Dental Services for Beneficiaries Age 21 and Older

4.202 Dental Services for Beneficiaries Age 21 and Older (05/12/17, GCR 16-120)

4.202.1 Definitions

For the purposes of this rule, the term:

(a) **"Dental services"** mean preventive, diagnostic, or corrective procedures including the treatment of:

(1) The teeth and associated structures of the oral cavity, and
(2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

(b) **"Dentist"** means an individual licensed to practice dentistry or dental surgery.

4.202.2 Covered Services

Coverage of dental services for beneficiaries age 21 and older is limited to medically necessary dental services.

4.202.3 Eligibility for Care

(a) Beneficiaries age 21, and older, are eligible for dental services under this rule.

(b) Dental services for pregnant and postpartum women, and/or beneficiaries under the age of 21, are covered under Rule 4.203 Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women.

4.202.4 Qualified Providers

Dental services must be provided by, or under the supervision of, a licensed dentist enrolled in Vermont Medicaid and working within the scope of his or her practice.

4.202.5 Conditions for Coverage

(a) Periodic prophylaxis, including topical fluoride application, is limited to once every six months. More frequent treatments require prior authorization by the Department of Vermont Health Access.

(b) Non-surgical treatment of temporomandibular joint (TMJ) disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

(c) Local anesthesia is covered as part of the dental procedure and shall not be separately reimbursable.

(d) Pulp capping and bases are covered as incidental to a restoration and shall not be separately reimbursable.

4.202.6 Conditions for Reimbursement

(a) Coverage of dental services for beneficiaries age 21 or older is limited to a maximum dollar amount of $510 per beneficiary per calendar year.

(b) The Department of Vermont Health Access publishes and periodically updates a Dental Procedures

Fee Schedule which sets the fees reimbursable under the Medicaid program and lists procedures excluded from the maximum dollar amount.

(c) Medical and surgical services of a dentist, as described in Rule 4.204, are not subject to the maximum dollar amount.

(d) Providers may bill a beneficiary for procedures after the maximum annual dollar amount for services has been reached, or for procedures not covered by Vermont Medicaid.

(e) Providers shall follow these conditions when billing a beneficiary:

(1) Billed amounts may not exceed the appropriate procedure rate in the Dental Procedures Fee Schedule. This condition does not apply to procedures that are not covered by Vermont Medicaid.
(2) Providers shall acquire written acknowledgement of financial liability from a beneficiary prior to performing the procedure.

4.202.7 Prior Authorization Requirements

The Dental Procedures Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization. The Dental Procedures Fee Schedule can be found on the Department of Vermont Health Access website.

4.202.8 Non-Covered Services

Services that are not covered include: procedures for cosmetic purposes; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.