Chapter 14

Medicaid Provider Manual

January 2011

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14.1 GENERAL SERVICES

All dental services for Hawaii Medicaid and QUEST recipients are covered through the fee-for-service program administered by a third party administrator. The benefit package differs depending on the recipient's age.

"Dental services" includes (with limitations) diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, orthodontic and some oral surgery services. Oral surgery services associated with fracture management and the treatment of oral pathology including cysts and tumors are covered though a recipient's medical managed care / QUEST plan rather than through the dental fee-for-service program described here.

This fee-for-service program utilizes CDT 2009-2010 as the claims submission coding standard.

14.2 SERVICES COVERED BY MEDICAL BENEFITS PLAN

The QUEST medical plans are responsible for inpatient and outpatient hospital services, including ambulatory surgical center or same day surgery services, anesthesiology services, and medical services that are required as part of a dental treatment plan. Prior authorization and claims for such medical services should be submitted to patient's QUEST medical plan.

14.3 PROVIDER OBLIGATIONS

All health care providers shall abide by the provisions outlined within your signed Provider Agreement and Condition of Participation with State of Hawai`i Department of Human Services. Through that agreement, providers also agree to abide by the provisions outlined in this manual and the Hawaii Administrative Rules, Title 17, Subtitle 12 Med-QUEST Division and federal provisions set forth in the Code of Federal Regulations (CFR).

Among providers obligations, presented here a few common issues which should be clearly understood.

- Providers may not submit claims to Medicaid for services rendered by another dentist.

- Medicaid recipients are not eligible for reimbursement if dental services are rendered by a non-participating dentist.

- Dental services not covered by Medicaid, may be made available to Medicaid recipients at their own personal expense. The charges for uncovered services are independent of Medicaid but should not exceed a provider's customary fee.

  Example:

  If the Medicaid patient is insisting on implants or if an adult Medicaid patient needs amalgam or composite restorations, neither of which are **uncovered Medicaid services**, the provider may make private arrangements with the patient for payment and cannot bill Medicaid for any portion of the procedure.

- "Code substitution" (the application of allowable procedure codes to submit claims for uncovered dental services) is prohibited. Medicaid does not reimbursement for "screening" or "office visits" encounters, and billing for oral examination would be considered false coding.

- "Up-coding" is prohibited. Providers shall bill Medicaid accurately for the service rendered. For example, billing surgical extractions for simple extractions is considered "up-coding".

- "Code Parceling" is prohibited. For example, Medicaid reimburses for restorations based upon tooth number of surfaces per tooth. Separate MO and DO restorations on tooth # 13 would be billed as #13 MOD; not #13 MO + #13 DO. Claims submitted with parceled restorations may be denied or reconciled at a later date on claims audit.

- "Balance Billing" is prohibited. Medicaid providers must accept Medicaid payment rates as payment in full. Additional compensation may not be sought or accepted for services for which payment has already been made or will be made by Medicaid. Providers may not collect from Medicaid patients, or other sources, the balance between their usual fee and Medicaid reimbursement.

  Example:

  If a Medicaid patient is fitted with a crown which usually costs the provider $500 and the provider has billed and received a $200 payment from Medicaid, the provider cannot charge the patient the balance of $300. **The reimbursement received by Medicaid is payment in full.**

- "Multiple payments" are prohibited. Providers are responsible for reconciling their claims and payments. If a provider receives multiple payments for the same service, he/she shall notify the third party administrator.

- Code substitution, up-coding, parceling, balance billing and accepting multiple payments are all serious breaches of program policy which could have serious ramifications.

14.4 CHILDREN'S DENTAL SERVICES REQUIRING PRIOR AUTHORIZATION

The following dental services require prior authorization in order to qualify for reimbursement. The list includes but is not limited to the below. Emergency services do NOT require prior authorization.

- Crowns
- Dentures
- Dental procedures requiring general anesthesia and hospitalization (inpatient and outpatient, excluding hospital-based dental clinics)
- Maxillofacial prosthodontic procedures
- Orthodontics

14.4.1 Requesting Prior Authorization

For dental services requiring prior authorization, providers must complete and submit a Prior Authorization Form with supporting documentation, including radiographs and a stated diagnosis.

14.4.2 Expedited Approval of Authorization Requests

Expedited approval may be granted for procedures that require prior authorization but which should not be delayed until a written approval is obtained (approximately five working days). Expedited approval may be obtained by writing "Urgent" on the top of the Dental Authorization form and faxing the form to the third party administrator.

14.5 CLAIM SUBMITTAL

Until further notice, dental claims for reimbursement must be filed using American Dental Association (ADA) form 2006 and the appropriate CDT 2009/2010 codes. As stated in 14.1, coding of dental procedures shall be true and accurate as defined by CDT 2009/2010. This coding standard is expected to be updated every two years. Every effort will be made to keep pace with CDT version changes as they occur.

Claims shall be submitted upon completion of a dental procedure. For instance, an endodontic procedure which takes two visits to complete, shall be billed out only upon completion on the second visit.

Claims submitted shall reflect a provider's customary fee and not the reimbursement rate of the Medicaid program.

When a quadrant is required, enter the quadrant in Field 29 on the ADA 2006 form.

If films or reports are required, the claim must be submitted as a hard copy rather than on-line.

14.5.1 Billing Information

When preparing your claims, please note the following information must be accurate. Failure to complete claims completely and accurately will lead to delays in payment:

- Do not code for multiple units through a single line item. That is, if you bill for 3 D0230 radiographs, post them on three separate lines rather than one line posted as D0230 x 3. Claims are processed by line-item rather than utilizing the modifier for number of units.
- Preventive services and services for dentures should be billed separately from all other services.
- Paying Provider – Field 48
- Mailing address – Field 48
- Tax ID No. – Field 51 (Must match the billing address – Field 48)
- Servicing Provider – Field 53 (Please print name of servicing provider)

14.5.2 Billing Information for FQHC's

Federal Qualified Health Centers (FQHC) must submit procedure codes D9999, which is used to cover children preventive/restorative benefits. FQHCs are required to submit the appropriate dental procedure codes for dentures for children to be reimbursed at the full rate. For adult emergency dental services, the FQHCs must submit procedure code D0140 and ICD-9 diagnosis code 525.9 for these adult emergency claims.

