



JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETAR

December 2, 2004

Dear Medicaid Dental Provider:

The 2004 Legislature appropriated funding to the Medicaid program to restore coverage for adult dental services for recipients ages 21 and older. Medicaid coverage of adult dental services will resume with dates of services on and after January 1, 2005. Medicaid will reimburse dental providers for the provision of dentures and all denture-related services, including repairs and relines. Extractions and other surgical procedures essential to prepare the mouth for the seating of dentures will also be covered.

Effective January 1, 2005, by authority of 42 Code of Federal Regulations (CFR), Section 447.54(a)(2), a five (5) percent coinsurance may be charged by dental providers to adult Medicaid recipients for dental services rendered. The coinsurance applies to the amount of Medicaid payment made for services and not to the provider's charges. The coinsurance will be deducted from the provider's reimbursement amount. Providers may not deny services to recipients who are unable to meet their coinsurance. If the recipient is unable to pay the coinsurance at the time services are rendered, the provider may bill the recipient for it. Per 42 CFR, section 447.53(b)(1)-(5), certain adult categories of recipients are exempt from paying the cost sharing coinsurance charges. They are as follows:

- Recipients who are enrolled in Medicaid health maintenance organizations (HMOs);
- Recipients who are receiving hospice services;
- Recipients requiring emergency services after the sudden onset of a medical condition which, if left untreated, would place the recipient's health in serious jeopardy;
- Recipients who are eligible under the Medicaid Institutional Care Program (ICP). To be exempt, ICP recipients must meet the Medicaid income and asset requirements, and be inpatients in long-term care facilities, hospitals, or other medical institutions, where, as a condition of receiving services they are required to spend all of their income for medical care costs, except for a minimum amount that is exempted for personal needs;
- Pregnant women when the services relate to the pregnancy or to any other medical condition that may complicate the pregnancy or conditions or complications of the pregnancy extending through the end of the month in which the 60-day period following termination of pregnancy ends.



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The *Medicaid Dental Services Coverage and Limitations Handbook* is under revision to include the restored dental services coverage for the adult Medicaid population. Handbooks will be distributed to all Medicaid participating dental providers as soon as printing is complete. A new dental services fee schedule will be posted on the fiscal agent website at the following address: <http://floridamedicaid.acs-inc.com>. When you reach the website, please scroll to and click on "Provider Support"; then click on "Fees"; select "Fee Schedule 2005", and scroll down to "Dental". There you will find the codes and fees for all covered dental services for children and adults effective January 1, 2005.

Until January 1, 2005, adult dental services remain limited to emergency services which include extractions, incision and drainage procedures needed for the relief of pain and/or infection. In the case of an emergency, Medicaid will allow the extraction of one or two teeth without the requirement that a complete denture replace the teeth.

If you have any questions, please call your area Medicaid office. You will find your area office phone number in Appendix C of the *Medicaid Provider Reimbursement Handbook, Dental III*.

We appreciate the services you provide to Florida's Medicaid recipients and look forward to our continued relationship.

Sincerely,



Thomas W. Arnold
Deputy Secretary for Medicaid