EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – COVERED SERVICES

The dental services that are covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program are divided into eleven categories:

- Diagnostic
- Preventive
- Restorative
- Endodontic
- Periodontal
- Removable Prosthodontics
- Maxillofacial Prosthetics
- Fixed Prosthodontics
- Oral and Maxillofacial Surgery
- Orthodontic
- Adjunctive General Services

NOTE: Services that require prior authorization (PA) are identified by an asterisk {*}. Services requiring PA in certain situations only are identified with an underlined asterisk {*}.

Initial Dental Screening and Annual Recall Visits

The dental visit, which includes the initial dental screening (Comprehensive Oral Examination) and annual recall visit (Periodic Oral Examination), must include (but is not limited to) the following diagnostic and preventative services:

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination);

- Bitewing radiographic images;

- Prophylaxis, including oral hygiene instructions; and,

- Topical fluoride application (under 16 years of age).

This visit should also include preparation and/or updating the patient's records, development of a current treatment plan, and the completion of reporting forms.

The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1208) is limited to once per six months.

Providers must ask new patients when they last received a Medicaid covered oral examination, prophylaxis, bitewing radiograph and fluoride and record that information in the patient's treatment record. For the established patient, the provider must check the office treatment record to ensure that it has been over six months since the patient received these services. If it is determined that it has been less than six months, the recipient must schedule for a later date.

The dental provider should maintain a recall system of patients for future examinations and treatment (if required).

For new and established patients, dental providers must utilize the electronic Clinical Data Inquiry (e-CDI) application which is available in the provider restricted area of the Louisiana Medicaid website (see Appendix J) in order to determine whether the recipient has received a Medicaid-reimbursed oral examination, bitewing radiograph, prophylaxis, and fluoride. Providers must select the option for "Ancillary Services" in order to review the recipient's dental claims history. The e-CDI application provides up to 12 months of history information. A printout of the dental claims history from the e-CDI application must be placed in the patient's chart prior to each initial or recall visit.

Diagnostic Services

Diagnostic services include examinations, radiographic images and oral/facial images, diagnostic casts and accession of tissue - gross and microscopic examination.

Codes

D0120 Periodic Oral Examination (established patient)
D0145 Oral Examination for a Patient under Three Years of Age and Counseling with Primary Caregiver
D0150 Comprehensive Oral Examination (new patient)
D0210* Intraoral- complete series of radiographic images
D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical each additional radiographic image
D0240* Intraoral – occlusal radiographic image
D0272 Bitewings – two radiographic images
D0330 Panoramic radiographic image
D0350* Oral/Facial Images
D0470* Diagnostic Casts

D0473* Accession of tissue, gross and microscopic examination, preparation and transmission of written report

D0474* Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report

Examinations

The following are the descriptive codes and guidelines for dental examinations.

Codes

D0120 Periodic Oral Examination (established patient)
D0145 Oral Examination for a Patient under Three Years of Age and Counseling with Primary Caregiver
D0150 Comprehensive Oral Examination (new or established patient)

The following EPSDT Dental Program Services are limited to one per six months (with noted exception) per recipient:

- One D0145 (Oral Examination for a Patient under Three Years of Age and Counseling with a Primary Caregiver; OR
- D0120 (Periodic Oral Examination –Patient of Record-3 through 20 years of age) per recipient is covered as is age appropriate.

Procedure code D0150 (Comprehensive Oral Examination-new or established patient- 3 through 20 years of age) remains the appropriate procedure code for new patients who are 3 through 20 years of age. A new patient is described as a recipient that has not been seen by this provider for at least three years; therefore, procedure code D0150 is reimbursable only once in a three year period when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider. In addition the recall visit (D0120) must be schedule at least six months after the initial visit (D0150) is rendered.

D0120 Periodic Oral Examination (established patient)

An examination performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic examination.

This procedure may be reimbursed once in a six month period.

The periodic oral examination must include (but is not limited to) examination of the oral cavity and all of its structures, using a mirror and explorer, and periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination).

D0145 Oral Examination for a Patient under Three Years of Age and Counseling with Primary Caregiver

Diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

This procedure may be reimbursed once in a six month period except when performed by a Medicaid recognized dental specialist.

Procedure code D0145 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to the same billing provider or another Medicaid provider in the same office as the billing provider within the prior 12 month period for the same recipient. In addition, procedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to the same billing provider or another Medicaid provider located in the same office as the billing provider within the prior 12 month period for the same recipient.

D0150 Comprehensive Oral Examination (new or established patient)

Medicaid recognizes this code for a new recipient only. A new patient is described as a recipient that has not been seen by this provider for at least three years. This procedure code is to be used by a general dentist and/or specialist when evaluating a patient comprehensively for the first time. This would include the examination and recording of the patient's dental and medical history and a general health assessment.

The dental visit that includes the Comprehensive Oral Examination must include (but is not limited to) examination of the oral cavity and all of its structures, using a mirror and explorer, and periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination).

After the comprehensive oral examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified. If no subsequent visit is required, the bitewing radiographic images, prophylaxis, and fluoride must be provided at the time of the initial comprehensive or periodic oral examination. If subsequent treatment is required, these services

must be provided at the first treatment visit if they were not provided at the initial comprehensive periodic oral examination.

The dental provider should maintain a recall of the recipient for future examinations and treatment, (if required).

This procedure should not be billed to Medicaid unless it has been at least three years since the recipient was seen by the specified provider or another provider in the same office. An initial comprehensive oral examination (D0150) is limited to once per three (3)years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Recipients are only allowed one exam within a six month period unless when performed by a Medicaid recognized dental specialist.

Radiographic Images (Radiographic images)

Codes

D0210* Intraoral – complete series of radiographic images
D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical each additional radiographic image
D0240* Intraoral – occlusal radiographic image
D0272 Bitewings – two radiographic images
D0330 Panoramic radiographic image
D0350* Oral / Facial Images

Radiographic images taken should be of **good diagnostic quality** and when submitted for prior authorization should be properly mounted. Radiographic mounts and panographic-type radiographic images should indicate the date taken, the name of the recipient, and the provider. Radiographic copies should also indicate the above as well as be marked to indicate the left and right sides of the recipient's mouth.

In order for the Medicaid Dental Prior Authorization Unit to be able to make necessary authorization determination, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for PA that contain radiographic images and oral/facial images 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 sides. Scanned images that are not diagnostic will be returned for new images.

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

In cases where the provider considers radiographic images to be medically contraindicated, a narrative stating the contraindication must be documented both in the recipient's record as well as on any claims submitted for authorization.

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

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

D0210* Intraoral- complete series of radiographic images

In order to be reimbursed, a complete series must consist of the following numbers and types of films:

- Two cavity-detecting (bitewing) radiographic images, and six periapical radiographic images, for recipients six years of age or younger.
- Two cavity-detecting (bitewing) radiographic images, and 10 periapical radiographic images, for recipients age 7 through age 13.
- Two cavity-detecting (bitewing) radiographic images, and 14 periapical radiographic images, for recipients age 14 or older.

