MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Elizabeth Pitts

Phone Number: 517-284-0842

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

In compliance with the Medicare Physician Fee Schedule Final Rule 2025, this bulletin announces billing changes for select dental services provided to Medicare/Medicaid dually eligible beneficiaries. Michigan Medicaid will implement changes to align with the new Medicare billing requirements. The new billing requirements are applicable to claims submitted for Medicare/Medicaid dually eligible beneficiaries only and do not apply to the broader Medicaid population.

Reason for policy (problem being addressed):

In the Calendar Year (CY) 2025 Medicaid Physician Fee Schedule Final Rule, the Centers for Medicare & Medicaid Services (CMS) finalized two policies related to billing of dental services inextricably linked to covered medical services. Effective July 1, 2025, CMS will require the submission of the KX modifier on claims for dental services that clinicians believe to be inextricably linked to covered medical services. In addition, CMS will require the submission of a diagnosis code on the 837D dental claims format beginning July 1, 2025.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

Yes.

Does policy have operational implications on other parts of MDHHS?

Yes. The other parts of MDHHS that will be impacted include Claims and the Rates and Encounter data section.

Does policy have operational implications on other departments?

No.

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services	Meghan E. Groen, Director Behavioral and Physical Health and Aging Services Administration	
	Project Number: 2501-Dental	**Date:** February 6, 2025

Comments Due: March 13, 2025
Proposed Effective Date: July 1, 2025
Direct Comments To: Elizabeth Pitts
E-Mail Address: pittse@michigan.gov
Phone: 517-284-0842 **Fax:**

Policy Subject: Medicare Physician Fee Schedule Final Rule 2025 – Dental Service Billing Requirements

Affected Programs: Medicaid, Healthy Michigan Plan, MI Health Link, Program of All-Inclusive Care for the Elderly (PACE)

Distribution: Hospitals, Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments, PACE Providers

Summary: In compliance with the Medicare Physician Fee Schedule Final Rule 2025, this bulletin announces billing changes for select dental services provided to Medicare/Medicaid dually eligible beneficiaries. Michigan Medicaid will implement changes to align with the new Medicare billing requirements. The new billing requirements are applicable to claims submitted for Medicare/Medicaid dually eligible beneficiaries only and do not apply to the broader Medicaid population.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: N/A

State Plan Amendment Required: Yes ☐ **No** ☒	**Public Notice Required: Yes** ☐ **No** ☒

Tribal Notification: Yes ☐ **No** ☒ - Date: _____

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Hospitals, Dentists, Dental Clinics, Dental Health Plans, Medicaid Health Plans, Integrated Care Organizations, Federally Qualified Health Centers, Tribal Health Centers, Local Health Departments, Program of All-Inclusive Care for the Elderly (PACE) Providers

Issued: June 1, 2025 (Proposed)

Subject: Medicare Physician Fee Schedule Final Rule 2025 – Dental Service Billing Requirements

Effective: July 1, 2025 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MI Health Link, PACE

In compliance with the Medicare Physician Fee Schedule Final Rule 2025, this bulletin announces billing changes for select dental services provided to Medicare/Medicaid dually eligible beneficiaries. The Michigan Department of Health and Human Services (MDHHS) will implement changes to align with the new Medicare billing requirements. The new billing requirements are applicable to claims submitted for Medicare/Medicaid dually eligible beneficiaries only and do not apply to the broader Medicaid population.

Effective July 1, 2025, the Centers for Medicare & Medicaid Services (CMS) will require the submission of the KX modifier and ICD-10 diagnosis on claims for dental services that are inextricably linked to covered Medicare Part A or B medical services. Refer to 42 CFR § 411.15(i)(3) for examples of dental services inextricably linked to covered medical services furnished in the inpatient or outpatient setting. Providers must be enrolled in Medicare to bill for Medicare-covered dental services.

For dates of service on or after July 1, 2025, MDHHS will also require dental providers to report the KX modifier and ICD-10 diagnosis on the 837D or 837P electronic claims inextricably linked to a Medicare-covered medical service when a beneficiary is eligible for both Medicare and Medicaid benefits. The KX modifier must be reported in loop 2400, segment SV301-3,4,5,6 of the 837D claim and in loop 2400, segment SV101-3,4,5,6 of the 837P claim. Diagnosis codes should be reported in loop 2300, segment HI01-12 for both claim types. If the valid ICD-10 diagnosis is not included, the claim will be denied. This diagnosis is not required to be the diagnosis for the covered medical service; it may be a diagnosis reflective of the dental treatment. The beneficiary's medical record must include appropriate documentation to support the medical necessity of the service and its linkage to a Medicare-covered medical service.