months old, or not of diagnostic quality the case will be denied. If the submitted records are not of diagnostic quality, the provider must provide new diagnostic quality records at no additional cost to MCNA or the member.

Every orthodontic prior authorization case is clinically reviewed by a licensed Orthodontist in order to properly evaluate criteria for services.
Most cases involving craniofacial anomalies and/or cleft palates will be covered by the Arkansas Medicaid fee-for-service medical program. If a provider wants to submit a preauthorization for the orthodontic component of such a case, please include all documentation including the appropriate ICD-10 diagnostic codes on your completed ADA claim form (2012 or newer).

The billing date for orthodontic services is the day that bands, brackets, or appliances are placed in the member's mouth. The member must be eligible on this date of service. The member and/or responsible party must sign a non-covered treatment form for any services they agree to pay for under a private pay agreement. Please note that no orthodontic service should be performed without an approved prior authorization and no orthodontic claim should be submitted until placement has occurred.

For comprehensive orthodontic services (CDT codes: D8070, D8080 and D8090), reimbursement for approved orthodontic services will be made. When a pre-authorization request is approved, MCNA will authorize a total of eight (8) units of the requested orthodontic procedure code. The date of banding must be submitted and 30% will be paid for that initial submission. The remaining amount due will be divided evenly over the remaining 7 units. These units are to be billed on a quarterly basis with the first quarter being billed at least 90 days after banding. The total authorized reimbursement will equal the allowed fee on the current fee schedule for the approved CDT code. Please note that the 180-day window to file a claim related to an approved pre-authorization only applies to the date-of-service of the banding visit. Payments will continue to be made to the provider quarterly as long as the provider continues to provide follow-up treatments and submit quarterly claims. In the event the member moves or requests a transfer, or is discharged by the treating provider prior to the completion of the treatment plan, any remaining payments will be remitted to the member's new treating dentist.

For comprehensive orthodontic services paid via quarterly payments, in the event of a member’s loss of Medicaid eligibility, MCNA will pay the remaining balance in full. Upon notice of loss of eligibility, the provider should file a claim for the remaining unpaid balance using the previously approved orthodontic code. The member’s final date of eligibility with MCNA should be used as the DOS on the claim. A narrative is also required. See the Transfer Cases section below if a member undergoing orthodontic treatment transfers to a different AR Medicaid dental plan.

Payment for an approved limited, interceptive or comprehensive orthodontic treatment is fully inclusive and includes all appliances, retainers, dental records (case work ups), and follow-up visits. Broken and loose appliances or broken and loose brackets/bands are not reimbursed separately and may not be charged to the member. Members may not be charged for missed appointments. There is no additional reimbursement allowed for the replacement of removable orthodontic appliances, including retainers. The member's medical record should also contain a final treatment photo.

Orthodontic dental records are considered an integral part of orthodontic treatment and payment for an approved orthodontic service includes the reimbursement for these services. Orthodontic dental records may include: D0140, D0330, D0340, D0350, D0470.

In the event that an approved pre-authorization is issued but the approved orthodontic service is not initiated for any reason, the provider can submit a claim for documented orthodontic dental records services performed to secure the approval including D0140, D0330, D0340, D0350, and D0470. The claim will be reviewed for payment by the MCNA Arkansas Dental Director. A narrative is required with the claim; Records will be paid with:
• Evidence the member will not be returning, or
• A documented referral to MCNA member outreach and member outreach has been unsuccessful in making contact for a minimum of 30 days

If a comprehensive prior authorization request is denied, and the HLD score, as calculated by the MCNA clinical reviewer, is 21 or higher, a claim for records will be paid.

For proposed limited and interceptive services (D8020, D8030, D8040, D8060), if a prior authorization is denied, all related records services are also denied. An Oral exam D0140 fee is permitted related to a denied prior authorization (subject to existing frequency and other benefits limits).
Transfer Cases
Transfers will be considered and must be submitted for prior authorization along with all required documentation, which may include:

- ADA claim form (2012 or newer) describing the treatment to be completed, including a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time
- Completed MCNA Request for Orthodontic Treatment HLD Scoring Form
- Full mouth diagnostic quality radiographs or a panoramic radiograph
- Complete set of diagnostic quality color photos
- Diagnostic quality study models (or OrthoCad equivalent)
- Diagnostic quality Cephalometric radiograph w/millimeter scale
- Treatment plan describing the continuation of treatment
- Treatment and records from the banding provider, office or group
- Statement of account and EOBs for any third party payments to the banding provider, office or group
- Approved prior authorization issued by a non-MCNA AR Medicaid dental plan

1. Member transfers to a different MCNA provider
   a. In the event an MCNA member transfers to a different MCNA provider, office or group after banding has occurred, a new prior authorization should be submitted by the new provider/office/group covering the remaining follow-up treatment and de-banding. New records are not required unless requested by the MCNA orthodontic dental director. The orthodontic dental director will review the case and determine the fee for all remaining services. The orthodontic dental director will also determine the amount (if any) to be recouped from the original provider, facility or group.

2. Member Transfer from MCNA Plan
   a. For comprehensive orthodontic services paid via quarterly payments, in the event of a member’s transfer from MCNA to a different AR Medicaid dental plan, the new plan will be responsible for any remaining follow-up treatment and payments. The orthodontic dental director will review the case and determine the amount (if any) to be recouped from the original provider, facility or group.

3. Member Transfer to MCNA Plan
   a. If a member assigned to MCNA has an orthodontic appliance(s) placed prior to the member’s MCNA effective date that was not provided by the AR Medicaid dental program:
      i. MCNA will only cover payment for continuation of orthodontic treatment if BOTH of the following conditions are met:
         1. It can be determined that the member’s pre-banding condition would have qualified for orthodontic treatment under AR Medicaid orthodontic benefit guidelines. Pre-banding records should be obtained from the original provider and submitted for review by MCNA, and
         2. There is no evidence of previous third party payment for the requested treatment; an account statement and third party EOBs should be obtained from the original provider and submitted for review by MCNA.
ii. A prior authorization is required. In the event pre-banding records are not available from the banding provider, continuation treatment will only be approved if, in the opinion of the MCNA orthodontic dental director, the member’s pre-banding dentition would have qualified for treatment under existing AR Medicaid guidelines. The provider should file a prior authorization with both pre-banding (if available) and current records and a treatment plan using D8999.

iii. If continuation treatment is not approved, the member has the option to continue treatment under a self-pay arrangement with the provider or MCNA will cover de-banding.
   1. If the member elects to continue treatment and self-pay, an MCNA Patient Responsibility Form should be signed
   2. If the member elects to de-band, the provider should submit a prior authorization with appropriate records and a narrative using D8999. When the claim is submitted, the DOS of the claim should be the de-band date. If approved, the de-banding fee will be manually priced by the orthodontic dental director up to a maximum of $518.70

b. If an AR member assigned to MCNA has transferred from a different AR Medicaid dental plan and has an orthodontic appliance(s) provided by that plan:
   i. MCNA will cover any remaining follow up treatment and payment based on the previously approved treatment plan beginning on the member’s date of assignment to MCNA.

If any prior authorized orthodontic treatment is not completed, the dentist who obtained the original authorization and initiated the treatment shall refund to MCNA the portion of the amount paid by MCNA that applies to the treatment not completed. The request to discontinue treatment must be submitted and reviewed by MCNA to determine the amount to be refunded.

In the most severe cases (skeletal Class II and Class III; HLD score of 28 or higher), a two-phased treatment plan involving an initial limited treatment of the transitional dentition, followed at a later time by a treatment of the adolescent or adult dentition, may be requested. D8070 is only to be used for the phase one treatment of a two-phase treatment plan. The total fee paid for both phases cannot exceed the lifetime maximum benefit of $4174.30. If a provider intends to implement a two-phased treatment plan, both phases must be documented in the prior authorization request for the phase one treatment. If the phase one treatment is approved, a second prior authorization request must be submitted and approved prior to the phase two treatment. As a result of the phase one treatment, the HLD score related to the phase two treatment may not meet the required 28 points. Only in the case of a phase two treatment, the 28 points minimum will not apply for a requested comprehensive treatment. The phase two prior authorization request must include the approved phase one treatment plan as well as all required clinical documentation.

