CareQuest Institute for Oral Health®

Making Sense of Medicaid: EPSDT, Billing, and Reimbursement

October 9, 2025

Webinar Notes

All lines will be muted to avoid background noise.

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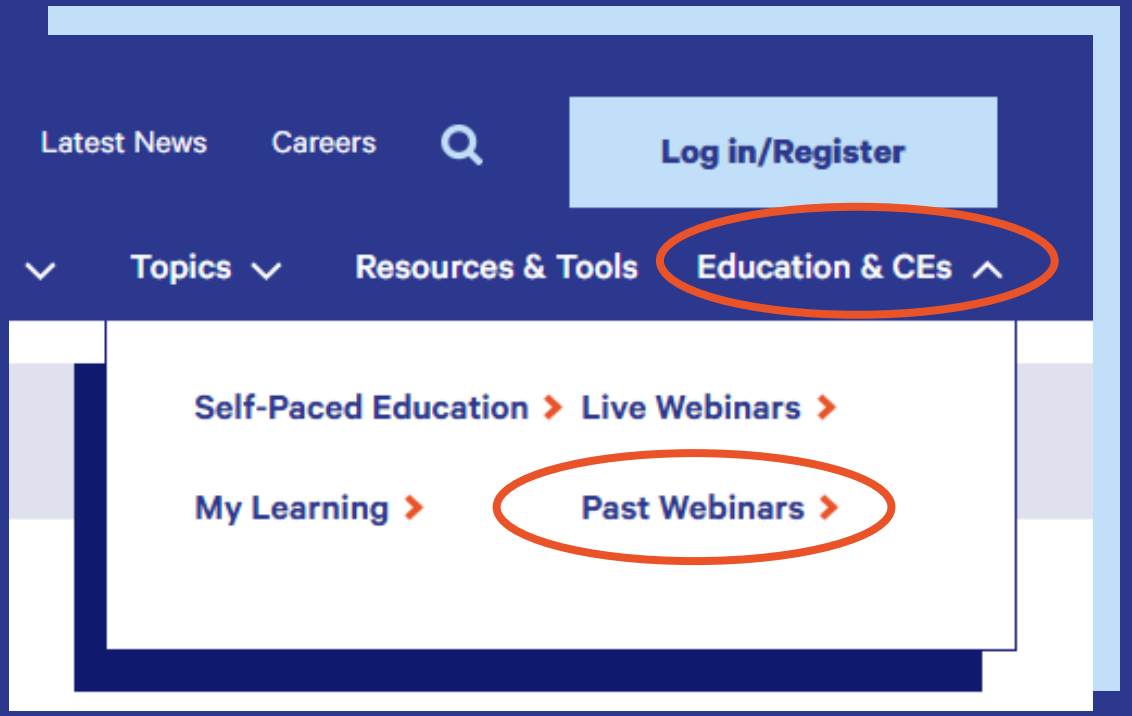

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- Feel free to enter your questions into the **Question & Answer box** throughout the presentations.
- We will turn to your questions and comments toward the end of the hour.

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Webinar

Making Sense of Medicaid:

EPSDT, Billing, and Reimbursement

Thursday
October 9, 2025

7-8 p.m. ET

1 CE Credit

Moderator

Sherry Jenkins, BS, RDH

MCNA Dental

Presenter

Linda M. Altenhoff, DDS

MCNA Dental

Learning Objectives

- **Explain** the core components of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental benefit, including how “medical necessity” is defined and applied in Medicaid policy.
- **Describe** how Medicaid dental reimbursement rates are established, including the role of medical loss ratio and the impact of billing practices on rate-setting.
- **Identify** practical billing strategies, including the use of usual and customary fees that support accurate reporting, equitable reimbursement, and the long-term sustainability of Medicaid dental programs.

Polling Question

How familiar are you with the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and its requirements?

a) Very familiar – I understand how EPSDT applies to dental services

b) Somewhat familiar – I know the basics but want a refresher

c) Unfamiliar – I've heard of it but not sure how it works

d) Very unfamiliar – This is completely new to me

Polling Question

Which best describes your experience with Medicaid dental programs?

a) I routinely provide or support care for Medicaid-enrolled patients

b) I occasionally provide or support care for Medicaid-enrolled patients

c) I do not currently work with Medicaid-enrolled patients but have in the past

d) I have never worked with Medicaid-enrolled patients

CareQuest Institute for Oral Health

Making Sense of Medicaid: EPSDT, Billing, and Reimbursement

CareQuest Webinar

October 9, 2025 – 7 pm ET

Linda M. Altenhoff, DDS

No Conflict of Interest

I, Linda M. Altenhoff, DDS, and no member of my family have any financial arrangement or affiliation with any person or entity offering financial support, products, and/or services mentioned or related to the content of the presentation.

I, Sherry R. Jenkins, RDH, and no member of my family have any financial arrangement or affiliation with any person or entity offering financial support, products, and/or services mentioned or related to the content of the presentation.

