Frequently Asked Questions (as of July 2011)

General Information:

Q. What verification will I need to keep proving the client was eligible for adult dental services?

A. You will need screen shots from the ProviderOne Benefit screens to show client eligibility as of the date of service. You will also need to take a copy of any forms or documents provided by the client to support their eligibility as indicated below.

Q. What is the difference between Comprehensive Dental coverage and Emergency Oral Health Coverage?

A. Comprehensive is the full dental benefit, available prior to 2011, with HCA current coverage policies only available to children and specifically eligible adults.

The Emergency Oral Healthcare benefit does not include any restorative or preventive services and is only a list of 17 procedure codes done for emergency conditions and is available to all Medicaid eligible clients. For additional information regarding the Oral Healthcare Benefit go to this link: Emergency Oral Healthcare Benefit (see page B.29 for all clients Age 21 and Older)

Pregnant clients:

Q. Can I accept the client's word that she is pregnant and provide dental treatment?

A. No, you must obtain documentation from her physician/medical provider verifying her pregnancy and documenting the expected date of delivery.

Q. A client may be eligible for pregnancy medical coverage during the post-partum period after the birth of her child. Can I provide dental treatment during this period?

A. Yes, the client is eligible during the post partum period. **

Q. How do I bill for a pregnant client?

A. Follow regular billing procedures using EPA # 870000018 at the claim header.

** Post partum period = comprehensive dental coverage for women who qualify because they are pregnant, allows continued dental coverage through the end of the month in which the 60th day following the end of the pregnancy falls (e.g., pregnancy ends June 10, medical benefits continue through August 31). This is applicable regardless of how the pregnancy ends.

Clients of the Division of Developmental Disabilities (January 2011 – September 2011):

Q. If the client shows a DDD indicator when I check the client eligibility, the client is eligible for adult dental services, correct?

A. Yes, until September 30, 2011, as long as the client is currently eligible for Medicaid and the client has a DDD indicator, they are eligible for dental services, regardless of the medical coverage group.

Q. How does coverage change for DD clients on October 1, 2011 and after?

A. See Frequently Asked Questions for DD clients

Q. What if the client states they are a DDD client but the DDD indicator is not present when I check client eligibility?

A. You will need to refer the client to contact their DDD case manager to request that the DDD indicator be added to the ProviderOne system.

Q. How do I bill for a DDD client?

A. Follow regular billing procedures using EPA # 870000004 at the claim header.

Clients of Aging & Disability Services Administration who reside in a nursing home, state veteran's home, Residential Habilitation Center or private ICF/ID (institutions)

Q. Are there specific ACES coverage groups which indicate a client is eligible for adult dental services because they are living in an institution?

A. Most medical only clients who live in a nursing home or state veteran's home are eligible under the ACES coverage groups L01, L02, L04, L95 or L99. However some clients may also be recipients of TANF, ABD cash (formerly GA-X) or refugee cash assistance and live in a nursing home. These clients could be eligible under ACES coverage groups F01, G01 or G02, R01 In rare circumstance clients may receive coverage under ACES coverage groups K01, K95 or K99.

Q. How do I bill for an HCS nursing home client?

A. Follow regular billing procedures using EPA # 870000020 at the claim header.

Clients of Home & Community Services who are receiving waiver services:

Q. What are 'waiver' services?

A. Waiver services are long-term care services authorized by the Aging & Disability Services Administration to their clients to help the client continue to live in a community setting and avoid nursing home care. Waiver services may be authorized for clients who live in their own home or who live in boarding homes, assisted living facilities or adult family homes. All clients who are approved for waiver services receive a Planned Action Notice (PAN) indicating which program they are approved for and the begin date of the services.

Q. What are the HCS waiver programs?

A. HCS waivers are COPES (Community Options Program Entry), New Freedom, Medically Needy Residential Waiver (MNRW), Medically Needy In-Home Waiver (MNIW), or HCS Roads to Community Living (RCL) program.

Q. Are there specific ACES coverage groups which indicate a client is eligible for adult dental services because they are approved under an HCS waiver program?

A. Most medical only clients who are approved for HCS waiver services are eligible under the ACES coverage groups L21 or L22. If client is eligible for L21 or L22 on the date of service and there is no hospice information coded on the client eligibility screen, the client is eligible for adult dental services. No additional documentation will be needed from the client.
If hospice is coded on an L21 or L22 client, you will need to also get a copy of the PAN verifying the client is approved for the COPES, New Freedom waiver or Roads to Community Living (RCL).

Q. What about the other ACES coverage groups listed for this group?

A. Waiver services may be provided to clients under several other ACES coverage groups. In addition to confirming the client is eligible on one of these coverage groups on the date of service, you *must* obtain a copy of the client's Planned Action Notice (PAN) to confirm the client was approved for an HCS waiver program.

- S08 – Healthcare for Workers with DisabilitiesS99 – SSI-related MN medical assistance under the spenddown program (used by HCS for the MNIW program)
- G95 or G99 – SSI-related MN medical assistance for clients who live in an alternate living facility (ALF). (Used by HCS for the MNRW program)
- F01 – TANF cash assistance
- R01 - Refugee cash assistance
- G02 – ABD cash assistance (formerly GA-X)

Q. How do I bill for an HCS waiver client?

A. Follow regular billing procedures using EPA # 870000019 at the claim header.