In the event that submitted case records justify Limited or Interceptive orthodontic treatment, pricing will be performed by the clinical reviewer according to the following guidelines:

- **D8020 - Limited, Transitional Dentition**
  1. Will be manually priced and if approved will pay either $1600.00, $2000.00, or $2450.00 as follows:
     1. Single tooth anterior crossbite $1600.00
     2. Multiple tooth anterior crossbite $2000.00
     3. Unilateral crossbite $2000.00
4. Unilateral crossbite with RPE  $2000.00
5. Impactions, anterior teeth only $2450.00

- **D8030 - Limited, Adolescent Dentition**
  1. Will be manually priced and if approved will pay $1600.00, $2000.00, or $2450.00 as follows:
     1. Single tooth anterior crossbite $1600.00
     2. Multiple tooth anterior crossbite $2000.00
     3. Anterior & posterior crossbite $2450.00
     4. Unilateral crossbite $2000.00
     5. Bilateral posterior crossbite $2450.00
     6. Impactions, anterior teeth only $2450.00

- **D8040 - Limited, Adult Dentition**
  1. Will be manually priced and if approved will pay $1600.00, $2000.00, or $2450.00 as follows:
     1. Single tooth anterior crossbite $1600.00
     2. Multiple tooth anterior crossbite, one arch treatment $2000.00
     3. Anterior & posterior crossbite $2450.00
     4. Unilateral crossbite $2000.00
     5. Bilateral posterior crossbite $2450.00
     6. Impactions, anterior teeth only $2450.00

- **D8060 - Interceptive, Transitional Dentition**
  1. If approved will pay as follows:
     1. Anterior crossbite with RPE $2450.00
     2. Bilateral posterior crossbite $2450.00
     3. Impactions, anterior teeth only $2450.00

Please note: In the event a case includes more than one qualifying condition, treatment will be approved and the fee established based on the most severe condition.

**HLD Scoring guidelines**

For Comprehensive treatment:

- Must score 28 or higher on the Arkansas HLD score sheet
- Must be over 13 or have no deciduous teeth remaining (unless primary teeth retained due to ectopic position of underlying permanent tooth or a missing permanent tooth in the area). This does not apply for cleft or craniofacial cases
- Must have full diagnostic records (with quality photos) and written treatment plan
- Cannot double score ectopic eruption and crowding
- Cannot score overjet and class III
- Open bite cannot show vertical overlap
- No records fee is allowed if a case is scored at 20 or less by a clinical reviewer

For Limited/Interceptive treatment:

- Records must clearly demonstrate one or more qualifying conditions:
  1. Single or multiple tooth anterior crossbite
  2. Unilateral crossbite with functional shift (must be documented with photos - midlines off)
  3. Bilateral posterior crossbite (2 or more teeth on each side)
• Impacted teeth, must:
  1. Have abnormal eruptive path
  2. be an anterior tooth
  3. be covering a portion of the root of an adjacent tooth on a panoramic radiograph
  4. posterior impactions do not qualify
• A case exhibiting obvious Class III skeletal malocclusion as evidenced by a Cephalometric Radiograph (Class III molar relationship does not automatically qualify)
• Records will not be paid if the prior authorization is denied. A D0140 can be billed on a denial (subject to existing frequency and other benefit limits)
• In the event a case includes more than one qualifying condition, treatment will be approved and the fee established based on the most severe condition
# Orthodontic Fee Schedule

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8020</td>
<td>Limited orthodontic treatment of the transitional dentition</td>
<td>A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services.</td>
<td>Manually priced ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

Requires:

- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.
- Completed Handicapping Labiolingual Deviation (HLD) Index form.
- Full mouth diagnostic quality radiographs or a panoramic radiograph.
- Complete set of diagnostic quality color photos.
- Diagnostic quality study models or OrthoCad equivalent (or digital images)
- Diagnostic quality Cephalometric radiograph w/millimeter scale.

Must cause dysfunctional malocclusion and have one (1) or more qualifying conditions.

A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Eligibility</th>
<th>Requirements</th>
<th>ARKids-B Copay</th>
</tr>
</thead>
</table>
| D8030  | Limited orthodontic treatment of the adolescent dentition                  | A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services | Requires:  
- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.  
- Completed Handicapping Labiolingual Deviation (HLD) Index form.  
- Full mouth diagnostic quality radiographs or a panoramic radiograph.  
- Complete set of diagnostic quality color photos.  
- Diagnostic quality study models or OrthoCad equivalent (or digital images)  
- Diagnostic quality Cephalometric radiograph w/millimeter scale.  
Must cause dysfunctional malocclusion and have one (1) or more qualifying conditions.  
A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090) | Manually priced $10 }
<table>
<thead>
<tr>
<th>D8040</th>
<th>Limited orthodontic treatment of the adult dentition</th>
<th>A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services.</th>
<th>Manually priced ARKids-B $10 copay</th>
</tr>
</thead>
</table>

Requires:

- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.
- Completed Handicapping Labiolingual Deviation (HLD) Index form.
- Full mouth diagnostic quality radiographs or a panoramic radiograph.
- Complete set of diagnostic quality color photos.
- Diagnostic quality study models or OrthoCad equivalent (or digital images)
- Diagnostic quality Cephalometric radiograph w/millimeter scale.

Must cause dysfunctional malocclusion and have one (1) or more qualifying conditions.

A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
</table>
| D8060 | Interceptive orthodontic treatment of the transitional dentition | A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services. Interceptive orthodontics may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth or the correction of a dental crossbite. Requires:  
- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.  
- Completed Handicapping Labiolingual Deviation (HLD) Index form.  
- Full mouth diagnostic quality radiographs or a panoramic radiograph.  
- Complete set of diagnostic quality color photos.  
- Diagnostic quality study models or OrthoCad equivalent (or digital images)  
- Diagnostic quality Cephalometric radiograph w/millimeter scale. Must cause dysfunctional malocclusion and have one (1) or more qualifying conditions. A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090). | Manually priced ARKids-B $10 copay |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requirements</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional dentition</td>
<td>A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services. D8070 is only to be used for the phase one treatment of a two-phase treatment plan. Requires: &lt;ul&gt;&lt;li&gt;ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.&lt;/li&gt;&lt;li&gt;Completed Handicapping Labiolingual Deviation (HLD) Index form.&lt;/li&gt;&lt;li&gt;Full mouth diagnostic quality radiographs or a panoramic radiograph.&lt;/li&gt;&lt;li&gt;Complete set of diagnostic quality color photos.&lt;/li&gt;&lt;li&gt;Diagnostic quality study models or OrthoCad equivalent (or digital images)&lt;/li&gt;&lt;li&gt;Diagnostic quality Cephalometric radiograph w/millimeter scale.&lt;/li&gt;&lt;/ul&gt;Must cause dysfunctional malocclusion and have one (1) or more qualifying conditions. A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090)</td>
<td>$3,838.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | A 0-20. One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services. Requires:  

- ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.  
- Completed Handicapping Labiolingual Deviation (HLD) Index form.  
- Full mouth diagnostic quality radiographs or a panoramic radiograph.  
- Complete set of diagnostic quality color photos.  
- Diagnostic quality study models or OrthoCad equivalent (or digital images)  
- Diagnostic quality Cephalometric radiograph w/millimeter scale.  

