

**CHAPTER 16**  
**DENTAL PROGRAM**

**CHAPTER CONTENTS**

**16.0 GENERAL GUIDELINES AND POLICY FOR DENTAL PROVIDERS..... 3**

16.1 PROVIDER ENROLLMENT AND PARTICIPATION GUIDELINES..... 3

    16.1.1 *Location and Service Limits of Practice (Applicable to Adult Dental Providers) .... 4*

    16.1.2 *Recipient Eligibility ..... 4*

    16.1.3 *Securing Recipients..... 5*

    16.1.4 *Picking and Choosing Recipients/Services..... 5*

    16.1.5 *Missed Appointments ..... 6*

    16.1.6 *CommunityCARE ..... 6*

    16.1.7 *Prior Authorization..... 6*

    16.1.8 *Payment for Services..... 11*

    16.1.9 *Third Party Payments ..... 12*

    16.1.10 *Interruption of Treatment ..... 12*

    16.1.11 *Record Keeping..... 13*

16.2 EPSDT DENTAL PROGRAM ..... 14

    16.2.1 *Initial Dental Screening and Annual Recall Visits ..... 14*

    16.2.2 *Subsequent Treatment Visits..... 15*

    16.2.3 *General Coding Information..... 15*

    16.2.4 *Tooth Numbering System and Oral Cavity Designators..... 15*

16.3 EPSDT DENTAL PROGRAM COVERED SERVICES ..... 16

    16.3.1 *Diagnostic Services..... 16*

    16.3.2 *Preventive Services ..... 21*

    16.3.3 *Restorative Services..... 24*

    16.3.4 *Endodontic Services..... 31*

    16.3.5 *Periodontal Services ..... 35*

    16.3.6 *Removable Prosthodontics..... 37*

    16.3.7 *Maxillofacial Prosthetics..... 44*

    16.3.8 *Fixed Prosthodontics ..... 45*

    16.3.9 *Oral and Maxillofacial Surgery Services ..... 46*

    16.3.10 *Orthodontic Services..... 52*

    16.3.11 *Adjunctive General Services..... 54*

16.4 NON-COVERED SERVICES ..... 60

16.5 ADULT DENTURE PROGRAM ..... 61

    16.5.1 *General Coding Information..... 61*

    16.5.2 *Tooth Numbering System and Oral Cavity Designators..... 61*

16.6 COVERED SERVICES ..... 62

    16.6.1 *Diagnostic Services..... 63*

    16.6.2 *Removable Prosthodontics..... 65*

**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

---

16.7 NON-COVERED SERVICES .....	71
APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE .....	73
APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE .....	88
APPENDIX C: CONSCIOUS SEDATION FORM/TMJ SUMMARY .....	91

## 16.0 GENERAL GUIDELINES AND POLICY FOR DENTAL PROVIDERS

### 16.1 PROVIDER ENROLLMENT AND PARTICIPATION GUIDELINES

**Providers should refer to Chapters 3 and 4 for more information about Provider Enrollment and Requirements including Standards for Participation.**

#### **General Information**

A dentist must enroll as a Louisiana Medicaid dental provider in order to receive reimbursement from the Medicaid Program for dental services performed on eligible Medicaid recipients. Individual dentists not enrolled in the Louisiana Medicaid program may not use the name and/or provider number of an enrolled dentist in order to bill Medicaid for services rendered.

#### **Dental Groups**

For Louisiana Medicaid purposes, a dental group consists of two or more dentists offering dental services to the Louisiana Medicaid recipient population. Dental groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid recipient.

Dental groups must complete an enrollment packet for the group, which includes information for the group as well as the individual dentists comprising the group.

When billing, the group must bill for services rendered by the individual providers using the group name and group provider number. On these claims, the individual dentist's provider number would be entered as the attending dentist on the claim form. The attending dentist must sign and date the claim form and provide his individual provider number on the signature line of the claim form. Dentists should use the American Dental Association claim form when billing Medicaid for services rendered.

A dentist, using his individual provider number, cannot bill the Louisiana Medicaid program for services rendered under a group that is enrolled in the Louisiana Medicaid program. If the group chooses not to enroll as a Louisiana Medicaid provider, the individual dentist must enroll and bill the Medicaid program for services performed in the group using the individual provider number.

