CareQuest
Institute for Oral Health®

Rubric for Assessing Extensiveness of State Medicaid Adult Dental Benefits

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Rubric developed in 2020

Introduction and Statement of Purpose

The Current Landscape

Medicaid is a key source of health care coverage for millions of Americans. Although states are required to provide comprehensive dental benefits for children covered by Medicaid and the Children's Health Insurance Program (CHIP), there are no minimum requirements for dental coverage for adult Medicaid beneficiaries.[1]

Today, while most states provide at least emergency/urgent dental benefits (defined differently by states) for adults, approximately one-third of all states do not provide dental care beyond emergency procedures.[2]

Rationale and Purpose of a Refined Definition of "Extensive" Medicaid Adult Dental Benefits

As part of shared and coordinated efforts to improve oral health across the lifespan, a group of stakeholders[3] began convening in 2014 to review an often-used classification of Medicaid adult dental benefits categories, developed by the American Dental Association (ADA) in 2008.

The ADA uses four classification categories: "Extensive," "Limited," "Emergency Only," and "None," as defined in Table 1.

Table 1: Categories of Adult Dental Benefits in Medicaid[4] (Existing ADA categorization system)	
Benefit Level	**Definition**
None	No dental benefit.
Emergency Only	Services for relief of pain and infection. While many services might be available, care may only be delivered under defined emergency situations
Limited	A limited mix of services, including some diagnostic, preventive, and minor restorative procedures. It includes benefits that have a per-person annual expenditure cap of less than $1,000 and covers fewer than 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature.
Extensive	A more comprehensive mix of services, including many diagnostic, preventive, minor and major restorative procedures. It includes benefits that have a per-person annual expenditure cap of at least $1,000 and covers at least 100 procedures out of the approximately 600 recognized procedures per the ADA's Code on Dental Procedures and Nomenclature.

As noted in Table 1, the definition of an "extensive" dental benefit is based on coverage of a minimum number of covered procedures across broad categories of services, as well as an expenditure cap of at least $1,000. However, it provides no clear guidance on: 1) the specific covered service categories necessary to constitute an extensive benefit; 2) the specific procedures to be covered within each service category; 3) the specific service frequency to be covered; and 4) whether coverage is offered to all adult Medicaid beneficiaries or only to select subset(s) (e.g., pregnant women).

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1   Children under the age of 21 are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, which include comprehensive dental benefits. Available from: http://www.medicaid.gov/medicaid/benefits/epsdt/index.html

2   Center for Health Care Strategies, Inc. Medicaid Adult Dental Benefits: An Overview. November 2018. Available from: Medicaid Adult Dental Benefits: An Overview (chcs.org)

3   See page 6 for a list of members.

4   Nasseh K, Vujicic M, O'Dell A. *Affordable Care Act expands dental benefits for children but does not address critical access to dental care issues.* Health Policy Resources Center Research Brief. American Dental Association. April 2013. Available from: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/HPIBrief_0413_3.pdf?la=en

As a result of these limitations, a state's dental benefits package may include services that are not aligned with the evidence base for care that is necessary to maintain oral health, yet still be considered extensive. Further, a benefits package that meets the above threshold for "extensive" may give the erroneous impression that its coverage has no room for improvement. Lastly, the definition's lack of specificity hinders its reliability, leading to the risk of various entities classifying a given state's coverage differently and impeding the identification of states where improvement in coverage might be in order.

This workgroup thus sought to develop a more useful and reliable framework that would:

1. Capture point-in-time information at the state level about specific adult dental procedures covered by Medicaid.

2. Serve as a resource to better enable states to evaluate the extensiveness of their Medicaid adult dental benefits and serve as a self-assessment tool to identify specific opportunities for improvement.

3. Promote understanding of the term "extensive."

Accordingly, the Rubric for Assessing the Extensiveness of State Medicaid Adult Dental Benefits (Rubric) is a points-based tool that acknowledges coverage of specific services (including allowed frequency) in eight service categories, explained in greater detail in the User Guide that follows. Further, it distinguishes coverage that applies to the largest group of Categorically Needy Medicaid adults ages 21–64 versus specific sub-populations only.

The Rubric is not meant to serve as a critique of a specific state Medicaid agency or administrator. Nor is it meant to inform a publicly disseminated score card. Rather, the goal is for states to utilize the Rubric in an effort to move towards coverage of a more extensive set of Medicaid adult dental benefits.