Must cause dysfunctional malocclusion and score at least 28 points on the Arkansas Medicaid Handicapping Labio-Lingual Deviations (HLD) Scoresheet.  
A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090) |

$3,924.45
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Coverage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8090</td>
<td>Comprehensive orthodontic treatment of the adult dentition</td>
<td>A 0-20.  One (1) per lifetime. Pre-authorization requests must be submitted and approved prior to providing orthodontic services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$4,174.30</td>
</tr>
<tr>
<td></td>
<td>Requires:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ADA claim form (2012 or newer) describing the treatment to be completed including: a treatment plan, a narrative description of the diagnosis and prognosis, and the total anticipated treatment time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Completed Handicapping Labiolingual Deviation (HLD) Index form.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Full mouth diagnostic quality radiographs or a panoramic radiograph.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete set of diagnostic quality color photos.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic quality study models or OrthoCad equivalent (or digital images)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic quality Cephalometric radiograph w/millimeter scale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Must cause dysfunctional malocclusion and score at least 28 points on the Arkansas Medicaid Handicapping Labio-Lingual Deviations (HLD) Scoresheet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A habit appliance (D8210, D8220) is not considered in determining a member’s lifetime limit for limited or comprehensive orthodontic treatment (D8020, D8030, D8040, D8060, D8070, D8080, D8090)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8210</td>
<td>Removable appliance therapy (thumb-sucking &amp; tongue thrust)</td>
<td>A 0-20.  One (1) per lifetime. Only approved to control harmful habits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$624.15 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed appliance therapy (thumb-sucking and tongue thrust)</td>
<td>A 0-20.  One (1) per lifetime. Only approved to control harmful habits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$825.55 ARKids-B $10 copay</td>
</tr>
<tr>
<td>D8999</td>
<td>Unspecified orthodontic procedure, by report</td>
<td>A 0-20.  One (1) per lifetime.</td>
<td>By Report</td>
</tr>
</tbody>
</table>
Adjunctive General Services
Reimbursement includes local anesthesia.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain-minor procedures</td>
<td>A 0-20. Limited to one (1) per date of service per member. Examples of palliative treatment are treatment of soft tissue infection or smoothing a fractured tooth. Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service. Not allowed with any services other than radiographs. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. May not be used as a follow up to a prior treatment. Requires pre-payment review, rationale, and TID or area.</td>
<td>$43.70 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>
Anesthesia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9222, D9223, and D9248 must have the appropriate permit for the level of sedation provided.</td>
<td>Providers are responsible for submitting the correct permit for the level of sedation to MCNA as part of the credentialing process.</td>
<td>MCNA does not reimburse for D9230 or D9248 unless there is evidence of a restorative, endodontic, simple extraction or surgical procedure performed on the same DOS; if a planned restorative, endodontic, simple extraction or surgical procedure is aborted, a claim for D9230 or D9248 will require a narrative.</td>
<td></td>
</tr>
<tr>
<td>D9222</td>
<td>Deep sedation/general anesthesia - first 15 minute increment</td>
<td>A 0-20. Not allowed with D9230 or D9248.</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

If a claim for payment is received for sedation and there is no restorative, endodontic and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service, the payment for sedation will be denied.

Requires pre-authorization with a narrative of medical necessity and the treatment plan. Claim submission must include narrative of medical necessity, monitored vital signs, anesthesia time log, including start and stop times, medication administered, and dose.

Licensed and permitted Oral Surgeons are not required to submit a pre-authorization for general anesthesia services D9222/D9223. For claims of two units or less (one unit of D9222 or one unit of D9222 and one unit of D9223) Oral Surgeons are not required to submit documentation (a narrative, treatment plan, sedation record, etc.) with an anesthesia claim. These records must be available for inspection on request. Oral Surgeons must submit all required records with claims for three or more units of general anesthesia.

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.
| D9223 | Deep sedation/general anesthesia  
- each additional 15 minute increment | A 0-20. Not allowed with D9230 or D9248.  
Limited up to four (4) units per visit.  
If a claim for payment is received for sedation  
and there is no restorative, endodontic and/or  
surgical service(s) listed on the claim form or no  
Medicaid claims history record indicating that a  
restorative and/or surgical service was  
previously reimbursed for the same date of  
service, the payment for sedation will be denied.  
Requires pre-authorization with a narrative of  
medical necessity and the treatment plan. Claim  
submission must include narrative of medical  
necessity, monitored vital signs, anesthesia time  
log, including start and stop times, medication  
administered, and dose.  
Licensed and permitted Oral Surgeons are not  
required to submit a pre-authorization for  
general anesthesia services D9222/D9223. For  
claims of two units or less (one unit of D9222 or  
one unit of D9222 and one unit of D9223) Oral  
Surgeons are not required to submit  
documentation (a narrative, treatment plan,  
sedation record, etc.) with an anesthesia claim.  
These records must be available for inspection  
on request. Oral Surgeons must submit all  
required records with claims for three or more  
units of general anesthesia.  
Anesthesia time begins when the doctor  
administering the anesthetic agent initiates the  
appropriate anesthesia and non-invasive  
monitoring protocol and remains in continuous  
attendance of the patient. Anesthesia services  
are considered completed when the patient may  
be safely left under the observation of trained  
personnel and the doctor may safely leave the  
room to attend to other patients or duties.  
$95.95  
ARKids-B  
$10 copay |
Inhalation of analgesia, anxiolysis - nitrous oxide

A 0-20. Not allowed with D9222 or D9223.

May not be submitted more than once per member per day. If a claim for payment is received for nitrous oxide and there is no restorative, endodontic and/or surgical service listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same DOS as the nitrous oxide, the payment for nitrous oxide will be denied.

MCNA does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis or sealants unless other procedures are performed at the same time.

Non-intravenous conscious sedation

A 0-20. Not allowed with D9222 or D9223. May not be submitted more than once per member per day.

If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation, the provider must document the circumstances in the member’s treatment record.

Providers must administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the provider or staff from administration through the time of discharge.

Administration of oral pre-medication is not a covered service.

Professional Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9310</td>
<td>Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>A 0-20. Requires pre-authorization with a narrative of medical necessity.</td>
<td>$40.13 ARKids-B $10 copay</td>
</tr>
</tbody>
</table>

D9310 cannot be billed by the requesting provider. D9310 cannot be billed with a D0140 for the same member by the same provider on the same DOS.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9920</td>
<td>Behavior management, by report</td>
<td>A 5-20. Smoking cessation only. Two (2) units per year, each unit is 15 minutes. Must consist of tobacco counseling for the control and prevention of oral disease.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider must deliver 8 to 15 minutes of tobacco prevention/cessation-specific counseling; A shorter, unscripted statement that tobacco products are bad and the member should not start/quit smoking is not sufficient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providers are encouraged to develop an outline or specific script to follow to ensure the counselling session meet minimum requirements for payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider must document the delivery of the tobacco prevention/cessation-specific counseling in the member’s medical record.</td>
</tr>
<tr>
<td>D9999</td>
<td>Unspecified adjunctive procedure by report</td>
<td>A 0-20. Requires pre-authorization with a narrative of medical necessity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
</tr>
</tbody>
</table>
Arkansas Adult Covered Services

Benefit Limits Key

A = Age range limitations
TID = Tooth ID

Initial Dental Screening and Annual Recall Visits

Adult members 21 and older have a $500 limit per year. This includes the following services:

- Diagnostic services
- Preventive services
- Restorative Services (Fillings and Crowns)
- Oral and Maxillofacial Surgery (Extractions)
- Periodontal Services (Treatment of Gums)
- Prosthodontics (Dentures)

Most extraction and denture procedure codes are excluded from the $500 benefit limit. The benefit limit will be administered on a calendar year basis beginning January 1, 2018. Adult members will have their accumulation towards the limit returned to $0 as of this date, and will begin accumulating to a new calendar year benefit limit.

The dental office visit, which includes the initial dental screening (comprehensive oral evaluation) or annual recall visit (periodic oral evaluation), must include (but is not limited to) the following diagnostic and preventive services:

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required), and necessary diagnostic or vitality tests (considered part of the examination)
- Bitewing radiographic images
- Prophylaxis, including oral hygiene instructions
- Topical fluoride application

This visit should also include either the initial preparation or the updating of the member’s dental record, as appropriate. It should also include the development of a current treatment plan and the completion of reporting forms. The member may have one (1) initial comprehensive oral examination (D0150) or one (1) periodic oral examination (D0120) per calendar year subject to other benefit limits. Prophylaxis (D1110) and Topical application of fluoride (D1208) are both limited to once (1) in a calendar year.
Diagnostic Services
Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for recipients.

Examinations

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation – established patient</td>
<td>A 21+. One (1) per year. Only one (1) D0120 or D0150 per calendar year per member.</td>
<td>$26.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
<td></td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation - problem focused</td>
<td>A 21+. Limited to one (1) service per day by the same provider, facility or group.</td>
<td>$34.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not reimbursable on the same day as D0120 by the same provider, facility or group.</td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not payable for follow-up care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D0140 by the same provider, facility or group within 30 days of a D0120 or D0140 will require a rationale.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not payable with dentures, orthodontics or other services paid as all-inclusive procedures.</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation – new or established patient</td>
<td>A 21+. One (1) per three (3) years per member. Only one (1) D0120 or D0150 per year per member.</td>
<td>$34.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
<td></td>
</tr>
</tbody>
</table>
Radiographic Images

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if MCNA determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within a 45-day period will be limited to the allowance for a full mouth series (intraoral complete series).