14.6 EMERGENCY TREATMENT CLAIM SUBMISSION

Prior authorization is not required for emergency exams and palliative treatment (e.g. extraction of infected teeth). However, claims must be submitted as follows to avoid pended or rejected claims:

The ICD-9 diagnosis code 525.9 must be entered in form locator (FL) block 35 on the 2006 ADA form, followed by the description - “Emergency Services 525.9”.

“525.9” functions your certification that the service rendered was for an emergent situation. Before certifying this, be sure that the service claimed was indeed a service requiring immediate intervention for the control of pain, for the treatment of infection, or for the management of trauma. Use the Remarks section of the claim form to provide a brief narrative description which includes your diagnosis and treatment. Payment is based on medical necessity as determined by the dental consultant.

If the code requires radiograph(s), the claim MUST be filed hard copy, rather than via the internet, with the radiographs attached. Otherwise, the claim will be rejected.

14.7 PAYMENT REQUIREMENTS

The patient must be eligible under Medicaid/QUEST and the provider must be approved for participation under Medicaid at the time services are rendered or an approved expense incurred. Payment cannot be made to a non-approved provider even if the patient was eligible and the services approved. Additionally, services requiring authorization must be approved before services are rendered. Provision of services before receipt of the required prior authorization will result in the possible rejection of the claim and denial of payment. Approval of a treatment plan is not an authorization for payment or an approval of the charges.

14.8 CHILDREN'S DENTAL SERVICES (INDIVIDUALS UNDER THE AGE OF 21)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children up to age 21(that is, through age 20) which emphasizes disease prevention and control through early detection of medical, dental and behavioral health conditions and timely management of disorders.

The scope of dental services available through the EPSDT program is broader than that available to adult Medicaid recipients. Federal requirements imposed by the EPSDT statutory provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA'89) mandate that the State covers all Title XIX services included in Section 1905 (a) of the Act when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening services. For more details on this program, please refer to Chapter 5 ESPDT Program. With regard to dental services, Medicaid provides coverage for comprehensive preventive and treatment services, the most notable exception being the limitation of orthodontic therapy to cases involving development oro-facial clefts. In addition, Medicaid does not cover elective surgery, including the extraction of teeth for orthodontic purposes and third molars without documented signs of pathology.

14.8.1 EPSDT Diagnostic Services

EPSDT Clinical Oral Evaluations		
Code	**Description**	**PA Required?**
D0120	Periodic oral examination – established patient ▪ Limited to 2 times per service year	No
D0140	Limited oral evaluation – problem focused ▪ Relating to a dental emergency, may not be used while patient undergoing comprehensive care ▪ May not be used more than once per day ▪ Third party administrator may require documentation of findings, diagnosis and treatment plan	No
D0150	Comprehensive oral evaluation – new or established patient ▪ Limited to 2 times per service year	No

- **Oral Examinations**

  Oral examinations are covered two times per service year starting at age 1, optional as early as age 6 months.

EPSDT Radiographs/Diagnostic Imaging (Including Interpretation)		
Code	**Description**	**PA Required?**
D0210	Intraoral – complete series (including bitewings) ▪ Limited one set per 5 service years ▪ PA is required for a set taken prior to the 5 year service limitation ▪ Includes not less than 14 images	No
D0220	Intraoral - peripapical 1st film ▪ One per day	No
D0230	Intraoral - periapical each additional film ▪ Not to exceed 4 per day	No
D0240	Intraoral – occlusal film ▪ Not to exceed 1 per day	No
D0270	Bitewing – single film ▪ Limited to 2 times per service year and service dates no less than 5 months apart.	No
D0272	Bitewing – two films ▪ Limited to 2 times per service year and service dates no less than 5 months apart.	No
D0274	Bitewing – four films ▪ Limited to 2 times per service year and service dates no less than 5 months apart.	No
D0290	Posterior-anterior or lateral skull and facial bone survey ▪ 1 per day	Yes
D0310	Sialography ▪ 1 per day ▪ Dental reviewed - justification for radiograph required	No

EPSDT Radiographs/Diagnostic Imaging (Including Interpretation)		
Code	**Description**	**PA Required?**
D0330	Panoramic – film ▪ Limited to one set every 2 service years, not to be used with D0210 ▪ Dental reviewed – see criteria below	No
D0340	Cephalometric – film ▪ 1 per day	Yes

- **Panoramic - film**

  D0330 for children is limited to one set every two service years, and cannot be used with D0210. If a patient exceeds this limitation, an additional claim for D0330 may be reimbursed under the following clinical circumstances:

  - When a periapical (PA) radiograph is not practical for the following reasons:
    - Patient cannot sufficiently open mouth to take a PA.
    - PA cannot sufficiently record the necessary anatomy to diagnose dental condition for treatment
    - Teeth planned for extractions are in multiple quadrants and would not be practical to take multiple (5 or more) PAs.
    - Other circumstances deemed necessary by the Dental Consultant
    -

EPSDT Tests and Examinations		
Code	**Description**	**PA Required?**
D0470	Diagnostic Casts	Yes

14.8.2 Preventive

EPSDT Dental Prophylaxis/Topical Fluoride Treatment/Other Preventive Service		
Code	**Description**	**PA Required?**
D1110	Prophylaxis – adult ▪ Limited to 2 times per service year and service dates no less than 5 months apart. ▪ Limited to ages 15 through 20	No
D1120	Prophylaxis – child ▪ Limited to 2 times per service year and service dates no less than 5 months apart. ▪ Limited to birth through age 14	No
D1203	Topical application of fluoride – child ▪ Limited to 2 times per service year and service dates no less than 5 months apart. ▪ Limited to birth through age 14 ▪ Limited to only gel, foam, or fluoride varnish applications	No
D1204	Topical application of fluoride – adult ▪ Limited to 2 times per service year and service dates no less than 5 months apart. ▪ Limited to ages 15 through 20 ▪ Limited to only gel, foam, or fluoride varnish applications	No
D1351	Sealant – per tooth ▪ Covered for 1st and 2nd permanent molars ▪ A tooth may be re-sealed every 5 service years if necessary ▪ Limited to ages 5 through 20	No

- **Prophylaxis and Topical Fluoride**

  Prophylaxis and topical fluoride are covered two times per service year. When billing for prophylaxis and topical fluoride, use different codes for children between birth and age 14, and recipients between the ages of 15 through 20. Prophylaxis and topical fluoride are not covered for recipients age 21 and over. The following codes should be used for these procedures:

Recipient's birth through age 14:

