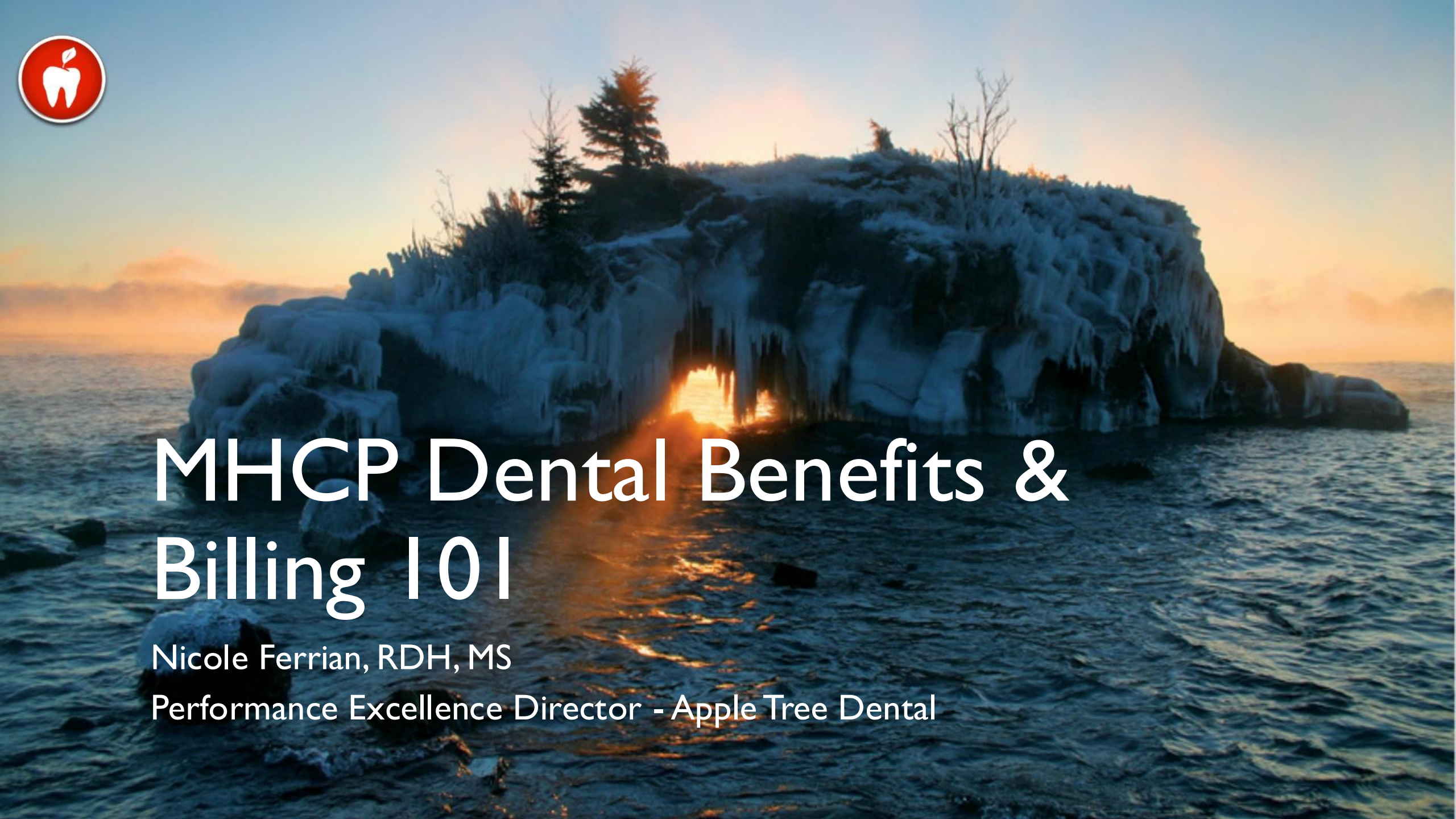

MHCP Dental Benefits & Billing 101

Nicole Ferrian, RDH, MS

Performance Excellence Director - Apple Tree Dental

Nicole Ferrian - Professional Background

Education – MSU, Mankato

- Bachelor of Science, Dental Hygiene
- Master of Science, Community Health

Work experience

- Private practice dental hygiene
- U of MN SOD – Outreach Specialist
- UCare – Clinical Care Coordination Liaison
- Delta Dental of MN – Public Programs Administrator, Manager of Government Programs, Director of Government Programs
- Apple Tree Dental – Clinical Innovations Director, Performance Excellence Director