Diagnostic and preventive services include oral examination, selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for recipients.

MCNA utilizes the guidelines published by the U.S. Department of Health and Human Services Center for Devices and Radiological Health. Please consult the following benefit tables for benefit limitations.

In order for MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and/or oral/facial images that are not of good diagnostic quality will be denied.

All radiographs must be of good diagnostic quality, properly mounted, dated, and identified with the member’s name, date of birth, indication of tooth ID, and left and right. Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. The reason must be documented in the member’s record and be in accordance with the accepted standard of care.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images</td>
<td>A 21+. One (1) D0210 or D0330 per five (5) years per member by the same provider, facility, or group.</td>
<td>$86.45</td>
</tr>
</tbody>
</table>

Counts toward $500.00
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Service Requirements</th>
<th>Fee</th>
<th>Coverage Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
<td>A 21+. Limited to once (1) per date of service per member by the same provider, facility, or group. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
<td>$18.05</td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image</td>
<td>A 21+. The total cost of periapicals and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination of x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
<td>$14.25</td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two (2) radiographic images</td>
<td>A 21+. One set of two (2) images per calendar year per member. The total cost of bitewings and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
<td>$24.70</td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings – four (4) radiographic images</td>
<td>A 21+. One set D0272 or D0274 images per calendar year per member. The total cost of bitewings and other radiographs performed within a 45-day period cannot exceed the payment for a complete intraoral series. When the fee submitted for any combination x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films are the equivalent of a complete series, procedure D0210.</td>
<td>$24.70</td>
<td>Counts toward $500.00</td>
</tr>
</tbody>
</table>
Panoramic radiographic image

A 21+. One (1) D0210 or D0330 per five (5) years per member by the same provider, facility, or group.

Covered more frequently if necessary with a rationale for treatment in the event of an oral surgery service. This will be allowed subject to post authorization or prepayment review. In the event of an emergency, this can also be allowed with third molar involvement or trauma, also subject to prepayment review.

$62.70
Counts toward $500.00

## Diagnostic Casts

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>A 21+. Initial diagnostic cast related to a full or partial dentures are included in the reimbursement for dentures and cannot be billed separately.</td>
<td>$47.50</td>
</tr>
</tbody>
</table>

Counts toward $500.00

## Caries Risk Assessment Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0601</td>
<td>Caries risk assessment and documentation, with a finding of low risk</td>
<td>A 21+. Claims for this service must include a valid exam code (D0120 or D0150) on the same claim.</td>
<td>$5.00</td>
</tr>
<tr>
<td>D0602</td>
<td>Caries risk assessment and documentation, with a finding of moderate risk</td>
<td>A 21+. Claims for this service must include a valid exam code (D0120 or D0150) on the same claim.</td>
<td>$5.00</td>
</tr>
<tr>
<td>D0603</td>
<td>Caries risk assessment and documentation, with a finding of high risk</td>
<td>A 21+. Claims for this service must include a valid exam code (D0120 of D0150) on the same claim.</td>
<td>$5.00</td>
</tr>
</tbody>
</table>
Preventive Services
Preventive services include prophylaxis, topical fluoride treatments, sealants and space maintainers.

### Dental Prophylaxis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>A 21+. One (1) D1110 per calendar year per member. Includes scaling and polishing procedure to remove coronal plaque, calculus, and stains. If billed on the same DOS as any 4000-series code, this procedure code will be denied.</td>
<td>$48.45 Counts toward $500.00</td>
</tr>
</tbody>
</table>

### Preventive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1208</td>
<td>Topical application of fluoride excluding varnish (prophylaxis not included)</td>
<td>A 21+. One (1) per calendar year per member.</td>
<td>$19.95 Counts toward $500.00</td>
</tr>
</tbody>
</table>

### Other Preventive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
</table>
| D1320 | Tobacco counseling for the control and prevention of oral disease | A 21+. Two (2) sessions per calendar year. **$25.00**
Counts toward **$500.00**

The provider must document that the member is an active tobacco user in the member's medical record.

The provider must deliver 8 to 15 minutes of tobacco prevention/cessation-specific counseling; A shorter, unscripted statement that tobacco products are bad and the member should not start/quit smoking is not sufficient.

Providers are encouraged to develop an outline or specific script to follow to ensure the counseling session meets minimum requirements for payment.

The provider must actively refer the member to the AR Department of Health tobacco cessation program. Referral to a tobacco cessation program without 8 to 15 minutes of tobacco prevention/cessation-specific counseling is not sufficient.

The provider must document the delivery of the tobacco prevention/cessation-specific counseling and the referral in the member's medical record. |
Restorative Services

Reimbursement for each covered service includes tooth preparation, temporary restorations, cement bases, pulp capping, impressions and local anesthesia. Operative dentistry fees include local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 24 months, unless there is recurrent decay or material failure.

All restorative services are subject to medical necessity review. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or-more-surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration.

Restorative procedures should be billed on the date the final restoration is completed.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is disallowed.

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, facility, or group is responsible for the replacement of the original restoration within the first 24 months after initial placement. Duplicate surfaces are not payable on the same tooth in a 24-month period by same provider, office, or group. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 24-month period by same provider, office, or group. Additional restorative services on the same tooth within a 24-month period by the same provider, office, or group do not require prior authorization. Additional restorative services on the same tooth and surface(s) within a 24-month period by a different provider, office, or group require x-rays.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161) or resin-based composite, four (4) or more surfaces or involving incisal angle, anterior (D2335).

All restoration placement must extend through the enamel and into dentin to ensure a successful long-term outcome. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal-occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.
If two (2) or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>Amalgam - one (1) surface posterior - primary or permanent</td>
<td>A 21+. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surface with claim submission. Allowed every 24 months.</td>
<td>$65.55</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amalgam restorations are permitted on anterior teeth if clinically appropriate with a rationale.</td>
<td></td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two (2) surfaces posterior - primary or permanent</td>
<td>A 21+. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$80.75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amalgam restorations are permitted on anterior teeth if clinically appropriate with a rationale.</td>
<td></td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three (3) surfaces posterior - primary or permanent</td>
<td>A 21+. This procedure is reimbursable for tooth A, B, I, J, K, L, S, T, 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$94.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amalgam restorations are permitted on anterior teeth if clinically appropriate with a rationale.</td>
<td></td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four (4) or more surfaces posterior - permanent</td>
<td>A 21+. This procedure is reimbursable for tooth 1-5, 12-21, and 28-32. Requires TID and surfaces with claim submission. Allowed every 24 months.</td>
<td>$114.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amalgam restorations are permitted on anterior teeth if clinically appropriate with a rationale.</td>
<td></td>
</tr>
</tbody>
</table>
### Resin-Based Composite Restorations - Direct

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2330</td>
<td>Resin-based composite - one (1) surface, anterior</td>
<td>A 21+. One (1) D2330, D2331, D2332, or D2335 per 24 months, per member, per tooth, per surface.</td>
<td>$76.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID C-H, M-R, 6-11, 22-27 and surface.</td>
<td></td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two (2) surfaces, anterior</td>
<td>A 21+. One (1) D2330, D2331, D2332, or D2335 per 24 months, per member, per tooth, per surface.</td>
<td>$95.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID C-H, M-R, 6-11, 22-27 and surfaces.</td>
<td></td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three (3) surfaces, anterior</td>
<td>A 21+. One (1) D2330, D2331, D2332, or D2335 per 24 months, per member, per tooth, per surface.</td>
<td>$114.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID C-H, M-R, 6-11, 22-27 and surfaces.</td>
<td></td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four (4) or more surfaces or involving incisal angle, anterior</td>
<td>A 21+. One (1) D2330, D2331, D2332, or D2335 per 24 months, per member, per tooth, per surface.</td>
<td>$144.40 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID C-H, M-R, 6-11, 22-27 and surfaces.</td>
<td></td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite – one (1) surface, posterior</td>
<td>A 21+. One (1) D2140, D2150, D2160, D2161, D2391, D2392, D2393, or D2394 per 24 months, per member, per tooth, per surface.</td>
<td>$65.55 Counts toward $500.00</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite – two (2) surfaces, posterior</td>
<td>A 21+. One (1) D2140, D2150, D2160, D2161, D2391, D2392, D2393, or D2394 per 24 months, per member, per tooth, per surface.</td>
<td>$80.75 Counts toward $500.00</td>
</tr>
</tbody>
</table>

Resin restoration includes composites or glass ionomer.

