

## EMERGENCY DENTAL SERVICES

The recipient must have Medicaid with no applied income and be a resident of a nursing facility. He/she must be referred by the attending physician, and have the services provided by a dentist licensed by the Texas State Board of Dental Examiners.

The facility must accept payment by The Department of Human Services (TDHS) as payment in full for services and neither the dentist nor the facility may charge an additional fee to the recipient, his family or his trust fund.

### Services Covered

Emergency Dental Services (EDSS) covers dental problems which, if not treated could become potentially life-threatening. Reimbursement is limited to procedures necessary to control bleeding, relieve pain, and eliminate acute infection.

Examples of covered EDSS procedures are:

PROCEDURE	TDHS REIMBURSES
Extractions	D7110 -1 <sup>st</sup> extraction - \$32.50; D7120 - 2 <sup>nd</sup> and subsequent extractions - \$29.35
Root Canal	Determined by ADA code
Alleviation of Pain	D9215 – Local Anesthesia - \$12.50 D9220 – General Anesthesia - \$87.50 (first 30 min) D9221 – General Anesthesia - \$31.25 (each additional 30 min)
Treatment of Infection	

Examples of excluded services are:

- Cleaning
- Dentures
- Amalgam or fillings
- Bridges and crowns

## **Reimbursement**

The cost of emergency dental services provided to eligible Medicaid residents residing in nursing facilities will be reimbursed to facilities on a voucher system, provided that the services are not reimbursable by NHIC or the EPSDT program. Dental Claims must be submitted and received by the 95<sup>th</sup> day of the service date. The following items must be submitted to DHS, Emergency Dental Services System, Mail Code W-519, P. O. Box 149030, Austin, Texas 78714-9030:

1. A State of Texas Purchase Voucher completed and signed by the facility Administrator. The voucher must include the name of the facility, resident's name, the procedures performed, and the False Claim Statement: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements of documents, or concealment of a material fact may be prosecuted under applicable federal or state laws". Use the form included to submit your dental claim. Fax the form and a copy of the itemized billing statement from the dentist to 512-438-4621. If you have any questions, please call 1-800-792-1109.;
2. Include a copy of the dentist's treatment notes in which the nature of the emergency is clearly documented; and
3. Include an itemized bill (statement) the facility signed and was provided by the treating dentist which includes a statement regarding whether or not the services were also billed to NHIC. American Dental Association procedure codes must be used for billing.

## DENTAL CLAIM

1) CMS Provider No.	2) Nursing Facility	3) Address	4) FAX Number
5) Client LAST Name		6) Client First Name	7) Client Medicaid Number
			8) Payee identification Number

Line	9) Date of Service	10) ADA Code	11) Procedure Provided	12) Number of Units	13) Unit Rate	14) Line Item Total
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<p>I certify that this information is true, accurate, and complete to the best of my knowledge. I understand that claiming for services not actually provided constitutes fraud.</p>	<p>_____</p> <p>16) Administrator Signature</p>	<p>_____</p> <p>17) Date</p>	<p>Claim Total</p> <table border="1" style="float: right; margin-left: auto;"> <tr> <td style="width: 50px; height: 20px;">15)</td> </tr> </table>	15)
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