D1120 Prophylaxis

D1203 Topical application of fluoride – child

Recipients ages 15 through 20:

D1110 Prophylaxis

D1204 Topical application of fluoride – adult

EPSDT Space Maintenance (Passive Appliances)		
Code	**Description**	**PA Required?**
D1510	Space maintainer – fixed unilateral ▪ 4 per 2 service years ▪ Limit 2 per day	No
D1515	Space maintainer – fixed bilateral ▪ 4 per 2 service years ▪ Limit 2 per day	No
D1550	Re-cementation of space maintainer ▪ Once per year	No

14.8.3 Restorative

EPSDT Restorative		
Code	**Description**	**PA Required?**
D2140	Amalgam – 1 surfaces (primary or permanent) ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32	No
D2150	Amalgam – 2 surfaces (primary or permanent) ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32 ▪	No
D2160	Amalgam – 3 surface s (primary or permanent) ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32	No

EPSDT Restorative		
Code	**Description**	**PA Required?**
D2161	Amalgam – 4 surfaces or more (primary or permanent) ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32	No
D2330	Resin-based composite – 1 surface, anterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only C thru H, and M thru R ▪ Covered permanent teeth – only 6 thru 11, and 22-27	No
D2331	Resin-based composite – 2 surfaces, anterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only C thru H, and M thru R ▪ Covered permanent teeth – only 6 thru 11, and 22-27	No

EPSDT Restorative		
Code	**Description**	**PA Required?**
D2332	Resin-based composite – 3 surfaces, anterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only C thru H, and M thru R ▪ Covered permanent teeth – only 6 thru 11, and 22-27	No
D2335	Resin-based composite – 4 surfaces or more, anterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only C thru H, and M thru R ▪ Covered permanent teeth – only 6 thru 11, and 22-27	No
D2391	Resin-based composite – 1 surface, posterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only A, B, I, J, K, L, S, T ▪ Covered permanent teeth – 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No

EPSDT Restorative		
Code	**Description**	**PA Required?**
D2392	Resin-based composite – 2 surfaces, posterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only A, B, I, J, K, L, S, T ▪ Covered permanent teeth – 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	No
D2393	Resin-based composite – 3 surfaces, posterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only A, B, I, J, K, L, S, T ▪ Covered permanent teeth – 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	Yes, with radiographs
D2394	Resin-based composite – 4 surfaces or more, posterior ▪ Coding per restoration is on a per tooth basis ▪ Separate multiple restorations per tooth are not covered ▪ Duplicated restorative surface(s) – one per tooth per 2 years ▪ Non-duplicated restorative surface(s) – one per tooth per year ▪ Covered primary teeth – only A, B, I, J, K, L, S, T ▪ Covered permanent teeth – 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	Yes, with radiographs

EPSDT Restorative		
Code	**Description**	**PA Required?**
D2752	Crown – porcelain fused to noble metal ▪ Limited to cases involving endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of the clinical crown (anterior). ▪ Radiographs not needed with claim unless the third party administrator requests ▪ One per tooth every five years ▪ Covered teeth – 2 thru 15 and 18 thru 31	Yes, with radiographs.
D2792	Crown – full cast noble metal ▪ Limited to cases involving endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of the clinical crown (anterior). ▪ Radiographs not needed with claim unless the third party administrator requests ▪ One per tooth every five years ▪ Covered teeth – 2 thru 15 and 18 thru 31	Yes, with radiographs.
D2910	Recement inlay, onlay or partial coverage restoration ▪ One per tooth per day ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32	No
D2920	Recement crown ▪ One per tooth per day ▪ Covered primary teeth – A thru T ▪ Covered permanent teeth – 1 thru 32	No
D2930	Prefabricated stainless steel crown – primary teeth ▪ One per tooth per year ▪ Covered teeth - A thru T	No
D2931	Prefabricated stainless steel crown-permanent tooth ▪ Limited to cases involving endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of the clinical crown (anterior). ▪ Radiographs not needed with claim unless the third party administrator requests ▪ One per tooth per year	Yes, with radiographs

EPSDT Restorative		
Code	**Description**	**PA Required?**
	▪ Covered teeth - 2 thru 15 and 18 thru 31	
D2932	Prefabricated resin crown ▪ Limited to cases involving endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of the clinical crown (anterior). ▪ Radiographs not needed with claim unless the third party administrator requests ▪ One per tooth per year ▪ Covered teeth – 2 thru 15, 18 thru 31	Yes, with radiographs
D2950	Core buildup – includes any pins ▪ Covered permanent teeth – 2 thru 15, 18 thru 31	No
D2951	Pin retention – per tooth, in addition ▪ Covered permanent teeth – 2 thru 15, 18 thru 31	No
D2952	Post and core – addition to crown, indirectly fabricated ▪ Covered permanent teeth – 2 thru 15, 18 thru 31	No
D2954	Prefabricated post and core – in addition to crown ▪ Covered permanent teeth – 2 thru 15, 18 thru 31	No
D2970	Temporary crown (fractured tooth) ▪ Limited to cases involving endodontic treatment, loss of at least one major cusp or loss of not less than 40% of the clinical crown (anterior). ▪ Must be accompanied by narrative justification that it was used for a fractured tooth emergency and radiograph. ▪ Covered teeth- 2 thru 15, 18 thru 31	No

- **Restorative Services**

Composite and amalgam restorations are reimbursable based upon total number of restored surfaces, not to exceed four surfaces per tooth. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.
Upon dental necessity, composite and amalgam restorations that exceed the coverage limits for duplicated restorative surface(s) – one per tooth per two

years and non-duplicated restorative surface(s) – one per tooth per year may be approved for reimbursement through the submittal of a prior authorization.

- **Crowns**

Posterior - Limited to tooth numbers 2, 3, 14, 15, 18, 19, 30, 31 and codes D2792; D2752; D2932 or D2931. These codes include associated temporary crowns. The procedures are limited to cases involving endodontic treatment or loss of at least one major cusp and require prior authorization.

Anterior - Limited to tooth numbers 4 through 13, 20 through 29 and code D2792; D2752; D2932 or D2931. The procedures are limited to cases involving endodontic treatment or loss of not less than 40% of the clinical crown and require prior authorization.

D2970 must be accompanied by narrative justification that it was used for a fractured tooth emergency.

Radiographs must be submitted with the prior authorization request. Radiographs are not required when submitting the claim unless requested by the third party administrator.

