COVERED SERVICES

The Expanded Dental Services for Pregnant Women (EDSPW) Program is designed to address the periodontal needs of the recipients. Covered services are divided into five categories:

- Diagnostic Services;
- Preventive Services;
- Restorative Services;
- Periodontal Services; and
- Oral and Maxillofacial Surgery Services.

Services requiring Prior Authorization (PA) are identified by an asterisk (*). Dental services should not be separated or performed on different dates of service solely to enhance reimbursement. The guidelines and policies related to each service should be reviewed carefully prior to rendering the service.

For Medicaid purposes, local anesthesia, when applicable, is considered part of any procedure covered by Medicaid.

Dental Visit (Initial)

The initial dental visit must include the following diagnostic and preventive services:

- Comprehensive Periodontal Examination; and
- Bitewing radiographs (unless contraindicated); and
- Prophylaxis, including oral hygiene instructions (unless a Full Mouth Debridement D4355 is required.

These services are limited to one each per pregnancy.

Providers must ask new recipients when they last received a Medicaid covered comprehensive periodontal examination, bitewing radiographs, and/or prophylaxis and record that information in the recipient's treatment record. For the established recipient, the provider must check the office treatment record to ensure that these services have not been rendered during the current pregnancy.

If it is determined that the recipient has already received a comprehensive periodontal examination, bitewing radiographs and/or prophylaxis during the current pregnancy, the recipient is ineligible for these services. If the recipient seeks additional eligible services from a second dental provider, the second dental provider should request a copy of the patient's treatment record and/or radiographs from the previous provider.

Diagnostic Services

Diagnostic services include a comprehensive periodontal examination and radiographs.

D0180 Comprehensive Periodontal Examination - new or established patient
D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film (maximum of 4)
D0240* Intraoral – occlusal film
D0272 Bitewings – two films
D0330* Panoramic Film Examination

D0180 Comprehensive Periodontal Examination - new or established patient

A comprehensive periodontal examination is limited to one per pregnancy.

This procedure code is indicated for recipients showing signs or symptoms of periodontal disease. It includes, but is not limited to, evaluation of periodontal conditions, probing and charting, evaluation and recording of the recipient's dental and medical history, and general health assessment. It also includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer screening.

This visit should also include preparation and/or updating of the recipient's records, development of a current treatment plan, and the completion of reporting forms.
After the comprehensive examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified.

Radiographs (X-Rays)

D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film (maximum of 4)
D0240* Intraoral – occlusal film
D0272 Bitewings – two films
D0330* Panoramic Film

A lead apron and thyroid shield must be used when taking any radiographs reimbursed by the Medicaid program. This is a generally accepted standard of care practice and is part of normal, routine, radiographic hygiene.

Radiographs taken must be of **good diagnostic quality** and, when submitted for PA or post payment review, must be properly mounted. Radiographic mounts and panographic-type radiographs must indicate the date taken, the name of the recipient, and the provider. Radiographic copies must also indicate the above as well as be marked to indicate the left and

right sides of the recipient's mouth. Radiographs that are not of good diagnostic quality will be rejected.

Scanned radiographic images should be of an adequate resolution to be diagnostically acceptable and must indicate right and left side. Scanned images that are not diagnostic will be returned for new images.

According to the accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis should be taken.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Prior authorization requests not accompanied by the appropriate radiographs must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring PA will be denied.

Any periapical radiographs, occlusal radiographs or panoramic radiographs taken routinely at the time of a dental examination appointment for screening purposes are not covered. If a routine practice of taking such radiographs, without adequate diagnostic justification is discovered during post payment review, all treatment records may be reviewed and recoupment of money paid for all radiographs will be initiated.

D0220 Intraoral – periapical first film
D0230 Intraoral – periapical each additional film

Payment for periapical radiographs taken in addition to bitewings is limited to a total of five and is payable when their purpose is to obtain information in regard to a specific pathological condition other than caries (e.g. periapical pathology or extensive periodontal conditions).

Periapical radiographs, unless contraindicated, must be taken prior to any tooth extraction.

For reimbursement by the Medicaid program, the radiographs must be associated with a specific unextracted Tooth Number 1 through 32 or Tooth A through T. The appropriate tooth number or letter must be identified in the "Tooth Number(s) or Letter(s)" column of the American Dental Association (ADA) Dental Claim Form when requesting reimbursement for this procedure.

D0240* Intraoral – occlusal film
A #2 size film taken in an occlusal orientation will be considered an anterior periapical radiograph for payment. The fee for an occlusal radiograph will be paid only when a true occlusal film (2" x 3") is used to evaluate the maxillary or mandibular arch. The actual occlusal radiograph must be sent with the PA request for an occlusal film.