The categories of procedures in this Rubric encompass specific services that are most commonly reimbursed by employer-based dental benefit plans, and that are critical to maintaining lifelong oral health.[5] Lastly, the Rubric's points-based system allows for states that meet the threshold of extensive to identify additional areas for improvement.

Definition of an Extensive Dental Benefit

The Rubric defines an extensive dental benefit as one that provides coverage for a range of dental procedures considered adequate for the prevention of disease and promotion of oral health, the restoration of oral structure to health and function, and the treatment of emergency/urgent conditions for the largest group of Categorically Needy Medicaid adult beneficiaries ages 21–64. Included as Categorically Needy are low-income, childless adults who live in states that have opted to expand their Medicaid eligibility.[6]

As a result of states' flexibility in their Medicaid program design, they may opt to offer dental coverage only to certain groups of Categorically Needy Medicaid adult beneficiaries. These include but are not limited to caretakers (e.g., parents), pregnant women, Supplemental Security Income recipients, and certain aged, blind, and disabled adults.

While the Rubric does not assign points in cases where procedures are covered for only one or more (but not all) discrete groups of beneficiaries, it is important for states to track this information in order to detail progress toward a more robust benefit for all adult beneficiaries. To this end, and as detailed in the User Guide, the Rubric contains checkboxes to indicate discrete populations eligible for each category of service.

The included procedures are intended to be representative of the hundreds of dental procedures contained in the ADA's Current Dental Terminology code set. This sample is not exhaustive and should not be considered as constituting a complete benefits package.

Lastly, state Medicaid programs can vary significantly in important dimensions such as service limitations, prior authorization requirements, reimbursement rates, program administration, or provider participation, which are beyond the scope of this Rubric.

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5   Analysis was conducted in March 2016 and is available upon request.

6   For a full listing of Medicaid eligibility groups and criteria, please refer to the following website: https://www.medicaid.gov/Medicaid-CHIP-ProgramInformation/By-Topics/Waivers/1115/Downloads/List-of-Eligibilty-Groups.pdf

Extensiveness of Benefits Is a Critical Component of Assessing Adequacy

An essential part of assuring access to care and improved health is including a dental benefit with a sufficient range of services. Policies to promote adequate provider panels, reimbursement rates, and monitoring of access are enhanced when policymakers have a shared understanding of the rationale for coverage of specific procedures.

Use of and Future Revisions to the Rubric

This document is intended to: 1) provide a single definition of an extensive adult dental benefit that all states and organizations can use, and 2) serve as a tool to assess how closely a state's benefits match this definition.

The Rubric is designed to be completed by state Medicaid dental directors or other state employees with detailed knowledge of their Medicaid adult dental benefit. Upon completion, an independent evaluator contracted by CareQuest Institute for Oral Health® will review and compile the responses and present them in a report. The report will capture point-in-time information about selected adult dental procedures covered by a state's Medicaid agency, serve as a resource to better enable states to evaluate the extensiveness of their Medicaid adult dental benefits, and identify areas for development.

With extensive time and input from experts in oral health care and public policy at the state and national levels, the Rubric has been widely tested and undergone numerous revisions. As the provision of dental services and the methodology of accurately capturing the information continues to evolve, the Rubric will be updated and shared with states and other oral health stakeholders on a regular basis.

Summary

The purpose of the Rubric is to:

- capture point-in-time information about selected adult dental procedures covered by a state's Medicaid agency

- serve as a resource to better enable states to evaluate the extensiveness of their Medicaid adult dental benefits and self-identify areas for improvement

- promote understanding of the term "extensive"

- illustrate over time how the national coverage landscape has changed

The Rubric is not a:

- "report card" to rank or order states

- critique or scored assessment of a Medicaid agency or administrator

- tool to assess appropriate levels of provider participation within a Medicaid network or adequate provider reimbursement rates

- tool that specifies appropriate treatment for an individual

Core Group and Advisory Committee Members

This document was prepared by members of the Medicaid Core Group and Advisory Committee.[7] Members are listed alphabetically by last name below.