Nicole Ferrian - Professional Background

Committees

- Dental Services Advisory Committee (since 2020) – Dental Hygienist

Dental Services Advisory Committee / Office of Inspector General

- CAD-MN – Government Affairs and Industry Affairs

Home - Association of Critical Access Dental Providers of Minnesota

Presentation summary

This presentation will provide an overview of how Minnesota Health Care Programs (MHCP) dental benefits and billing work from a non-profit dental provider perspective, including information about regulators, payers, third party administrators, the dental benefit set, prior authorizations, medical/dental services, payment rates, and charging for non-covered services.

Regulators

Centers for Medicare & Medicaid Services (CMS)

- Federal regulator
- Provides oversight to state regulator (MN DHS)

MN Department of Human Services (DHS)

- State regulator
- Provides oversight to health plans (i.e. payers)

*The above entities determine budgets, benefit sets, rules/regulations, etc.

MHCP health plans/payers

- In MN, health plans (also known as payers) contract with MN DHS
- Current payers include Blue Plus, DHS, HealthPartners, Hennepin Health, Itasca Medical Care (IMCare), Medica, PrimeWest, South Country Health Alliance (SCHA), and UCare
- Contracts include requirements for health plans administering public program policies
- Examples: Grievance and appeal processes/timelines, utilization review turnaround times, member communications, eligibility files, etc.
- Contracts are public and can be found here: MHCP contracts with managed care plans / Office of Inspector General

Managed care contracts

View Minnesota Department of Human Services (DHS) current contracts with managed care organizations (MCOs) for the various groups of people covered by Minnesota Health Care Programs (MHCP), including Medical Assistance (MA) and MinnesotaCare.

Current contracts between DHS and managed care plans

These are the individual contracts between DHS and the MCOs for health care and long-term care services for various groups of people enrolled in MHCP. Managed care contracts are amended throughout the year in response to legislative or other legal requirements, for risk adjustment, and to correct errors. Amendments can be obtained by request via the "Questions?" link near the bottom of the page.

2026 MA and MinnesotaCare families and children contracts

- Blue Plus MA and MinnesotaCare families and children contract (DOCX)
- HealthPartners families and children contract (DOCX)
- Hennepin Health MA and MinnesotaCare families and children contract (DOCX)
- Itasca Medical Care families and children contract (DOCX)
- Medica Health MA and MinnesotaCare families and children contract (DOCX)
- PrimeWest Health MA and MinnesotaCare families and children contract (DOCX)
- South Country Health Alliance families and children (DOCX)
- UCare Community Health Plan MA and MinnesotaCare families and children contract (DOCX)

MHCP health plans/payers

- Health plans are currently responsible for administering both medical and dental services
- 2021 legislation set a 55% utilization benchmark for health plans with a trigger for administrative change if not met
- Effective 1/1/28, due to health plans not meeting a 55% utilization rate, a single administrator will administer dental (dental benefits will no longer be administered by health plans) **County-Based Purchasers (IMCare, PrimeWest, and SCHA) will continue administration of dental services*

- **Carve-Out Consequence:** If health plans collectively fail to meet this 55% participation benchmark, the Minnesota Department of Human Services (DHS) is required to "carve out" dental benefits entirely from managed care companies and consolidate them under a single, statewide dental administrator. mn.gov

- Delta Dental of MN was chosen via a Request for Proposal (RFP) process to be the single administrator

2025 Minnesota Statutes

256B.0371 PERFORMANCE BENCHMARKS FOR DENTAL ACCESS; CONTINGENT DENTAL ADMINISTRATOR.