This radiograph is reimbursable for Oral Cavity designators 01 and 02.

D0272 Bitewings – two films
Bitewing radiographs are required (unless contraindicated) at the comprehensive periodontal examination and are limited to one set per pregnancy. In cases where the provider considers radiographs to be medically contraindicated, a narrative describing the contraindication must be documented in the recipient's record.

D0330* Panoramic film
Panoramic radiographs are not indicated and will be considered insufficient for diagnosis in periodontics and restorative dentistry and will not be reimbursed. Panoramic radiographs are only reimbursable in conjunction with oral and maxillofacial surgery services. The dental consultants may request the actual panoramic radiograph before a PA request can be completed.

Preventive Services

Adult Prophylaxis

D1110 Adult Prophylaxis
This procedure includes removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis. This service is limited to one per pregnancy.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be subsequently reimbursed during this pregnancy.

Restorative Services

Restorative services include: amalgam restorations, resin-based composite restorations, stainless steel crowns and resin crowns. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the recipient's dental record.

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, permanent
D2330 Resin-based composite, one surface, anterior
D2331 Resin-based composite, two surfaces, anterior
D2332 Resin-based composite, three surfaces, anterior
D2335* Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390* Resin-based composite crown, anterior
D2391 Resin-based composite, one surface, posterior
D2392 Resin-based composite, two surfaces, posterior
D2393 Resin-based composite, three surfaces, posterior
D2394 Resin-based composite – four or more surfaces (posterior)
D2930* Prefabricated stainless steel crown – primary tooth
D2931* Prefabricated stainless steel crown – permanent tooth
D2932* Prefabricated resin crown, primary or permanent
D2951 Pin retention, per tooth, in addition to restoration

Since this program is designed to address the periodontal needs during pregnancy, the location of the caries to be restored must be in an area that would impact the gingival integrity and affect the periodontal health of the woman. Radiograph(s), unless contraindicated, that support the need for the restoration to maintain the gingival integrity (e.g. significant subgingival decay, etc.) must be taken and submitted with the request for PA. Restoration of dental caries not penetrating the dentin will be denied.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated

- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any PA requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment; the services requiring PA will be denied.

Local anesthesia is considered to be part of restorative services. Tooth and soft tissue preparation, all adhesives (including amalgam bonding agents), liners and bases, are included as part of amalgam restorations. Tooth and soft tissue preparation, all adhesives (including resin bonding agents), liners and bases and curing are included as part of resin-based composite restorations. Pins should be reported separately.

The original billing provider is responsible for the replacement of the original restoration within the first twelve months after initial placement.

Laboratory processed crowns are not covered.

NOTE: The EDSPW Program does not cover endodontic therapy; however, it is possible for Medicaid to cover a final restoration following completed endodontic therapy when the final restoration is one covered in the EDSPW Program. The PA request, when required, for a final restoration following endodontic therapy should be submitted to Medicaid only after completion. The PA request for the final restoration must contain documentation which confirms completion for the specified tooth. If the documentation submitted does not confirm the completion of the endodontic therapy for the specified tooth, the PA request for the final restoration will be denied.

Amalgam Restorations (including polishing)

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surfaces, primary or permanent
D2160 Amalgam – three surfaces, primary or permanent
D2161 Amalgam – four or more surfaces, permanent

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.

Procedure code D2140 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2140.**

Procedure codes D2150, D2160, and D2161 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s). If the restoration is a mesial occlusal or distal occlusal restoration, the preparation must extend down the mesial or distal surface far enough for the restoration to contact the periodontally affected gingival tissue.

Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period.

If two or more restorations are placed on the same tooth, a maximum amalgam fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.

The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of non-duplicated surfaces when performed within a 12-month period. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same 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 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 (see Appendix G).

Procedure codes D2140, D2150 and D2160 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through C, H through M, and R through T.

Procedure code D2161 is reimbursable for Tooth Numbers 1 through 32 only. Code D2161 is not payable for primary teeth.

Resin-Based Composite Restorations

D2330 Resin-based composite, one surface, anterior
D2331 Resin-based composite, two surfaces, anterior
D2332 Resin-based composite, three surfaces, anterior
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390* Resin-based composite crown, anterior
D2391 Resin-based composite, one surface, posterior
D2392 Resin-based composite, two surfaces, posterior

D2393 Resin-based composite, three surfaces, posterior
D2394 Resin-based composite – four or more surfaces (posterior)

Posterior composite restorations are not reimbursable under the guidelines of Louisiana Medicaid.