Learning Objective 1

- Explain the core components of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental benefit
- How "medical necessity" is defined and applied to Medicaid policy

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Medical Necessity

- Established by the Social Security Act of 1965, EPSDT is a federal and state partnership within Medicaid that provides healthcare services including dental for eligible individuals from birth through 20 years of age
- Funded through federal and state tax dollars
  - Federal funds designated by Congress
  - State funds designated by state legislatures
- Federal rules and regulations developed and administered by the Centers for Medicare and Medicaid Services (CMS)
- State rules and regulations developed by each state legislature and designated state agency

Medical Necessity – Core Components Federal Perspective

- **Related to Diagnosis and Treatment** – Services must address a specific health condition
- **Direct Care** – Provided for diagnosis, care or treatment
- **Standard Practice** – Must follow accepted medical/dental standards – safe, effective, and not experimental
- **Not for Convenience** – Should not be primarily for patient or provider convenience, not for cosmetic reasons only
- **Appropriate and Effective** – Suitable in type, frequency, and duration; better than alternatives
- **Qualified Providers** – Ordered and delivered by qualified professionals in proper settings

- **States incorporate the federal perspective into their statutory language**

Example of State Medical Necessity Language - Florida

To be considered medically necessary, care, goods, or services must:

- Protect life, prevent serious illness/disability, or relieve severe pain.
- Be individualized and specific to the patient's confirmed diagnosis or symptoms—not excessive or generalized.
- Align with accepted medical standards and not be experimental or investigational.
- Reflect the safest and most appropriate level of care, with no equally effective, more conservative, or less costly alternative available statewide.
- Not be provided primarily for convenience of the patient, caregiver, or provider.
- A provider's recommendation alone does not guarantee that the service is medically necessary or covered.

Example of State Medical Necessity Language - Colorado

A service or treatment is considered medically necessary if it:

- Improves or prevents physical, mental, cognitive, or developmental effects of a condition—including pain and suffering—even if that means no treatment or just observation.
- Follows accepted U.S. medical standards.
- Is clinically appropriate in terms of type, frequency, extent, site, and duration.
- Is not for economic gain of the provider or convenience of anyone involved.
- Is delivered in the most appropriate setting for the client's condition.
- Is not experimental or investigational.
- Is cost-effective, meaning it's not more expensive than other equally effective options.

Learning Objective 2

- Describe how Medicaid dental reimbursement rates are established
- The role of medical loss ration (MLR)
- The impact of billing practices on rate-setting

Establishing Medicaid Dental Reimbursement Rates

- Each state Medicaid agency utilizes a rate setting methodology to establish reimbursement rates for covered benefits. Factors include, but are not limited to:
  - Historical claim information
    - What is the difference between the amount billed and the established reimbursement rate
  - Analysis of rates from other state Medicaid programs
  - State budgetary allocations
  - Federal Medical Assistance Percentage (FMAP) for the state
  - Input obtained during public rate hearings

What is a Medical Loss Ratio (MLR)

- **Medical Loss Ratio is defined as:**
  - A measure of the percentage of premium dollars that a health plan spends on healthcare claims and quality improvements, versus administrative costs; meant to protect Medicaid from paying for excessive administrative expenses or profits
  - Many state Medicaid managed care contracts have defined MLR requirements
    - If the MLR is set at 85%, for every $1.00 of premiums the healthcare plan receives from the state they must expend $0.85 on the payment of covered/allowable healthcare costs
    - If the MLR is not met, several remediation options are available to the states, such as:
      - Reducing monthly premiums paid to the healthcare plan
      - Sanctioning the healthcare plan through the application of liquidated monetary damages

The Impact of Billing Practices on Rate-Setting

- **Billing only the Medicaid reimbursement fee**
  - **Pro** – easier bookkeeping within the dental office
  - **Con** – no difference between a provider's usual and customary fee and the Medicaid reimbursement fee
  - **Result** – Rate setters don't consider the need to increase reimbursement rates based on review of claims data
- **Billing a provider's usual and customary rates (UCR)**
  - **Pro** – Rate setters have data showing discrepancies between UCR and Medicaid reimbursement rates
  - **Con** – Need to adjust difference between UCR and Medicaid rate from account receivables
  - **Result** – Rate setters have data showing gap(s) in Medicaid reimbursement fees for consideration in proposing rate increases

Learning Objective 3

- Identify practical billing strategies, including the use of usual and customary rates (UCR) that support:
  - Accurate reporting,
  - Equitable reimbursement, and
  - Long-term sustainability of Medicaid dental programs

Practical Strategies

- **Accurate Reporting**
  - Per HIPAA bill the most accurate CDT code to report the service(s) rendered
  - Maintain comprehensive documentation within the patient records to support the medical necessity for the treatment rendered that is patient specific
- **Equitable Reimbursement**
  - Submit your usual and customary fee (UCR) for the service(s) rendered
  - Work with state dental associations to support reimbursement rate increases
  - Participate in scheduled rate hearings
- **Sustainability**
  - Fair compensation should increase provider participation
  - Consider accepting 5 to 10 Medicaid beneficiaries into your practice(s)
  - Educate yourself about your state's Medicaid dental benefits and limitations

Question and Answer

Share your

QUESTIONS!

Submit questions for the panelists in the Q&A box

CareQuest Institute for Oral Health

Thank You to Our Speakers

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Next Webinar:

Quality Improvement in Action: Creating Pathways to Better Care on **Thursday October 23 at 7–8 p.m. ET**

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