Duplicate surfaces are not payable on the same tooth in resin-based restorations in a 24-month period by the same provider, office, or group. The maximum allowable fee for any combination of amalgam and resin surfaces is the fee for a four-or-more-surface restoration.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requirements</th>
<th>Cost $</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2393</td>
<td>Resin-based composite – three (3) surfaces, posterior</td>
<td>A 21+. One (1) D2140, D2150, D2160, D2161, D2391, D2392, D2393, or D2394 per 24 months, per member, per tooth, per surface. Requires TID A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 and surfaces.</td>
<td>$94.05</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite – four (4) or more surfaces, posterior</td>
<td>A 21+. One (1) D2140, D2150, D2160, D2161, D2391, D2392, D2393, or D2394 per 24 months, per member, per tooth, per surface. Requires TID A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 and surfaces.</td>
<td>$114.95</td>
</tr>
</tbody>
</table>
Crowns
Crown services require radiographic images that depict the pre- and post-treatment condition. The documentation supporting the need for crown services must be available for review by MCNA upon request.

Other Restorative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2920</td>
<td>Re-cement or re-bond crown</td>
<td>A 21+. Not payable for the initial six (6) months after crown placement, then limited to one (1) per tooth every six (6) months. Not allowed within six (6) months of D2930 or D2931.</td>
<td>$43.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The billing provider, office, or group is responsible for recementation within the first six (6) months after placement of the crown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID 1-32, A-T.</td>
<td></td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>A 21+. One (1) D2930 per 24 months, per member, per tooth.</td>
<td>$140.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID A-T.</td>
<td></td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>A 21+. One (1) D2931 per 24 months, per member, per tooth.</td>
<td>$158.65</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prior authorization with x-ray required for TIDs 1,16, 17, 32. Prior authorization allowed with x-ray for all other TIDs. Pre-operative x-rays must be retained in patient record and available for inspection on request for all TIDs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
</tbody>
</table>
Periodontal Services

All covered periodontal services require x-rays and rationale with documentation of medical necessity. Documentation is required when medical necessity is not evident on radiographs for procedure codes D4210 and D4355. Claims for any 4000 series periodontal procedure codes will be denied when submitted for the same date of service as preventive dental procedure codes D1110.

Periodontal services include gingivectomy, periodontal scaling and root planing, full mouth debridement, and unspecified periodontal procedures. Local anesthesia is considered to be part of periodontal procedures. Surgical services include usual post-operative care.

### Nonsurgical Periodontal Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing, four (4) or more teeth, per quadrant</td>
<td>A 21+. One (1) D4341 per calendar year, per member, per quadrant (10, 20, 30, 40). A minimum of four (4) affected teeth in the quadrant. Periapical x-rays must show subgingival calculus and/or loss of crestal bone. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes or with D1120 or D1110. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-payment review, x-rays, periodontal charting, rationale, and indication of quadrant (10, 20, 30, 40). Prior authorization is allowed with x-rays, periodontal charting, rationale, and indication of quadrant (10, 20, 30, 40).</td>
<td>$142.50 Counts toward $500.00</td>
</tr>
<tr>
<td>D4346</td>
<td>Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation</td>
<td>A 21+. Only one (1) D4346 or D1110 per member per calendar year. Denied when submitted for the same date of service as any other D4000 series codes.</td>
<td>$48.45 Counts toward $500.00</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Reimbursement Details</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit</td>
<td>A 21+. Reimbursable once every calendar year per member. Limited to patients with excessive plaque that prevents the dentist from completing a comprehensive oral evaluation. D4355 will be denied if billed on the same DOS as any CDT oral evaluation code and/or D1110, D1120 or D4910. D4355 will be denied if provided within 21 days of D4341. Denied when submitted for the same date of service as other D4000 series codes. This procedure will not be reimbursed if payment has previously been made for D1110 or D1120 to the same billing provider, office, or group within a 12-month period. Requires a pre-payment review, x-rays, and rationale. Prior authorization is allowed with x-rays and rationale.</td>
<td></td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance procedures</td>
<td>A 21+. One (1) per calendar year. Must have received D4341 periodontal scaling and root planing. Not payable on the same DOS as D1110, D4346, or D4355. The D1110 or D4346 will be denied if billed for the same DOS as D4910. Requires pre-authorization with date of completion of D4341 and periodontal chart. Eligible for post authorization (Refer to Pre-Approval of Care section)</td>
<td></td>
</tr>
</tbody>
</table>

$93.10 Counts toward $500.00

$66.50 Counts toward $500.00
Removable Prosthodontics

Medically necessary partial or full mouth dentures and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member’s dental problem. Eligible members have a lifetime limit of one partial and one full denture per arch. A minimum of 24 months must have elapsed after a partial is placed before a full denture benefit will be paid.

Provision for dentures for cosmetic purposes is not a covered service.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Billing for space maintainers fixed and removable prosthetics, is to be on the insertion or cementation date.

Removable prosthodontic services include complete dentures, partial dentures, denture repairs, and denture relines.

Documentation requirements are included to conform to state and federal regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

The provider is required to obtain acceptance of esthetic appearance from the member prior to processing. This acceptance must be documented by the member’s signature in the treatment record.

1) The denture should be flasked and processed under heat and pressure in a commercial or dental office laboratory using ADA-certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the member’s dental record.

2) Upon delivery:
   a) The denture bases must be stable on the lower and retentive on the upper.
   b) The clasp must be appropriately retentive for partial dentures.
   c) The vertical dimension of occlusion should be comfortable to the member (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
   d) The denture must be fitted and adjusted for comfort, function, and esthetics.
   e) The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The delivery date of the denture and/or partial dentures is the billing date of service.

All dentures must be covered by a one-year warranty covering manufacturing defect or component failure. Dentures that do not meet acceptable quality, fit and finish standards as determined by MCNA clinical reviewers are subject to recoupment.

The dentist is responsible for all necessary adjustments required during the first six (6) months following delivery. Any exams are inclusive to this process and not reimbursable.
### Complete Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110</td>
<td>Dentures complete maxillary</td>
<td>A 21+. One (1) per lifetime.</td>
<td>$474.00</td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization including pre-operative x-rays and rationale explaining medical necessity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5120</td>
<td>Dentures complete mandibular</td>
<td>A 21+. One (1) per lifetime.</td>
<td>$474.00</td>
</tr>
<tr>
<td></td>
<td>Requires pre-authorization including pre-operative x-rays and rationale explaining medical necessity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following codes require x-rays. The provider must inform the member that no reline is covered within twelve (12) months of the delivery date of the denture. A minimum of 24 months must elapse between coverage for a partial and coverage for a full denture on the same arch. **D5110 and D5120 do not count towards the annual adult $500.00 benefit limit.**

### Partial Dentures (Including Routine Post Delivery Care)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following codes require pre-authorization, x-rays, and rationale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid may provide a partial denture (D5211, D5212) in cases where the recipient has matured beyond the mixed dentition stage in the following cases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing one (1) or more adjacent maxillary anterior teeth, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing one (1) or more adjacent mandibular anterior teeth, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing at least two (2) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries-free or have been completely restored and have sound periodontal support. For those members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographs may be requested prior to approval of a partial denture.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch and must serve to increase masticatory function and stability of the entire mouth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only permanent teeth are eligible for replacement by a partial denture.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>D5211, D5212, D5225, and D5226 do not count towards the annual adult $500.00 benefit limit</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Adjustments to Dentures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5410</td>
<td>Adjust complete denture maxillary</td>
<td>A 21+. Not covered within six (6) months of initial placement. Three (3) per lifetime.</td>
<td>$41.80 Counts toward $500.00</td>
</tr>
<tr>
<td>D5411</td>
<td>Adjust complete denture mandibular</td>
<td>A 21+. Not covered within six (6) months of initial placement. Three (3) per lifetime</td>
<td>$41.80 Counts toward $500.00</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture maxillary</td>
<td>A 21+. Not covered within six (6) months of initial placement. Three (3) per lifetime.</td>
<td>$41.80 Counts toward $500.00</td>
</tr>
</tbody>
</table>
Repairs to Complete and Partial Dentures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5422</td>
<td>Adjust partial denture mandibular</td>
<td>A 21+. Not covered within six (6) months of initial placement. Three (3) per lifetime</td>
<td>$41.80 Counts toward $500.00</td>
</tr>
</tbody>
</table>