Procedure code D2330 is payable only for Class V type restorations on the buccal or lingual surface in direct contact with the periodontally affected gingival tissue. **Occlusal surfaces and buccal, lingual, and occlusal pits are specifically excluded from reimbursement for code D2330.**

Procedure codes D2331, D2332, D2335, D2390, D2392, D2393, and D2394 are payable only for restorations in which at least one of the involved surfaces is in direct contact with the periodontally affected gingival tissue.

In addition to the requirement of gingival contact, resin-based composite restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin, and follows established dental protocol that the preparation and restoration include all grooves and fissures on the billed surface(s).

Procedure codes D2330, D2331, D2332, D2335, D2390, D2392, D2393 and D2394 represent final restorations. If two restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of surfaces when performed within a 12-month period.

In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same 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 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 (see Appendix G).

Procedures D2335 or D2394 are reimbursable only once per day, same tooth, any billing provider.

To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration.

The resin-based composite – four or more surfaces or involving incisal angle (D2335 or D2394) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an

anterior tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two D2332 or D2393 restorations would not adequately restore the tooth or in cases where two D2335 or D2394 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment. Crown services require radiographs (unless contraindicated) or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by Medicaid or its designee upon request.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11, 22 through 27 and Tooth Letters C, H, M and R.

Procedure codes D2391, D2392, D2393, and D2394 are reimbursable for Tooth Numbers 1 through 5, 12 through 21, and 28 through 23 and Tooth Letters A, B, I, J, K, L, S, and T.

Non-Laboratory Crowns

D2930* Prefabricated Stainless Steel Crown –primary teeth
D2931* Prefabricated Stainless Steel Crown – permanent tooth
D2932* Prefabricated Resin Crown – primary or permanent tooth

Procedure codes D2930, D2931 and D2932 represent final restorations. These restorations must be in direct contact with the periodontally affected gingival tissue. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable.

Crown services require radiographs (unless contraindicated).

Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the recipient's treatment records if radiographs are medically contraindicated. The documentation that supports the need for crown services must be available for review by the Medicaid or its designee upon request. Prior authorization is required.

D2930* Prefabricated Stainless Steel Crown-primary tooth
Procedure code D2930 is reimbursable only for Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.

D2931* Prefabricated Stainless Steel Crown – permanent tooth
This procedure is reimbursable for Tooth Numbers 1 through 32.

D2932* Prefabricated Resin Crown – primary or permanent tooth
This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M, and R.

Other Restorative Services

The EDSPW Program does not cover endodontic therapy; however, it is possible for Medicaid to cover a final restoration following completed endodontic therapy when the final restoration is one covered in the EDSPW Program. The PA request, when required, for a final restoration following endodontic therapy should be submitted to Medicaid only after completion. The PA request for the final restoration must contain documentation which confirms completion for the specified tooth. If the documentation submitted does not confirm the completion of the endodontic therapy for the specified tooth, the PA request for the final restoration will be denied.

D2951 Pin retention - per tooth, in addition to restoration
Reimbursement for pins is limited to one per tooth within a 12 month period and may only be billed in conjunction with the complex restoration codes D2160 or D2161.

This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.

Periodontal Services

Periodontal services include periodontal scaling and root planning and full mouth debridement. Local anesthesia is considered to be part of periodontal procedures.

Prior authorization is required for all periodontal services.

D4341* Periodontal scaling and root planning – four or more teeth per quadrant
D4355* Full mouth debridement

Unless contraindicated, radiograph(s) that support the need for the periodontal services must be taken and submitted with the request for PA.

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the dental treatment record and in the remarks section on any claims submitted for authorization:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the oral condition's effect on the periodontal health

Any PA requests, which are not accompanied by the appropriate radiographs, must be accompanied by a copy of the recipient's treatment record as created on the Comprehensive Periodontal Examination appointment. The recipient's name and Medicaid number must be indicated on the copy of the treatment records submitted for review.

If the treatment records do not adequately describe the conditions requiring treatment, the services requiring PA will be denied.

D4341* Periodontal scaling and root planning – four or more teeth per quadrant

Radiographic evidence of large amounts of subgingival calculus, deep pocket formation, and bone loss must be submitted. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces as well as the removal of rough, calculus-contaminated cementum and dentin. It is therapeutic not prophylactic in nature, usually requiring local anesthesia.

This procedure requires PA. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planning may be reimbursed per day.

This procedure is reimbursable for Oral Cavity Designators 10, 20, 30 and 40.

