ERROR CODE 515 CLAIM DENIAL SIMPLIFICATION PROCESS

The restoration policy which is provided below applies to multiple restorations on the same patient, same tooth within 12 months from the date of the original restoration by the same billing provider or another Medicaid provider located in the same office as the billing provider. Providers should note that the policy differs between permanent and primary teeth. Currently, providers who receive a claim denial for error code 515 must resubmit the request for payment to the Medicaid Dental Program along with certain documentation and a request to override the claim denial. By following the guidelines on Page 3 of this document, providers will not have to resubmit their 515 claim denials for reconsideration of payment. Failure to follow the guidelines on Page 3 will continue to result in a 515 claim denial and the provider will be responsible for resubmitting the required information.

Permanent Tooth Restorations

Medicaid currently performs a cutback in the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same recipient, same permanent tooth when billed within 12 months from the date of the original restoration. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same permanent tooth will not exceed the maximum fee of the larger restoration.

In addition, Medicaid policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same recipient, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. The chart on Page 2 of this document identifies the specific procedure codes for permanent teeth that are eligible for full reimbursement as a second or subsequent restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury.

Currently, the second and subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee due to pulpal necrosis (root canal) or traumatic injury are denied by Medicaid with a 515 claim denial (Override Required-Send to Dental PA Unit) and the provider is required to submit a 515 override request along with certain documentation to the Medicaid Dental Program in order to have the claim reconsidered for payment.

If no additional payment is made by Medicaid for a second or subsequent restoration for a permanent tooth for the same patient, same permanent tooth within a 12 month period, the provider is responsible for the restoration.

Procedure Codes Available for Reimbursement at the Full Fee for Multiple Restorations on the Same Permanent Tooth Within 12 Months Due to pulpal necrosis or traumatic injury.

The chart below will identify the specific restoration procedure codes that are available for reimbursement at the full fee when billed as a second or subsequent restoration for the same patient, same permanent tooth within 12 months from the date of the original restoration due to pulpal necrosis (root canal) or traumatic injury. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury require prior authorization including codes D2140 and D2330 which usually does not require Medicaid prior authorization. The prior authorization unit must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The PA number must be entered in the appropriate block on the claim for payment.

Code Previously Reimbursed Within 12 Months for the Same Patient, Same Permanent Tooth	Codes Available for Reimbursement at the Full Fee When Billed as a Second or Subsequent Restoration for the Same Patient, Same Permanent Tooth, Within 12 Months Due to pulpal necrosis (root canal) or traumatic injury (PA required). NOTE: The code must be reimbursable by Medicaid for the specific tooth number.	
Code	Anterior Permanent Teeth	Posterior Permanent Teeth
D2140	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2150	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2160	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2161	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931

Code Previously Reimbursed Within 12 Months for the Same Patient, Same Permanent Tooth	Codes Available for Reimbursement at the Full Fee When Billed as a Second or Subsequent Restoration for the Same Patient, Same Permanent Tooth, Within 12 Months Due to pulpal necrosis (root canal) or traumatic injury (PA required). NOTE: <u>The code must be reimbursable by Medicaid for the specific tooth number.</u>	
Code	Anterior Permanent Teeth	Posterior Permanent Teeth
D2330	D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2331	D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2332	D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2335	D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2390	D2140 or D2330 or D2335 or D2390	
D2931	D2140 or D2330 or D2931 or D2932	D2140 or D2931
D2932	D2140 or D2330 or D2931 or D2932	D2140 or D2931

Prior Authorization Requirements for Multiple Permanent Tooth Restorations (Same Tooth) that are Reimbursable within 12 Months Due to pulpal necrosis or traumatic injury.

Providers must use their patient records and the chart on Page 2 of this document in order to determine if the second or subsequent restoration performed on the same patient, same permanent tooth within 12 months from the date of the original restoration due to pulpal necrosis (root canal) or traumatic injury is eligible for reimbursement by Medicaid. This policy applies to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If the requested code is eligible for reimbursement as a second or subsequent restoration due to pulpal necrosis (root canal) or traumatic injury for the same permanent tooth, a prior authorization is required. The prior authorization request must provide the following:

- An indication in the "Remarks" section of the ADA Claim Form (Block 35) that this is the second or subsequent restoration in a 12-month period, same tooth (provide tooth number); and
- An indication in the "Remarks" section of the ADA Claim Form (Block 35) as to whether the restoration is necessary due to pulpal necrosis (root canal) or traumatic injury; and
- Submit a copy of the entire treatment record. Note: The reason that the tooth requires a second or subsequent restoration must be well documented in the patient's record; and
- Submit all pertinent radiographs that were taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

Reminders:

All codes that are to be submitted for payment as a second or subsequent restoration in a 12-month period for the same patient, same permanent tooth requires prior authorization including codes D2140 and D2330 which normally does not require PA. The PA number must be entered in the appropriate block on the claim for payment.

If the above-referenced guidelines are not followed when the prior authorization request is submitted, the claim will receive a 515 denial and the provider will be responsible for resubmitting the required information to the Dental Medicaid Unit in order to have the claim reconsidered for payment.

If you have questions regarding this policy, you may contact the Medicaid Dental Program.

Primary Tooth Restorations

Currently, Medicaid performs a cutback in the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150 and D2160); and a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same patient, same primary tooth when the date of service of the second restoration is within 12 months from the date of the original restoration. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same primary tooth will not exceed the maximum fee of the larger restoration.

Effective September 13, 2007 (regardless of the date of service), Medicaid will also perform a cutback in the payment of other second or subsequent primary restorations that are rendered within a 12-month period for the same patient, same primary tooth. In these situations, the maximum combined fee for two or more restorations within a 12-month period on the same primary tooth, same recipient will not exceed the maximum fee of the higher reimbursed restoration. These services will no longer receive an error code 515 and will no longer require additional action by the provider.

If no additional payment is made by Medicaid for a second or subsequent restoration for a primary tooth for the same patient, same primary tooth within a 12 month period, the provider is responsible for the restoration.

Providers should refer to the EPSDT Dental Program Fee Schedule to determine whether the procedure code is reimbursable for the specific tooth letter and requires Medicaid prior authorization based on the specific age of the patient

If you have questions regarding this policy, you may contact the Medicaid Dental Program.