Subdivision 1. **Benchmark for dental access.** For coverage years 2022 to 2024, the commissioner shall establish a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare through a managed care or county-based purchasing plan received at least one dental visit during the coverage year.

Subd. 2. **Corrective action plan.** For coverage years 2022 to 2024, if a managed care or county-based purchasing plan under contract with the commissioner to provide dental services under this chapter or chapter 256L has a rate of dental utilization that is ten percent or more below the performance benchmark specified in subdivision 1, the commissioner shall require the managed care or county-based purchasing plan to submit a corrective action plan to the commissioner describing how the entity intends to increase dental utilization to meet the performance benchmark. The managed care or county-based purchasing plan must:

(1) provide a written corrective action plan to the commissioner for approval;

(2) implement the plan; and

(3) provide the commissioner with documentation of each corrective action taken.

§ Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care and county-based purchasing plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, 2028, for recipients of medical assistance and MinnesotaCare who are served under fee-for-service and persons receiving services through managed care plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation;

(10) management of third-party liability requirements; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be based on rates recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

Continued -

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

(f) Notwithstanding the contract term limits under section 16C.06, subdivision 3b, the commissioner may extend the implementation contract for the single dental administrator under paragraph (a) up to three years from the date of execution and may contract with the same contractor as the single dental administrator for up to five years, beginning in 2028.

Third party administrators (TPAs)

- While health plans are responsible for administering dental benefits currently, many of them hire a dental TPA to do this work on their behalf
- Current TPAs include Delta Dental of MN (Blue Plus, Hennepin Health, Medica, South Country Health Alliance) and DentaQuest (UCare)
- DHS, HealthPartners, PrimeWest, and IMCare administer their own dental benefits

MHCP dental benefit set

- Same benefits for adults and children effective 1/1/24
- Can be found here:

Dental Benefits

and here:

mn.gov/dhs/assets/mhcp-fee-schedule_tcm1053-294225.pdf

Dental Benefits

Revised: July 2, 2026

PURCHASING AND SERVICE DELIVERY
540 CEDAR STREET
ST. PAUL, MINNESOTA 55155

SUBJECT - Minnesota Health Care Programs Fee Schedule

The fee schedule amount listed in the Total Allow, Tech Component, Prof Component, Rental Allow or APC/ASC Allow do not include the legislative decreases or increases.

DENTAL SERVICES:

The fee schedule amount for dental exam and dental x-ray services provided on or after 01/01/02 to children under the age of 21, is based on 85% of the 1999 median charge. The fee schedule amounts for those services can be found under factor code Q.

For all dental services provided on or after 01/01/22, an additional 98% must be added to the fee schedule total amount to determine the total reimbursement amount.

Listed below is an explanation of each of the data elements that appear on the CURRENT FEE SCHEDULE.

SVC CODE - HCPCS level I (CPT), level II and level III procedure codes.
*****Inclusion on this report does not imply coverage.**
See 'FACT CODE' below.

PA IND - indicates whether the procedure code requires prior authorization:
A = always requires prior authorization
B = sometimes requires prior authorization
(only after limits are exceeded or other conditions have been met; see the Provider Manual for details)
C = always requires service agreement
D = sometimes requires service agreement

EFF DATE - the effective date of the current TOTAL ALLOWABLE

FACT CODE - indicates the current coverage/price factor for the procedure

FACT CODE - indicates the current coverage/price factor for the procedure

A	prof comp fee schedule	R	other tech comp
B	RBRVS professional	S	other by report
C	prof comp price by report	T	other tech comp by report
D	prof comp price not covered	V	ACA enhanced general fee
E	tech comp fee schedule	W	general DME comp bid fee
F	RBRVS technical	X	rental DME comp bid fee
G	tech comp price by report	Z	information/for reporting
H	tech comp price not covered	1	general fee schedule
I	anesthesia "base value"	2	RBRVS non-fac & global radiology
J	anesthesia relative value	3	general price by report
K	anesthesia price by report	4	general price not covered
L	anesthesia price not covered	5	repair fee schedule
M	rental fee schedule	6	RBRVS facility
N	rental relative value	7	repair price by report
O	rental price by report	8	repair price not covered
P	rental price not covered	9	discontinued procedure code
Q	other fee schedule		