The dentist is responsible for all necessary adjustments for the first six (6) months after delivery. Cost of repairs cannot exceed replacement costs. A repair is allowed in conjunction with a reline on the same prosthesis as long as the repair makes the denture fully serviceable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
<td>A 21+. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$76.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-payment review.</td>
<td></td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
<td>A 21+. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$76.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-payment review.</td>
<td></td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
<td>A 21+. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$76.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-payment review.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary</td>
<td>A 21+. Must include the location and description of the fracture in the “Remarks” section of the claim form or in an attached narrative.</td>
<td>$76.95 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If the same provider, office, or group requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-payment review.</td>
<td></td>
</tr>
<tr>
<td>D5640</td>
<td>Replace broken teeth (each tooth)</td>
<td>A 21+. Requires pre-payment review, rationale and TID 1-32.</td>
<td>$75.05 Counts toward $500.00</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
<td>A 21+. Requires pre-payment review, rationale and TID 1-32.</td>
<td>$97.85 Counts toward $500.00</td>
</tr>
</tbody>
</table>

**Denture Reline Procedures**

Allowed if the reline makes the denture serviceable. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. The dentist is responsible for all necessary adjustments for a period of twelve (12) months.

Not covered within six (6) months of initial placement of dentures. Reimbursement for complete and partial denture relines are allowed only if six (6) months has elapsed since the previous complete or partial denture was constructed. If billing provider requests a complete or partial denture for the same arch within six (6) months after delivery of the reline, the reline fee will be deducted from the new prosthesis fee.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
<td>A 21+. Not covered within six (6) months of initial placement. One (1) per five (5) years. Requires pre-authorization and rationale explaining medical necessity.</td>
<td>$163.40 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
<td>A 21+. Not covered within six (6) months of initial placement. One (1) per five (5) years. Requires pre-authorization and rationale explaining medical necessity.</td>
<td>$163.40 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
<td>A 21+. Not covered within six (6) months of initial placement. One per five (5) years.</td>
<td>$163.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-authorization and rationale explaining medical necessity.</td>
<td>Counts toward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
<td>A 21+. Not covered within six (6) months of initial placement. One per five (5) years.</td>
<td>$163.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-authorization and rationale explaining medical necessity.</td>
<td>Counts toward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
</tbody>
</table>

**Fixed Prosthodontics**

**Other Fixed Partial Dental**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>A 21+. Not covered within six (6) months of initial placement.</td>
<td>$64.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-payment review with rationale.</td>
<td>Counts toward</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Oral and Maxillofacial Surgery Services

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic teeth is not a covered benefit. Symptomatic conditions include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. Extractions for dentures are a covered benefit.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>A 21+. Requires TID 1-32, 51-82, A-T, AS-TS. TIDs 1, 16, 17, 32 require submission of an x-ray and rationale with claim submission.</td>
<td>$72.20</td>
</tr>
</tbody>
</table>

Surgical Extractions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7210</td>
<td>Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>A 21+. Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Requires TID 1-32, 51-82, A-T, AS-TS, Processed using pre-payment review with x-rays, and rationale. Prior authorization allowed with x-rays and rationale.</td>
<td>$138.70</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Benefit Limits</td>
<td>Fee</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires TID 1-32, 51-82, A-T, AS-TS, Processed using pre-payment review with x-rays, and rationale. Prior authorization allowed with x-rays and rationale.</td>
<td></td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>A 21+. Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, aberrant tooth position, or unusual depth of impaction. Removal of asymptomatic tooth not covered. Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis, which means that providers must submit pre- and post-operative x-rays and detailed rationale on the claim submission outlining the unusual surgical complications. Requires TID 1-32, 51-82, A-T, AS-TS with pre- and post-operative x-rays and detailed rationale.</td>
<td>$306.85</td>
</tr>
<tr>
<td>D7250</td>
<td>Removal of residual tooth roots (cutting procedure)</td>
<td>A 21+. Will not be paid to the provider, office, or group that removed the tooth.</td>
<td>$158.65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. Requires TID 1-32, 51-82, A-T, AS-TS, Processed using pre-payment review with x-rays, and rationale. Prior authorization allowed with x-rays and rationale.</td>
<td></td>
</tr>
</tbody>
</table>

**Other Surgical Procedures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7285</td>
<td>Incisional biopsy of oral tissue - hard (bone, tooth)</td>
<td>A 21+. Processed using pre-payment review with x-rays, and rationale. Prior authorization allowed with x-rays and rationale. A pathology report must be available for review on request.</td>
<td>$119.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counts toward $500.00</td>
<td></td>
</tr>
</tbody>
</table>
### Incisional biopsy of oral tissue - soft

D7286  
Incisional biopsy of oral tissue - soft  
A 21+.  
Processed using pre-payment review, with color photograph and rationale. Prior authorization allowed with color photograph and rationale. A pathology report must be available for review on request.  
$110.20  
Counts toward $500.00

### Alveoloplasty

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions –</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>four or more teeth/spaces per quadrant</td>
<td>A 21+.</td>
<td>$135.85</td>
</tr>
<tr>
<td></td>
<td>Processed using pre-payment review with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>quadrant ID (10, 20, 30, 40), x-rays, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rationale. Prior authorization allowed with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>quadrant ID (10, 20, 30, 40), x-rays, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rationale. This code may be utilized for up to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90 days following covered extractions when post-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>extraction recovery time is clinically required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>before performing this service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$135.85 $500.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions –</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>one to three teeth/spaces per quadrant</td>
<td>A 21+.</td>
<td>$104.50</td>
</tr>
<tr>
<td></td>
<td>Processed using pre-payment review with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>quadrant ID (10, 20, 30, 40), x-rays, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rationale. Prior authorization allowed with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>quadrant ID (10, 20, 30, 40), x-rays, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>rationale. This code may be utilized for up to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>90 days following covered extractions when post-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>extraction recovery time is clinically required</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>before performing this service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$104.50 $500.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Torus Removal

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7472</td>
<td>Removal of torus palatinus</td>
<td>A 21+. One (1) unit per lifetime. Processed using pre-payment review with a quadrant ID (10, 20), color photo, and rationale. Prior authorization allowed with a quadrant ID (10, 20), color photo, and rationale.</td>
<td>$249.85 Counts toward $500.00</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal of torus mandibularis</td>
<td>A 21+. Two (2) units per lifetime. Processed using pre-payment review with a quadrant ID (30, 40), color photo, and rationale. Prior authorization allowed with a quadrant ID (30, 40), color photo, and rationale.</td>
<td>$249.85 Counts toward $500.00</td>
</tr>
</tbody>
</table>

### Surgical Incision

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
<td>A 21+. Not payable on same DOS as D7140, D7210, D7220, D7230, D7240, D7241, or D7250 for the same tooth per day, per member. Requires TIDs 1-32, 51-82, A-T, AS-TS. Not payable for same tooth on the same DOS as the extraction.</td>
<td>$87.40 Counts toward $500.00</td>
</tr>
</tbody>
</table>
**Adjunctive General Services**
Reimbursement includes local anesthesia.