#### **Individual Dentists**

The Louisiana Medicaid Program will assign only one provider number per individual provider type. For this reason, an individual dentist may have only one "Pay To" address regardless of the number of locations where individual services are rendered. For example, if an individual dentist practices at multiple locations, Medicaid payments will be sent to only one address for all services provided.

However, if an individual dentist practices with an enrolled group and maintains a private practice, the group must bill for services performed in the group setting and the individual dentist

must bill individual services rendered in the private practice. This is the only situation in which payment for services provided by one dentist would be made to more than one address. Payment would be made to the group at its address and to the individual dentist at the private address.

**ALL CHANGES OF ADDRESS, GROUP AFFILIATION, CONTRACT STATUS, ETC. MUST BE REPORTED IN WRITING TO:**

PROVIDER ENROLLMENT UNIT  
P. O. Box 80159  
Baton Rouge, LA 70898-0159

### **16.1.1 Location and Service Limits of Practice (Applicable to Adult Dental Providers)**

Adult Denture Program providers reimbursed under the Medicaid Program and conducting business at locations other than their principal place of practice shall provide the physical address and business telephone number of their principal place of practice to the Provider Enrollment Unit and the DHH dental consultants (LSU School of Dentistry). This address must be on file with the Louisiana State Board of Dentistry. Records documenting the services provided shall be maintained at this location. To be eligible for reimbursement under the Adult Denture Program, the service must be performed in either the parish where the provider's principal place of practice is located, any surrounding parish with a contiguous border of at least one mile, or any parish with a land border of at least one mile contiguous with those parishes.

Providers should be familiar with additional Louisiana State Board of Dentistry requirements concerning the delivery of dental services in locations other than private offices.

### **16.1.2 Recipient Eligibility**

#### *16.1.2.1 EPSDT Dental Program Eligibility*

The recipient is eligible for the EPSDT Dental Program if they are Medicaid eligible AND *under 21 years of age on the date of the service*. Please note that some categories of Medicaid, such as LaCHIP, end once the recipient reaches 19 years of age. It is the responsibility of the provider to verify recipient eligibility. The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. The recipient must be eligible for each date of service. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS.

#### *16.1.2.2 Adult Denture Program Eligibility*

The recipient may be eligible for the Adult Denture Program if they are Medicaid eligible, 21 years of age or older, AND missing all the teeth in the maxillary and/or mandibular arches. It is the responsibility of the provider to verify recipient eligibility. Recipient eligibility should be

verified prior to providing services to the patient. The recipient must be eligible for each date of service. The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS. Adult recipients who are certified for Medicaid in the “Medically Needy Program” (MNP) or as “Qualified Medicare Beneficiary Only” (QMB Only) are NOT eligible to receive services in the Adult Denture Program. These recipients can be identified using MEVS or REVS.

**NOTE: Procedures for verifying recipient eligibility by way of the REVS and MEVS systems are given in Chapter 2, Section 2.2.1 and Section 2.2.2.**

### **16.1.3 Securing Recipients**

EPSDT and LaCHIP recipients are encouraged to obtain an annual oral examination, and if needed, subsequent treatment. A recipient may elect to contact a participating dentist of their choice directly or have KIDMED, the Louisiana Medicaid Early and Periodic Screening, Diagnosis and Treatment Program, make the initial appointment. The KIDMED office maintains a database of participating providers. A recipient or provider needing a participating provider for purposes of making a referral may contact the KIDMED office by calling 1-877-455-9955.

Eligible adult recipients who are in need of denture services should schedule an appointment with a participating provider. It is the responsibility of the recipient to choose a participating dental provider and to schedule appointments.

It is a violation of the **Louisiana Dental Practice Act** and the **Louisiana Medicaid Program Integrity Act** to solicit or subsidize anyone by paying or presenting any person, money or anything of value for the purpose of securing recipients. Providers, however, may use lawful advertising that abides by rules and regulations of the Louisiana State Board of Dentistry regarding advertising by dentists. Any provider found to be in violation shall be reported to the Louisiana State Board of Dentistry.

### **16.1.4 Picking and Choosing Recipients/Services**

Providers have the option of picking and choosing from which patients they will accept Medicaid. Providers are not required to accept every Medicaid patient requiring treatment. Providers shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by the provider as a Medicaid patient. This policy prohibits Medicaid providers from “picking and choosing” the services for which they agree to accept reimbursement from Medicaid. Providers must accept Medicaid reimbursement as payment in full for all services covered by Medicaid.

