MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-13

Distribution: Dentists and Dental Clinics

Issued: May 1, 2012

Subject: Revisions to Dental Radiograph Policy

Effective: June 1, 2012

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

The use of digital radiographic imaging is rapidly replacing the use of traditional film exposure and processing of dental radiographs. Dental radiograph policy is being updated to include references to digital radiographic Imaging as well as traditional film.

Effective June 1, 2012, the following changes apply to dental radiographs.

General Radiograph Policy:

The policy applies to all radiographs and radiographic procedures, both digital and traditional film, unless otherwise stated. (Refer to the Directory Appendix for website information.)

Radiographs are benefits for all beneficiaries and are limited to the number medically necessary to make a diagnosis (other limitations apply to radiographs—see below). The provider must maintain documentation in the beneficiary's file stating the reason the radiographs were necessary, the diagnosis/radiographic findings, treatment plan, and referral if appropriate.

Technical Considerations and Additional Requirements:

All radiographs submitted must be diagnostically acceptable and meet the following technical considerations and additional requirements:

Technical Considerations:

- All teeth or areas of concern must be visible on the radiographs
- Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty.
- On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone.
- Where pathologic change is in question, healthy bone must be seen surrounding the questionable area.
- Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration.
- Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.

Additional requirements:

- All film radiographs submitted must be mounted in an x-ray mount with the exception of single films, which may be submitted in an envelope. Only actual films or diagnostically acceptable duplicates will be accepted (no paper copies).
- Digital radiographs submitted must be regulation film size and printed on quality photo paper.
- All radiographs must be identified with the beneficiary's name and Medicaid ID Number.
- All radiographs must have the date the radiograph was taken.
- All full-mouth radiographs and panoramic radiographs must have "Right" and "Left" identification.
- All submitted radiographs must include the dentist's name and address.

Occlusal Radiograph
An occlusal radiograph is a covered benefit for beneficiaries under age 21 once every three years per arch. All occlusal radiographs, regardless of film size or method of exposure, will be reimbursed at the established fee for a periapical, first film.

Panoramic Radiographs
A panoramic radiograph is a covered benefit once every five years for all beneficiaries ages 5 years and older.

Full Mouth or Complete Series
A full mouth or complete series is a covered benefit once every five years for all beneficiaries ages 5 years and older.

A full mouth or complete series consists of:

- A minimum of 10 periapical radiographs in conjunction with a minimum of two bitewing radiographs; or
- An intraoral/extraoral combination of a panoramic radiograph in conjunction with a minimum of two bitewing radiographs.

The maximum reimbursement for any combination of radiographs will not exceed the established fee for a full mouth or complete series. Any combination of 10 or more intraoral Radiograph will be considered a full mouth series.

Radiographs submitted for prior authorization and audit purposes will be returned to the provider.

Manual Maintenance

Retain this bulletin until it has been incorporated into the Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
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