COVERED SERVICES

The dental services that are covered under the Adult Denture Program are divided into two categories: Diagnostic Services and Removable Prosthodontics. **Services that require prior authorization (PA) are identified by an asterisk (*).**

Only those services described below are payable under the Adult Denture Program:

1. Examination (only in conjunction with denture construction);
2. Radiographs (only in conjunction with denture construction);
3. Complete dentures;
4. Denture relines;
5. Denture repairs; or
6. Acrylic partial dentures (only in conjunction with an opposing full denture).

Although similar services are available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Dental Program, different program guidelines apply to the Adult Denture Program.

NOTE: The Adult Denture Program does not reimburse any adult restorative or surgical procedures.

Diagnostic Services

Examination

D0150 Comprehensive oral examination - new or established patient

This procedure code is to be used for the comprehensive examination of the adult Medicaid beneficiary who is in need of a complete denture.

Reimbursement for this procedure code requires that radiographs be taken and maintained in the beneficiary's record and must be furnished to post-payment review if requested. The

comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs.

Procedure code D0150 should be entered on the first line of the Dental Claim Form followed on the second line by the procedure code for radiographs D0210.

Code D0150 is reimbursable once every eight years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Examinations in Anticipation of Denture Construction

If, after verifying the beneficiary's eligibility for Medicaid, the provider perceives that the beneficiary is eligible for the services available in the Adult Denture Program; e.g. the beneficiary is edentulous in one arch or the beneficiary is going to have the remaining teeth in an arch extracted, the provider must proceed with a thorough oral examination and the necessary radiographs.

The provider must record in the treatment record that the beneficiary is in need of a dental prosthesis and that she/he has determined that the beneficiary desires dentures; the beneficiary can physically and mentally tolerate the construction of a new denture, and will be able to utilize the denture once completed. The provider must also document the condition of any remaining teeth and any treatment required (including extractions and restorations).

Minimum Examination Requirements for the Clinical Examination

The beneficiary's oral cavity must be examined for abnormalities, such as tori, neoplasms, anomalies, and systemic manifestations of diseases that may be present in the mouth. Findings must be recorded on the treatment record and appropriate treatment recommendations made.

Examination of Ineligible Beneficiaries

If the beneficiary is not eligible for Medicaid denture services or if the provider perceives that the beneficiary does not require a complete denture; e.g. the beneficiary does not have an edentulous arch; the provider should not continue with the examination or take radiographs. In addition, the provider should not submit a claim for authorization or for payment of the examination code D0150 or the code for radiographs.

Examination in Conjunction with a Denture Repair

Radiographs are not required in conjunction with a denture repair; therefore the fees for the examination and radiographs are not reimbursable. Claims for eligible denture repairs should be forwarded directly to the fiscal intermediary (FI) for payment.

Examination in Conjunction **with** a Denture Reline.

Radiographs are not required in conjunction with a denture reline. Therefore, the fees for the examination and radiographs are not reimbursable.

Radiographs

D0210 Intraoral – complete series

A complete series consists of:

1. Minimum of five (5) mounted periapical radiographs of each edentulous or partially edentulous arch for which a prosthesis is requested (three periapical radiographs if the arch does not require a prosthesis);

2. An occlusal film (only for an edentulous arch); or

3. A panoramic radiograph.

If radiographs are unobtainable, e.g. the beneficiary is physically unable to receive this service or the beneficiary is a resident of a long- term care facility where radiographic equipment is unavailable, the reason for the lack of radiographs must be recorded in the beneficiary's dental treatment record. In this instance, as radiographs were not taken, the provider will not be reimbursed for the examination code D0150.

In order for the Medicaid Dental Program or its designee to be able to make necessary authorization determination, radiographs and/or oral/facial images must be of good diagnostic quality. These radiographs must be maintained in the beneficiary's record and must be furnished to post-payment review if requested.

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

The comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs. The comprehensive oral examination will be denied if post payment review discovers the radiographs and/or oral/facial images were not provided prior to the delivery of dentures.

Code D0210 is reimbursable once every eight (8) years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

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 Prosthetics

Denture services provided to beneficiaries 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 patient esthetic acceptance prior to processing.
This acceptance must be documented by the beneficiary's signature in the treatment record.

The denture must be flasked and processed under heat and pressure in a commercial or dental office laboratory using American Dental Association (ADA) certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient's treatment record.