14.8.4 Endodontics

EPSDT Endodontics		
Code	**Description**	**PA Required?**
D3220	Therapeutic pulpotomy (excluding final restoration) ▪ 1 per tooth per day per lifetime ▪ Only primary teeth (A – T)	No
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development ▪ 1 per tooth per day per lifetime ▪ Limited to permanent teeth (2 thru 15 and 18 thru 31)	No

EPSDT Endodontics		
Code	**Description**	**PA Required?**
D3310	Endodontic therapy – anterior tooth (excluding final restoration) ▪ One per tooth per lifetime ▪ Limited to permanent teeth (6 thru 11, 22 thru 27) ▪ Completed root canal radiograph shall be submitted with the claim for payment ▪ Radiographs related to the RCT cannot be billed separately Default to D9110, D0140 and radiographs for incomplete RCT	No
D3320	Endodontic therapy – bicuspid tooth (excluding final restoration) ▪ One per tooth per lifetime ▪ Limited to permanent teeth (4, 5, 12, 13, 20, 21, 28, 29) ▪ Completed root canal radiograph shall be submitted with the claim for payment ▪ Radiographs related to the RCT cannot be billed separately ▪ Default to D9110, D0140 and radiographs for incomplete RCT	No
D3330	Endodontic therapy – molar tooth (excluding final restoration) ▪ One per tooth per lifetime ▪ Limited to permanent teeth (2, 3, 14, 15, 18, 19, 30 , 31) ▪ Completed root canal radiograph shall be submitted with the claim for payment ▪ Radiographs related to the RCT cannot be billed separately ▪ Default to D9110, D0140 and radiographs for incomplete RCTs	No
D3351	Apexification / Re-calcification – initial visit ▪ One per tooth per lifetime ▪ Limited to permanent teeth (2 thru 15 and 18 thru 31) ▪ Submit post radiograph with claim.	No

EPSDT Endodontics		
Code	**Description**	**PA Required?**
D3352	Apexification / Re-calcification – interim medication replacement ▪ One per tooth per lifetime ▪ Limited to permanent teeth (2 thru 15 and 18 thru 31) ▪ Submit post radiograph with claim.	No
D3353	Apexification / Re-calcification – final visit ▪ One per tooth per lifetime ▪ Limited to permanent teeth (2 thru 15 and 18 thru 31) ▪ Submit post radiograph with claim.	No

- **Endodontic Therapy**

  Therapeutic pulpotomy - Limited to primary teeth and code D3220.

  Root Canal Therapy (RCT) - Limited to permanent teeth and codes D3310, D3320 and D3330. Radiographs related to RCT procedures are not billable separately. Prior authorization is not required. If the patient fails to return for completion of RCT, bill as palliative (D9110), plus emergency examination (D0140) and appropriate radiographs. This is covered once per tooth per lifetime.

  Re-treatment of a RCT is not covered except for special circumstances. A prior authorization is required and the request will be reviewed on a case-by-case basis.

  Apexification - Limited to permanent teeth and codes D3351, D3352 and D3353.

Apicoectomy - Codes D3410, D3421 and D3425 are no longer a covered benefit.

14.8.5 Periodontics

EPSDT Periodontics		
Code	**Description**	**PA Required?**
D4355	Full Debridement – enable comprehensive evaluation and diagnosis	Yes
D4910	Periodontal maintenance ▪ Periodontal probing chart required with PA submittal	Yes

- **Periodontics**

  Scaling and root planning (D4341 and D4342) is not covered except for special circumstances. A prior authorization is required and the request will be reviewed on a case-by-case basis. Periodontal probing chart required with PA submittal.

14.8.6 Prosthodontics (Removable)

EPSDT Prosthodontics		
Code	**Description**	**PA Required?**
D5110	Complete maxillary denture ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5120	Complete mandibular denture ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting or radiographs ▪ See reference below for denture eligibility.	Yes
D5130	Complete immediate denture - maxillary ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes

EPSDT Prosthodontics		
Code	**Description**	**PA Required?**
D5140	Complete immediate denture - mandibular ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5211	Maxillary partial denture – resin based ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5212	Mandibular partial denture – resin based ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5213	Maxillary partial denture – cast metal framework with resin denture based ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5214	Mandibular partial denture – cast metal framework with resin denture based ▪ Limited one per five years ▪ Requires documentation of missing teeth, charting and/or radiographs ▪ See reference below for denture eligibility.	Yes
D5410	Adjust complete denture – maxillary ▪ One per day	No
D5411	Adjust complete denture – mandibular ▪ One per day	No
D5421	Adjust partial denture – maxillary ▪ One per day	No

EPSDT Prosthodontics		
Code	**Description**	**PA Required?**
D5422	Adjust partial denture – mandibular ▪ One per day	No
D5510	Repair broken complete denture base ▪ One per day	No
D5520	Replace missing or broken teeth– complete denture (each tooth) ▪ Three per day	No
D5610	Repair resin denture base ▪ One per day	No
D5620	Repair cast framework ▪ One per day	No
D5630	Repair or replace broken clasp ▪ One per day	No
D5640	Replace broken teeth – per tooth ▪ Three per day	No
D5650	Add tooth to existing partial denture ▪ One per day	No
D5660	Add clasp to existing partial denture ▪ Two per day	No
D5710	Rebase complete maxillary denture	No
D5711	Rebase complete mandibular denture	No
D5720	Rebase maxillary partial denture	No
D5721	Rebase mandibular partial denture	No
D5750	Reline complete maxillary denture (laboratory) ▪ Allowed after one (1) year of initial fitting of a new denture ▪ Subsequent relines are limited to once every two (2) years	Yes

EPSDT Prosthodontics		
Code	**Description**	**PA Required?**
D5751	Reline complete mandibular denture (laboratory) ▪ Allowed after one (1) year of initial fitting of a new denture ▪ Subsequent relines are limited to once every two (2) years	Yes
D5760	Reline maxillary partial denture (laboratory) ▪ Allowed after one (1) year of initial fitting of a new denture ▪ Subsequent relines are limited to once every two (2) years	Yes
D5761	Reline mandibular partial denture (laboratory) ▪ Allowed after one (1) year of initial fitting of a new denture ▪ Subsequent relines are limited to once every two (2) years	Yes

- **Dentures**

Denture benefits allow recipients one (1) set of prosthetic appliances in any five (5) year period. Full dentures are defined as providing prosthetic replacement of all natural teeth. Partial dentures are defined as providing prosthetic replacement of teeth in partially edentulous individuals.

