

SPECIAL BULLETIN
Dental, Durable Medical
Equipment, Optical,
Hearing Aid
Vol. 22, No. 1
July 23, 1999



Missouri

MEDICAID



Bulletin

INDEX

PAGE

PAYMENT FOR CUSTOM MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO RECIPIENT'S LOSS OF ELIGIBILITY OR DEATH	2
ITEMS/SERVICES INITIATED OR PRIOR AUTHORIZED BY THE STATE AGENCY PRIOR TO MC+ HEALTH PLAN ENROLLMENT	3
ORTHODONTIC TREATMENT PRIOR AUTHORIZED BY THE STATE AGENCY PRIOR TO MC+ ENROLLMENT	4
DENTAL PROGRAM - REPLACEMENT DENTURES	5
DENTAL PROGRAM - ADD -ON PROCEDURE CODES	5
DENTAL PROGRAM - PROCEDURE CODE REVISIONS	6

PAYMENT FOR CUSTOM MADE ITEMS WHEN DELIVERY OR PLACEMENT CANNOT BE MADE PRIOR TO RECIPIENT'S LOSS OF ELIGIBILITY OR DEATH

Providers are reminded that Medicaid provider payment may be made for custom-made items such as eyeglasses, dentures, orthotics, prosthetics, custom wheelchairs, custom HCY equipment, etc., when the recipient becomes ineligible (either through complete loss of Medicaid eligibility or change of assistance category to one for which the particular service is not covered) or dies after the item is ordered or fabricated and prior to the date of delivery or placement of the item.

The following prerequisites will apply to all such payments:

- The recipient must have been eligible when the service was first initiated (and following receipt of an approved Prior Authorization if required) and at the time of any subsequent service, preparatory and prior to the actual ordering or fabrication of the device or item;
- The custom-made device or item must have been fitted and fabricated to the specific medical needs of the user in such a manner so as to preclude its use for medical purpose by any other individual;
- The custom-made device or item must have been delivered or placed if the recipient is living;
- The provider must have entered "See attachment" in Field 19 of the claim form--and must have attached a provider signed statement to the claim. The statement must explain the circumstances and include the date of actual delivery or placement for a living recipient or the date of death when delivery or placement is not possible due to this reason. The statement must also include the total amount of salvage value which the provider estimates is represented in cases where delivery or placement is not possible.

Payments regarding the aforementioned devices will be made as follows:

- a. If the item is received by the recipient following loss of Medicaid eligibility or eligibility for the service, the payment will be the lesser of the "net billed charge" or the Medicaid maximum allowable amount for the total service, less any applicable cost sharing or coinsurance.
- b. If the item cannot be delivered or placed due to death of the recipient, the payment will be the lesser of the "net billed charge" or the Medicaid maximum allowable amount for the total service, less any applicable cost sharing or coinsurance. The "net billed charge" shall be the provider's usual and customary billed charge(s) as reduced by any salvage value amount.

- Salvage value would exist whenever there is further profitable use that can be made by the provider of materials or components of the device or item. Dentures would be an example of an item representing no reasonable salvage value, whereas a custom-made wheelchair may, in its components, represent salvage value.
 - Any provider-determined retail salvage value of the unplaced or undelivered item must be subtracted by the provider from the charge for the item, and only the net reduced charge entered on the claim form line for the item. These claims will be subject to review as to salvage value adjustment represented in the billed charge.
- c. The date of service that is shown on the claim form for the item (glasses, dentures, braces, etc.) when situation a. or b. applies must be the last date on which service is provided to the eligible recipient (and following receipt of an approved Prior Authorization if required) prior to the ordering or fabrication of the item. The provider is responsible for verifying recipient eligibility each time service is provided. Use of a date for which the recipient is no longer eligible for Medicaid coverage of the service will result in a denial of the claim. The claim (with attachment) is to be submitted to the Fiscal Agent in the same manner as other claims.

Payments made as described in a. or b. will constitute the allowable Medicaid payment for the service and, less the applicable cost sharing or coinsurance amount due, no further collection from the recipient or other persons is permitted.

If the provider determines the recipient has lost eligibility after the service is first initiated and before the custom-made item is actually ordered or fabricated, the recipient must be immediately advised that completion of the work and delivery or placement of the item will not be covered by Medicaid. It would then be the recipient's choice as to request completion of the work on a private payment basis. If recipient death is the reason for loss of eligibility, the provider can, of course, proceed no further and there will be no claim for the non-provided item of service.

If a recipient refuses to accept the item/service Missouri Medicaid will not reimburse the provider.

**ITEMS/SERVICES INITIATED OR PRIOR AUTHORIZED BY THE STATE AGENCY
PRIOR TO MC+ HEALTH PLAN ENROLLMENT**

Certain items and services that have been initiated or prior authorized by the Division of Medical Services (DMS) before the effective date in MC+ will be reimbursed on a fee-for-service basis by the state agency when placement occurs after MC+ health plan enrollment is effective. DMS will be financially responsible for these items or services in accordance with the following:

- Augmentative communication devices and evaluations, prosthetics, and orthotic devices that have been ordered, initiated or prior authorized prior to the enrollment effective date

in the MC+ health plan, but placement occurs after the effective date of MC+ health plan enrollment.

