Dental Screening and Assessment

PURPOSE

Dental screenings and assessments are screenings to determine a member's need to be seen by a dentist for treatment. This service promotes prevention of oral health problems and future complications.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

Dental Screening and Assessment services can be provided by the following enrolled providers as allowed by the scope of their licensure:

- Dentists (D0190, D0191);
- Registered Dental Hygienist or Registered Dental Assistant under the direct or general supervision of a licensed dentist (claim must be submitted under the enrolled practitioner's NPI) (D0190, D0191);
- Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) under the direct supervision of a physician, family nurse practitioner, or physician assistant (claim must be submitted under the enrolled practitioner's NPI):
    - Use code T1002 when an RN completes the screening. This service must be billed electronically on a professional claim form (CMS-1500).
    - Use code T1003 when an LPN completes the screening. This service must be billed electronically on a professional claim form (CMS-1500).

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System by dialing 1.877.328.7098.

Refer to the Member Eligibility policy for additional information regarding eligibility including information regarding limited coverage categories.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled with ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

Dental screening and assessment services may be done at the time of a wellness visit, in a school setting, via teledentistry, or in addition to other dental services (i.e., fluoride varnish or prophylaxis).

Limits

Medicaid will allow any combination of these services for a total of two (2) times per calendar year per member. For example, a member may have two (2) of D0190, or two (2) of D0191, or one of each service.

SERVICE AUTHORIZATION REQUIREMENTS

A service authorization is required should limits be exceeded within any given calendar year. Documentation is required to support medical necessity.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

Dental screening and assessment services are not allowed when billed in conjunction with dental oral evaluation codes D0120-D0180. Dental screening and assessment services are considered inclusive when performed in conjunction with any dental exam or evaluation on the same date of service.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

Documentation of dental screening and assessment services must include the following:

- Date of service;
- Member name;
- Results of dental screening and assessment;
- Treatment recommendations; and
- A valid provider signature.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

The following CDT® codes should be used for billing dental screenings and assessments:

- D0190 – screening of a patient; and
- D0191 – assessment of a patient.

CLAIM FORM

Dental Screening and Assessment must be billed using the American Dental Association (ADA) Dental Claim form or an 837D. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

CONTACT

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POLICY UPDATES

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Section	Summary
	Template changes and clarifications added throughout.