Upon delivery:

1. The denture bases must be stable on the lower and retentive on the upper;

2. The clasping must be appropriately retentive for partial dentures;

3. The vertical dimension of occlusion must be comfortable to the patient (not over or under-closed). The proper centric relation of occlusion must be established for complete dentures or partial dentures opposing full dentures;

4. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch;

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

6. 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 (6) months.

Records must include a chronological (dated) narrative account of each beneficiary's 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 sent in for authorization or payment is deemed insufficient documentation of services delivered.

If the beneficiary 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 reimbursed under the Medicaid Adult Denture Program must have the following unique identification information processed into the acrylic base:

1. The first four letters of the beneficiary's last name and first initial;

2. The month and year (mm/yy) the denture was processed; and

3. The last five digits of the provider's Medicaid identification (ID) number.

Complete Dentures

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

Only one complete or partial denture per arch is allowed in an eight-year period. The eight-year period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in an eight-year period as prior authorized by Medicaid.

All missing teeth or teeth to be extracted must be marked in Block 34 of the ADA Dental Claim Form in the following manner: "X" out missing teeth and "/" out teeth to be extracted.

Immediate dentures are not considered temporary. The provider must inform the beneficiary 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. Radiographs must confirm that no more than six (6) teeth remain; or if more than six (6) teeth remain, the attending dentist must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken.

An immediate denture that is not delivered cannot be reimbursed nor will Medicaid reimburse any payment under the interruption of treatment guidelines.

Since the Medicaid Adult Denture Program does not reimburse for extractions, providers must make final arrangements for the removal of the remaining teeth prior to starting an immediate denture. Failure to deliver the immediate denture because the beneficiary is not able to pay for the extractions of the remaining teeth is not an acceptable reason for not delivering the denture.

Partial Dentures

D5211* Maxillary partial denture – resin base (including any retentive/clasping materials, rests and teeth)
D5212* Mandibular partial denture – resin base (including any retentive clasping materials, rests and teeth)

The Adult Dental Program only provides for acrylic partials to oppose a full denture and does not provide for two partial dentures in the same oral cavity.

Medicaid may provide an acrylic partial denture when the opposing arch has a functioning complete denture, or is having a complete denture fabricated simultaneous to the partial denture and the arch requiring the partial denture is:

1. Missing two or more maxillary anterior teeth;

2. Missing three or more mandibular anterior teeth; or

3. Missing at least four posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion.

Only one complete or partial denture per arch is allowed in an eight-year period. The eight-year period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two (2) complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in an eight-year period as prior authorized by Medicaid.

For relines, at least one (1) year shall have elapsed since the complete or partial denture was delivered or last relined.

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 beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post-treatment radiographs may be requested prior to approval of an acrylic partial denture.

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. On the tooth number chart on the ADA form, "X" out missing teeth, "/" out teeth to be extracted or if only a few teeth are present "O" teeth that are to be retained when the partial is delivered. The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Denture Repairs

D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary
D5520 Replace missing or broken tooth – complete denture – per tooth
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
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

Repairs to partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Beneficiaries who do not have a complete denture are not eligible for the partial denture repair services of the Adult Denture Program.

Reimbursement for repairs of complete and 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 unit.

If the same billing provider (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 beneficiary as long as the repair makes the denture fully serviceable.

A limit in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same beneficiary is allowed within a single one-year period for the same billing provider or another Medicaid provider located in the same office as the billing provider (see Appendix B).

Procedure Codes D5511 and D5611 are reimbursable for Oral Cavity Designation area 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

Procedure Codes D5512 and D5612 are reimbursable for Oral Cavity Designation area 01.

The request for payment for procedure codes D5511, D5512, D5611 and D5612 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 B.

Procedures D5520, D5640 and D5650 are reimbursable for Tooth Number 2 through 15 and 18 through 31. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designator 10, 20, 30 and

The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting reimbursement for these procedures.

Minimal procedural requirements for repair services include the following:

1. The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the beneficiary's treatment record;

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

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

4. 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 Medicaid or its authorized representative will result in recoupment of monies paid by the program for the repair.

Denture Relines

D5750* **Reline complete maxillary Denture – indirect**
D5751* **Reline complete mandibular Denture – indirect**
D5760* **Reline maxillary partial denture - indirect**
D5761* **Reline mandibular partial denture - indirect**

Relines for partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Beneficiaries who do not have a complete denture are not eligible for the partial denture reline services of the Adult Denture Program.

A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one reline per arch is allowed in an eight-year period as prior authorized by Medicaid or its designee. The eight-year period begins from the date the previous complete or partial denture for the same arch was delivered.

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 the same billing provider (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee.