

10. Dental Services

All dental services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- a. Routine dental examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.
- b. Experimental – Dental care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) dental literature research and 3) qualified dental experts.

- c. The services requiring prior approval are: complete dentures, partial dentures, complete and partial denture relines, orthodontic services, periodontal services, elective root canal therapy, and complex or extensive oral maxillo-facial surgical procedures. Emergency services are exempt from prior approval. The Division of Medical Assistance will have the responsibility of prior authorization of dental services.
- d. Endodontic treatment is covered for anterior teeth only.
- e. Experimental appliances are non-covered services.
- f. Payment for full mouth x-ray series is allowed only once every five (5) years.
- g. Replacement of complete dentures may be made once every ten years. Replacement of partial dentures may be made once every eight years. Replacement after the expiration of fewer than ten years for complete dentures and after fewer than eight years for partial dentures may be made with prior approval if failure to replace the dentures will cause an extreme medical problem or irreparable harm. Initial reline of dentures may only be made if six months have elapsed since receipt of dentures. For an immediate denture, the initial reline may be approved and rendered earlier than six months from denture delivery if the provider determines that healing of extraction sites is essentially complete and a reline is necessary to ensure proper fit and function of the denture. Subsequent relines are allowed only at five year intervals; if failure to reline in fewer than five years will cause an extreme medical problem or irreparable harm, relines may be made with prior approval. Standard procedures and materials shall be used for full and partial dentures.
- h. The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary.

12.b Dentures

See Attachment 3.1-A.1 Page 13d under “Dental Services” Section 10.g. for denture, partial denture and relined limitations.

- 12.c Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed healthcare practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. Items which require prior approval are indicated by an asterisk beside the HCPCS code on the Orthotic and Prosthetic Fee Schedule. This fee schedule is located at [www.dhhs.state.nc.us/dma/fee/fee.htm](http://www.dhhs.state.nc.us/dma/fee/fee.htm).

A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

Prior approval is required for certain orthotic and prosthetic devices. The decision to require prior approval for a specific procedure, product or service and the requirements that must be met for prior approval are based on evaluation of the factors such as: utilization; efficacy; safety; potential risk to patients; potential for misuse or abuse; high cost; the availability of more cost effective or equivalent procedures, products and services; and legislative mandate. High cost is cost in comparison to other covered items and related maintenance. Such a designation would usually be arrived at by a team of DMA staff from fiscal, programmatic and Program Integrity areas. Whether the recipient gets the item or not is dependent on the rationale for medical need and the unavailability of another less costly item that would adequately address the need. Session Law 2004-124 states “medically necessary prosthetics and orthotics are subject to prior approval and utilization review.” Specific prior approval requirements are published in Medicaid Clinical Coverage Policies on the NC Division of Medical Assistance website ([www.dhhs.state.nc.us/dma/dme/5B.pdf](http://www.dhhs.state.nc.us/dma/dme/5B.pdf)).

*\*EPDST Orthotic and Prosthetic Information is located at: Attachment 3.1-A.1, Page 7b.*

12.d Eyeglasses

- (1) All visual aids require prior approval.
- (2) No eyeglass frames other than frames made of zylonite, metal or combination zylonite and metal shall be covered.
- (3) Eyeglass repair or replacement, or any other service costing five dollars \$5.00 or less, shall not be covered.