Core Group Organizational Members

American Dental Association Health Policy Institute
http://ada.org/hpi

CareQuest Institute for Oral Health
http://carequest.org

Center for Health Care Strategies
http://chcs.org

National Academy of State Health Policy
http://nashp.org

Advisory Committee Members

Stacey Auger, MPH
Policy Consultant,
CareQuest Institute for Oral Health

Donna Balaski, DMD
Healthcare Administration Management,
State of Connecticut, Department of Social Services
Division of Health Services

Stacey Chazin, MPH, MSODL
Health Policy and Leadership Consultant, formerly with the
Oral Health Progress and Equity Network

Dora Fisher
Formerly Director of Older Adult Programs,
Oral Health America

Mary E. Foley, RDH, MPH
Executive Director,
Medicaid Medicare CHIP Services Dental Association

Chelsea Fosse, DMD, MPH
Senior Health Policy Analyst,
American Dental Association Health Policy Institute

Steven Geiermann, DDS
Retired, Senior Manager,
Access, Community Oral Health Infrastructure and Capacity,
American Dental Association Council on Advocacy for
Access and Prevention

Tracy Gilman, CDA, MSM
Regional Director,
MassHealth Contract at DentaQuest

Carrie Hanlon, MPP
Project Director,
National Academy of State Health Policy

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Formerly Dental Program Consultant,
California Department of Health Care Services

Michael Monopoli, DMD, MPH, MS, FACD, FICD
Vice President for Grant Strategy,
CareQuest Institute for Oral Health

Bianca Rogers
Formerly Advocacy Coordinator,
Oral Health America

Andrew Snyder, MPA
Formerly Project Director,
National Academy of State Health Policy

Madeline Steward, MPH
Program Officer,
Center for Health Care Strategies

Cassandra Yarbrough, MPP
Formerly Lead Public Policy Analyst,
American Dental Association Health Policy Institute

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7   In August 2014 a group of stakeholders (Core Group) was convened by CareQuest Institute for Oral Health (formerly DentaQuest Partnership for Oral Health Advancement) to review the assumptions behind the existing ADA Categories of Adult Dental Benefits in Medicaid and Classification of States, ensure consistency and consensus around the use of this classification, and monitor individual state standings as policy changes occurred within states. Shortly thereafter, there was interest among the Core Group in developing a new tool (Rubric) to objectively assess where states' Medicaid adult dental benefits fell in relation to a shared understanding of extensive benefits. In April 2015, requests for participation were sent to individuals who are considered experts in their fields and who could provide feedback and perspectives representative of those in their sector of the oral health network (Advisory Committee). Between spring 2015 and winter 2020, the Core Group and Advisory Committee solicited external feedback from experts at the state and national level, conducted testing of, and made numerous revisions to the Rubric presented here.

User Guide

This User Guide provides definitions for key terms used throughout the Rubric, as well as descriptions and selection rationale for specific procedures in the Code on Dental Procedures and Nomenclature (Current Dental Terminology (CDT) codes). The CDT codes in the Rubric are effective for procedures provided January 1–December 31, 2018. For more detailed definitions of the specific CDT codes, see the ADA's CDT 2018 Dental Procedures handbook.[8]

User Information and Sources Used

It is recommended that the state Medicaid dental director or another state employee with detailed knowledge of the Medicaid adult dental benefit complete the Rubric. Users are asked to provide full references (and URL addresses whenever possible) of sources used to verify responses.

Assignment of Point Values

The Rubric's scoring strategy was developed by members of the Core Group and Advisory Committee.[9] It includes specific procedures that are most commonly reimbursed by employer-based dental benefit plans and that are considered essential to preventing and treating diseases of the teeth and supporting structures and maintaining oral health.[10]

Points are assigned to each service category based on the coverage of these procedures for the largest group of Categorically Needy Medicaid adults ages 21–64. For example, in most cases:

0 *points are assigned if the service is never covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

1 *point is assigned if the service is only covered in emergencies for the largest group of Categorically Needy Medicaid adults ages 21–64.*

2 *points are assigned if the service is covered on a routine basis for the largest group of Categorically Needy Medicaid adults ages 21–64.*

A service is considered "covered" if: 1) the state plan specifically indicates that it is covered for Categorically Needy Medicaid adults ages 21–64, or 2) all the managed care organizations (MCOs) contracted with a state's Medicaid program cover the service for that population.