A Medicaid provider cannot limit his practice to diagnostic and preventive services only. A Medicaid dental provider must offer the same services to a Medicaid recipient as those offered to a non-Medicaid recipient, provided these services are reimbursable by the Medicaid program.

### 16.1.5 Missed Appointments

Providers cannot charge recipients for missed/failed appointments. See Chapter 3, Section 3.2, “STANDARDS FOR PROVIDER PARTICIPATION” for complete listing of provider’s responsibilities.

### 16.1.6 CommunityCARE

Dental services billed on the ADA claim form using Medicaid-covered dental procedure codes are exempt from CommunityCARE referrals. **Services billed on a CMS -1500 claim form, or other claim forms, using CPT procedure codes are subject to the CommunityCARE referral process, including those billed by a dentist/oral surgeon; or a facility related to the provision of services, e.g. outpatient hospital facility.** For additional information regarding CommunityCARE, please refer to Chapter 5 of this manual.

### 16.1.7 Prior Authorization

Requests for prior authorization (PA) are made on the ADA claim form, the same claim form used for billing. Providers should complete the ADA Claim Form for prior authorization following the instructions found in Chapter 7 (E), Claims Filing chapter. When requesting prior authorization, two identical copies of the ADA form must be submitted with the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs should be attached to each request for authorization. The dental consultants at the LSU School of Dentistry will return all requests for prior authorization that do not have adequate information or radiographs necessary to make the authorization determination. If radiographs are contraindicated or unobtainable the reason must be stated in the “Remarks” section of the claim forms submitted for prior authorization and documented in the treatment record as well.

Please staple together all claim forms and radiographs for a single recipient.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the patient record and provide that information to the Prior Authorization Unit.

For ease of billing it is preferable to group services requiring authorization on a single claim form so that only one Prior Authorization Number need be issued per recipient.

EPSDT Dental Program procedure codes, which conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature, are provided in Appendix A. **The procedure codes for services requiring prior authorization are marked with an asterisk (\*)** and must be authorized by the dental consultants at the LSU School of Dentistry before payment will be made.

All Adult Denture Program services (except for repairs) require prior authorization. Adult Denture Program procedure codes, which conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature, are provided in Appendix B. The procedure codes for services requiring prior authorization are marked with an asterisk (\*) and must be authorized by the dental consultants at the LSU School of Dentistry before payment will be made.

It is the provider's responsibility to utilize the appropriate procedure code in a request for prior authorization. Prior authorization of a requested service does not constitute approval of the fee indicated by the provider.

When requesting prior authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for the dental consultants reviewing the case to fully understand the general dental health and condition of the recipient for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the "Remarks" section of the claim form. If the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be certain it includes the date of the request, the recipient's name, the recipient's Medicaid ID #, the provider's name and the provider's Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record. Without the complete treatment plan, appropriate radiographs, or explanations it may not be possible for the consultant to approve isolated services.

At the completion of the review one of the following will occur:

- 1) A copy of the claim form and the radiographs will be returned to the provider (at the address listed on the claim form) and the other copy will be retained by the Medicaid Dental Prior Authorization Unit. Unisys will send a prior authorization letter to the provider detailing those services that have been prior authorized. A prior authorization number will be furnished on the prior authorization letter to allow the provider to bill for services as they are completed. The

recipient also receives a copy of the prior authorization letter. An example of a PA Letter can be found on page 16-10. The returned copy of the claim form and the prior authorization letter must be filed in the patient's treatment record.

2) In some cases both copies of the claim form (and radiographs) may be returned requesting additional radiographs, additional information or with questions or suggestions concerning the proposed treatment. These cases have not been approved or denied. In order to complete the prior authorization process, they must be returned to the dental consultants with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the "Remarks" section of the claim form.

3) In other cases, the copy of the claim form and radiographs returned to the provider will have denied services lined out, a maximum fee stated, the number of requested services decreased, or other changes. In these cases, Unisys will send a prior authorization letter to the provider detailing those services that have been prior authorized and list any denied services along with an explanation of those denials. A prior authorization number will be furnished to allow the provider to bill for services as they are completed. The recipient also receives a copy of the prior authorization letter and in the case of a denial, the explanation of denied benefits will advise them of their appeal rights. The returned copy of the claim form and the prior authorization letter must be filed in the patient's treatment record.

Please be certain that both copies of the claim form submitted for prior authorization are identical so that the provider will have accurate copy in the patient's treatment record.

