MEDICAID DENTAL PROGRAMS
CODING, POLICY AND RELATED FEE REVISION INFORMATION

Effective for dates of service on and after November 1, 2005, the following dental coding, policy and related fee revisions will apply. With exception to the specific revisions identified below, existing dental program policy for the applicable dental program still applies. The EPSDT Dental, Adult Denture and Expanded Dental Services for Pregnant Women (EDSPW) Program revised fee schedules are located at the following website: www.lamedicaid.com under the link entitled "Fee Schedules".

EPSDT DENTAL PROGRAM

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

D0150 – Comprehensive Oral Evaluation (New Patient)

Medicaid recognizes this code for a new patient only. A new patient is described as a patient 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 should 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 radiographs, 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 or periodic oral examination.

The dental provider should maintain a recall of the patient 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 patient was seen by this provider or another provider in the same office. An initial comprehensive oral examination (D0150) is limited to once per three years when performed by

the same billing provider or another Medicaid provider located in the same office as the billing provider.

D0350 – Oral / Facial photographic images

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

Oral / Facial Photographic Images are required when dental radiographs do not adequately indicate the necessity for the requested treatment in the following situations:
Buccal and lingual decalcification prior to crowning; prior to gingivectomy; prior to full mouth debridement; or with the presence of a fistula prior to retreatment of previous root canal 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.

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 per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be 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 per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

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 code D4355 (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).

D1203 – Topical Fluoride Treatment – (prophylaxis not included) – Child

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 should be provided to children less than 12 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D1204 - Topical Fluoride Treatment – (prophylaxis not included) – Adult

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 should be provided to children 12 through 15 years of age. This procedure is limited to once per year to the same billing provider or another Medicaid provider located in the same office as the billing provider.

D3310 - Root canal, anterior (excluding restoration)
D3320 - Root canal, bicuspid (excluding restoration)
D3330 - Root canal, molar (excluding restoration)

Complete root canal therapy (procedures D3310, D3320 and D3330) includes all appointments necessary to complete treatment and all intra-operative radiographs, which must include a post operative radiograph.

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. 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 radiographs, 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 radiographs do not indicate the need for a root canal, the provider must include a written statement as to why the root canal is necessary.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographs 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.

A lifetime maximum of six root canals is allowed in the entire mouth and will be allowed as follows:

- A lifetime maximum of two posterior root canals (D3320 or D3330) is allowed per recipient. Posterior root canals will be approved only when the tooth is in occlusion and will serve to stabilize the arch.

- A lifetime maximum of four anterior root canals (D3310) is allowed per recipient.

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.

The date of service on the payment request must reflect the final treatment date. Intraoperative 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 treatment record.

D3310 - Root canal, anterior (excluding restoration)
This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. 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 prior authorization or reimbursement for this procedure.

D3320 - Root canal, bicuspid (excluding restoration)
This procedure is reimbursable for Tooth Number 4, 5, 12, 13, 20, 21, 28 and 29. 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 prior authorization or reimbursement for this procedure.

D3330 - Root canal, molar (excluding restoration)
This procedure is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30 and 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 prior authorization or reimbursement for this procedure.

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 prior authorization. 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 should 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. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4341 - Periodontal scaling and root planing – <u>four or more teeth per quadrant</u>

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 prior authorization. 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 patients 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 prior authorization 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 Designator 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355 – Full mouth debridement to enable comprehensive evaluation and diagnosis

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.

<u>This service must be performed at the initial visit if this service is indicated</u>.

<u>No other dental services except examination, radiographs or oral /facial photographic images are reimbursable on the same date of service as full mouth debridement</u>. 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 radiographs 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 radiographs 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 patients when they last received a Medicaid covered prophylaxis (D1110 or D1120) 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 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 Prophy) or D1120 (Child Prophylaxis), whichever is applicable based on the patient's age.

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.

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

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

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

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

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

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

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.

Since this procedure no longer includes the placement of orthodontic attachment, the reimbursement for this procedure will be changed to $50.00 (fixed rate) effective for dates of service on and after November 1, 2005. Refer to the new procedure code D7283 below for information related to the orthodontic attachment.

This procedure requires prior authorization. All existing unused prior authorization approvals for procedure D7280 with an approval "thru" date beyond October 31, 2005 will be revised by the Dental Prior Authorization (PA) Unit in order to set the "thru" date to October 31, 2005. A revised prior authorization letter will be mailed to the recipient and provider.

Providers who have received a revised prior authorization approval for procedure code D7280 as mentioned above and who have not rendered the service prior to November 1, 2005 should submit a new request to the Dental PA Unit utilizing the proper code(s) which are effective for dates of service on and after November 1, 2005. Once a new prior authorization is issued and the service is rendered, the provider may then submit a claim for payment to Medicaid utilizing the new prior authorized codes.

Procedure Code D7280 is reimbursable for Tooth Numbers 2 through 15; and 18 through 31. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D7281 – Surgical exposure of impacted or unerupted tooth to aid eruption

This procedure code is discontinued and no longer payable effective for dates of service on and after November 1, 2005.

All existing unused prior authorization approvals for procedure D7281 with an approval "thru" date beyond October 31, 2005 will be revised by the Dental Prior Authorization (PA) Unit in

order to set the "thru" date to October 31, 2005. A revised prior authorization letter will be mailed to the recipient and provider.

Providers who have received a revised prior authorization approval for procedure code D7281 as mentioned above and who have not rendered the service prior to November 1, 2005 should submit a new request to the Dental PA Unit utilizing the proper code(s) which are effective for dates of service on and after November 1, 2005. Once a new prior authorization is issued and the service is rendered, the provider may then submit a claim for payment to Medicaid utilizing the new prior authorized codes.

D7283 – Placement of device to facilitate eruption of impacted tooth

This is a new CDT 2005 code and is being included by Medicaid as a reimbursable procedure effective for dates of service on and after November 1, 2005.

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 code requires prior authorization. Reimbursement for this procedure is $250.00 (fixed rate).

Procedure Code D7283 is reimbursable for Tooth Numbers 2 through 15; and 18 through 31. The appropriate tooth number must be identified in the "Tooth Number(s) or Letter(s)" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

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 should be submitted to the Prior Authorization Unit when requesting post authorization.

This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for these procedures.

ADULT DENTURE PROGRAM

There are no policy revisions related to the Adult Denture Program.

EXPANDED DENTAL SERVICES FOR PREGNANT WOMEN PROGRAM

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

D1110 – Prophylaxis – Adult

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

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

D4341 - Periodontal scaling and root planing – four or more teeth per quadrant

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

This procedure requires prior authorization. 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.

This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40. The appropriate oral cavity designator must be identified in the "Area of Oral Cavity" column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

D4355 – Full mouth debridement to enable comprehensive evaluation and diagnosis

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

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

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

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

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

Prior to requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new patients if they have received a Medicaid covered prophylaxis (D1110) during this pregnancy 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 a D1110 has not been reimbursed by Medicaid for this recipient during this pregnancy. If it is determined that a D1110 has been reimbursed by Medicaid for this recipient during this pregnancy, the recipient is not eligible for a D4355.

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

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

This procedure includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.

Radiograph(s), unless contraindicated, must be taken prior to this procedure (D7140).

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

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

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

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

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

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

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

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

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