Partial Denture - Eligibility	Complete Denture – Eligibility
• Any missing anterior permanent teeth (incisors or canines) • Two (2) missing permanent first molars in an arch • Three (3) missing posterior permanent teeth in an arch • Two (2) adjacent missing posterior permanent teeth in an arch	▪ Replacement of all natural teeth

Note: Only permanent teeth (excluding missing third molars) are applicable when determining coverage for partial and full denture coverage.

Unilateral, free-saddle partials are not covered. Dentures are not covered, if a recipient already has dentures that may be adjusted and/or relined; the adjustment and realign may be covered.

Prior authorization must be submitted through the recipient's primary dentist. Denture coverage includes all office visits related to denture services, including dental visits associated with denture preparation and all denture adjustment visits for six (6) months after the delivery date. The date of delivery shall be used as the date of service for payment of denture(s).

Laboratory relines for dentures are allowed after one (1) year of initial fitting of a new denture and must be laboratory processed (in-office and other cold cure relines are not covered). A reline prior to the one (1) year initial fitting must be medically necessary and requires a prior authorization. Subsequent relines are limited to once every two (2) years.

14.8.7 Maxillofacial Prosthetics

EPSDT Maxillofacial Prosthetics		
Code	**Description**	**PA Required?**
D5925 through D5999	See specific codes in the CDT ▪ A report is required with the prior authorization and with the submission of a claim. ▪ Dental reviewed - for confirmation of completed procedure	Yes, with report

- **Maxillofacial Prosthetics**

Codes D5925 through D5999 require prior authorization and report. A report is also required at the time the claim is submitted

14.8.8 Oral & Maxillofacial Surgery

EPSDT Oral Surgery		
Code	**Description**	**PA Required?**
D7140	Simple extraction – erupted tooth or exposed root (elevation and/or forceps removal) ▪ One per lifetime ▪ Covered teeth- all primary and permanent	No
D7210	Surgical extraction – surgical removal of erupted tooth ▪ Requires elevation of mucoperiosteal flap and removal of bone and/or resection of tooth ▪ One per lifetime ▪ Covered teeth- all primary and permanent ▪ Requires a periapical or panoramic radiograph*	No
D7220	Soft tissue extraction – removal of impacted tooth ▪ Occlusal surface of tooth covered by soft tissue ▪ Requires mucoperiosteal flap elevation ▪ One per lifetime ▪ Covered teeth- all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7230	Partial bony impacted extraction ▪ Part of crown covered by bone ▪ Requires mucoperiosteal flap elevation and bone removal ▪ One per lifetime ▪ Covered teeth- all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No

EPSDT Oral Surgery		
Code	**Description**	**PA Required?**
D7240	Complete bony impacted extraction ▪ Most or all crown covered by bone ▪ Requires mucoperiosteal flap elevation and bone removal ▪ One per lifetime ▪ Covered teeth- all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7241	Complete bony impacted extraction – with unusual surgical complications ▪ Most or all crown covered by bone ▪ Usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position ▪ One per lifetime ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7250	Surgical removal of residual tooth roots - cutting procedure ▪ Includes cutting of soft tissue and bone ▪ Removal of tooth structure and closure ▪ Applicable to fistulas, not applicable to iatrogenic sinus exposure ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7260	Oro-anthral fistula closure ▪ Requires a periapical or panoramic radiograph ▪ Dental reviewed – for description of the procedure completed	No
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth ▪ 1 tooth per lifetime ▪ Covered teeth – 1 thru 32 ▪ Dental reviewed – for description of the procedure completed	No

EPSDT Oral Surgery		
Code	**Description**	**PA Required?**
D7280	Surgical access of an unerupted tooth (including orthodontic attachments) ▪ Limited to cases approved for orthodontic coverage ▪ Limited for teeth 2 thru 15, and 18 thru 31 Requires a periapical or panoramic radiograph	Yes
D7283	Placement of device to facilitate eruption of impacted tooth ▪ Limited to cases approved for orthodontic coverage ▪ Limited for teeth 2 thru 15, and 18 thru 31 ▪ Requires a periapical or panoramic radiograph	Yes
D7285	Biopsy of oral tissue-hard (bone, tooth) ▪ Requires the submission of a copy of the pathology report ▪ Dental reviewed – review of the pathology report	No
D7286	Biopsy of oral tissue-soft ▪ Requires the submission of a copy of the pathology report ▪ Not applicable to the routine removal of the peri-radicular inflammatory tissues ▪ Dental reviewed – review of the pathology report	No
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant ▪ 4 per day	Yes
D7311	Alveoloplasty in conjunction with extractions- one to three teeth or tooth spaces, per quadrant. ▪ 4 per day	Yes
D7320	Alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant ▪ 4 per day	Yes
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant ▪ 4 per day	Yes

EPSDT Oral Surgery		
Code	**Description**	**PA Required?**
D7410	Radical excision-lesion diameter up to 1.25 cm ▪ Dental reviewed – for description of the procedure completed	No
D7510	Incision and drainage of abscess-intraoral soft tissue ▪ Requires separate surgical procedure involving tissue incision and drain placement ▪ Covered teeth –A through T or 1 thru 32 ▪ Dental reviewed – for description of the procedure completed	No
D7960	Frenulectomy (frenectomy or frenotomy) separate procedures ▪ Once per lifetime ▪ Dental reviewed – for description of the procedure completed	No
D7970	Excision of hyperplastic tissue- per arch ▪ Dental reviewed – for description of the procedure and arch completed	No
D7971	Excision of pericornal gingival ▪ Dental reviewed – for description of the procedure and area completed	No

- **Oral Surgery**

Tooth extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection or peri-radicular radiographic evidence of defect.

Elective tooth extractions are not covered by Medicaid. "Elective Tooth Extraction" is the extraction of asymptomatic teeth, that is, teeth without symptoms and/or signs of pathology. It includes the removal of teeth for orthodontic purposes and the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molar (tooth numbers 1, 16, 17 and 32) in teens and young adults.

- **Extractions**

Coverage is limited to cases involving symptomatic teeth with clinical signs of pathology. Elective dental extractions are not covered, including extractions for orthodontic purposes and extractions of asymptomatic teeth without evidence of pathology (as in the case of a routine third molar removal in young adults).

