Methods and Standards for
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10. Dental Services

Dental services for recipients age 21 or older are limited to emergency treatment for the relief of pain and acute infection and the following prior authorized additional services up to an annual limit of $1150 per Medicaid recipient:

1) routine diagnostic examination and radiographs;
2) preventive care,
3) restorative care,
4) certain endodontic services,
5) periodontics,
6) prosthodontics,
7) oral surgery,
8) professional consultation.

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

12b. Dentures

Recipients age 21 and older are limited to dentures up to an annual limit of $1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

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Dental Services for Recipients age 21or older:
Payment is made at the lesser of billed charges, the Medicare Resource Based Relative Value Scale Methodology used for physicians **in those instances where Medicare sets an RVU for the billed dental service**, the provider's lowest charge, or the statewide fee schedule up to an annual limit of $1150 per Medicaid recipient age 21or older.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dental services. The agency's rates for dental services were updated on 07/01/2011 and are effective for services rendered on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://medicaidalaska.com/providers/FeeSchedule.asp. This fee schedule includes dental procedures whose payments are limited by the physician payment amount for dental procedures.

Dentures
For recipients age 21 and older, dentures and the authorized services to prepare for them, are paid up to an annual limit of $1150 per recipient. When upper and lower dentures are necessary and the annual limit is not adequate to cover the cost of the dental claim, twice the annual limit may be authorized by the Department. When authorizing twice the annual limit for dentures, the maximum amount authorized is the remaining amount from the current fiscal year and the entire amount allotted for the succeeding fiscal year. The recipient is not allowed a new or additional annual limit for the succeeding year beyond that already paid for the dentures.

Except as otherwise noted in the plan, state developed rates are the same for both public and private providers of dentures. The agency's rates for dentures were updated on 07/01/2011 and are effective for services rendered on or after that date. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule for dental services published at http://medicaidalaska.com/providers/FeeSchedule.asp.