Frequently asked Questions Respecting the Adult Dental Program under the Newfoundland and Labrador Dental Health Plan (NLDHP)

Provider Questions:

1. **What do I need to know about delivering services to my clients through the Adult Dental Program?**

   There is a new Adult Dental Program Payment Schedule. Please note that even though the rates of payment (fees) for specific services are unchanged, there are new billing codes to use when billing for services in the Program. These codes are required for data collection and monitoring purposes.

2. **How do I confirm a client's eligibility under the Adult Dental Program?**

   All plans under the Newfoundland and Labrador Prescription Drug Program (NLPDP) have specific criteria to be met before a resident is accepted into the program. Each adult eligible for one of the following NLPDP Plans is automatically eligible for coverage under the Adult Dental Program. There is no separate application process for the Adult Dental Program.

   Note: Each client must have their own individual documentation when presenting at the dental/denturist office to qualify for the program.

   Foundation Plan – No application is necessary. A Prescription Drug Program card is automatically issued when the Department of Health and Community Services is notified that an individual is in receipt of income support benefits through the Department of Advanced Education and Skills (DAES), or receiving services through the Regional Health Authorities, including children in the care of Child, Youth and Family Services and individuals in supervised care.

   65Plus Plan – No application is necessary unless the resident is a landed immigrant. The Department is notified by Service Canada that a resident is in receipt of the GIS and Old Age Security benefits. This is usually after the resident has received their first GIS payment. An eligibility letter is sent out to the resident asking for his/her Medical Care Plan (MCP) number, date of birth, and gender so that an NLPDP drug card can be issued.

   65Plus Plan for Landed Immigrants – To apply for the 65Plus Plan for Landed Immigrants, you must complete an application form available at http://www.health.gov.nl.ca/health/prescription/index.html. You may also call 1-888-859-3535 and ask that an application be mailed to you.

Access Plan – Application must be completed. The application form is available at http://www.health.gov.nl.ca/health/prescription/index.html; also you can call 1-888-859-3535 and ask that an application be mailed to you. Applications may also be obtained at some pharmacies and dental/denturist offices.

When presenting at the office of a dental health provider clients are required to bring the following documentation:

Foundation Plan Members (those whose eligibility stems from services received through the Department of Advanced Education and Skills) – Bring your NLPDP Drug Card and your valid DAES Client card.

Foundation Plan Members (those whose eligibility stems from services received through the Regional Health Authorities) – The client is required to bring their dental/ambulance card. The dental provider should confirm the client's eligibility by calling 1-888-859-3535.

65Plus Plan Members – Copy of the letter you received from the NLPDP indicating your eligibility for the 65Plus Plan.

Access Plan Members – Copy of the letter you received from the NLPDP indicating your eligibility for the Access Plan.

If there is any question respecting eligibility, dental care providers are encouraged to call 1-888-859-3535 to confirm the client's coverage under the Adult Dental Program.

3. What do I do if the client indicates he/she is eligible, but does not present the proper documentation?

Prior to providing services, the dental care provider should call 1-888-859-3535 to confirm the client's eligibility for coverage under the Adult Dental Program if adequate documentation is not provided by the patient.

4. What should I discuss with the client?

Dentist/denturists should discuss the following with their clients:

a) the client's eligibility under the Adult Dental Program;
b) the services covered under the Adult Dental Program;
c) the need for prior approval for some services;
d) the annual caps for eligible services under the program;
e) whether or not you are billing under the Program;
f) the types of denture (i.e., standard denture) covered by the program and whether or not a special, more expensive denture, is recommended with the additional fees being charged directly to the client; and

g) whether or not the client has insurance and if so, to advise that the Adult Dental Program is payer of last resort and the private insurer must be billed first.

5. Who do I call if I have a question regarding what is covered under the Adult Dental Program, including whether the client has already received their allowable examination and/or x-ray by another provider or whether a client has reached their annual cap?

Call the MCP Claims Office in Grand Falls-Windsor at 1-800-440-4405.

6. Is balance billing permitted under the Adult Dental Program?

No. If the dental provider is submitting claims to the Program, he/she is not permitted to charge additional fees for eligible services that are provided under the annual cap.

Any services a client chooses to receive above their cap is their responsibility and considered outside of the Program.

7. My patient informs me he/she has dental insurance. What do I do?

As with all components of the Provincial Dental Health Plan, Government is payer of last resort. The service being supplied must first be submitted to the patient's private insurer. In the case of specialized dentures only, the insurance policy may be billed using NLDA or DANL codes and fees. For all services provided, the Adult Dental Program must be billed according to the predetermined percentage of a standard denture as defined in the Adult Dental Payment Schedule.

8. I need multiple x-rays to diagnose the dental condition of my patient. What is covered?

The Adult Dental Program covers basic services as listed in the Adult Dental Payment Schedule. Effective July 2, 2015, these eligible services are subject to an annual per client cap of $1,500 for dentures and $300 for basic dental services. At the initial examination, 2 bitewing x-rays are eligible for coverage. In cases of emergencies for pain and/or infection, up to two periapical x-rays are eligible to aid in the diagnosis of the presenting complaint.

9. Why do we need prior approval to provide denture services to our patients covered under the Adult Dental Program?

Prior approval is required to ensure the program stays within its budgetary allocation. Prior approval is not required for eligible routine exams and x-rays; however, providers may wish to confirm that their client has not had these services previously, and, effective July 2, 2015, that they have not exceeded their annual cap of $300 for basic services and $1,500 for dentures.

10. Do all dental procedures require prior approval?

Prior approval will not be required for eligible exams and x-rays.

Effective May 1, 2013, prior approval will not be required for an emergency exam, diagnostic x-ray and extraction for recipients of Income Support who present to a dentist's office with pain and/or infection. Provision of these services will not be subjected to the patient's annual cap.

11. Where do I send Prior Approval Applications?

Prior Approval Applications can be mailed/faxed to:

MCP
P. O. Box 5000
Grand Falls-Windsor, NL A2A 2Y4
Fax (709) 292-4053

12. Is any other documentation required with the Prior Approval Application?

The most recent proof of eligibility for the patient must be included with the application.

13. How will the Prior Approval Applications be processed?

Processing of all prior approval applications will be done on an "as received" basis and the results of the processing will be sent to your office via return mail.

14. What is required on prior approval applications for patients covered under the Foundation Plan (Income Support)?

The traditional identifiers will be required. These are a valid MCP number, a Department of Advanced Education and Skills (DAES) PIN number, a DAES File Number and an effective date.

15. When is the per person cap renewed? Calendar or Fiscal Year?

The per person caps will be renewed on April 1st of each year.