*Periapical or panoramic radiograph(s) clearly showing the involved tooth/teeth must accompany the claim except for procedure code D7140. If the radiograph is not attached to the claim, the payment shall default to the simple extraction fee, D7140.

Alveoloplasty, D7310; D7311; D7320; D7321, is covered for children with prior authorization only.

14.8.9 Orthodontics

EPSDT Orthodontics		
Code	**Description**	**PA Required?**
D0330	Panoramic radiograph ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored.	Yes
D0340	Cephalometric radiograph ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored.	Yes
D8050	Interceptive orthodontic treatment of the primary dentition ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. ▪ Used for Phase I interceptive orthodontic treatment, inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation-problem focused (D0160), and braces if necessary.	Yes

EPSDT Orthodontics		
Code	**Description**	**PA Required?**
D8060	Interceptive orthodontic treatment of the transitional dentition ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. ▪ Used for Phase I interceptive orthodontic treatment, inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation-problem focused (D0160), and braces if necessary.	Yes
D8070	Comprehensive orthodontic treatment of the transitional dentition ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. ▪ Used for Phase II comprehensive orthodontic treatment, inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), and detailed and extensive oral evaluation-problem focused (D0160).	Yes
D8080	Comprehensive orthodontic treatment of the adolescent dentition ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. ▪ Used for Phase II comprehensive orthodontic treatment, inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), and detailed and extensive oral evaluation-problem focused (D0160).	Yes

EPSDT Orthodontics		
Code	**Description**	**PA Required?**
D8090	Comprehensive orthodontic treatment of the adult dentition ▪ Limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. ▪ Used for Phase II comprehensive orthodontic treatment, inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), and detailed and extensive oral evaluation-problem focused (D0160).	Yes

- **Orthodontics**

Coverage is limited to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing or chewing is restored. For cleft lip and palate clients, it is strongly recommended that they be evaluated and treated at the Kapiolani Children's Cleft and Cranial Facial Center (KCCCFC) during orthodontic treatment.

Orthodontic services require a prior authorization before the start of treatment. Include medical and dental diagnoses, treatment plan, anticipated treatment time and other relative information for treatment with the prior authorization request.

For interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment, the reimbursement fee is inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), and detailed and extensive oral evaluation – problem focused (D0160). Cephalometric (D0340) and panoramic (D0330) radiographs are reimbursed separate from the procedure codes identified above.

Providers are required to submit (to the third party administrator's Dental Consultant) clinical records documenting the completion of orthodontic treatment for Phase I (D8050 and D8060) and Phase II (D8070, D8080, and D8090) orthodontic procedures. During the course of treatment, KCCCFC will provide (to the Dental Consultant) periodic progress/treatment notes for each child undergoing Phase I or II treatment when applicable to client. If the client is not participating in KCCCFC, third party administrator may be requesting clinical records from the treating orthodontists or oral surgeons.

If a pre-orthodontic treatment visit (D8660) is completed and subsequent patient treatment was not implemented or started, D8660 is covered for reimbursement. In these cases, the provider is not reimbursed for interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment.

For orthodontic cases in which a client is being seen by a new provider (different provider than the one which initiated treatment for the client) to continue or complete treatment, reimbursement shall be made on a case to case basis.

Since payment is made in full at the beginning of the treatment, it is understood that the client will receive the complete treatment. Clinical records documenting completion must be submitted. Audits may be performed to verify that treatments are completed. Cases in which treatment is not completed will result is recoupment of funds.

14.8.10 Adjunctive General Services

EPSDT Adjunctive General Services		
Code	**Description**	**PA Required?**
D9110	Palliative Treatment/Palliative (emergency) treatment of dental pain-minor procedure ▪ Billable only once per visit regardless of the number of teeth treated, not covered if performed within14 days prior to completion date of D33XX. ▪ When submitting a claim, the provider shall document the nature of the emergency, the area of the oral cavity and/or teeth involved and the specific treatment involved ▪ Limited to one treatment per tooth per year	No
D9230	Analgesia, Anxiolysis, inhalation of nitrous oxide ▪ Limited to under 13 years old only and in conjunction with a treatment service, requires training through a formal post-graduate (accredited clinical specialty, residency and fellowship programs).	No
D9241	Intravenous sedation/analgesia-first 30 minutes ▪ See I.V Sedation section below for limitations ▪ Dental reviewed - see criteria below	No

EPSDT Adjunctive General Services		
Code	**Description**	**PA Required?**
D9242	Intravenous sedation/analgesia-each additional 15 minutes ▪ See I.V Sedation section below for limitations ▪ Dental reviewed - see criteria below	No
D9310	Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician ▪ Dental specialist billing the consultation code may provide treatment for which the consultation is obtained ▪ Limited to formally trained dental specialists. ▪ One per day ▪ Only Pedo, Oral, Endo specialties ▪ Dental reviewed – for referring provider	No
D9420	Hospital call ▪ One per day • Dental reviewed – reason for the hospital call	No
D9440	Office visit after regularly scheduled hours ▪ Only billable in conjunction with an emergency service. This code can only be used when the dentist is returning to the office for an unscheduled, emergency visit after the office has been closed for the day. ▪ Dental reviewed – office hours for the day of treatment and time of treatment	No
D9999	Unspecified adjunctive procedure, by report ▪ Used to cover children preventive/restorative benefits provided by FQHCs.	No

- **Consultations**

Code D9310 is limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist for a specific problem. The dental specialist billing the consultation code may provide the treatment for which the consultation is obtained. A written report of the consultation results must be returned to the referring dentist and documented in the patient's record. Not applicable for patients seen at long term care facilities.

- **Office Visit After Regularly Scheduled Hours**

  Code D9440 is only billable in conjunction with an emergency service. This code can only be used when the dentist is returning to the office for an un-scheduled emergency visit after the office has closed for the day. Emergency services performed during this visit may be billed separately. A narrative describing the circumstances must be included with the claim, including the time of day the service was performed.