States should assign points if the code(s) within a service category are covered or can be covered by prior authorization, benefit limit exception, or other related terminology. Respondents are encouraged to provide information about the prior authorization requirements for specific codes in the "Additional Information" section at the end of the document. A state's Medicaid adult dental benefits program is "extensive" if it receives a total of 19 points or greater, does not receive a "0" in any category, and receives a "4" or "6" in question 1 (Dollar Cap on Benefits/Benefit Maximum).

Key Terms

Extensive Dental Benefit
An extensive dental benefit is one that provides coverage for a range of dental procedures considered adequate for the prevention of disease and promotion of oral health, the restoration of oral structures to health and function, and the treatment of emergency/urgent conditions for the largest group of Categorically Needy Medicaid adult beneficiaries ages 21–64.

Medicaid-Eligible Adults
The Rubric defines Medicaid-eligible adults as those individuals ages 21–64. Adults ages 19–20 and over the age of 64 are not included in this definition based on the following rationale:

- Although the Centers for Medicare and Medicaid Services (CMS) defines individuals ages 19–20 as adults, states have the option to define them as children eligible for additional services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit

- Individuals over the age of 64 are eligible for Medicare.[11]

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8   American Dental Association. CDT 2018 Dental Procedure Codes. Chicago: American Dental Association. 2017. Available from: https://www.ada.org/en/publications/cdt

9   See page 6 for a list of members.

10 The CDT codes included in this Rubric are comparable to the majority of those included in Oral Health America's 2018 A State of Decay, Vol. IV report. Report available upon request. The included CDT codes are also comparable to those included in MSDA's 2015 National Profile of State Medicaid and CHIP Oral Health Programs. Available from http://www.msdanationalprofile.com/.

11 Only select individuals continue to be eligible for Medicaid over the age of 64. Although an important adult population to consider, due to program differences by state, and for simplicity and to promote consistency across states, these individuals are not included in the Rubric's definition of Medicaid eligible adults. Respondents can, however, note coverage for these individuals throughout the Rubric in the space provided in boxes that note coverage "only for certain groups of Medicaid beneficiaries." Please see "Certain Groups of Medicaid Beneficiaries" on page 8 for additional information.

Certain Groups of Medicaid Beneficiaries

In many states, dental procedures are covered for only certain groups of Medicaid adult beneficiaries (e.g., parents of Medicaid-enrolled children, Medicaid-expansion adults, pregnant women, individuals with developmental disabilities, elderly individuals, those residing in long-term care settings). These groups are included for tracking purposes, but not assigned points, in the Rubric.[12,13]

The Rubric contains boxes under each service category (questions 2–8) where users can place a check mark to indicate populations eligible for each category of service (see sample). Boxes indicating coverage for certain groups of Medicaid adult dental beneficiaries should only be checked if the service is not covered for the largest group of Categorically Needy adults ages 21–64, via either a state-administered benefit or an MCO, or if the group is unique from the largest group of Categorically Needy Medicaid adult beneficiaries ages 21–64 in some way (e.g., has a higher income eligibility level).

Sample Check Box

Covered only for certain groups of Medicaid adult beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children
☐ Medicaid Expansion
☐ Pregnant Women
☐ Developmentally Disabled
☐ Long-Term Care
☐ Other (please list):

Covered Commonly Provided Dental Services, Covered Emergency Dental Services, and Non-Covered Dental Services

This Rubric assigns point values to the level of coverage provided for several categories of services, distinguishing between commonly provided, emergency, and no coverage.

Covered Commonly Provided Dental Services:

Regardless of how a provider is reimbursed, an eligible adult Medicaid beneficiary can receive the procedure from an eligible provider. While a state may impose frequency limitations (e.g., how often a filling can be replaced) or require pre-authorization of the procedure, the procedure is generally available to the largest group of Categorically Needy Medicaid adult beneficiaries ages 21–64 in the state.

Covered Emergency Dental Service(s):

The procedure is reimbursed only if the provider documents that the procedure was provided to address an emergency. Although states differ in how they define emergencies, most include emergency coverage of treatment for pain, infection, or trauma.

Non-Covered Dental Services:

The procedure is not reimbursed under any circumstance. The Rubric assigns zero points to this level of coverage. Note that even in these circumstances, all states cover hospital-based emergency procedures for Medicaid beneficiaries, including dental emergencies. Reimbursement may still be available for Medicaid beneficiaries presenting at a hospital emergency department with a dental injury such as a broken tooth or profuse bleeding. In such cases, the procedures may be billed using a different coding system (e.g., Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, or Revenue Center (RC) codes).