The dental consultants review the dental prior authorization requests in an expedient manner. However, some requests are held over for additional consultation. All Adult Denture Program prior authorization requests require a minimum of two weeks to process.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within two weeks (three weeks for Adults) time should alert the provider that the claim form might have been misdirected. In these instances, please contact the dental consultants at the LSU School of Dentistry. If the claim form is returned to the provider but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the LSU School of Dentistry. All contacts with the LSU School of Dentistry must be documented in the patient's record.

To amend or request reconsideration of a prior authorization, the provider should submit a copy of the Prior Authorization letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single Prior Authorization Letter should match the services originally requested on a single page of the claim submitted for prior authorization. Requests for additional treatment must be submitted as a new



**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

---

claim for which a new prior authorization will be issued. For administrative changes only, e.g. provider number or recipient number corrections, date of service changes, etc., a copy of the PA Letter with the requested changes noted, may be sufficient.

If the provider proceeds with treatment before receiving prior authorization, the provider should consider that the request may not be authorized for services rendered. However, providers may provide and bill for services that do not require prior authorization while they are awaiting prior authorization of those services that do.

Prior authorization is not a guarantee of recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization of services becomes void.

All prior authorization requests should be sent to:

**LSU School of Dentistry  
Dental Medicaid Program  
1100 Florida Avenue, Box F5-510  
New Orleans, LA 70119**

A sample of a PA letter appears below:

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
P O BOX 91030, BATON ROUGE, LOUISIANA 70821-9030

DATE 04/01/2003                      RECIPIENT NAME xxxxxx    xxxxx  
PRIOR AUTH. NBR 999999999    RECIPIENT NUMBER 999999999999

xxxxxxxxxx    xxxxx    xxxxx \*  
xxxx xxxxxxxxx  
xxxxxxxxxxxxxx    xx 99999

PROVIDER NUMBER 9999999

DEAR PROVIDER,

THIS LETTER IS TO CONFIRM THAT THE REQUEST FOR PRIOR AUTHORIZATION OF DENTAL SERVICES FOR ABOVE NAMED PATIENT HAS BEEN PROCESSED AS INDICATED BELOW.

PROCEDURE	UVS	AMOUNT	DATES OF SERVICE	STATUS
D2930-STAINLESS STEEL CROWN	2	.00	01/01/2003-01/01/2004	APPROVED
D3310-ROOT CANAL 1 CANAL	1	.00	01/01/2003-01/01/2004	DENIED -460

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,  
460 – ROOT CANAL DENIED BECAUSE OF MISSING TEETH

IF FURTHER CLARIFICATION IS NEEDED, CONTACT LSU SCHOOL OF DENTISTRY,  
DENTAL PRIOR AUTHORIZATION UNIT AT 504-619-8589.

THIS AUTHORIZATION IS NOT A GUARANTEE OF RECIPIENT MEDICAID ELIGIBILITY. PAYMENT ON A CLAIM WILL ONLY BE MADE WHEN THE CLAIM IS BILLED CORRECTLY AND ALL CONDITIONS FOR PAYMENT ARE MET.

ALL CLAIMS FOR COMMUNITY CARE RECIPIENTS MUST HAVE APPROPRIATE REFERRALS TO BE PAID.

SINCERELY,  
BUREAU OF HEALTH SERVICES FINANCING

### **16.1.8 Payment for Services**

The date of service on a claim for payment must reflect the date the service is completed/delivered. For example, a crown, a space maintainer, a complete denture, a partial denture, a restoration, root canal, etc. must be completed/delivered (placed in the recipient's mouth) by the provider before payment can be requested.

Providers are to bill their usual and customary charge when billing for covered services. However, payment is based on the lower of the provider's charge or the established Medicaid fee for the procedure.

Providers cannot provide a service that has a defined CDT procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

Medicaid reimbursement is payment in full. A recipient cannot be required to pay a co-payment for Medicaid covered dental services. Also, the recipient should not be billed for any Medicaid covered services. It is the responsibility of the provider to follow up with Medicaid regarding any reimbursement issues. The provider should contact Unisys Provider Relations should there be questions regarding Medicaid reimbursement.

Payment on a claim will only be made when the claim is billed correctly and all conditions for payment are met.

A claim form submitted for payment cannot contain more than one PA Number.