- **Dental Services Requiring General Anesthesia being Performed in a Hospital Based Setting**

  General anesthesia ("GA") for dental services is only covered when administered in a hospital based setting and the following conditions are met:

  a) Prior authorization is obtained from the dental and medical plan (except for Urgent or Emergency Services). All providers requesting a prior authorization for GA, shall first submit the request to the third party administrator for review and approval. Upon approval for GA, the third party administrator will submit the prior authorization to the appropriate medical health plan for final review and approval;

  b) Dental services for an individual that cannot be safely performed in an office setting due to underlying medical conditions. This includes but are not limited to the following conditions:

     - developmental disabilities
     - mental retardation
     - cerebral palsy
     - autism
     - down syndrome
     - other types of medical conditions that may affect one's mental and/or physical capacities

     Or

     Dental services for an individual that cannot be safely performed in an office setting due to being extremely uncooperative, fearful, anxious, or physically resistant, and when extensive oral treatment is necessary and postponement of treatment can result in adverse affects upon patient's medical or dental condition

Or

Local anesthesia is ineffective or contraindicated for dental treatment of individual. This can be a result of an acute infection, allergy to local anesthesia, or anatomical variation

Or

Individuals who have sustained extensive orofacial or dental trauma for which treatment under local anesthesia would be ineffective or compromised; and

c) Dental treatment cannot be performed safely or effectively in an office using adjunctive techniques or modalities such as behavioral management techniques, protective stabilizations, medications, nitrous oxide or conscious sedation.

Supporting clinical documentation must be submitted with the prior authorization and include the following:

a) Medical diagnosis of patient;

b) Medical clearance by primary physician;

c) Narrative/report that clearly substantiates that medical/dental management of the patient requires that GA be used on patient to safely perform the dental procedure(s). This includes but are not limited to failed or contraindicated use of local anesthesia, nitrous oxide, conscious sedation, and/or protective stabilization on patient; and

d) A treatment plan itemizing a list of clinical procedures that will be performed under GA. If a provider cannot formulate a treatment plan based on patient's medical condition or behavior management issues, clinically justify the use of GA with dentistry in patient's case.

Note: GA approval does not purport that all services completed in the operating room will be covered; rather, services will require a prior authorization (PA) if known prior to treatment. A retro PA may be submitted for noncovered services not know prior to treatment. Noncovered services that are approved via PA or retro PA will be reimbursed but those that are not approved will not be reimbursed. If applicable, the provider should discuss with their patients that some dental procedures done during the operating time may not be covered by Medicaid.

- **Palliative Treatment**

  Code D9110 can only be billed once per visit regardless of the number of teeth treated, as described in CDT 2009/2010. Submit tooth numbers for each tooth that is treated and/or area of the oral cavity involved.

- **Emergency Treatment**

  Emergency services do not require prior authorization. Please refer to section 14.6 for directions on how to bill for these services.

- **Intravenous (IV) and Intramuscular (IM) Sedation Performed in the Office Setting**

  These services are covered when the following conditions are met:

  a) The patient's medical/dental condition is such that IV/IM sedation can be safely performed in the office setting.

  b) The medical/dental management of the patient requires that the patient be sedated to safely perform the dental procedure.

  c) Supporting clinical documentation must be submitted with the claim that clearly and legibly substantiates:

     1. That the patient is combative; or

     2. That the patient is uncooperative and that in the provider's judgment, the dental procedure cannot be performed safely without sedation.

  d) Supporting clinical documentation must be submitted with the claim and include all of the following:

     1. Medical history

     2. Sedation record

     3. Diagnosis

     4. Pre-surgical radiographs

5. Post-operative reports

- **Inhalation (Nitrous Oxide) Sedation Provided in the Office Setting**

  These services are covered when the following conditions are met:

  a) Providers must be deemed eligible to be reimbursed for nitrous oxide sedation. Eligibility is limited to dentists who have documented formal post-graduate training in the use of nitrous oxide. Training shall be consistent with that gained through an accredited post-graduate hospital-based residency or clinical specialty program.

  b) Inhalation sedation is limited to children under 13 years of age and as an adjunct to local anesthesia associated with oral surgery or operative dentistry.

     1. The child's medical/dental condition is such that inhalation sedation, oral surgery/operative dentistry can be safely performed in the office setting.

     2. The child must be able to correctly use the mask and inhale, and follow instructions of the dentist.

     3. Supporting documentation must be submitted with the claim that clearly and legibly substantiates that inhalation sedation is appropriate for the child.

  Supporting Documentation must be submitted with the claim and include all of the following:

     1. Brief statement justifying the medical need for use on the specific patient;

     2. Sedation record; and

     3. An itemized list of clinical procedures performed.

- ***Exclusions***

  Intravenous (IV) and Intramuscular (IM) Sedation performed in the office setting are not covered and not separately reimbursable in the following situations:

  a) IV/IM sedation is offered to patient or requested by the patient to lower anxiety.

  b) IV/IM sedation is primarily for patient comfort.

c) No supporting documentation for IV/IM sedation is submitted with the claim.

Inhalation (Nitrous Oxide) Sedation provided in the office setting is not covered and not separately reimbursable in the following situations:

a) The dentist has no formal post-graduate training in the administration of inhalation sedation.

b) The patient is over the age of 13.

c) When provided associated with diagnostic and/or preventative services
d) without oral surgery or operative dentistry.

14.9 ADULT DENTAL SERVICES (INDIVIDUALS OVER 20 YEARS OF AGE) FOR EMERGENCY TREATMENT

Individuals over 20 years of age are eligible for dental coverage limited to the treatment of dental emergencies. This program change became effective August 10, 2009. Adult dental benefits are restricted to a limited panel of services necessary for the control or relief of dental pain, elimination of infection of dental origin, management of trauma and/or treatment of acute injuries to teeth and supporting structures.

Services eligible for reimbursement are limited to basic diagnostic services associated with a recipient's emergent condition, chief complaint, and surgical intervention. Restorative dentistry and prosthetics are excluded.