Any request for a complete series must be justified by the findings of a clinical examination. Complete series or panoramic radiographic images should not be used for diagnostic purposes when a lesser number of periapical radiographic images would provide the necessary diagnostic information.

This procedure is reimbursable only once in a 12 month period, except when performed by a Medicaid recognized dental specialist.

If a full mouth x-ray (D0210) is billed within 12 months of bitewing radiographic images (D0272), the fee for the full mouth radiographic images will be cutback by the amount of the fee for the bitewing radiographic images. If bitewing radiographic images (D0272) are billed within 12 months of full mouth radiographic images (D0210), the bitewing radiographic images (D0272) will be cutback to $0.

D0220 Intraoral – periapical first radiographic image
D0230 Intraoral – periapical each additional radiographic image

Payment for periapical radiographic images (D0220 and D0230) taken in addition to bitewings is limited to a total of five and is payable when the purpose is to obtain information in regard to a specific pathological condition other than caries (ex. periapical pathology or serious doubt regarding the presence of the permanent dentition).

Under the following circumstances periapical radiographic images must be taken or written documentation as to why the radiograph(s) was contraindicated must be in the recipient's record:

- An anterior crown or crown buildup is anticipated; or
- Posterior endodontic therapy is anticipated (root canal working and final fill films are included in the fees for endodontic treatment); or
- Anterior **initial** or **retreatment** endodontic therapy is anticipated (both maxillary and mandibular anterior films) (root canal working and final fill films are included in the fees for endodontic treatment); or
- Prior to any tooth extraction.

These radiographic images are reimbursable for and must be associated with a specific un-extracted Tooth Number 1 through 32 or Letter 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 radiographic image

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. The appropriate oral cavity designator must

be identified in the "Area of Oral Cavity" column of the ADA Dental Claim Form when requesting prior authorization or reimbursement for this procedure.

D0272 Bitewings – two radiographic images

Bitewing radiographic images are required at the comprehensive oral examination and annually at the periodic oral examination. These radiographic images are limited to one set per year to the same billing provider or Medicaid recognized dental specialist. If radiographic images cannot be obtained, a narrative explaining the reason why they could not be taken must be documented both in the recipient's record as well as in the remarks section on any claims submitted for PA.

D0330 Panoramic film

Panoramic radiographic images are not indicated and will be considered insufficient for diagnosis in periodontics, endodontics, and restorative dentistry and it will not be reimbursed. Panoramic radiographic images are reimbursable for oral and maxillofacial surgery and orthodontic services.

This procedure code is reimbursable only once in a 12 month period, except when provided by a Medicaid recognized dental specialist.

D0350* Oral/Facial Photographic Images

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images must be a part of the patient's clinical record.

Oral/facial photographic images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations: prior to gingivectomy; prior to frenulectomy; or with the presence of a fistula prior to retreatment of previous endodontic therapy, anterior. The provider should bill Medicaid for oral/facial photographic images ONLY when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated.

Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

This procedure is limited to two units per same date of service.

This procedure is reimbursable for oral cavity designators 01, 02, 10, 20, 30 and 40.

This procedure code requires PA.

Other Diagnostic Services

Codes

D0470* Diagnostic Casts
D0473* Accession of tissue, gross and microscopic examination, preparation and transmission of written report
D0474* Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission ofwritten report
D0470* Diagnostic Casts

Diagnostic casts will be prior authorized only when the reviewing consultant requests them.

D0473* Accession of tissue, gross and microscopic examination, preparation and transmission of written report

Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request PA or bill this code on the pathologist's behalf.

For PA of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286.

D0474* Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report

Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request PA or bill this code on the pathologist's behalf.

For PA of the surgical procedure to obtain the specimen for biopsy please refer to the section on ORAL SURGERY SERVICES, codes D7285 and D7286.

Preventive Services

Preventive services include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and recementation of space maintainer.

Codes

D1110 Adult Prophylaxis
D1120 Child Prophylaxis
D1208 Topical Application of Fluoride
D1206 Topical Fluoride Varnish; Therapeutic application for Moderate to High Caries Risk Patients
D1351 Sealants
D1510* Unilateral Space Maintainer
D1515* Bilateral Space Maintainer
D1550 Recementation of Space Maintainer
D1555 Removal of Fixed Space Maintainer

Prophylaxis

D1110 Prophylaxis – Adult

Adult prophylaxis for children 12 through 20 years of age 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 procedure is limited to once in a six month period.

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 codeD4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis).

D1120 Prophylaxis – Child

Child prophylaxis for children under 12 years of age includes removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once in a six month period.

If, at the initial visit, it is determined that the Child Prophylaxis is the appropriate treatment and code D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid, then procedure codeD4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis).

Fluoride Treatment

D1206 Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients

Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization. Procedure code D1206 is reimbursable by Medicaid only for recipients **under six years of age.**

Procedure code D1206 is reimbursable by Medicaid to the same billing provider or another Medicaid provider located in the same office as the billing provider **once per six month period, per same recipient.**

In addition, Medicaid reimbursement of fluoride for recipients less than six years of age is limited to either of the following per six months, per recipient:

- Two D1206 (Topical Fluoride Varnish – one per six months); OR
- One D1208 (Topical Application of Fluoride – Prophylaxis Not Included-Child).

NOTE: A combination of D1208 and D1206 are NOT reimbursable in the same six month period for recipients under six years of age.

D1208 Topical Application of Fluoride

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Topical fluoride treatment must be provided to children less than 16 years of age in order to be reimbursed under this procedure code. This procedure is limited to once in a six month period.

Sealants

D1351 Sealants – per tooth

A sealant is a mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are limited to six and twelve-year molars only. Sealants are further limited to one application per tooth per 24 months.

Six-year molar sealants will be paid only for recipients under 10 years of age. Twelve year molar sealants will be paid only for recipients under 16 years of age.

All sealants must be performed on a single date of service, unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services.

This procedure is reimbursable for tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 only.

In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Space Maintenance

D1510* Space maintainer – fixed - unilateral
D1515* Space maintainer – fixed – bilateral

Fixed-space maintainers require PA and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided.

Procedure Code D1510 is reimbursable for Oral Cavity areas 10, 20, 30, and 40. Procedure Code D1515 is reimbursable for Oral Cavity areas 01 and 02.

When requesting prior authorization, please indicate the tooth/teeth that have been or will be extracted in Block 34 of the ADA Dental Claim Form ("X" for missing teeth and "/" for teeth to be extracted).

D1550 Recementation of Space Maintainer

The billing provider is responsible for replacement within the first 12 months after placement of the space maintainer. This procedure does not require authorization and is limited to one recementation per appliance, in a five-year period.

This procedure is reimbursable for Oral Cavity areas 01, 02, 10, 20, 30 and 40.