Multiple claim forms can be submitted in the same envelope, however, please do not include EPSDT Dental Program claim forms and Adult Denture Program claim forms in the same envelope.

Please submit all claims for payment to:

**Unisys  
P. O. Box 91022  
Baton Rouge, LA 70821**

Note: Refer to Chapter 7 (E) of this manual for complete information regarding claims filing.

### 16.1.9 Third Party Payments

Please refer to Chapter 2, Section 2.2.6 and Chapter 7, Section 7.3 of this manual for third party information. Questions regarding Dental third party payments can be directed to the LSU School of Dentistry, Medicaid Dental Prior Authorization Unit by calling (504) 619-8589.

### 16.1.10 Interruption of Treatment

The interruption of treatment guidelines apply to codes D5110, D5120, D5211, D5212, D5213 and D5214 ONLY. No other codes are eligible for payment under the interruption of treatment guidelines.

A provider must make every effort to deliver the denture. The provider must document all attempts to deliver the denture and the reasons the denture was not delivered in the recipient's dental treatment record.

If due to circumstances beyond the provider's control, the recipient discontinues treatment, or loses eligibility during the course of the construction of a denture qualified under the interruption of treatment guidelines, the provider should not bill Medicaid using the procedure code as originally prior authorized. As the original procedure has not been completed, the case must be resubmitted to the prior authorization unit at LSU so the prior authorization number can be reissued the proper procedure code relating to the service attempted. The provider will then be able to bill Medicaid for that portion of the treatment that has been completed using the reissued procedure code and prior authorization number.

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

For purposes of determining the amount the provider will be paid for interrupted services, the denture fabrication process is divided into four stages:

1. Impressions (initial impression, construction of custom dental impression tray and final impressions)
2. Bite registration (wax try-in with denture teeth)
3. Processing
4. Delivery

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to the dental consultants. If treatment is interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made. If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to the dental

consultants. If treatment is interrupted after completion of Stage 3 (Processing), 75% of the Medicaid reimbursement fee will be paid upon submission of the denture to the dental consultants.

For further information concerning billing of interrupted services, providers may contact the dental consultants at the following address:

**LSU School of Dentistry  
Dental Medicaid Program  
1100 Florida Avenue, Box F5-510  
New Orleans, LA 70119  
504-619-8589 (voice)  
504-619-8560 (fax)**

#### **16.1.11 Record Keeping**

State law and Medicaid regulations require that all services provided under the EPSDT dental program are documented. Services not adequately documented are considered not to have been delivered. Providers are required to maintain radiographs, and treatment records of all appointments that should reflect all procedures performed on those appointments. For services provided to recipients under the EPSDT Dental Program and Adult Denture program, records and radiographs must be maintained for at least five years. It is strongly suggested that the Adult Denture Provider maintain records for seven years as the program allows for the provision of prosthetics once every seven years. Failure to produce these records on demand by the Medicaid program or its authorized designee will result in sanctions against the provider.

Records must include a detailed charting of the oral condition that is updated on each visit and a chronological (dated) narrative account of each patient visit indicating what services were provided or what conditions were present on those visits. Also included in the recipient's record are copies of all claim forms submitted for prior authorization including any attachments, all PA Letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs would constitute examples of additional supporting documentation.

A check off list of codes and services billed is insufficient documentation.

The claim forms or copies of the claim forms submitted for reimbursement are not considered sufficient to document the delivery of services; however these items must be maintained in the patient's dental treatment record.

Since dental records are legal documents, providers should be familiar with additional Louisiana State Board of Dentistry requirements in the area of record keeping and of delivery of dental services in locations other than private offices.

## **16.2 EPSDT DENTAL PROGRAM**

Federal regulations found at 42CFR 440.40 and 42CFR 440.50 describe the services including dental care required for children under the age of 21. The fiscal intermediary provider relations staff can answer questions regarding policy and claims processing. LSU School of Dentistry, under contract to the Bureau, provides dental prior authorization services and consultation on dental policy.

Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid established guidelines, limitations and/or policies are not exceeded.

Providers are not allowed to provide services to a Medicaid recipient beyond the intent of Medicaid guidelines, limitations and/or policies for the purpose of maximizing payments or circumventing Medicaid guidelines, limitations and/or policies. If this practice is detected, Medicaid will apply sanctions.