14.9.1 Diagnostic

Adult Clinical Oral Evaluations		
Code	**Description**	**PA Required?**
D0140	Limited Oral Evaluation – problem focused ▪ Relating to a dental emergency, may not be used while patient undergoing comprehensive care ▪ May not be used more than once per day ▪ Third party administrator may require documentation of findings, diagnosis and treatment plan	No

Adult Radiographs/Diagnostic Imaging (Including Interpretation)		
Code	**Description**	**PA Required?**
D0220	Intraoral - peripapical 1st film ▪ One per day	No
D0230	Intraoral - peripapical each additional film ▪ Not to exceed 4 per day	No
D0330	Panoramic – film ▪ Allowed for certain clinical situations only ▪ Dental reviewed – see criteria below	No

- **Panoramic - film**

  An adult claim for D0330 may be reimbursed under the following clinical circumstances:

  - When a periapical (PA) radiograph is not practical for the following reasons:
    - Patient cannot sufficiently open mouth to take a PA.
    - PA cannot sufficiently record the necessary anatomy to diagnose dental condition for treatment
    - Teeth planned for extractions are in multiple quadrants and would not be practical to take multiple (5 or more) PAs.
    - Other circumstances deemed necessary by the Dental Consultant

  - In addition to the circumstances described above, Oral Surgeons and Queens Dental Clinic may be reimbursed for the following reasons:

    - One or more third molar extraction
    - Two or more extraction of teeth

14.9.2 Oral & Maxillofacial Surgery

Adult Oral Surgery		
Code	**Description**	**PA Required?**
D7140	Simple extraction – erupted tooth or exposed root (elevation and/or forceps removal) ▪ One per lifetime ▪ Covered teeth – all primary and permanent	No
D7210	Surgical extraction – surgical removal of erupted tooth ▪ Requires elevation of mucoperiosteal flap and removal of bone and/or resection of tooth ▪ One per lifetime ▪ Covered teeth – all primary and permanent ▪ Requires a periapical or panoramic radiograph*	No

Adult Oral Surgery		
Code	**Description**	**PA Required?**
D7220	Soft tissue extraction – removal of impacted tooth ▪ Occlusal surface of tooth covered by soft tissue ▪ Requires mucoperiosteal flap elevation ▪ One per lifetime ▪ Covered teeth – all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7230	Partial bony impacted extraction ▪ Part of crown covered by bone ▪ Requires mucoperiosteal flap elevation and bone removal ▪ One per lifetime ▪ Covered teeth – all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7240	Complete bony impacted extraction ▪ Most or all crown covered by bone ▪ Requires mucoperiosteal flap elevation and bone removal ▪ One per lifetime ▪ Covered teeth – all primary and permanent ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7241	Complete bony impacted extraction – with unusual surgical complications ▪ Most or all crown covered by bone ▪ Usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position ▪ One per lifetime ▪ Covered teeth – all primary and permanent ▪ Requires a periapical or panoramic radiograph*	No

Adult Oral Surgery		
Code	**Description**	**PA Required?**
	▪ Dental reviewed – for use of appropriate code for extraction	
D7250	Surgical removal of residual tooth roots - cutting procedure ▪ Includes cutting of soft tissue and bone ▪ Removal of tooth structure and closure ▪ Applicable to fistulas, not applicable to iatrogenic sinus exposure ▪ Requires a periapical or panoramic radiograph* ▪ Dental reviewed – for use of appropriate code for extraction	No
D7260	Oro-anthral fistula closure ▪ Requires a periapical or panoramic radiograph ▪ Dental reviewed – for description of the procedure completed	No
D7270	Tooth implantation and/or stabilization of accidentally evulsed or displaced tooth ▪ 1 tooth per lifetime ▪ Covered teeth – 1 thru 32 ▪ Dental reviewed – for description of the procedure completed	No
D7285	Biopsy of oral tissue-hard (bone, tooth) ▪ Requires the submission of a copy of the pathology report ▪ Dental reviewed – review of pathology report	No
D7286	Biopsy of oral tissue-soft ▪ Requires the submission of a copy of the pathology report ▪ Not applicable to the routine removal of the periradicular inflammatory tissues, by report ▪ Dental reviewed – review of pathology report	No

Adult Oral Surgery		
Code	**Description**	**PA Required?**
D7410	Radical excision-lesion diameter up to 1.25 cm ▪ Dental reviewed – for description of the procedure completed	No
D7510	Incision and drainage of abscess-intraoral soft tissue ▪ Requires separate surgical procedure involving tissue incision and drain placement ▪ Covered teeth –A through T or 1 thru 32 ▪ Dental reviewed – for description of the procedure completed	No
D7970	Excision of hyperplastic tissue- per arch ▪ Dental reviewed – for description of the procedure and arch completed	No
D7971	Excision of pericornal gingival ▪ Dental reviewed – for description of the procedure and area completed	No

14.9.3 Adjunctive General Services

Adult Adjunctive General Services		
Code	**Description**	**PA Required?**
D9110	Palliative Treatment/Palliative (emergency) treatment of dental pain-minor procedure ▪ Billable only once per visit regardless of the number of teeth treated, not covered if performed within 14 days prior to completion date of D33XX. ▪ When submitting a claim, the provider shall document the nature of the emergency, the area of the oral cavity and/or teeth involved and the specific treatment involved ▪ Limited to one treatment per tooth per year	No

Adult Adjunctive General Services		
Code	**Description**	**PA Required?**
D9241	Intravenous sedation/analgesia-first 30 minutes ▪ See I.V Sedation section above for limitations ▪ Dental reviewed – see criteria in Section 14.8.10	No
D9242	Intravenous sedation/analgesia-each additional 15 minutes ▪ See I.V Sedation section above for limitations ▪ Dental reviewed – see criteria in Section 14.8.10	No
D9310	Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician ▪ Dental specialist billing the consultation code may provide treatment for which the consultation is obtained ▪ Limited to formally trained dental specialists. ▪ One per day ▪ Only Pedo, Oral, Endo specialties ▪ Dental reviewed – for referring provider	No
D9420	Hospital call ▪ One per day ▪ Dental reviewed – reason for hospital call	No
D9440	Office visit after regularly scheduled hours ▪ only billable in conjunction with an emergency service. This code can only be used when the dentist is returning to the office for an un-scheduled, emergency visit after the office has been closed for the day. ▪ Dental reviewed – office hours for the day of treatment and time of treatment	No

- **Emergency Treatment**

  Emergency treatment may be charged once per tooth per benefit year. These services may control bleeding, relieve pain, eliminate acute infection, and/or treat injuries to the teeth or supporting structures. Examples of emergency services include:

a) Extractions

- No prior authorization required for the following procedure codes: D7140; D7210; D7220; D7230; D7240; D7241; D7250
- *Periapical or panoramic radiograph(s) clearly showing the involved tooth/teeth must accompany the claim except for procedure code D7140. If the radiograph is not attached to the claim, the payment shall default to the simple extraction fee, D7140.

b) Incision and drainage of abscesses

c) Excision of pericoronal gingiva

d) Surgical removal of residual tooth roots

e) Closure of oro-antral fistulas

f) Gingivectomy for gingival hyperplasia associated with medical conditions or treatment

g) Other medically necessary emergency dental services

Please refer to section 14.6 for information on how to bill for emergency services.