### Unclassified Treatment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain-</td>
<td>A 21+. Limited to one (1) per date of service per member. Examples of palliative treatment are treatment of soft tissue infection or smoothing a fractured tooth. Palliative treatment on a specific tooth is not covered if definitive treatment (e.g. restorative or endodontic treatment) was provided on the same tooth for the same date of service. Not allowed with any services other than radiographs. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. May not be used as a follow up to a prior treatment. Requires pre-payment review, clinical notes and TID or area.</td>
<td>$43.70 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td>minor procedures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Professional Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Benefit Limits</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9920</td>
<td>Behavior management, by report</td>
<td>A 21+. Smoking cessation only. Two (2) units per calendar year, each unit is 15 minutes. Must consist of tobacco counseling for the control and prevention of oral disease.</td>
<td>$20.00 Counts toward $500.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider must deliver 8 to 15 minutes of tobacco prevention/cessation-specific counseling; A shorter, unscripted statement that tobacco products are bad and the member should not start/quit smoking is not sufficient.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providers are encouraged to develop an outline or specific script to follow to ensure the counselling session meet minimum requirements for payment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The provider must document the delivery of the tobacco prevention/cessation-specific counseling in the member’s medical record.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>D9999</td>
<td>Unspecified adjunctive procedure, by report</td>
<td>Manually Priced Counts toward $500.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires pre-authorization with narrative of medical necessity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eligible for post authorization (Refer to Pre-Authorization of Care section)</td>
<td></td>
</tr>
</tbody>
</table>
Department of Human Services Non-Covered Services

Non-covered services include, but are not limited to, the following:

- Plaque control
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- Administration of in-office pre-medication
- Prescription medications
- Services for cosmetic reasons
- Services that are costlier than another, equally effective available service
- Services not within the coverage criteria
- Services determined to be not medically necessary
- Experimental, investigational or non-FDA approved
Dental Guidelines

MCNA’s Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA’s criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association’s Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization including but not limited to treatment plans, narratives, radiographs and periodontal charting.

These criteria are approved and annually reviewed by MCNA’s Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the section of this manual titled, “Covered Services,” for a list of all codes covered under the program and additional limitations and requirements for coverage.

Guidelines for Oral Surgery

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the general dentist or pediatric specialist. The member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the general dentist or pediatric specialist.

Criteria

- A tooth broken below the bone level
- Supernumerary tooth
- Dentigerous cyst
- Untreatable periodontal disease
- Pathology not treatable by other means
- Recurrent pericoronitis
- Non-restorable carious lesion
- Pain and/or swelling due to impeded eruption
- Orthodontic extractions (requires approval of the orthodontic case)
- Exfoliation of a deciduous tooth not anticipated within six (6) months
- No extractions of third molars if roots are not substantially formed
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent
- In the event an extraction is performed within a six-month period of a prior placement of a restoration on the same tooth, the restoration payment is subject to being recouped

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical, or panorex
- Narrative demonstrating medical necessity
Code Descriptions

- **D7140** - extraction, erupted tooth or exposed root (Elevation and/or forceps removal)
  Includes removal of tooth structure, minor smoothing of socket of socket bone, and closure, as necessary.

- **D7210** - extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
  Includes related cutting of gingival and bone, removal of tooth structures, minor smoothing of socket bone and closure.

- **D7220** - removal of impacted tooth - soft tissue
  Occlusal surface of tooth covered by soft tissue. Requires mucoperiosteal flap elevation.

- **D7230** - removal of impacted tooth - partially bony
  Part of crown covered by bone. Requires mucoperiosteal flap elevation and bone removal.

- **D7240** - removal of impacted tooth - completely bony
  Most or all crown covered by bone. Requires mucoperiosteal flap elevation and bone removal.

- **D7241** - removal of impacted tooth-complete bony, with unusual surgical complications
  Most or all of crown covered by bone. Usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, or aberrant tooth position.

- **D7250** - removal of residual tooth roots (cutting procedure)
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

- **D7280** - exposure of an unerupted tooth
  o An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

- **D7510** - incision and drainage of abscess – intraoral soft tissue
  o Involves incision through mucosa, including periodontal origins.

Guidelines for Endodontics

Criteria

- The tooth is infected and/or abscessed.
- There has been trauma or a fracture that damages the pulp.
- The pulp of the primary tooth is infected and the exfoliation of the deciduous tooth is not anticipated within six (6) months (for pulpotomy or pulpectomy only).
- The tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3.
- Root canal therapy not completed in anticipation of placement of an overdenture.

Criteria for Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, that is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal (therefore this will cause a denial for a retreatment)
- Fractured root tip is not reachable (therefore this will cause a denial for a retreatment)
Criteria for Apexification
- Apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

Criteria for Apicoectomy and Retrograde Filling
- Apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; requires a filling to be placed in the apical part of the tooth to seal that part of the root canal
- Perforation of the root in the apical one-third of the canal

Documentation Required for Authorization
- Provider must submit the appropriate radiographs that demonstrate both crown and apex with authorization request: periapical or panorex. Films must include entire structure of the tooth including the apex.
- Emergency treatment will require a dated pre- and post-operative radiograph for claims review.
- In situations where pathology is not apparent, a written narrative justifying treatment is required.

Other Considerations
- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a final root canal fill radiograph.
- In cases where the root canal filling does not meet MCNA’s treatment standards, MCNA can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA reviews the circumstances.

Procedure Codes
- D3310, anterior routine endodontic therapy
- D3320, premolar endodontic therapy
- D3330, molar tooth endodontic therapy
- D3220, therapeutic pulpotomy

Guidelines for Non-Intravenous and IV Sedation

Requirements
- Dentists providing sedation or anesthesia services must have the appropriate certification from the Arkansas State Board of Dental Examiners for the level of sedation or anesthesia provided.
- MCNA must have on file a copy of the certification prior to rendering sedation services.

Criteria
Acceptable conditions include, but are not limited to, one or more of the following:
- There is documented local anesthesia toxicity.
- Patient displays severe cognitive impairment or developmental disability.
- Patient displays severe physical disability.
- Patient displays uncontrolled behavior management problem.
- Treatment plan requires extensive or complicated surgical procedures.
• Local anesthesia fails.
• There are documented medical complications.
• Patient presents with acute infection(s).

Documentation Required for Claims Processing
• Certain procedures require submission of narrative stating medical necessity.
• Certain procedures require submission of a sedation record. The sedation record must fully comply with the standards of the Arkansas Dental Practice Act and related rules and regulations.
• In determining the number of reimbursable units of D9223 general anesthesia, a minimum of seven (7) additional minutes of general anesthesia time must be documented before an additional 15-minute unit of D9223 will be paid. For example: 0 to 21 min of GA would pay 1 D9222; 22 to 36 min of GA would pay one (1) D9222 and one (1) D9223; 37 to 51 min of GA would pay one (1) D9222 and two (2) D9223.

Procedure Codes
• D9222, deep sedation/general anesthesia - first 15 minutes
• D9223, deep sedation/general anesthesia - each additional 15 minutes
• D9248, non-intravenous conscious sedation

Guidelines for Crowns

Criteria
• Criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
• Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four (4) or more surfaces and two (2) or more cusps.
• Permanent bicuspids teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three (3) or more surfaces and at least one (1) cusp.
• Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge.

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.

Crowns will not meet criteria if:
• A lesser invasive restoration is possible
• Tooth has subosseous and/or furcation caries
• Tooth has advanced periodontal disease
• Crowns are being planned to alter vertical dimension
Guidelines for Crowns following Root Canal Therapy

Criteria
- The tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the provider’s ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material should not extend excessively beyond the apex.
- The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3.

Documentation Required for Authorization
- Providers must submit appropriate radiographs with authorization request: periapical or panorex. Films must include entire structure of the tooth including the apex.
- The submission of radiographs clearly showing the adjacent and opposing teeth are required to be submitted with the claim for review of payment.
- If RCT was done by dentist who submitted the claims request, the claims request should include a dated radiograph of RCT.

Procedure Codes
- D2930, prefabricated stainless steel crown primary tooth
- D2931, prefabricated stainless steel crown permanent tooth

Guidelines for Periodontal Treatment

Criteria
- Periodontal charting indicates abnormal pocket depths in multiple sites. Probing depths must be 4mm or greater.
- Radiographic evidence of root surface calculus.
- Radiographic evidence of noticeable loss of bone support. Attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession.

Criteria for Gingivectomy
- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacologically induced gingival hyperplasia.

Criteria for Full Mouth Debridement
- Presence of significant gingival inflammation and/or supragingival calculus

Documentation Required for Authorization
- Submit appropriate radiographs with authorization request: bitewings or periapical preferred.
- Complete periodontal charting
- Narrative
Procedure Codes

- D4341, periodontal scaling and root planning requiring radiographs and perio chart.

