Iowa Medicaid Policy Clarification # PC000263

Date: July 8, 2022

Dental Emergency Services

Managed Care Plans (MCPs) and Iowa Medicaid shall ensure enrollees have access to services as specified in contract, which includes emergency dental services.

1. Prior authorization is not required for emergency services
2. Emergency dental service claims must include an indicator from the provider upon submission
    a. Indicate Emergency in box 35 (Remarks) of the ADA claim form
    b. Submit clinical documentation that demonstrates an emergency dental condition as defined by the American Dental Association Emergency Dental Condition Guidelines[1]
3. Emergency services do not count towards an Annual Benefit maximum
4. Emergency services are reimbursed at the contracted Medicaid fee schedule[2]

Emergency Medical and Dental Conditions Defined

Emergency services[3] are defined as covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services.
(ii) Needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(ii) Serious impairment to bodily functions.
(iii) Serious dysfunction of any bodily organ or part.

Poststabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, to improve or resolve the enrollee's condition when

(i) the poststabilization care services are obtained from a network provider or non-network provider;
(ii) the services are not pre-approved by the MCP but are administered to maintain, improve, or resolve the enrollee's stabilized condition if:
    (1) The MCP does not respond to a request for prior approval within 1 hour;
    (2) The MCP cannot be contacted; or

(3) The MCP representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCP must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR§ 422.113(c)(3) is met.

Payment to Providers

In accordance with 42 CFR 438.114, managed care plans must pay for emergency services and poststabilization services, regardless of whether a health care provider is in-network with the MCP or enrolled with Iowa Medicaid.

All health care providers are encouraged to enroll in Iowa Medicaid and credential with the MCP to receive payment. Any claim submitted by a billing or rendering provider is subject to audit by Iowa Medicaid. Any claim that is unsupported by clinical documentation will be denied payment. Any billing, ordering, referring and/or prescribing provider that is excluded from receiving state or federal funded reimbursement will be considered an overpayment, and is recoverable.

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[1]American Dental Association Emergency Dental Condition Guidelines
https://www.uccitdp.com/branded/tdp/docs/American%20Dental%20Association%20Dental%20Emergency%20Guidelines.pdf#:~:text=dental%20emergency%2C%20nonemergency%20care%20The%20ADA%20provided%20its,alleviate%20the%20burden%20on%20hospital%20and%20emergency%20departments.

[2] U.S.C. 1396u-2 (b)(D) Emergency Services Furnished by Non-Contract Providers
Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

[3] 441 IAC – 73.1(249A), 42 CFR 438.114 Definitions