D1555 Removal of Fixed Space Maintainer

This procedure code is reimbursable for the removal of Space Maintainer, Fixed, Unilateral (D1510) or the removal of a Space Maintainer, Fixed, Bilateral (D1515).

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.

The billing provider is responsible for replacement within the first 12 months after placement of the space maintainer

This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.

Restorative Services

Restorative services include those services listed below:

Codes

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
D2920 Re-cement crown
D2930* Prefabricated Stainless Steel Crown – primary tooth
D2931* Prefabricated Stainless Steel Crown – permanent tooth
D2932* Prefabricated Resin Crown (primary and permanent teeth)
D2933* Prefabricated stainless steel crown with resin window
D2950* Core Buildup, including any pins, in addition to crown
D2951 Pin retention – per tooth, in addition to restoration
D2954* Prefabricated post in addition to crown
D2999* Unspecified Restorative Procedure, by report

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 must be reported separately.

The surfaces that may be billed as restored can be any one or combination of five of the seven recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

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

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.

Laboratory processed crowns are not covered.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four or more surfaces, permanent (D2161); resin-based composite, four or more surfaces, posterior (D2394); resin-based composite, four or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932 or D2933).

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 patient's dental record.

Amalgam Restorations (including polishing)

Codes

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 D2161 is not payable for primary teeth.

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

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 patient, 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), traumatic injury to the tooth, or in the event of failed restoration (see Appendix F).

Providers must utilize the Clinical Data Inquiry (e-CDI) application in order to determine whether the recipient has received a restoration within 12 months from the date of original restoration.

Amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal buccal or occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. 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 be in a cleanable, inspectable area.

Procedure codes D2140, D2150 and D2160 are reimbursable for Tooth Number 1 through 32 and A through T. Please note that restorations are only reimbursable for Tooth Number D, E, F, G, N, O, P, and Q if the recipients are under five years of age.

Procedure code D2161 is reimbursable for Tooth Number 1 through 32 only.

If the restoration requires a second or subsequent restoration, PA is required.

Resin-Based Composite Restorations - Direct

Codes

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

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, 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, by any provider.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

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 patient, 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), traumatic injury to the tooth, or in the event of failed restoration (see Appendix F).

Providers must utilize the Clinical Data Inquiry (e-CDI) application in order to determine whether the recipient has received a restoration within the 12 months from the date of original restoration.
All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. 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. If the tooth is decayed extensively, a crown should be considered.

The resin-based composite – four or more surfaces or involving incisal angle (D2335 & 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 a 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 restorations would not adequately restore the tooth or in cases where two D2335 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.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11 and 22 through 27 with PA; and Tooth Letters C, H, M, and R for recipients under 21 years of age. These procedures are also reimbursable for Tooth Letters D, E, F, G, N. O, P and Q only if the recipient is under 5 years of age.

Procedure codes D2330, D2331, D2332, and D2390 require prior authorization for Tooth Letters C, H, M and R **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.

The resin-based composite – four or more surfaces (D2394) is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

Procedure codes D2391, D2392, D2393, and D2394 are reimbursable for Tooth Numbers 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and Tooth Letters A, B, I, J, K, L, S and T.

If the restoration requires a second or subsequent restoration, PA is required.

Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau or its designee upon request.

Codes

D2930* Prefabricated Stainless Steel Crown – primary tooth
D2931* Prefabricated Stainless Steel Crown – permanent tooth
D2932* Prefabricated Resin Crown (primary and permanent teeth)
D2933* Prefabricated Stainless Steel Crown with Resin Window
D2934* Prefabricated Esthetic Coated Stainless Steel Crown – primary tooth

Neither stainless steel crowns (D2930 and D2933) nor prefabricated resin crowns (D2932) are payable on primary central or lateral incisors after the **fifth** birthday.

Prior authorization is not required for stainless steel crowns (D2930) on primary teeth, except in the following circumstances:

- Teeth B, I, L, S (1st primary molars {D's}) for recipients 9 years of age and older; and
- Teeth A, C, H, J, K, M, R, T (primary canines {C's} and primary second molars {E's}) for recipients 10 years of age and older.

Procedure codes D2930, D2931, D2932, D2933 and D2934 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.

If a non-laboratory crown is required within the first 12 months after a tooth is restored with amalgam or resin, e.g. fracture of the tooth, pulpal necrosis, etc., the reason why the tooth requires additional restoration must be documented in the recipient's treatment record and in the "Remarks" section of the claim form submitted for PA.

Crown services require radiographic images (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 radiographic images are medically contraindicated. The documentation that supports the need for crown

services must be available for review by the Bureau or its designee upon request. Prior authorization is required.

D2930* Prefabricated Stainless Steel Crown – primary tooth

Stainless steel crowns (D2930) may be placed on primary teeth that exhibit any of the following indications, when failure of other available restorative materials is likely to occur prior to the natural shedding of the tooth:

- Extensive caries;
- Interproximal decay that extends in the dentin;
- Significant, observable cervical decalcification;
- Significant, observable developmental defects, such as hypoplasia and hypocalcification.
- Following pulpotomy or pulpectomy;
- Restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
- Fractured teeth

Additionally, a stainless steel crown (D2930) may be authorized to restore an abscessed primary 2nd molar (in conjunction with a pulpectomy) prior to the eruption of the permanent 1st molar to avoid placement of an indicated distal shoe space maintainer.

Stainless steel crowns (D2930) are not medically indicated and reimbursement should not be claimed in the following circumstances:

- Primary teeth with abscess or bone resorption; or
- Primary teeth where root resorption equals or exceeds 75% of the root; or
- Primary teeth with insufficient tooth structure remaining so as to have a poor prognosis of success, e.g. unrestorable; or
- Incipient carious lesions.

This procedure code is payable 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 procedure code D2930 is required only for Tooth Letters B, I, L, and S for recipients **9 years of age and older**; and for Tooth Letters A, C, H, J, K, M, R and T for recipients **10 years of age and older**.

D2931* Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32.

D2932* Prefabricated Resin Crown (primary and permanent teeth)

This procedure is reimbursable for Tooth Numbers 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.

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.

D2934 Prefabricated Esthetic Coated Stainless Steel Crown – primary tooth

A prefabricated esthetic coated stainless steel crown-primary tooth is a stainless steel crown with exterior esthetic coating.

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.

Other Restorative Services

Codes

D2920 Re-cement Crown
D2950* Core Buildup, including any pins, in addition to crown
D2951 Pin Retention – per tooth, in addition to restoration
D2954* Prefabricated Post in addition to crown
D2999* Unspecified Restorative Procedure, by report

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth and can be billed only after receiving Prior Authorization.

D2920 Re-cement Crown

The billing provider is responsible for recementation within the first 12 months after placement of the crown.

This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter A through T.

D2950* Core Buildup, including any pins, in addition to crown

This procedure refers to the building up of anatomical crown when restorative crown will be placed, whether or not pins are used. Prior authorization is required and is only available for permanent teeth that have undergone endodontic treatment. A core build-up cannot be authorized in conjunction with a post and core or for primary teeth.