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12   For a complete list of Medicaid eligibility groups, please refer to https://www.medicaid.gov/sites/default/files/2019-12/list-of-eligibility-groups.pdf.

13   Although points are not earned in cases where dental procedures are covered for only one or more of these groups, it is valuable for states to track this information given the variability in benefits provided by enrollee groups across states.

Service Categories and CDT Codes

The service categories below encompass a range of oral health procedures that are critical to maintaining lifelong oral health in adults. However, users should not interpret coverage of these procedures as coverage of all procedures within a CDT service category.

The Rubric includes specific CDT procedures within each service category based on two criteria: (1) those that are most commonly reimbursed by employer-based dental plans and (2) expert opinion. To analyze dental care utilization among adults with private dental benefits, data from the IBM MarketScan® Dental Database (i.e., Dental Database) for 2013 were used.[14] The Dental Database includes dental claims and enrollment data from large employers and health plans across the United States that provided private dental benefits to employees, their spouses, and dependent children. In 2013, there were 10.7 million covered lives included in the Dental Database. Using data from the 2012 Medical Expenditure Panel Survey (MEPS) to measure the total number of individuals with private dental benefits in the U.S.,[15] we estimate that the Dental Database covered approximately 7.6 percent of privately insured individuals in the United States. The Dental Database includes claims from a variety of fee-for-service and preferred provider organizations, as well as capitated health plans.

The workgroup's analysis examined 24,730,649 dental claims across 5,970,386 adults who were enrolled in a private dental benefits plan for 365 continuous days. Utilization was analyzed across all adults in this sample, determining the average number of times an adult utilized a specific dental procedure within the year. The total number of claims for a procedure was divided by the total number of adults in the sample. This calculation was completed for every dental procedure included in the claims database, followed by the ranking of the dental procedures by average utilization from most utilized to least utilized. Out of the 63 procedures included in the Rubric, 34 rank in the top-100 utilized procedures among adults with private dental benefits. The clinical expertise of dentists among the Core Group, Advisory Committee, and external reviewers defined the parameters of the remaining 29 codes.

1. Dollar Cap on Benefits

The dollar cap on benefits/benefit maximum section assigns points based on whether there is an annual dollar cap for Medicaid adult dental benefits as it applies to the largest group of Categorically Needy Medicaid beneficiaries ages 21–64. The cap does NOT apply to procedures that may need to be prior authorized because they exceed usual frequency limitations or for other reasons.

There are four answer options for this question: (1) no coverage or emergency coverage only, limited to extractions, relief of pain, and biopsy; (2) an annual limit that is less than $1,000; (3) an annual limit that is greater than or equal to $1,000; or (4) no annual limit. The selection of $1,000 as the cutoff point between the second and third categories is based on feedback from state partners and analyses completed by oral health and policy organizations. Further, many states and oral health organizations already use $1,000 as a cutoff when assessing annual dollar caps in Medicaid. To assess whether a dollar cap/benefit maximum can be overridden in certain circumstances, the Rubric asks whether the maximum is "hard" (cannot be exceeded) or "soft" (can be exceeded).

2. Diagnostic Services

The diagnostic services section consists of two parts. The first (a) focuses on CDT code D0140 — limited oral evaluation that is problem-focused — when used for emergencies or for relief of acute pain, infection, or trauma. The second (b) focuses on two CDT codes: D0120 – periodic oral evaluation, and D0150 – comprehensive oral evaluation. In all three instances, points are earned only if the CDT codes are covered.

These CDT codes were chosen because their coverage will help to ensure that providers can perform the evaluation necessary to understand a specific patient's oral health status while accurately diagnosing any problems and creating an appropriate treatment plan. Radiograph codes are not included in the assignment of points; it is assumed they are covered when medically necessary.

3. Preventive Services

The preventive services section consists of two parts. The first (a) focuses on CDT code D1110 — adult prophylaxis — with a frequency of at least twice per year. While frequency of prophylaxis should be determined by a patient's risk and individual consideration, it is important that states cover at least two prophylaxis treatments annually for those adults that are at higher risk for oral disease. Additionally, covering two adult prophylaxis

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14   Analysis was conducted in March 2016 and is available upon request.