D4355* Full Mouth Debridement

This procedure involves the gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

This service must be performed at the initial visit if the service is indicated.

No other dental services except an examination and/or radiographs are reimbursable on the same date of service as full mouth debridement. When an exam is performed on the same date of service as a full mouth debridement, the exam must be performed after completion of the full mouth debridement.

Only one full mouth debridement is allowed per pregnancy. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) to the same billing provider or another Medicaid provider in the same office as the billing provider during this pregnancy.

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographs (unless contraindicated) that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In cases where radiographs are contraindicated or in which the radiographs do not visually satisfy the two quadrant minimum, the provider must include in the request for authorization a copy of the written recipient record that provides narrative documentation that describes and supports the necessity for this procedure. Although not reimbursable in the EDSPW Program, intraoral photographs that clearly depict the extent of debris and need for D4355 can be submitted.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new recipients if they have received a Medicaid covered prophylaxis (D1110) during this pregnancy and record that information in the recipient's treatment record. For the established patient, the provider must check the office treatment record to ensure that a D1110 has not been reimbursed by Medicaid for this recipient during this pregnancy. If it is determined that a D1110 has been reimbursed by Medicaid for this recipient during this pregnancy, the recipient is not eligible for a D4355.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a Adult Prophylaxis (D1110) for the recipient during this pregnancy, the provider may render and bill Medicaid for a Adult Prophylaxis (D1110).

Oral and Maxillofacial Surgery Services

Dental providers who are qualified to bill for services using the Current Physician's Terminology (CPT) codes, may bill for certain medical oral surgery services using the CPT codes which are covered under the Professional Services Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Professional Services Program. The prophylactic removal of an asymptomatic impacted tooth is not covered.

Due to the potential risk of complications involved in the surgical removal of teeth, including the extraction of impacted teeth, minimal standards of care require that these procedures not be attempted without radiographic evaluation.

Requests for PA for surgical extractions, including the extraction of impacted teeth, will not be considered without radiographs. The radiographic findings determine the necessity of surgical extraction and the degree of impaction and correspond to the current dental terminology (CDT) definitions of impactions. The PA letter will list the tooth numbers and will correspond to the

CDT definitions. Therefore, it is suggested that PA be used to resolve differences in interpretation prior to the day of surgery.

Procedure codes D7240 and D7241 are not reimbursable in this program.

Extractions

D7111 Extraction, coronal remnants – deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210* Surgical removal of erupted tooth
D7220* Removal of impacted tooth – soft tissue
D7230* Removal of impacted tooth - partial bony

These codes include local anesthesia, suturing (if needed), and routine post-operative care.

Procedure codes D7140, D7210, D7220, and D7230 are reimbursable for Tooth Numbers 1 through 32 and Tooth Letters A through T. ADA tooth numbering codes for Supernumerary Teeth 51 through 82 or AS through TS should be used when needed.

Non-surgical Extractions

D7111 Extraction, coronal remnants – deciduous tooth

This procedure includes removal of soft tissue-retained coronal remnants for deciduous teeth only. This procedure code is reimbursable for Tooth Letters A through T and As through TS.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary. Radiograph(s), unless contraindicated, must be taken prior to this procedure (D7140).

In cases where the medical professional considers radiographs to be medically contraindicated (as noted on the BHSF Form 9-M) or upon any other medical contraindications for the radiographic evaluation, the following must be noted in the recipient's treatment record:

- Reason the x-rays were contraindicated
- Description of the oral condition/dental problem that requires treatment, including documentation of the effect of the oral condition on the periodontal health

Surgical Extractions

D7210* Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

This procedure includes the cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone, and closure.

This procedure requires prior authorization. All requests for PA of the surgical removal of erupted tooth require the submission of radiographs.

For pre-surgical PA, the radiographic evidence must clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure.

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, the PA request will be denied. After the tooth is removed, the provider may bill Medicaid for a D7140 or resubmit the PA request for reconsideration (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications and the radiographs.

In the event a planned simple extraction becomes a surgical procedure, the provider may submit a "post" authorization request (indicating the date of service) with a copy of the post surgical operative report and/or treatment record describing the surgical complications along with the radiographs which will be used by the dental consultants in the authorization determination.

D7220* Removal of impacted tooth - soft tissue

The occlusal surface of the tooth is covered by soft tissue and removal of the tooth requires mucoperiosteal flap elevation.

All requests for PA of the removal of impacted tooth - soft tissue (D7220) require the submission of radiographs.

D7230* Removal of impacted tooth – partial bony

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

All requests for PA of the removal of impacted tooth – partial bony
(D7230) require the submission of radiographs.