This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

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.

D2954* Prefabricated Post and core in addition to crown

Refers to a core built around a pre-fabricated post when a restorative crown will be placed. This procedure includes the core material. The post and core can be used on endodontically treated permanent teeth (2-15 and 18-31) when there is insufficient natural tooth structure to receive the final full coverage restoration. The post must extend at least one-third the length of the root and must closely approximate the canal walls. Prior authorization is required and will not be authorized in combination with a core build-up.

This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

D2999* Unspecified Restorative Procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Endodontic Therapy Services

Endodontic therapy includes those services listed below.

Codes

D3110 Pulp Cap – direct (excluding final restoration)
D3220* Therapeutic Pulpotomy (excluding final restoration)
D3222* Partial Pulpotomy for Apexogenisis – permanent tooth with incomplete root development
D3240* Pulpal Therapy (resorbable filling), pulpectomy – posterior, primary tooth
D3310* Endodontic Therapy, Anterior Tooth (excluding final restoration)
D3320* Endodontic Therapy, Bicuspid Tooth (excluding final restoration)
D3330* Endodontic Therapy, Molar (excluding final restoration)
D3346* Retreatment of previous root canal therapy - anterior
D3352* Apexification (excluding root canal)
D3410* Apicoectomy
D3430* Retrograde Filling
D3999* Unspecified Endodontic Procedure, by report

Pulp Capping

D3110 Pulp Cap – direct (excluding final restoration)

Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp. Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth. Pre-operative radiographic images must substantiate the need for this service.

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

D3220* Therapeutic Pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament

Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure code D3220 is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under five years of age.

This service is defined as the surgical removal of the coronal portion of the pulp and completely filling the pulp chamber with a restorative material. It should not be applied to primary teeth where the roots show signs of advanced resorption (more than two-thirds of the root structure is resorbed), where there are radiographic signs of infection in the surrounding bone, or where there is mobility on clinical evaluation.

This procedure is limited to once in a 12 month period, per tooth.

D3222* Partial Pulpotomy for Apexogenesis – permanent tooth with incomplete root development

This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. This service is defined as the removal of a portion of the pulp and application of medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not constructed as the first stage of endodontic therapy and requires prior authorization.

This service is reimbursable only once a 12 month period, per tooth.

Endodontic Therapy on Primary Teeth

D3240* Pulpal Therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) (pulpectomy)

The Medicaid program provides for the endodontic treatment of posterior second primary molars (A, J, K or T) requiring complete extirpation of all pulpal material and filling with a resorbable filling material.

This procedure is not payable on primary incisors, cuspids and first primary molars. If the endodontic pathology on these teeth cannot be treated with a pulpotomy, then extraction and space maintenance may be indicated.

Authorization will be limited to a primary second molar in an arch (maxillary or mandibular), when the first permanent molar has not erupted and when a pulpectomy will eliminate the necessity for extraction and the placement of a distal shoe space maintainer. A pulpectomy will not be approved in cases where the primary roots are more than half resorbed or when the six year-molar has erupted.

Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the pulpal therapy and must be maintained in the patient treatment record.

This procedure is reimbursable for Tooth Letters A, J, K, and T.

Endodontic Therapy

D3310* Endodontic Therapy, anterior (excluding final restoration)
D3320* Endodontic Therapy, bicuspid (excluding final restoration)
D3330* Endodontic Therapy, molar (excluding final restoration)

Complete endodontic therapy (procedures D3310, D3320 and D3330) includes treatment plan, all appointments necessary to complete treatment, clinical procedures, all intraoperative radiographic images (which must include a post-operative radiograph) and follow-up care.

Medical necessity for all endodontic procedures must be documented in the patient's chart and be supported by radiographic documentation. If the radiographic images do not indicate the need for endodontic therapy, the provider must include a written statement as to why the endodontic therapy is necessary.

Prior authorization is required. Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must be submitted. If the radiographic images do not indicate the need for a root canal, the provider must include a written statement as to why the root canal is necessary. Approval of any requested root canal will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographic images do not adequately indicate the need for the root canal requested, the request for prior authorization will be returned to the provider requesting additional information.

In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable.

Final approvals for root canals require post authorization. Request for post authorization must be accompanied by the approved prior authorization request and post-operative radiographs prior to reimbursement.

The date of service on the payment request **must** reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the root canal and must be maintained in the patient's treatment record. Written documentation must also include the type of filling material used as well the notation of any complications encountered which may compromise the success of the endodontic treatment.

D3310* Endodontic Therapy, anterior (excluding final restoration)

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.

D3320* Endodontic Therapy, bicuspid (excluding final restoration)

This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29.

D3330* Endodontic Therapy, molar (excluding final restoration)

This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31.

Endodontic Retreatment

D3346* Retreatment of previous root canal therapy – anterior

This procedure is payable only to a different provider or provider group than whom originally performed the initial root canal therapy, and is reimbursable with prior authorization for Medicaid eligible recipients under 21 years of age.

The PA request of procedure code D3346 by the same provider or provider group who performed the initial root canal therapy will be denied with a denial code (452) which will state: "An anterior root canal retreatment is not payable to the same dentist or dental group who performed the initial root canal. Recipients may seek the service from a different dentist (dental group) who will submit for a new prior authorization."

Procedure D3346 may include the removal of post, pin(s), old root canal filling material, and the procedures necessary to prepare the canal and place the canal filing. This includes complete root canal therapy. The reimbursement for this procedure includes all appointments necessary to complete the treatment and all intra-operative radiographic images. The date of service on the payment request must reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the recipient's treatment records.

Approval of any requested root canal retreatment will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and past history of the recipient oral care. Request for PA must be accompanied by a treatment plan supported by sufficient readable, most current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the recipient. Specific treatment plans for final restoration of the tooth must also be submitted.

If the radiographic images do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary. If a fistula is present, a clear oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographic images do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographic images do not adequately indicate the need for the retreatment of a previous root canal, the request for PA will be returned to the provider requesting additional information.

Apexification/Recalcification Procedure

D3352* Apexification / Recalcification – interim medication (excluding root canal)

Apexification is defined as the placement of medication within a root canal space to promote biological closure of the apex. This service is limited to a maximum of three treatments per tooth with the root canal being billed separately. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. In order to obtain optimal results for these services, a three-month period must elapse between start of the root canal, each step in the treatment as well as the final endodontic fill.

This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

Apicoectomy/Periradicular Services

D3410* Apicoectomy/ periradicular surgery – anterior

Periradicular surgery of the root surface (apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. It does not include retrograde filling materials.

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.

D3430* Retrograde filling

This procedure is to be reported for placement of retrograde filling material during periradicular surgery procedures on anterior teeth only. **This procedure will be approved only in conjunction with code D3410.**

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27.