Guidelines for Orthodontics

Please see the “Orthodontic Services” section.

Guidelines for X-rays

Criteria

- Must be of diagnostic quality
- Must be marked right and left and indicate tooth ID
- Must have the patient’s name
- Must have the date x-rays were taken

Guidelines for Removable Prosthodontics (Full and Partial Dentures)

Criteria

- If favorable prognosis is present.
- If abutment teeth are more than 50% supported in bone.
- Adjustments, repairs and relines when covered are allowed when there are extenuating circumstances, and/or medical necessity.
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.
- If more than one posterior tooth will be replaced not including third molars.
- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain provider

Authorizations for removable prosthesis will not meet criteria if extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or clasp to a partial denture is a covered benefit if the addition makes the dentures functional.

Please see the “Removable Prosthodontics” section of each plan for benefit limitations and guidelines.

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex. Diagnostic colored photographs are acceptable in lieu of radiographs for denturists.

Procedure Codes

Complete Dentures

- D5110, complete denture maxillary (upper)
- D5120, complete denture mandibular (lower)

Partial Dentures
• D5211, upper partial resin base
• D5212, lower partial resin base
• D5225, maxillary partial denture – flexible base
• D5226, mandibular partial denture – flexible base

Adjustments to Dentures
• D5410, adjust complete denture, maxillary
• D5411, adjust complete denture, mandibular
• D5421, adjust partial denture, maxillary
• D5422, adjust partial denture, mandibular

Repairs to Complete Dentures
• D5511, repair resin partial denture base, mandibular
• D5512, repair broken complete denture base, maxillary

Repairs to Partial Dentures
• D5611, repair resin partial denture base, mandibular
• D5612, repair resin partial denture base, maxillary
• D5621, repair cast partial framework, mandibular
• D5622, repair cast partial framework, maxillary
• D5640, replace broken teeth - per tooth
• D5650, add tooth to existing partial denture

Denture Reline Procedures
• D5730, chairside reline complete maxillary denture (chairside)
• D5731, chairside reline complete mandibular denture (chairside)
• D5740, chairside reline partial maxillary denture (chairside)
• D5741, chairside reline partial mandibular denture (chairside)
• D5750, reline complete maxillary denture (laboratory)
• D5751, reline complete mandibular denture (laboratory)
Frequently Asked Questions

Program Overview and Contracting with MCNA

How do I sign up with MCNA Dental?
To apply online or to download MCNA’s credentialing application, please visit our website at www.mcnaar.net. If you have questions and would like to speak with an MCNA Dental representative, please call our Provider Hotline at 1-844-343-6262.

What is the average time to complete the MCNA Dental credentialing process?
Once MCNA Dental receives a completed application, the average turnaround time is 30 days.

Do I need to be credentialed by MCNA Dental if I am already a participating Medicaid provider?
Yes, all dental providers must complete MCNA Dental’s credentialing process in order to participate in our plan.

Is there a number I can call with questions about joining MCNA Dental’s network or completing the credentialing application?
Yes, we welcome your call! Our Provider Hotline phone number is 1-844-343-6262.

Pre-Authorization Requests, Claim Submissions, and Covered Services

How are requests for pre-authorization accepted?
MCNA Dental has an online Provider Portal where providers can submit requests for pre-authorization. Any supplemental materials such as narratives, charting, or x-rays can be attached and submitted via our Provider Portal. Pre-authorization requests may also be submitted electronically through a clearinghouse using MCNA’s payor ID, 65030. A third option for submission is by mail to MCNA at the following address:

MCNA Dental
Attn: Utilization Management
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

What is the turnaround time for processing pre-authorization requests?
MCNA Dental generally processes pre-authorization requests within 48 – 72 hours. Your office can check the status of a pre-authorization request using your Provider Portal account.

Does MCNA Dental accept electronic claims?
MCNA strongly encourages you to consider electronic claims submission if you do not already take advantage of this convenience! You may submit your claims electronically using one (1) of these methods:

- Online using MCNA’s Provider Portal – enter and submit your claims directly to MCNA using your Portal account and avoid the need to use a third-party clearinghouse.
- Electronically using a clearinghouse – use MCNA's payor ID 65030.
If you choose not to take advantage of convenient electronic claims submission, you may mail your claims to MCNA at this address:

**MCNA Dental**
Attn: Claims
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

What is MCNA Dental’s payor ID for electronic submission of claims and pre-authorization requests using a third-party clearinghouse?
MCNA’s payor ID is 65030.

My office uses the services of a third-party clearinghouse. Do I have to complete any forms in order to submit claims or pre-authorization requests electronically using MCNA’s payor ID?
If you are already submitting claims or pre-authorization requests electronically using a clearinghouse, you do not need to complete any additional forms with your clearinghouse. You may, however, need to take steps to add MCNA Dental as a new payor in your practice management system.

Does MCNA Dental accept NEA FastAttach?
Yes, MCNA participates as an NEA FastAttach payor. With FastAttach, you are able to transmit along with your claim or pre-authorization request any documentation, like x-rays, perio charts, and narrative, which may be required by MCNA for adjudication. Once you have transmitted your documentation to NEA FastAttach, you can provide your NEA tracking number to us through your claim or pre-authorization request submissions when you submit electronically using MCNA's Provider Portal or a third-party clearinghouse.

What are the periodicity limits for preventive services?
Preventive services follow the American Association of Pediatric Dentistry (AAPD) periodicity schedule. All periodicity limits are outlined in MCNA Dental’s Provider Manual.

Does MCNA Dental cover pharmacy benefits?
No, pharmacy benefit coverage remains with the member’s medical benefit either through fee-for-service Medicaid or the member’s health plan.

How frequently do providers receive Remittance Advices (RAs) from MCNA Dental?
MCNA Dental runs regularly occurring RA cycles each week. Please contact our Provider Hotline at 1-844-343-6262 for specific information about the frequency of this cycle for your office. In order to enjoy the most convenient claims payment experience possible, MCNA encourages your office to sign up for payments using electronic funds transfer (EFT). EFT payments are made with each RA cycle. To take advantage of this convenience, go to our website and download an EFT form.
Provider Portal and Provider Resources

What is MCNA’s Provider Portal and what features are available?
MCNA Dental’s Provider Portal is a great free, all-in-one tool that allows you to carry out a variety of administrative functions for your office. Using your Provider Portal account, you can:

- Instantly submit claims and pre-authorization requests.
- Track the progress of all of your submissions online.
- Instantly verify member eligibility.
- Download important forms and resources like your Provider Manual.
- View a history of your activity with MCNA.
- Stay up to date with important program reminders and updates.
- Sign up for our monthly provider newsletter delivered to your email inbox.
- Access many more convenient tools!

We encourage all of our valued network providers to take advantage of our Provider Portal.

Is there a special application to access MCNA’s Provider Portal?
No, you do not need to complete a special application to access the Provider Portal. Once you have successfully completed MCNA’s credentialing process and are an active provider in our network, you automatically qualify for a free account on our Provider Portal and all of the benefits it entails! All you need to do is visit MCNA’s Provider Portal at http://portal.mcna.net/ and complete the simple process of validating your information, then you are ready to go!

Is there a user guide I can reference for help navigating my Provider Portal account?
Yes, we have created a helpful Provider Portal User Guide to help you learn about the functions available to you on your Provider Portal account. To supplement the information in the User Guide and to demonstrate the benefits available to you with your Portal account, MCNA Dental has also created a series of Provider Portal tutorial videos. To access MCNA’s Provider Portal tutorial videos please visit our YouTube channel at https://www.youtube.com/playlist?list=PL3040EEECC110F60B.

I see that MCNA Dental provides training webinars and seminars for its contracted providers. If I cannot attend a scheduled webinar or seminar, can I still receive training?
Yes, MCNA Dental will be happy to schedule either an office-specific webinar or other type of training event for any of our credentialed providers. Please call your Provider Relations Representative and we will coordinate it accordingly.
Forms

The following forms can be downloaded using the links provided.

- **Provider Complaint Form**
  - [http://docs.mcna.net/forms/ar-provider-complaint](http://docs.mcna.net/forms/ar-provider-complaint)

- **Patient Responsibility Form**
  - [http://docs.mcna.net/forms/patient-responsibility](http://docs.mcna.net/forms/patient-responsibility)