15   Medical Expenditure Panel Survey (MEPS). MEPS HC-155: 2012 Full Year Consolidated Data File. Agency for Healthcare Research and Quality. September 2014. Available from: https://meps.ahrq.gov/mepsweb/data_stats/download_data_files_detail.jsp?cboPufNumber=HC-155.

treatments per year would align a state's Medicaid adult dental benefit with most employer-offered dental benefit plans.

The second (b) focuses on coverage for the application of fluoride for patients at moderate to high risk of caries. The two CDT codes in this section are D1206 – topical application of fluoride varnish, and D1208 – topical application of fluoride excluding varnish. Points are earned based on coverage of at least one of these CDT codes with a frequency of at least twice per year.

As most states do not cover fluoride treatments for their adult Medicaid population, this section provides an example of how states can continue to improve their adult Medicaid dental benefit.

4. Restorative Services

The restorative services section contains two parts. The first (a) focuses on restorative procedures (i.e., fillings) that mitigate the need to remove teeth, assigning points based on coverage of amalgam and resin-based composite fillings (D2140–D2161 or D2330–D2394). The second set of procedures (b) focuses on coverage for prefabricated or cast crowns, assigning points based on coverage of one of D2710–D2794 or D2931 or D2932. Earning points for coverage of one CDT code within a range of codes allows state flexibility on the type of crown to cover.

5. Endodontic Services

The endodontic services section contains two parts. The first (a) focuses on anterior endodontics and the CDT code D3310 – anterior root canal therapy. The second (b) focuses on posterior endodontics and two CDT codes: D3320 – endodontic therapy, bicuspid; and D3330 – endodontic therapy, molar.

Tooth loss, whether an anterior or posterior tooth, may result in oral and structural problems, such as bite collapse or increased risk of gum disease. When the posterior teeth are lost, and there is insufficient chewing capability, people use their front teeth to help chew food. This may lead to excessive wear and further destruction of the dentition.

6. Periodontal Services

The periodontal services section focuses on coverage of (1) one of two CDT codes: D4341 – periodontal scaling and root planing with four or more teeth per quadrant, or D4342 – periodontal scaling and root planing with one

to three teeth per quadrant; and (2) CDT code D4910 – periodontal maintenance. Points are earned based on coverage and frequency of that coverage.

Individuals may need periodontal procedures more frequently than once per year; periodontal maintenance is typically provided at least twice per year. Setting a frequency criterion of at least twice per year allows practitioners more flexibility in a beneficiary's specific treatment plan.

7. Prosthodontic Services

The prosthodontic services section contains three parts. The first (a) focuses on coverage for complete dentures. Points are earned for coverage of both complete denture CDT codes D5110 and D5120.

The second (b) focuses on coverage for partial dentures. Points are earned for coverage of partial denture CDT codes D5211 or D5213 and D5212 or D5214. The rationale for requiring states to cover one code between D5211 or D5213, and one code between D5212 or D5214 for partial dentures is that D5211 and D5213 address partial dentures in the maxillary or upper jaw, while D5212 and D5214 address partial dentures in the mandibular or lower jaw.

The third (c) focuses on states' coverage for chairside or laboratory reline of complete dentures, and rebasing. Points are earned for coverage of reline CDT codes D5730 and D5731 or D5750 and D5751 and rebasing codes D5710 and D5711 and D5720 and D5721.

8. Extraction Services

The extraction services section includes multiple CDT codes to allow for the extraction technique appropriate for different clinical presentations. Points are earned based on coverage of D7140 – single tooth extraction, D7210 – single tooth surgical extraction, D7220 – removal of impacted tooth (soft tissue), D7230 – removal of impacted tooth (partially bony), D7240 – removal of impacted tooth (completely bony), and D7241 – removal of impacted tooth (completely bony, with unusual surgical complications).

Using the Digital Form

The Rubric begins on the pages that follow and users are asked to provide information to the best of their knowledge. Users are asked to click on the bubble that corresponds with their answer to service category sections 1–8.