- Hearing aids, custom and power wheelchairs, custom HCY positioning equipment, HCY replacement eyeglasses, special eyeglass frames that have been prior authorized by DMS prior to the enrollment effective date in the MC+ health plan, but placement occurs after the effective date of MC+ health plan enrollment.
- Dental services, excluding orthodontics, that have been prior authorized by DMS prior to the MC+ health plan effective date, but provided or placed after the effective date of MC+ health plan enrollment.

Providers must contact the Provider Communications Unit at 1-800-392-0938 for instructions on how to bill for these items/services.

**ORTHODONTIC TREATMENT PRIOR AUTHORIZED BY THE STATE AGENCY
PRIOR TO MC+ ENROLLMENT**

The Division of Medical Services (DMS) is responsible for reimbursement of prior authorized orthodontic services that are provided prior to the recipient's effective date of enrollment with the MC+ health plan. The quarterly payment to the fee-for-service provider will be prorated based upon the effective date of the recipient's enrollment in a health plan. The remainder of the treatment is the responsibility of the MC+ health plan with whom the recipient is enrolled. If the recipient transfers to a different health plan or back to the fee-for-service program before treatment is completed, the party responsible for payment will be the party with whom the recipient is enrolled at the time the service is rendered.

When an MC+ enrolled individual who has been receiving orthodontic treatment initially approved by one of the MC+ health plans transitions back to the Medicaid fee-for-service program, a prior authorization file must be established through the fee-for-service program.

The provider must submit to the Division of Medical Services' fiscal agent, GTE Data Services, a completed Prior Authorization Request form and paper documentation from the health plan indicating the approved treatment amount and treatment time and remittance advice/payment records. This information will be used to determine the dollar amount payable through the Medicaid fee-for-service program.

The provider should complete all required fields on the Prior Authorization Request form and list the procedure code requested and approved by the health plan in field 18 and the portion of the remaining balance that is the responsibility of the Medicaid fee-for-service program in field 23. Following receipt of the approved authorization, the provider must bill Medicaid beginning with the first quarter following the transition to the fee-for-service program.

A prior authorization file will be established for the length of treatment time originally approved by the health plan. If additional treatment time is required, please indicate this on the Prior Authorization Request form in field 24 and briefly explain the reason an extension is needed.

If you have questions regarding transitional orthodontic cases, please contact the Provider Communications Unit at (800) 392-0938 or (573) 751-2896.

DENTAL PROGRAM - REPLACEMENT DENTURES

Missouri Medicaid coverage of partial and full dentures was revised in 1997 to allow a second set of dentures per recipient in cases where dentures no longer fit properly due to significant weight loss as a result of illness or a loss of bone or tissue due to some form of neoplasm and/or surgical procedure (Dental Bulletin, Vol. 20, No. 1, dated October 1, 1997). Coverage of replacement dentures is now expanded to include cases where the dentures no longer fit or function properly due to normal wear and/or deterioration resulting from use over an extended period of time. Providers were notified of the revised criteria for replacement dentures on remittance advice messages dated March 5 and March 19, 1999.

A narrative describing the condition of the existing denture and the reason for replacement must be submitted with the Prior Authorization Request form. This information may be entered in field 24 of the Prior Authorization Request form or submitted as an attachment. Requests for replacement dentures submitted without this information will be denied. Additional information and/or documentation may also be requested by the State Dental Consultant.

DENTAL PROGRAM - ADD-ON PROCEDURE CODES

The procedure codes listed below are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as “add-on” codes with a “+” symbol in the 1999 CPT book. Add-on codes can be readily identified by specific descriptor terminology which includes phrases such as “each additional” or “(List separately in addition to primary procedure).” The “add-on” code concept in CPT applies only to add-on procedures/services performed by the **same** practitioner. These codes describe additional intra-service work associated with the primary procedure. Add-on codes are always performed in addition to the primary service/procedure, and must **never** be reported as a stand-alone code. In addition to payment for the primary service/procedure, the add-on codes will also be paid at 100% of the Medicaid maximum allowable.

11101 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (List separately in addition to code for primary procedure)

(Use 11101 in conjunction with code 11100)

15241 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm (List separately in addition to code for primary procedure)

(Use 15241 in conjunction with code 15240)

15261 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm (List separately in addition to code for primary procedure)

(Use 15261 in conjunction with code 15260)

DENTAL PROGRAM - PROCEDURE CODE REVISIONS

Due to the large volume of substantially altered procedure descriptors for the 1999 Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) conversion, a number of codes have been reviewed, and the descriptions updated. Refer to the 1999 Physicians Current Procedure Terminology (CPT) book for the current description for each base code.

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion

15000 Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children

15120 Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

15240 Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less

15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

20240 Biopsy, bone, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)

20245 Biopsy, bone, excisional; deep (eg, humerus, ischium, femur)

