EPSDT DENTAL PROGRAM
Rate Increases, Policy Revisions and Additional Reimbursable Code Information
Effective for Dates of Service On and After November 1, 2006

RATE INCREASES

Effective for **dates of service on and after November 1, 2006**, all Early and Periodic creening, Diagnosis and Treatment (EPSDT) Dental Program covered services will receive a reimbursement rate increase with the exception of the following services which will remain at the same level of reimbursement that was in effect on October 31, 2006:

Complete Denture, Maxillary (D5110); Complete Denture, Mandibular (D5120); Immediate Denture, Maxillary (D5130); Immediate Denture, Mandibular (D5140); Maxillary Partial Denture, Resin Base (including clasps) (D5211); Mandibular Partial Denture, Resin Base (including clasps) (D5212); Reline Complete Maxillary Denture (Laboratory) (D5750); Reline Complete Mandibular Denture (Laboratory) (D5751); Reline Maxillary Partial Denture (Laboratory) (D5760); Reline Mandibular Partial Denture (Laboratory) (D5761); Hospital Call (D9420); Behavior Management, By Report (D9920).

Please refer to the revised EPSDT Dental Program Fee Schedule (revision date November 1, 2006) which is located at **www.lamedicaid.com** for complete fee information.

POLICY REVISIONS

The following policy revisions are effective for **dates of service on and after November 1, 2006.** These policy revisions replace current policy and apply only to the specific information provided below. Additional policy as stated in the 2003 Dental Services Manual and/or the Dental Services Provider Training Packets still applies.

RESTORATIVE SERVICES

General Restoration Policy

Current Policy: No restoration of any type will be payable for deciduous central or lateral incisor teeth (Tooth Letters D, E, F, G, N, O, P and Q) for recipients who have reached their fourth birthday.

Revised Policy: No restoration of any type will be payable for deciduous central or lateral incisor teeth (Tooth Letters D, E, F, G, N, O, P and Q) for recipients who have reached their **fifth** birthday.

D2335 Resin-based Composite, Four or More Surfaces, Anterior

Current Policy: This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior authorization required.

Revised Policy: This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 with prior authorization; and Tooth Letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of

age. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

D2390 Resin-based Composite Crown, Anterior

Current Policy: This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior authorization required.

Revised Policy: This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 with prior authorization; and Tooth Letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

D2932 Prefabricated Resin Crown

Current Policy: This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior authorization is required.

Revised Policy: This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 with prior authorization; and Tooth Letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

ENDODONTIC SERVICES

D3220 Therapeutic Pulpotomy (excluding final restoration)

Current Policy: Procedure code D3220 is reimbursable for Tooth Numbers 1 through 32; and Tooth Letters A through T. However, this procedure code is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior authorization is required for Tooth Number 1 through 32 only.

Revised Policy: Procedure code D3220 is reimbursable for Tooth Numbers 1 through 32; and Tooth Letters A through T. However, this procedure code is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.

D3310 Root Canal, Anterior (excluding restoration)
D3320 Root Canal, Bicuspid (excluding restoration)
D3330 Root Canal, Molar (excluding restoration)

Current Policy: A lifetime maximum of six root canals is allowed in the entire mouth and will be allowed as follows:

• A lifetime maximum of two posterior root canals (D3320 or D3330) is allowed per recipient with a limit of one (1) posterior root canal per covered tooth. Posterior root canals will be approved only when the tooth is in occlusion and will serve to stabilize the arch. Retreatment of previous root canal therapy is not a covered benefit for posterior teeth.

• A lifetime maximum of four anterior root canals (D3310) is allowed per recipient.

Revised Policy: A lifetime maximum of eight root canals is allowed in the entire mouth and will be allowed as follows:

• A lifetime maximum of four posterior root canals (D3320 or D3330) is allowed per recipient with a limit of one (1) posterior root canal per covered tooth. Posterior root canals will be approved only when the tooth is in occlusion and will serve to stabilize the arch. Retreatment of previous root canal therapy is not a covered benefit for posterior teeth.

• A lifetime maximum of four anterior root canals (D3310) is allowed per recipient.

REMOVABLE PROSTHODONTIC SERVICES

Denture Repairs (D5510 through D5660)

Current Policy: A total of $125.00 in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient is allowed within a single one-year period for a single billing provider.

Revised Policy: A monetary limit for base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient, per year no longer applies in the EPSDT Dental Program.

ORTHODONTIC SERVICES

Comprehensive Orthodontic Treatment

D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

Current Policy: Recipients, who only have crowded dentitions (crooked teeth), excessive spacing between teeth, or having horizontal/vertical (overjet/overbite) discrepancies, are not eligible to receive comprehensive orthodontic treatment.

Revised Policy: Recipients, who only have crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies, are not eligible to receive comprehensive orthodontic treatment.

Current Policy: Comprehensive orthodontic treatment is approved by Medicaid only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemifacial atrophy, hemi-facial hypertrophy; or other craniofacial deformities that result in a physically handicapping malocclusion.

Revised Policy: Comprehensive orthodontic treatment is approved by Medicaid only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemifacial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities that result in a physically handicapping malocclusion as determined by the Medicaid dental consultants in the Medicaid Dental Prior Authorization Unit.

ADDITIONAL REIMBURSABLE CODES AND RELATED POLICY

Effective for **dates of service on and after November 1, 2006**, the following two dental procedure codes are reimbursable in the EPSDT Dental Program. The related policy for each code is described below. Please refer to the EPSDT Dental Program Fee Schedule (revision date November 1, 2006) which is located at **www.lamedicaid.com** for fee information.

D2933 Prefabricated Stainless Steel Crown with Resin Window

A prefabricated stainless steel crown with resin window is an open-face stainless steel crown with aesthetic resin facing or veneer.

This procedure is reimbursable for Tooth Letters C, H, M and R for recipients under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.

Prior authorization is required for Tooth Letters C, H, M and R only for recipients 9 years of age or older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

The appropriate tooth letter must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization and reimbursement for this procedure.

D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar

This procedure requires Medicaid prior authorization and can only be considered for the removal of appliances due to interrupted or discontinued treatment cases.

This procedure is not reimbursable to the same billing provider who placed the appliance or another Medicaid provider located in the same office as the billing provider who placed the appliance.

This procedure is reimbursable for Oral Cavity Designators 01 and 02. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization and reimbursement for this procedurerior authorization is required for Tooth Number 1 through 32 only.