Other Endodontic Procedures

D3999* Unspecified Endodontic Procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Periodontal Services

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

Codes

D4210* Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant
D4341* Periodontal scaling and root planning, per quadrant
D4355* Full mouth debridement
D4999* Unspecified periodontal procedure, by report

Surgical Periodontal Services

D4210* Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant

This procedure involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets,

and to restore normal architecture when gingival enlargements or asymmetrical or unesthetic topography is evident with normal bony configuration.

This procedure requires PA. A gingivectomy may be approved by Medicaid only when the tissue growth interferes with mastication as sometimes occurs from Dilantin therapy.

Explanations or reasons for treatment must be entered in the "Remarks" section of the claim form and a photograph of the affected area(s) must be included with the request for authorization.

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

Non-surgical Periodontal Services

D4341* Periodontal scaling and Root Planing – four or more contiguous teeth or bounded teeth spaces 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 planing may be reimbursed per day. For recipients requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service if prior authorized. The claim form used to request PA or reimbursement must identify the "Place of Treatment" (Block 38) and "Treatment Location" (Block 56) if the service was performed at a location other than the primary office.

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

This service is reimbursable only once in a 12 month period.

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 this service is indicated.

No other dental services except examination, radiographic images or oral/facial photographic images 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 in a 12 month period. **This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to the same billing provider or another Medicaid provider in the same office as the billing provider within a 12 month period.**

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographic images that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In the occasional instance where the bitewing radiographic images do not supply evidence of significant calculus in at least two quadrants, Oral/facial photographic images that provide evidence of significant plaque and calculus are required.

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new recipients when they last received a Medicaid covered prophylaxis (D1110 or D1120) and record that information in the recipient's treatment record.

For the established patient/recipient, the provider must check the office treatment record to ensure that it has been over 12 months since a D1110 or D1120 was reimbursed by Medicaid for this recipient. If it is determined that it has been less than 12 months, the recipient must reschedule for a later date which exceeds the 12 month period.

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) within the preceding 12 months for this recipient, the provider may render and bill Medicaid for a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis), whichever is applicable based on the recipient's age.

Other Periodontal Services

D4999* Unspecified Periodontal Procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Removable Prosthodontics

Removable prosthodontic services include complete dentures, partial dentures, denture repairs and denture relines.

Documentation requirements are included to conform to federal and state regulations concerning the necessity of documentation linked to the payment for services funded by both the state and federal government.

Minimum Standards for Complete and Partial Denture Prosthodontics

Denture services provided to recipients under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing, delivery and adjustment. Although no minimum number of appointments is set, the following minimum standards must be adhered to:

- The providers are required to obtain recipient esthetic acceptance prior to processing. This acceptance must be documented by the recipient's signature in the treatment record.
- The denture should be flasked and processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the recipient's treatment record.
- Upon delivery:
    - The denture bases must be stable on the lower and retentive on the upper.
    - The clasping must be appropriately retentive for partial dentures.
    - The vertical dimension of occlusion should be comfortable to the recipient (not over-closed or under-closed). The proper centric relation of occlusion

should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.

- The denture must be fitted and adjusted for comfort, function, and aesthetics.

- The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The dentist is responsible for all necessary adjustments for a period of six months.

Records must include a chronological (dated) narrative account of each recipient visit indicating what treatment was performed/provided or what conditions were present on those visits. A check off list of codes for services billed as well as copies of claim forms submitted for authorization or payment is deemed insufficient documentation of services delivered.

If the recipient refuses delivery of the complete or partial denture, it cannot be considered delivered.

Failure to deliver a minimally acceptable full or partial denture, failure to provide adequate follow-up care, or failure to document the services provided will be considered grounds for recouping the fee paid for the denture.

Denture Identification Information

All full and partial dentures (excluding interim partials, D5820 and D5821) reimbursed under the Medicaid EPSDT Dental Program must have the following unique identification information processed into the acrylic base:

- The first four letters of the recipient's last name and first initial;

- The month and year (00/00) the denture was processed; and

- The last five digits of provider's Medicaid ID number.

Complete Dentures

Codes

D5110* Complete Denture - maxillary
D5120* Complete Denture - mandibular
D5130* Immediate Denture - maxillary
D5140* Immediate Denture – mandibular

Only one prosthesis per recipient per arch is allowed in a five-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. **Once the recipient becomes 21 years of age, the rules of the Adult Denture Program apply.**

All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for prior authorization. If an immediate denture is requested, the provider must state the reasons for the request in the "Remarks" section of the claim form.

Immediate dentures are not considered temporary. The provider must inform the recipient that no reline will be reimbursed by Medicaid within one year of the denture delivery.

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be prior authorized. Radiographic images should confirm that no more than six teeth remain; or if more than six teeth remain, the attending dentist must certify by statement in the "Remarks" section that six or fewer teeth will remain when the final impression is taken.

A**n immediate denture that is not delivered cannot be reimbursed nor will Medicaid reimburse any payment under the interruption of treatment guidelines (see section 16.1).**

Partial Dentures

Codes

D5211* Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212* Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213* Maxillary cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

D5214* Mandibular cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5820* Interim partial denture (maxillary) – Includes any necessary clasps and rests.
D5821* Interim partial denture (mandibular) – Includes any necessary clasps and rests.

Only one prosthesis (excluding interim partial dentures) per recipient per arch is allowed in a five-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana. **Once the recipient becomes 21 years of age, the rules of the Adult Denture Program apply.**

To receive consideration for approval for cast partial dentures, providers must submit periapical radiographic images of the abutment teeth and bitewings with the treatment plan.

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider must use the following symbols in Block 34 of the ADA Dental Claim Form to indicate tooth status:

- "X" will be used to identify missing teeth and
- "/" will be used to identify teeth to be extracted.

The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Only permanent teeth are eligible for replacement by an interim partial denture or a partial denture.

Opposing partial dentures are available if each arch independently fulfills the requirements.

Partial dentures that replace only posterior teeth must occlude against multiple posterior teeth in the opposing arch, and must serve to increase masticatory function and stability of the entire mouth.

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. On those recipients requiring extensive restorations, periodontal services, extractions, etc. post-treatment radiographic images may be requested prior to approval of a partial denture.

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth, or
- Missing two mandibular permanent anterior teeth, or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior)

Medicaid may provide a partial denture in cases where the recipient has matured beyond the mixed dentition stage in the following cases:

- Missing three or more maxillary anterior teeth, or
- Missing two or more mandibular anterior teeth, or
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same **arch** when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement), or
- Missing a combination of two or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch.

Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On those recipients requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

Denture Repairs

Codes

D5510 Repair broken complete denture base
D5520 Replace missing or broken tooth – complete denture – per tooth
D5610 Repair resin partial denture base
D5630 Repair or replace broken clasp
D5640 Replace missing or broken tooth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture

Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one year has elapsed since denture insertion by the same billing

provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture.

If the same provider/provider group (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture within the first year after a repair is paid, the repair fee for that arch will be deducted from the new prosthesis fee. A repair is allowed in conjunction with a reline on the same recipient as long as the repair makes the denture fully serviceable.