### **16.2.1 Initial Dental Screening and Annual Recall Visits**

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

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

Bitewing radiographs;

Prophylaxis, including oral hygiene instructions; and,

Topical fluoride application (under 16 years of age)

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

The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), bitewing radiographs (D0272), and topical fluoride application

(D1203 or D1204) is limited to once per year when performed by the same billing provider or another Medicaid provider in the same office as the billing provider.

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

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

### **16.2.2 Subsequent Treatment Visits**

Subsequent visits should be scheduled by the dentist to correct the dental defects that were found during the initial examination. If no subsequent visit is required, the bitewing radiographs, prophylaxis, and fluoride must be provided at the initial visit. If subsequent treatment is required, these diagnostic and preventive services must be provided at the first treatment visit if they were not provided at the initial visit.

### **16.2.3 General Coding Information**

The EPSDT Dental Program Fee Schedule, a complete list of Medicaid-covered procedure codes, can be found in Appendix A of this manual. These codes conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care.

### **16.2.4 Tooth Numbering System and Oral Cavity Designators**

Specific tooth numbers/letters and/or oral cavity designators may be required when requesting Medicaid prior authorization or reimbursement for certain procedure codes. Services requiring specific tooth numbers/letters and/or oral cavity designators are identified in the dental services manual and in Appendix A.

Medicaid uses Tooth Numbers 1 through 32 and A through T when identifying specific teeth. Certain Oral Surgery procedure codes may be billed for Supernumerary Teeth. The Supernumerary teeth are identified with Tooth Numbers 51 through 82 and AS through TS as per ADA policy. Only one tooth number or letter is allowed per claim line.

The following ADA oral cavity designators are used to report areas of the oral cavity:

00 – entire oral cavity

ISSUE DATE

MAY 1, 2003

REVISION DATE

MAY 1, 2003

01 – maxillary area

02 – mandibular area

03 – upper right sextant

04 – upper anterior sextant

05 – upper left sextant

06 – lower left sextant

07 – lower anterior sextant

08 – lower right sextant

10 – upper right quadrant

20 – upper left quadrant

30 – lower left quadrant

40 – lower right quadrant.

Only one oral cavity designator is allowed per claim line.

### 16.3 EPSDT DENTAL PROGRAM COVERED SERVICES

The dental services that are covered under the EPSDT Dental Program are divided into eleven categories: Diagnostic Services, Preventive Services, Restorative Services, Endodontic Services, Periodontal Services, Removable Prosthodontics, Maxillofacial Prosthetics, Fixed Prosthodontics, Oral and Maxillofacial Surgery Services, Orthodontic Services, and Adjunctive General Services. **Services that require prior authorization are identified by an asterisk {\*}. Services requiring prior authorization in certain situations only are identified with an underlined asterisk {\*}.**

#### 16.3.1 Diagnostic Services

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

#### Codes

D0120	Periodic Oral Examination (established patient)
D0150	Comprehensive Oral Examination (new patient)
D0210*	Intraoral – complete series (including bitewings)
D0220	Intraoral – periapical first film
D0230	Intraoral – periapical each additional film (maximum of 4)
D0240*	Intraoral – occlusal film
D0272	Bitewings – two films
D0330*	Panoramic Film



- D0350 Oral / Facial Images**  
**D0470\* Diagnostic Casts**  
**D0473\* Accession of tissue, gross and microscopic examination, preparation and transmission of written report**  
**D0474\* Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report**

### *16.3.1.1 Examinations*

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

#### **Codes**

#### **D0120 Periodic Oral Examination (Established Patient)**

#### **D0150 Comprehensive Oral Examination (New Patient)**

An initial comprehensive oral examination (D0150) or periodic oral examination (D0120) is limited to once per year when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

#### **D0120 Periodic Oral Examination (Established Patient)**

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

The periodic 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).

#### **D0150 Comprehensive Oral Examination (New Patient)**

For Medicaid billing, this code will be used for an oral examination for a new patient only. A new patient is described as a patient that has not been seen by this provider for at least two 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 or periodic 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).

#### *16.3.1.2 Radiographs (X-Rays)*

##### **Codes**

- D0210\*** Intraoral – complete series (including bitewings)
- D0220** Intraoral – periapical first film
- D0230** Intraoral – periapical each additional film (maximum of 4)
- D0240\*** Intraoral – occlusal film
- D0272** Bitewings – two films
- D0330\*** Panoramic Film
- D0350** Oral / Facial Images

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

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

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

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

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

**D0210\* Intraoral – complete series (including bitewings)**

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

Two cavity-detecting (bitewing) radiographs, and six periapical radiographs, for recipients who are six years of age or younger.

