



## Molina Healthcare of Mississippi Dental Clinical Criteria Provider Bulletin

### Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of dental literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from your local Molina Quality department.

Molina Dental Services Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry ([aapd.org](http://aapd.org)) and the American Dental Association ([ada.org](http://ada.org)). Molina Dental Services criteria are changed and enhanced as needed.

The procedure codes used by Molina Dental Services 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 Molina Dental Services 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 appendix titled, "Covered Services," for a list of all codes covered under the program and additional limitations and requirements for coverage.

### Guidelines for X-Rays

- 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 Crowns**

- 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 bicuspid 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**

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.

## **Guidelines for Endodontics**

- 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.

## **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)

## **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 Molina Dental Services treatment standards, Molina Dental Services can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after Molina Dental Services reviews the circumstances.

## **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

## **Guidelines for Periodontal Treatment**

- 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.
- Must interfere with mastication.

## **Criteria for Full Mouth Debridement**

- Presence of significant gingival inflammation and/or supragingival calculus

## **Documentation Required for Authorization of Scaling and Root Planing and Pre-payment Review of Gingivectomy and/or Gingivoplasty**

- Scaling and Root planing:

- Submit appropriate radiographs with authorization request: bitewings or periapical preferred.
- Complete periodontal charting
- Narrative
- Gingivectomy and/or Gingivoplasty:
- Pre-operative color photographs
- Narrative

### **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 Molina oral surgeon when it is beyond the scope of the general dentist or pediatric specialist.
- Any extractions that do not clearly meet these criteria should be submitted for preauthorization review.
- Covered for pain or infection.
- Extractions to reduce crowding without a Molina-approved orthodontic case, must demonstrate clear evidence of impaction or the severe deflection of the unerupted permanent tooth. Prior authorization, panoramic x-ray, and narrative are required.
- Over-retention of a primary tooth where the succedaneous permanent is ectopically erupting into the arch and the primary tooth is not mobile.
- Irregular root resorption interfering with path of permanent tooth progression.
- Extraction of primary tooth to prevent potential impaction of permanent canines when canine is mesially progressing and is overlapping the root of the lateral incisor.
- Removal of 3rd molars prior to orthognathic surgery
- Supernumerary tooth.
- Radiographic pathology (cyst, abscess)
- Orthodontic extractions (requires approval of the orthodontic case)
- Carious lesion or fracture making tooth non-restorable.
- No extractions of third molars if roots are not substantially formed.
- Recurrent pericoronitis
- Untreatable periodontal disease
- Recoupment of restorative fees may be necessary if tooth is extracted within 6 months of restorative treatment.
- Extractions are not payable for deciduous teeth when normal loss is imminent.
- There is no benefit for the extraction of asymptomatic teeth.

### **Guidelines for Orthodontia**

Medicaid covers prior authorized orthodontic treatment for clients who are age 20 or younger and have a handicapping malocclusion. For auditing purposes, Medicaid may request end of treatment diagnostic models and x-rays. Payment for the end of treatment records will be included in the dollar amount prior authorized. Medicaid uses the HLD form to determine whether coverage is appropriate based on a handicapping malocclusion. A score of 28 or greater being necessary to qualify for Medicaid coverage of

orthodontic treatment. The HLD form must be used to pre-screen orthodontic cases. To be eligible for orthodontic treatment, a client must be age 20 or younger when treatment is authorized, and have a handicapping malocclusion, which includes one or more of the following five documented conditions:

- HLD form
- Accident causing a severe malocclusion;
- Injury causing a severe malocclusion;
- Condition that was present at birth causing a severe malocclusion;
- Medical condition causing a severe malocclusion; and (e) Facial skeletal condition causing a severe malocclusion.

### **Authorization**

Treatment is prior authorized and paid on a single procedure code. In order for Medicaid clients to receive timely treatment, the request for approval will constitute the providers acceptance of the Medicaid fee, and a commitment to complete care.

### **Documentation Requirements**

The following documentation must be submitted with the prior authorization request:

- A pre-treatment request form that outlines treatment and the HLD form;
- Diagnostic records including: (i) Diagnostic casts and oral or facial photographic images; (ii) Full mouth radiographs and panoramic x-ray; and (iii) Cephalometric x-ray;
- A narrative description of the diagnosis, and prognosis;
- On surgical cases, include a description of the procedure to be completed. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee.

### **Interceptive Orthodontic Treatment of Transitional Dentition**

The interceptive orthodontic treatment of transitional dentition is covered if it is the cost- effective method to lessen the severity of a malformation such that extensive treatment is not required.

### **Continuation of Care**

A continuation of care form, along with required clinical documentation must be submitted as a prior authorization for code D8999 and all applicable orthodontic codes. The case will be reviewed by Molina Healthcare and approved or denied for the continuation of care. If approved, an approved reimbursement amount will be determined as well.

### **Required Documentation**

- Continuation of Care Form (all forms can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website).
- Completed 2019 ADA Dental Claim Form listing.
- D8999 and all applicable orthodontic codes.

Narrative that includes reason for leaving previous treating Provider, previous Provider contact information, additional treatment needed, and the approximate amount of additional time needed for treatment.

### **Guidelines for Non-Intravenous and IV Sedation**

#### **Requirements**

- Dentists providing sedation or anesthesia services must have the appropriate certification from the
- Mississippi State Board of Dentistry for the level of sedation or anesthesia provided.
- Molina Dental Services must have on file a copy of the certification prior to rendering sedation services.
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**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).

#### **Criteria for Medical Immobilization Including Papoose Boards**

The provider must obtain a written informed consent from the legal guardian. Written informed consent must be documented in the patient's treatment record prior to medical immobilization. The patient's treatment record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

#### **Goals of behavior management:**

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

### **Guidelines for Dental Services Rendered in an Outpatient or Ambulatory Service Center (ASC)**

Molina requires the following information to be submitted with prior authorization requests for dental therapeutic services and other procedures to be performed at a hospital outpatient or ambulatory surgical center:

- A completed Molina ASC Scorecard Molina ASC Scorecard fillable.pdf. In addition, all forms can be found on the SKYGEN's Provider Web Portal and Molina's Healthcare Website.
- A complete written treatment plan (electronic ADA form, 2019 ADA, or newer, claim form).
- Narrative of medical necessity for the need to have the requested services performed at a hospital outpatient or ambulatory surgical center.