CURRENT FEE SCHEDULE
AS OF 07/10/2026

SVC CODE	PA IND	EFF DATE	FACT CODE	ANESTH BASE VALUE	TOTAL ALLOW	TECH COMPONENT	PROF COMPONENT	RENTAL ALLOW	APC/ASC DATE	APC/ASC GRPR	APC/ASC ALLOW	PSI
D0485		01/01/05	4									
D0486		01/01/07	4									
D0500		10/31/85	9									
D0501		04/01/03	9									
D0502		10/01/92	3						08/01/00			A
D0510		10/31/85	9									
D0513		10/01/83	9									
D0515		10/01/83	9									
D0600		01/01/17	4									
D0601		01/01/14	4									
D0602		01/01/14	4									
D0603		01/01/14	4									
D0604		01/01/21	3						01/01/22			A
D0605		01/01/21	3						01/01/22			A
D0606		03/15/21	3						10/01/21			A
D0701		01/01/21	4									
D0702		01/01/21	4									
D0703		01/01/21	4									
D0704		01/01/23	9									
D0705		01/01/21	4									
D0706		01/01/21	4									
D0707		01/01/21	4									
D0708		01/01/21	4									
D0709		01/01/21	4									
D0801		01/01/23	3									
D0802		01/01/23	3									
D0803		01/01/23	3									
D0804		01/01/23	3									
D0999	A	01/01/11	3						08/01/00			A
D1110		08/01/00	1		26.52				08/01/00			A

Prior authorization criteria

- MN DHS determines what services require prior authorization (PA)
- Can be found here: Dental Services - Dental Authorization Requirement Tables

Overview

Minnesota Health Care Programs (MHCP) offers comprehensive dental benefits. The following codes all require prior authorization through MHCP and the medical review agent. Review Dental under Authorization in the MHCP Provider Manual for how to submit authorization requests for dental services. All services requested must be medically necessary and cost-effective.

Dental Authorization Requirement Tables

Revised: March 12, 2026

Medical/dental services

- Some dental services are paid for on the medical side vs. dental
- Alveoloplasty and gingivectomy are the two primary ones
- Dental Services

Alveoloplasty or Gingivectomy

Alveoloplasty and gingivectomy are dental surgical procedures that are considered covered services and do not require a denial from Medicare before billing MHCP.

MHCP allows billing for the following CPT codes for these services. Specify each quadrant:

- 41820: Gingivectomy, excision gingivia
- 41828: Excision of hyperplastic alveolar mucosa
- 41872: Gingivoplasty
- 41874: Alveoloplasty

Payment rate

- MN DHS sets the rate (it is much lower than commercial/employer group rates, causing access issues – not as many providers want to/are willing to participate)
- Health plans/payers may pay above the set rate to increase dental access
- Current state: General practitioners (GPs) and specialists are paid at the same rate (this creates access to specialty care issues; specialists are paid higher and often have more expensive equipment)
- The Critical Access Dental (CAD) program gives qualified providers (those who serve a significant portion of MHCP patients) an add-on payment

Critical Access Dental (CAD)

- The goals of the program are to support dental practices with a high volume of active Minnesota Health Care Programs (MHCP) members and to increase access to dental services
- Providers that meet the eligibility criteria must submit a request for designation with all other required documentation
- CAD providers receive an additional 20 percent above the MHCP payment rate, making it more sustainable to serve MHCP members
- More information can be found here: Dental Services - Critical Access Dental Payment Program (CADPP)

Charging for non-covered services

- Charging for non-covered services – what you need to do to be able to do so: edocs.dhs.state.mn.us/lfserver/Public/DHS-3640-ENG
- Providers cannot charge a member for a non-covered service unless this form is completed and signed prior to rendering the treatment
- This is also why it's important for providers to understand/know the benefit set (or where to reference it)
- Rendering non-covered services without this form can yield large write-offs for the provider

Questions?