Rubric for Assessing Extensiveness of State Medicaid Adult Dental Benefits

User Information

Name: _____

Title: _____

Agency/Organization: _____

Address: _____

Email/Phone number: _____

Users are encouraged to:

- Provide responses to the Rubric as defined by the Medicaid state plan for the largest group of Categorically Needy adults ages 21–64 covered by the state's Medicaid program. For information regarding Medicaid State Plan Amendments and to search for a specific state plan, please refer to: https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html

- Provide information on coverage of procedures for discrete groups of adult Medicaid beneficiaries (parents, developmentally disabled, pregnant women, etc.) in sections 2–8.

- Provide information regarding coverage of procedures offered by all MCOs operating within the state (if applicable). Points will not be assigned in a category unless all MCOs offer the same coverage of CDT codes in that category. Describe variations in coverage by MCO on the "Additional Information" page.

- Assign points if the code(s) within a service category are covered or can be covered by prior authorization, benefit limit exception, or other related terminology. Describe prior authorization requirements for specific codes in the "Additional Information" page.

- Share pertinent information regarding the state adult Medicaid program that is not captured in the Rubric on the "Additional Information" page.

As a reminder:

- Points are earned for a service if the State Medicaid Plan has language specifically stating that the service is covered for Categorically Needy Medicaid adults ages 21–64 or all of the MCOs contracted with the state Medicaid program cover the service for Categorically Needy Medicaid adults ages 21–64. Points are earned for value-added services covered by MCOs as long as all MCOs cover the same service.

1. Dollar Cap on Benefits/Benefit Maximum

Assess annual dollar cap/benefit maximum on adult dental benefits for the largest group of Categorically Needy Medicaid adults ages 21–64.

☐ **0** *No coverage*

☐ **2** *Annual limit < $1,000*

☐ **4** *Annual limit ≥ $1,000*

☐ **6** *No annual limit on dental service spending*

Please indicate if this is a "hard" or "soft" dollar cap/benefit maximum by checking the appropriate box below.

☐ Hard cap (i.e., cannot be overridden under any circumstance)

☐ Soft cap (i.e., can be overridden in certain circumstances such as emergency dental procedures; dentures; maxillofacial and complex oral surgery; maxillofacial services, including dental implants and implant-retained prostheses; and services provided in long-term care facilities)

Please explain:

_____

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

2a. Diagnostic Services

Assess coverage of examination code D0140 only when used for evaluation of a specific problem and/or dental emergencies or for relief of acute pain, infection, or trauma.
D0140

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

2b. Diagnostic Services

Assess coverage of both examination codes.
D0120 AND D0150

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain, infection, or trauma for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

3a. Preventive Services

Assess coverage for adult prophylaxis. Is this procedure covered with a frequency of at least twice per year? **D1110**

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64 once per year.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64 twice or more per year.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

3b. Preventive Services

Application of fluoride: D1206 OR D1208. Is at least one of these procedures covered with a frequency of at least twice per year for patients at moderate to high risk for caries? **D1206 OR D1208**

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64 twice or more per year.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

4a. Restorative Services

Fillings: Assess coverage for amalgam and resin-based composite filling procedures.
All codes within range D2140–D2161
OR
All codes within range D2330–D2394

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain or infection for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

4b. Restorative Services

Crowns: Assess coverage for prefabricated or cast crowns. Is at least one procedure in this code range covered?
All codes within range D2710–D2794 OR
D2931 OR
D2932

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain or infection for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

5a. Endodontic Services

Anterior Root Canal Therapy: Assess coverage for anterior root canal therapy.
D3310

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain or infection for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

5b. Endodontic Services

Posterior Root Canal Therapy: Assess coverage for posterior root canal therapy.
D3320 AND/OR D3330

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain or infection for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

6. Periodontal Services

Assess coverage for periodontal scaling and root planing with a frequency of at least once per year AND coverage for periodontal maintenance with a frequency of at least twice per year.