There is a limit to how much a provider can bill within a single year for base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient. This limit applies to the billing provider or another Medicaid-enrolled provider located in the same office as the requesting provider. See the EPSDT Fee Schedule on the Louisiana Medicaid website for limit.

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designator 01 and 02.

The request for payment for procedure codes D5510 and D5610 must include the location and description of the fracture in the "Remarks" section of the claim form.

The fee assigned for the first tooth billed using the codes D5520 or D5640 or D5650 will reflect the base price for the first denture tooth. When multiple teeth are replaced or added to the same prosthesis on the same date of service, the same procedure code is to be used for each tooth. However the fee assigned for the additional teeth will reflect the additional allowance per tooth as indicated in Appendix A.

Procedures D5520, D5640 and D5650 are reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designator 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the recipient's treatment record.

- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.

- The prosthesis must be finished in a workmanlike manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

- The treatment record must specifically identify the location and extent of the breakage.

Failure to provide adequate documentation of services billed as repaired when requested by DHH or its authorized representative will result in recoupment of monies paid by the program for the repair.

Denture Relines

Codes

D5750* Reline complete maxillary denture - Laboratory Reline
D5751* Reline complete mandibular denture - Laboratory Reline
D5760* Reline maxillary partial denture - Laboratory Reline
D5761* Reline mandibular partial denture - Laboratory Reline

Reimbursement for complete and partial denture relines are allowed only if one year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in a five-year period as prior authorized by Bureau or its designee.

Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five years. Chair-side relines (cold cure acrylics) are not reimbursable.

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material.

- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.

- Relines must be flasked and processed under heat and pressure in a commercial or office laboratory.

- Relines must be finished in a workmanlike manner; they must be clean; they must exhibit a high gloss; and they must be free of voids, scratches, abrasions, and rough spots.

- The denture must be fitted and adjusted for comfort and function.

The dentist is responsible for all necessary adjustments for a period of six months.

Failure to deliver a minimally acceptable reline, failure to provide adequate follow-up care, or failure to provide adequate documentation of services billed as relined when requested by DHH or its authorized representative will result in recoupment of the fee paid for the reline.

Other Removable Prosthodontics

D5899* Unspecified removable prosthodontic procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Maxillofacial Prosthetics

D5986* Fluoride Gel Carrier

A fluoride gel carrier is a prosthesis that covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.

This service requires prior authorization and is only available for recipients who are undergoing or who have undergone head and neck radiation therapy.

This procedure includes the materials necessary for the fabrication and delivery of a non-disposable, vacuum molded soft vinyl prosthesis adapted to the recipient's dental arch.

This procedure is reimbursable for Oral Cavity Designator 01 and 02.

Fixed Prosthodontics

Codes

D6241* Pontic – porcelain fused to predominantly base metal
D6545* Retainer – cast metal for resin bonded fixed prosthetics
D6999* Unspecified, fixed prosthodontic procedure, by report

When a patient is missing a single maxillary anterior incisor a resin-bonded fixed prosthesis (Maryland-type bridge consisting of two retainers and a pontic) can be approved. The following requirements apply:

- The recipient must have attained the age of sixteen.
- The abutment teeth must be caries free and restoration-free and have sound periodontal support.
- No other maxillary teeth are missing or require extraction.
- Providers must submit with the request for prior authorization periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed.
- On the tooth number chart on the ADA form, "X" out the missing tooth.

The overall condition of the mouth is an important consideration in whether or not a fixed partial denture is authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch.

Only one Maryland-type bridge can be authorized in a five year period.

Fixed Partial Denture Pontic

D6241* Pontic – porcelain fused to predominantly base metal

This code is only reimbursable when submitted in conjunction with code D6545. Procedure code D6241 is limited to one per recipient, in a five-year period.

This procedure is reimbursable for Tooth Number 7, 8, 9, and 10.

Fixed Partial Denture Retainer

D6545* Retainer – cast metal for resin bonded fixed prosthetics

This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two per recipient, one per recipient, in a five-year period.

This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.

Other Fixed Partial Denture Services

D6999* Unspecified, fixed prosthodontic procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires prior authorization. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the EPSDT Dental Program.

NOTE: Dental providers who are qualified to bill for services using the Current Physician's Terminology (CPT) codes, may bill for certain non-dental oral surgery services using the CPT codes which are covered under the Physician's Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Physician's Program. Refer to the Professionals Services Manual, Chapter 38 for specific details.

Codes

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
D7240* Removal of impacted tooth - full bony
D7241* Removal of impacted tooth - completely bony, with unusual surgical complications
D7250* Surgical removal of residual tooth roots (cutting procedure)
D7270* Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
D7280* Surgical access of an unerupted tooth

D7285* Biopsy of oral tissue – hard (bone, tooth)
D7286 Biopsy of oral tissue – soft (all others)
D7291* Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310* Alveoloplasty, in conjunction with extractions – per quadrant
D7510 Incision and drainage of abscess – intraoral soft tissue
D7880* Occlusal orthotic device, by report
D7910 Suture of recent small wound up to 5 cm
D7960* Frenulectomy (frenectomy or frenotomy) – separate procedure
D7997* Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999* Unspecified oral surgery procedure, by report

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

Post-payment reviews have shown that a number of providers are billing for the extraction of primary teeth in the advanced stages of natural exfoliation, with little or no therapeutic indication or benefit. Primary teeth that are being lost naturally must not be billed to Medicaid as an extraction. If a practice is noted during post-payment review of billing for the extraction of primary teeth that are shown radiographically to be in the advanced stages of root resorption (more than ¾ of the root resorbed), i.e., exfoliating naturally, there will be a recoupment of money paid for all such therapeutically unnecessary extractions.

If the extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph must be taken as a diagnostic aid and as means of documentation. This radiograph must be maintained in the recipient's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

Any request for prior authorization of extractions requires the submission of radiographic images. Removal of third molars will be authorized only if symptomatic, and the symptoms must be noted on the request for authorization.

The radiographic findings determine the degree of impaction. The PA Number will list the tooth numbers and will correspond to the Current Dental Terminology (CDT) definitions. Therefore, it is suggested that prior authorization be used to resolve differences in radiographic interpretation prior to the day of surgery.

The fee for any extraction (D7210 through D7241) performed on the same tooth which previously received a surgical access of an unerupted tooth (D7280) will be cut back to the maximum fee for the extraction. The fee for code D7140 performed on the same tooth which

previously received a surgical access of an unerupted tooth (D7280) will be paid at $0 since the fee for D7280 exceeds the maximum fee for the extraction.

Procedure codes D7140, D7210, D7220, D7230, D7240, D7241, and D7250 are reimbursable for Tooth Number 1 through 32 and A through T. ADA codes for Supernumerary Teeth 51 through 82 and AS through TS should be used when needed.

Non-surgical Extractions

D7111 Extraction, Coronal Remnants – deciduous tooth

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.

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.

If the patient's record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated.

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.