Two cavity-detecting (bitewing) radiographs, and 10 periapical radiographs, for recipients age 7 through age 13.

Two cavity-detecting (bitewing) radiographs, and 14 periapical radiographs, for recipients who are age 14 or older.

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

If a full mouth x-ray (D0210) is billed within 180 days (6 months) of bitewing x-rays (D0272), the fee for the full mouth x-ray will be cutback by the amount of the fee for the bitewing x-rays. If bitewing x-rays (D0272) are billed within 180 days (6 months) of a full mouth x-ray (D0210), the bitewing x-rays (D0272) will be cutback to \$0.

**D0220 Intraoral – periapical first film**

**D0230 Intraoral – periapical each additional film**

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

Under the following circumstances periapical radiographs must be taken, or written documentation as to why the radiograph(s) was (were) contraindicated must be in the patient's record:

- An anterior crown or crown buildup is anticipated; or
- Posterior root canal therapy is anticipated (root canal working and final fill films are included in the fees for endodontic treatment); or
- Anterior root canal therapy is anticipated (both maxillary and mandibular anterior films) (root canal working and final fill films are included in the fees for endodontic treatment); or

- Prior to any tooth extraction.

These radiographs are reimbursable for and must be associated with a specific unextracted Tooth Number 1 through 32 or Letter A through T. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

**D0240\* Intraoral – occlusal film**

A #2 size film taken in an occlusal orientation will be considered an anterior periapical radiograph for payment. The fee for an occlusal radiograph will be paid only when a true occlusal film (2" x 3") is used to evaluate the maxillary or mandibular arch. The actual occlusal radiograph must be sent with the prior authorization request for an occlusal film. This radiograph is reimbursable for Oral Cavity designators 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

**D0272 Bitewings – two films**

Bitewing radiographs are required at the comprehensive and periodic oral examinations on all recipients and are limited to one set per year to the same billing provider or another Medicaid provider located in the same office as the billing provider. If radiographs cannot be obtained, a narrative explaining the reason why they could not be taken must be documented both in the recipient’s record as well as in the remarks section on any claims submitted for prior authorization.

**D0330\* Panoramic film**

Panoramic radiographs are not indicated and will be considered insufficient for diagnosis in periodontics, endodontics, and restorative dentistry and it will not be reimbursed. The dental consultants may request the actual panoramic radiograph before a prior authorization request can be completed. Panoramic radiographs are reimbursable for oral and maxillofacial surgery and orthodontic services.

**D0350 Oral/Facial Images**

Oral / Facial images (photographs) 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; or
- Soft tissue biopsy; or
- Prior to gingivectomy.

The provider should bill Medicaid for oral/facial 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.

### *16.3.1.3 Other Diagnostic Services*

**D0470\* Diagnostic Casts**

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

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

**D0470\* Diagnostic Casts**

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

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

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

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

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

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

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

### **16.3.2 Preventive Services**

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

**Codes**

<b>D1110</b>	<b>Adult Prophylaxis</b>
<b>D1120</b>	<b>Child Prophylaxis</b>
<b>D1203</b>	<b>Topical Fluoride Treatment - Child</b>
<b>D1204</b>	<b>Topical Fluoride Treatment – Adult</b>
<b>D1351</b>	<b>Sealants</b>
<b>D1510*</b>	<b>Unilateral Space Maintainer</b>
<b>D1515*</b>	<b>Bilateral Space Maintainer</b>
<b>D1550</b>	<b>Recementation of Space Maintainer</b>

*16.3.2.1 Prophylaxis*

**D1110 Adult Prophylaxis**

Adult prophylaxis for children 12 years of age and older includes removal of calculus on the teeth, removal of acquired stains, and polishing of the teeth. 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.

**D1120 Child Prophylaxis**

Child prophylaxis for children under 12 years of age includes minor scaling of the teeth and removal of acquired stains. 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.

*16.3.2.2 Fluoride Treatment*

**D1203 Topical Fluoride Treatment (prophylaxis not included) - child**

Topical fluoride treatment should be provided to recipients less than 12 years of age. Fluoride must be applied separately from prophylaxis paste. 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**

Topical fluoride treatment should be provided to recipients 12 through 15 years of age. Fluoride must be applied separately from prophylaxis paste. 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.

