

WV MEDICAID ADULT DENTAL BENEFIT FREQUENTLY ASKED QUESTIONS

1. What services are included in this benefit?

Eligible members can receive emergent and preventive/restorative care. A complete listing of codes can be found at <https://dhhr.wv.gov/bms/Pages/Chapter-505-Dental-Services-.asp>

2. Where can members receive services?

Members can receive services at any West Virginia Medicaid enrolled provider.

3. Should codes that do not require prior authorization unless they go beyond service limitations, such as D0120, D0150 and D0180, be included in the prior authorization request?

No, only services outlined in Chapter 505 Appendix C apply to the expanded adult dental benefit and are subject to the \$1000 maximum and require to be prior authorized. A complete listing of codes can be found at <https://dhhr.wv.gov/bms/Pages/Chapter-505-Dental-Services-.asp>

4. Are we required to see both adults and children?

No, providers can choose to continue to see only pediatric patients, or expand to see both adults and children.

5. Are all Medicaid recipients supposed to qualify for the Preventative/Restorative Services?

Qualified Medicare Beneficiary (QMB) and/or other partial West Virginia Medicaid eligibility categories are not eligible for this service. This is an expansion of services to eligible members, not an expansion of eligibility categories. The same categories eligible for the Emergent dental benefit are the same categories eligible for the expanded services.

6. Are dentures covered under the \$1,000 limit?

Dentures are included in the expanded adult dental benefit outlined in Chapter 505 Appendix C. Due to cost, receipt of dentures may limit other services a member would have access to unless member is willing to pay out-of-pocket for those services.

7. If a member has reached the maximum \$1,000 cap, what portion of the excess should be written off?

Any amount over the \$1,000 Medicaid Cap is the member's responsibility. All charges included in or over the Medicaid \$1,000 limit, are to be based on the West Virginia Medicaid fee schedule. West Virginia Medicaid enrolled providers can only bill Medicaid members up to the West Virginia Medicaid fee schedule once the \$1,000 max has been reached.

8. Do I need Prior Authorization for Dental x-rays?

Yes, Prior Authorization for services outlined in Appendix C are for the purpose of pre-verification of remaining member balance.

9. If we have an emergency and the patient is in pain, are we unable to treat until prior authorization is received? How long does it take to get prior authorization?

Treatment rules and guidelines for emergent services have not changed. Prior Authorization timeframes may vary, however, most Prior Authorization request are resolved within 72 hours of receipt.

WV MEDICAID ADULT DENTAL BENEFIT FREQUENTLY ASKED QUESTIONS

10. What if the patient has a primary insurance and Medicaid as a secondary?

Medicaid remains the payer of last resort. Third party liability billing rules remain the same with this expanded service as those rules apply to other services provided. Only the amount paid by West Virginia Medicaid as secondary will apply to the \$1,000 yearly cap.

11. Are prior authorizations handled like a regular commercial insurance?

Prior Authorizations may be submitted over the phone or through appropriate web-based portals. Please contact the appropriate utilization management (U&M) vendor for additional information.

12. If over the \$1,000 limit, can we bill our fee to patients or only Medicaid set fee?

All services provided to West Virginia Medicaid members by an enrolled West Virginia Medicaid provider, can only be billed up to the West Virginia Medicaid fee schedule, whether those services are billed to West Virginia Medicaid and/or the member. Any amount that is the member's responsibility must be explained to the member prior to beginning services.

13. When prior authorizing for my patients and knowing their treatment will exceed the benefit of \$1,000 per calendar year maximum, do I need to place the codes in a priority? Do I start the list with the codes and treatment that need completed first?

Yes, codes will be approved in the order in which they are submitted.

14. How are FQHCs reimbursed for services?

Federally Qualified Health Centers (FQHCs) receive their encounter rate for dental services. The FQHC is required to bill the T1015 encounter code with itemized dental services underneath indicating the services rendered. The encounter rate is the amount that counts towards the member's \$1,000 limit as well.