D7230* Removal of impacted tooth - partial bony

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

D7240* Removal of impacted tooth - complete or full bony

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7241* Removal of impacted tooth - completely bony, with unusual surgical complications

Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.

This procedure code will only be authorized on a post surgical basis.

A PA request for this procedure will be returned as a D7240. Upon submission of a copy of the post-surgical operative report and/or treatment record describing the unusual surgical complications, the radiographic images, and a copy of the PA letter, the original PA may be changed to D7241 if approved.

D7250* Surgical removal of residual tooth roots (cutting procedure)

This procedure includes the cutting of soft tissue and bone, removal of tooth structure, and closure.

Other Surgical Procedures

D7270* Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth

This procedure includes splinting and/or stabilization. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form. This information must also be recorded in the recipient's treatment record. This procedure is not reimbursable for periodontal splinting. An Oral Cavity Designator is required on the claim for reimbursement.

This procedure is reimbursable for Oral Cavity Designator 01 and 02.

D7280* Surgical access of an unerupted tooth

This procedure includes an incision, the reflection of tissue, and the removal of bone as necessary to expose the crown of an impacted tooth not intended to be extracted.

This procedure no longer includes the placement of orthodontic attachment. Refer to procedure code D7283 below for information related to the orthodontic attachment. This procedure requires PA.

Procedure Code D7280 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

D7283* Placement of Device to Facilitate Eruption of Impacted Tooth

This procedure involves the placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

This procedure is only reimbursable in conjunction with a Medicaid-approved comprehensive orthodontic treatment plan. This procedure requires PA.

Procedure Code D7283 is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.

D7285* Biopsy of oral tissue – hard (bone, tooth)

This procedure is for the removal of specimen only. It involves the biopsy of osseous lesions and is not to be used for apicoectomy/periradicular surgery.

This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.

D7286* Biopsy of Oral Tissue – Soft

This procedure is for the surgical removal of an architecturally intact specimen only, and is not used at the same time as codes for apicoectomy/periradicular curettage.

This procedure requires post authorization. A copy of the pathology report must be submitted to the Dental Medicaid Unit when requesting post authorization.

This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30 and 40.

D7291* Transseptal fiberotomy/supra crestal fiberotomy, by report

This procedure is only reimbursable in conjunction with a Medicaid-approved comprehensive orthodontic treatment plan.

This procedure is reimbursable for Oral Cavity Designator 01 and 02.

Alveoloplasty

D7310* Alveoloplasty in conjunction with extractions - Per Quadrant

A minimum of three adjacent teeth must be extracted. Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed.

The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form.

This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.

Surgical Incision

D7510 Incision and Drainage of abscess – intraoral soft tissue

This service is not reimbursable for primary teeth. It is a specific surgical procedure designed to obtain drainage from a purulent abscess by incision through the mucosa. This procedure is not payable for a particular tooth on the same date of service as the extraction.

This procedure is reimbursable for Tooth Numbers 1 through 32.

Temporomandibular Joint (TMJ) Procedure

D7880* Occlusal orthotic device, by report

Only hard acrylic splints are reimbursed by Medicaid for the treatment of temporomandibular joint dysfunction.

The recipient must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The request for PA must include a completed TMJ Summary Form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. The TMJ Summary Form must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

This procedure is reimbursable for Oral Cavity Designator 01 and 02.

Other Repair Procedures

D7960* Frenulectomy (frenectomy or frenotomy) – separate procedure

This procedure includes the excision of the frenum when the tongue has limited mobility; large diastemas that persist beyond the eruption of the permanent cuspids; or when it is the etiology of periodontal tissue disease.

This procedure requires PA. An explanation of the circumstances must be provided in the "Remarks" section of the claim form. This information must also be recorded in the recipient's treatment record. The specific dental reason is required for authorization. If the specific reason is not dental, e.g. if a speech impediment is the reason for the request, then a written statement from a speech pathologist or physician must be submitted.

This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.

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

This procedure requires PA 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.

D7999* Unspecified oral surgical procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Orthodontic Services

Codes

D8050* Interceptive orthodontic treatment of the primary dentition
D8060* Interceptive orthodontic treatment of the transitional dentition
D8070* Comprehensive orthodontic treatment of the transitional dentition
D8080* Comprehensive orthodontic treatment of the adolescent dentition
D8090* Comprehensive orthodontic treatment of the adult dentition

D8220* Fixed appliance therapy
D8999* Unspecified orthodontic procedure, by report

Orthodontic treatment is available to recipients meeting specified criteria. All orthodontic procedures must be prior authorized. Providers are reminded that Medicaid reimbursement is payment in full for that procedure code.

Interceptive Orthodontic Treatment

D8050* Interceptive orthodontic treatment of the primary dentition
D8060* Interceptive orthodontic treatment of the transitional dentition

Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate.

The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.

This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.

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

Only dentists qualified under Chapter 3, Section 301, Parts (C) and (D) of the Rules promulgated by the Louisiana State Board of Dentistry as an approved specialty of "orthodontics and dentofacial orthopedics" are eligible to be reimbursed for Comprehensive Orthodontic Services (procedure codes D8070, D8080, and D8090) in the Medicaid EPSDT Dental Program.

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.

This code is used to report the coordinated diagnosis and treatment leading to the improvement of a recipient’s craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

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, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial 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.

Providers are reminded that Medicaid reimbursement is payment in full for the procedure code and should a recipient be unable to complete the treatment (for example patient moves away), the reimbursement is subject to recoupment pro-rata based on the number of months of treatment completed.

The request for PA must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, the PAU will authorize a maximum of three units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit. (See fee schedule for total maximum allowable billable fees)

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three claim lines with three distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and, the final date of service no earlier than 90 days after banding.

Medicaid reimbursement includes the brackets/appliance and all visits and adjustments.

Minor Treatment to Control Harmful Habits

D8220* Fixed appliance therapy

Certain fixed habit appliances will be considered if the appliance would be beneficial to the recipient to assist in the correction of a destructive habit such as thumb sucking or tongue thrusting. The request for PA must include sufficient documentation to substantiate the need for and the utility of the appliance.

For approval of procedure code D8220, the following must apply:

- *The child must be between the ages of 5 years through 8 years;*
- The maxillary incisors (7, 8, 9 and 10) are actively erupting;
- The child still displays the destructive habit; and
- The child has evidenced a desire to stop the destructive habit.

Other Orthodontic Services

D8999* Unspecified orthodontic procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Adjunctive General Services

Codes

D9110 Palliative (emergency) treatment of dental pain - minor procedure
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
D9241* Intravenous conscious sedation/analgesia – first 30 minutes
D9242* Intravenous conscious sedation/analgesia – each additional 15 minutes
D9248* Non-intravenous conscious sedation
D9420* Hospital call
D9440* Office visit – after regularly scheduled hours
D9920* Patient Management
D9940* Occlusal Guard, by report
D9951* Occlusal Adjustment – limited
D9999* Unspecified adjunctive procedure, by report

Palliative (Emergency) Treatment

D9110 Palliative (emergency) treatment of dental pain – minor procedure

Palliative treatment is the treatment of a specific dental complaint. It is to be used when a specific procedure code is not indicated and a service is rendered to the recipient. Records must indicate the tooth or area of the mouth that was treated.

