STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Effective July 1, 2010, NMAP will provide a supplemental payment for covered dental services when services are provided or supervised by a faculty or staff member of the University of Nebraska Medical Center (UNMC) College of Dentistry and who is providing or supervising the treatment as part of an approved program of the University.

For dentists qualifying under this section, a supplemental payment will be made. These payments are made in addition to payments otherwise provided under the state plan to dentists that qualify for such payments. The payment amount will be the difference between payments otherwise made to these practitioners and the average rate paid for the services by commercial insurers. The payment amounts are determined by:

1. Calculating annually an average commercial payment per procedure code for all services paid to the eligible providers by commercial insurers using the provider's contracted rates with the commercial insurers for each procedure code. The rate used will be the rate in effect in January for payments during the calendar year.
2. Multiplying the total number of Medicaid claims paid per procedure by the average commercial payment rate for each procedure to establish the estimated commercial payments made for these services. Supplemental and fee schedule/base payment may not in the aggregate exceed this reimbursement ceiling; and
3. Subtracting the initial fee-for-service Medicaid payments and all Third Party Liability payments already made for these services to establish the supplemental payment amount.

The supplemental payments will be calculated 30 days after the end of each FY quarter. The amount due is paid to the UNMC College of Dentistry. No payments are made with the expectation or requirement that some or all of the payment be transferred to another party. A final reconciliation of payments is made one year after the end of each quarter.

Initial fee-for-service payments made under this section will be paid on a claims-specific basis through the Department's claims processing system using the methodology outlined elsewhere in this state plan. The supplemental payment, which represents the final payment, will be made in four (4) quarterly payments.

For each fiscal quarter, the University of Nebraska Medical Center College of Dentistry will provide a listing of the identification numbers for their dentists that are affected by the payment adjustment to the Division of Medicaid and Long-Term Care. The Division will generate a report, which includes the identification numbers and utilization data for the affected dentists. This report will be provided to University of Nebraska Medical Center College of Dentistry.

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The University of Nebraska Medical Center College of Dentistry must review and acknowledge the completeness and accuracy of the report. After receipt of confirmation, the Division will approve the supplemental payment amount.

Assurances. The Department hereby assures that payment for dental services are consistent with efficiency, economy, and quality of care and payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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LIMITATIONS - DENTURES

DENTURES & PARTIALS: NMAP covers the following prosthetic appliances when coverage criteria is met: (1) Dentures (immediate, replacement/complete, or interim/complete); (2) Resin base partial dentures; (3) Flipper partials; and (4) cast metal framework with resin denture base partials for clients age 20 and younger.

Replacement prosthetic appliances are covered when:

1. The client's dental history does not show that previous prosthetic appliances have been unsatisfactory to the client; and
2. The client does not have a history of lost prosthetic appliances; and
3. A repair will not make the existing denture or partial wearable; or
4. A reline will not make the existing denture or partial wearable; or
5. A rebase will not make the existing denture or partial wearable;

NMAP covers partial dentures for clients that do not have adequate occlusion. Adequate occlusion is defined as first molar to first molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion.

NMAP prior authorizes replacement/complete dentures, maxillary resin base partials, and flipper partials.

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LIMITATIONS - DENTAL SERVICES

PRIOR AUTHORIZATION: NMAP requires prior authorization for certain dental services. Prior authorization must be obtained before the service is provided. Diagnostic services, as defined in state regulations, and routine corrective dental care, do not require prior authorization. Prepayment authorization for emergencies and other circumstances beyond the provider's control (insurance coverage, etc.) will be reviewed by Medicaid Division staff.

COVERED SERVICES: NMAP defines dental services as any diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist. Covered procedures are specified in state regulations.

For clients age 21 and older, dental coverage is limited to $1,000 per fiscal year.

DIAGNOSTIC DENTAL SERVICES: NMAP covers diagnostic dental services as defined in state regulations, as amended. This includes exams, radiology, prophylaxis, topical application of fluoride, and diagnostic casts. Exams are covered once each year on a routine basis for clients age 21 and older. For clients who are eligible for HEALTH CHECK (EPSDT), exams are allowed every 6 months or more often if medically necessary. Interperiodic dental exams will also be considered appropriate to determine the existence of suspected conditions. When a patient is referred to another dentist or specialist, NMAP covers one exam by the second dentist or specialist.

ORAL SURGERY: Oral surgery, as defined by HCPCS, is covered as a physician service.

HOSPITALIZATION FOR DENTAL SERVICES: Dental services must be provided at the least expensive appropriate place of service.

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LIMITATIONS - DENTAL SERVICES

COSMETIC SERVICES: NMAP does not cover cosmetic dental services.

RADIOLOGY: NMAP covers a maximum dollar amount for any combination of the following radiographs: Intraoral complete series, intraoral periapical films, extraoral films, bitewings, or panoramic films. A intraoral complete series is covered once every three years.

ENDODONTIA: NMAP covers endodontia for anterior and posterior permanent teeth when the prior authorization request of submitted x-rays substantiates medical necessity.

PERIODONTAL TREATMENT: All periodontal treatment must be prior authorized by the Medicaid Division. Covered periodontal services include those procedures necessary for the treatment of the tissues supporting the teeth.

ORTHODONTICS: NMAP covers orthodontic treatment for clients age 20 and younger. Orthodontic treatment is covered when the client has a handicapping malocclusion defined as (1) Craniofacial birth defect that is affecting the occlusion; or (2) Mutilated or severe occlusion.

Telehealth: Dental services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.