D4341 OR D4342;
AND D4910

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *D4341 or D4342 covered for the largest group of Categorically Needy Medicaid adults ages 21–64 at least once every two years AND D4910 covered for the largest group of Categorically Needy Medicaid adults ages 21–64 at least two times per year.*

☐ **2** *D4341 or D4342 covered for the largest group of Categorically Needy Medicaid adults ages 21–64 at least once every year AND D4910 covered for the largest group of Categorically Needy Medicaid adults ages 21–64 at least two times per year*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

7a. Prosthodontic Services

Assess coverage for complete dentures.
D5110 AND D5120

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered less than or equal to once per five years (60 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered more than once per five years (60 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

7b. Prosthodontic Services

Assess coverage for resin-based partial dentures.
**D5211 OR D5213
AND
D5212 OR D5214**

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered less than or equal to once per five years (60 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered more than once per five years (60 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

7c. Prosthodontic Services

Assess coverage for chairside reline of complete dentures; or laboratory reline of complete denture; and rebase.
D5730 AND D5731;
OR
D5750 AND D5751;
AND
D5710 AND D5711 AND D5720 AND D5721

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered less than or equal to once every three years (36 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered more than once per three years (36 months) for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

8. Extraction Services

Assess coverage of single tooth extraction; and single tooth surgical extraction; and removal of impacted tooth – soft tissue; and removal of impacted tooth – partially bony; and removal of impacted tooth – completely bony; and removal of impacted tooth – completely bony with unusual surgical complications.
D7140 AND D7210 AND D7220 AND
D7230 AND D7240 AND D7241

☐ **0** *No coverage for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **1** *Covered only in emergencies/for relief of acute pain or infection for the largest group of Categorically Needy Medicaid adults ages 21–64.*

☐ **2** *Covered for the largest group of Categorically Needy Medicaid adults ages 21–64.*

Covered only for certain groups of adult Medicaid beneficiaries. Check all that apply.

☐ Parents of Medicaid-enrolled children

☐ Medicaid Expansion

☐ Pregnant Women

☐ Developmentally Disabled

☐ Long-Term Care

☐ Other (please list):

_____

_____

Please use the "Additional Information" section on page 21 to share pertinent information regarding the dollar cap on benefits/benefit maximum and/or information about the state's adult Medicaid program not captured here.

Points Assignment Sheet

	Category	Points								
1	Dollar cap on benefits/ Benefit maximum (0–6)		☐ Hard cap	☐ Soft cap						
			All adults*	Parents of Medicaid-Enrolled Children	Medicaid Expansion	Pregnant Women	Developmentally Disabled	Long-term care	Other	
2a	Diagnostic Services (0–2)									
2b	Diagnostic Services (0–2)									
3a	Preventive Services — prophylaxis (0–2)									
3b	Preventive Services — fluoride (0–2)									
4a	Restorative Services — fillings (0–2)									
4b	Restorative Services — crowns (0–2)									
5a	Endodontic Services — anterior (0–2)									
5b	Endodontic Services — posterior (0–2)									
6	Periodontal Services (0–2)									
7a	Prosthodontic Services — complete dentures (0–2)									
7b	Prosthodontic Services — partial dentures (0–2)									
7c	Prosthodontic Services — relines and rebases (0–2)									
8	Extraction Services (0–2)									

Total	
EXTENSIVE BENEFITS (Y/N) (Score of 19 or more, no zeroes in any category, and a score of 4 or 6 in Question 1)	Yes No

* The largest group of Categorically Needy Medicaid adult beneficiaries ages 21–64.

Additional Information Regarding State Medicaid Program

Using the space provided below, please share any pertinent information regarding the state's Medicaid dental program that is not captured in the Rubric itself. Examples of such information may include procedures that are allowed but not included in the dollar cap, whether procedures can be provided and paid for out-of-pocket by the member once the dollar cap is reached, and whether beneficiaries may request a replacement denture through prior authorization before the replacement time limit has been achieved.

Please note that the information provided below will not impact the state's overall score or the score assigned to any individual measures.

User Feedback

Service Categories

Service Category	Please provide any feedback, questions and/or concerns about the codes included, frequency specified (if applicable), or assignment of points for the service categories below.
Q1 – Dollar Cap on Benefits/ Benefit Maximum	
Q2 – Diagnostic Services	
Q3 – Preventive Services	
Q4 – Restorative Services	
Q5 – Endodontic Services	
Q6 – Periodontal Services	
Q7 – Prosthodontic Services	
Q8 – Extraction Services	

Assignment of Points

Are the points attributed to your state via the Rubric consistent with your assessment? If not, please explain.	

General Feedback

Please share your overall feedback on the Rubric related to its usefulness, usability, strengths or weaknesses.	
Were you able to complete the Rubric in one sitting?	☐ YES ☐ NO
How long did it take you to complete the Rubric?	

CareQuest Institute for Oral Health

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This resource and others are available at carequest.org.