On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) if authorized, in addition to this procedure code.

If definitive therapeutic treatment is performed on the same date of service as the palliative treatment, the provider may choose to bill for the definitive therapeutic treatment instead of the palliative treatment.

A maximum of two palliative treatments per recipient are available annually. Emergency or palliative dental care services include the following:

- Procedures used to control bleeding; or
- Procedures used to relieve pain; or
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen; or
- Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings; or
- Complaint where assessment is provided, or diagnosis is determined, or referral is made; or
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

The recipient's treatment record must contain a narrative of the specific treatment rendered (tooth number, temporization, opened tooth for drainage, etc.). The treatment provided must **not** be one that the program lists as non-covered nor can it be a treatment that would be covered under a specific dental service code.

If endodontic therapy is anticipated and the provider has not already obtained bitewing radiographic images, bitewing radiographic images must be taken for inclusion with the request for PA of the root canal, in addition to any periapical radiographic images taken for diagnosis of the affected tooth.

Anesthesia

D9230 Nitrous Oxide - analgesia, anxiolysis, inhalation of nitrous oxide

Nitrous oxide inhalation analgesia is only payable to providers who possess a personal permit for its administration from the Louisiana State Board of Dentistry and administer it in a State Board approved facility. Nitrous oxide is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. Nitrous oxide, if provided, must be billed on the same claim form as the restorative and/or surgical service (s).

If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service (s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied.

NOTE: This code is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) by any provider.

D9241* Intravenous conscious sedation/analgesia – first 30 minutes
D9242* Intravenous conscious sedation/analgesia – each additional 15 minutes

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients.

Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting.

A maximum of two units of D9242 are available per recipient per visit; if requested, each must be listed on a separate claim line for both PA and payment.

D9248* Non-intravenous conscious sedation

Non-intravenous conscious sedation is a medically controlled state of depressed consciousness while maintaining the recipient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

Non-intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

This service is only reimbursable for children with behavioral problems under the age of six or for older children who are physically or mentally handicapped.

Hardcopy PAs are required only for recipients six years of age and older.

A maximum of four non-intravenous conscious sedation/analgesia administrations, per recipient, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Non-intravenous conscious sedation is not reimbursable on the same day, by any provider as procedure codes D9230 (Nitrous Oxide) and D9920 (Behavior Management).

The request for PA must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the patient. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration.

A request for PA for conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the dentist or staff from administration through the time of discharge.

The conscious sedation form found in Appendix I, must be completed and maintained in the recipient's treatment record. If the restorative /surgical phase of the treatment is aborted after the initiation of conscious sedation, the provider must document the circumstances in the recipient's treatment record.

Administration of oral pre-medication is not a covered service.

Professional Visits

D9420* Hospital call

This code may be reimbursed when providing treatment in hospital outpatient clinic or outpatient ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Those services must be covered under the EPSDT Dental Program (see Appendix A for EPSDT Medicaid covered dental codes).

A hospital call is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. A hospital call, if provided, must be billed on the same claim form as the restorative and/or surgical service(s). If a claim or payment is received for a hospital call and there are no restorative and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the hospital call, the payment for the hospital call will be denied.

Hospitalization solely for the convenience of the recipient or the dentist is not allowed.

Reimbursement for hospital call is limited to recipients under the age of six, unless the child is physically or mentally handicapped.

PA is required only recipient six years of age and older.

The request for PA must adequately justify the need for hospitalization in the "Remarks" section of the claim form. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). If the child is physically or mentally handicapped, the particular handicap and its impact on the delivery of dental treatment in the office setting must be stated in the "Remarks" section. The request for PA must outline the entire treatment plan with the hospital code listed first or last on one of the pages.

Additionally, the dental office treatment record for the recipient must also document the justification for hospitalization including accurate dental charting. A copy of the operative report must be maintained in the recipient's dental office treatment record.

Denial of a hospital call request does not prevent the provider from admitting the recipient, nor will it prevent the facility from receiving reimbursement. In addition, it does not prevent payment to the dental provider for any covered, prior authorized (if required) treatment performed in the hospital. The denial is only for the code D9420 and its accompanying fee for additional reimbursement to the provider as compensation for time out of the office.

Procedure code D9420 is reimbursable once per six month period, per recipient.

D9440 * Office Visit – after regularly scheduled hours

Procedure code D9440 is to be used for an office visit after regularly scheduled hours for the treatment of a dental emergency. The dental office must be reopened specifically to treat this emergency. The service(s) provided must be reimbursable under the Medicaid EPSDT Dental Program and must be listed on the claim form for PA and reimbursement. A statement describing the situation must be made in the "Remarks" section of the claim form.

Post Authorization of this procedure will be allowed due to the acute nature of the service.

Miscellaneous Services

D9920* Behavior Management

Additional compensation paid for behavior management is intended to help offset the additional cost of providing care to recipients displaying disruptive or negative behavior during restorative and surgical procedures and may be reimbursed under the following circumstances:

- The management technique involved extends the time of delivering treatment an additional 33% above that required for recipients receiving similar treatment who do not demonstrate negative or disruptive behavior; or
- Use of an additional dental personnel/assistant(s); or
- Use of restraint devices such as a papoose board

Behavior management is reimbursable for recipients below the age of eight, unless documentation indicates that the recipient is physically or mentally handicapped. The particular handicap and its impact on the delivery of dental treatment in the office setting must be stated in the "Remarks" section in the request for prior authorization. Behavior management is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) on the same day, by any provider.

Hardcopy PAs are required only for recipients eight years of age and older.

Providers must indicate on the request for prior authorization which dental treatment services are scheduled to be delivered at each treatment visit for which a management fee is requested. Behavior management is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7111 - D7999) are performed.

Behavior management, if provided, must be billed on the same claim form as the restorative and/or surgical service (s). If a claim for payment is received for behavior management and there are no restorative and/or surgical service (s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the behavior management, the payment for behavior management will be denied.

Documentation of the circumstances requiring behavior management as well as the specific efforts or techniques utilized must be recorded in the recipient's treatment record for each treatment visit.

A maximum of four behavior management services, per recipient, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider.

D9940* Occlusal Guard, by report

An Occlusal Guard is a removable dental appliance that is designed to minimize the effects of bruxism (grinding) and other occlusal factors.

The recipient must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The request for prior authorization must include a completed TMJ summary form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

This procedure is reimbursable for Oral Cavity Designator 01 and 02.

D9951* Occlusal Adjustment – limited

May also be referred to as equilibration; a reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth and is reported on a "per visit" basis.

The recipient must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The request for prior authorization must include a completed TMJ summary form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided.

D9999* Unspecified adjunctive procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.