*16.3.2.3 Sealants*

**D1351 Sealants – per tooth**

A sealant is a mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are limited to six- and twelve-year molars only. They are further limited to one application per tooth per lifetime by the same billing provider or another Medicaid provider located in the same office as the billing provider.

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

This procedure is reimbursable for tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 only. The appropriate tooth number must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

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

#### *16.3.2.4 Space Maintenance*

##### **D1510\* Space maintainer – fixed - unilateral**

##### **D1515\* Space maintainer – fixed – bilateral**

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

Procedure Code D1510 is reimbursable for Oral Cavity areas 10, 20, 30, and 40. Procedure Code D1515 is reimbursable for Oral Cavity areas 01 and 02. The appropriate oral cavity area must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for this procedure.

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

##### **D1550 Recementation of Space Maintainer**

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

This procedure does not require authorization and is limited to one recementation per tooth, per lifetime.

This procedure is reimbursable for Oral Cavity areas 01, 02, 10, 20, 30 and 40. The appropriate oral cavity area must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for this procedure.

### **16.3.3 Restorative Services**

Restorative services for teeth that can be restored include: amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, pins, core build-ups, and pre-fabricated posts and cores.

#### **Codes**

<b>D2140</b>	<b>Amalgam – one surface, primary or permanent</b>
<b>D2150</b>	<b>Amalgam – two surfaces, primary or permanent</b>
<b>D2160</b>	<b>Amalgam – three surfaces, primary or permanent</b>
<b>D2161</b>	<b>Amalgam – four or more surfaces, permanent</b>
<b>D2330</b>	<b>Resin-based composite, one surface, anterior</b>
<b>D2331</b>	<b>Resin-based composite, two surfaces, anterior</b>
<b>D2332</b>	<b>Resin-based composite, three surfaces, anterior</b>
<b>D2335*</b>	<b>Resin-based composite – four or more surfaces or involving incisal angle (anterior)</b>
<b>D2390*</b>	<b>Resin-based composite crown, anterior</b>
<b>D2920</b>	<b>Re-cement crown</b>
<b>D2930*</b>	<b>Prefabricated Stainless Steel Crown – primary tooth</b>
<b>D2931*</b>	<b>Prefabricated Stainless Steel Crown – permanent tooth</b>
<b>D2932*</b>	<b>Prefabricated Resin Crown (Primary and Permanent teeth)</b>
<b>D2950*</b>	<b>Core Buildup, including any pins, in addition to crown</b>
<b>D2951</b>	<b>Pin retention – per tooth, in addition to restoration</b>
<b>D2954*</b>	<b>Prefabricated post in addition to crown</b>
<b>D2999*</b>	<b>Unspecified Restorative Procedure, by report</b>

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

The surfaces that may be billed as restored can be any one or combination of five of the seven recognized tooth surfaces: **mesial**, **distal**, **occlusal** (or **incisal**), **lingual**, or **facial** (or **buccal**). The original billing provider is responsible for the replacement of the original restoration within the first twelve months after initial placement.



No restoration of any type will be payable for deciduous central or lateral incisor teeth for recipients who have reached their fourth birthday.

Laboratory processed crowns are not covered.

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

*16.3.3.1 Amalgam Restorations (including polishing)*

**Codes**

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

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations. Procedure code D2161 is not payable for primary teeth.

Duplicate surfaces are not payable on the same tooth in amalgam restorations.

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

The fee for any additional restorative service(s) on the same tooth will be cutback to the maximum fee for the combined number of non-duplicated surfaces when performed within a 12-month period.

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

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

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

The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

### *16.3.3.2 Resin-Based Composite Restorations - Direct*

#### **Codes**

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

Posterior composite restorations are not reimbursable under the guidelines of Medicaid of Louisiana. Providers cannot provide a service that has a defined CDT procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

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

All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration. If the tooth is decayed extensively, a crown should be considered.

The resin-based composite – four or more surfaces or involving incisal angle (D2335) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle. To receive reimbursement for a restoration

involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two D2332 restorations would not adequately restore the tooth or in cases where two D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Number 6 through 11, 22 through 27, and Tooth Letter C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.

The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

#### *16.3.3.3 Non-Laboratory Crowns*

##### **Codes**

- D2930\*** Prefabricated Stainless Steel Crown – primary tooth
- D2931\*** Prefabricated Stainless Steel Crown – permanent tooth
- D2932\*** Prefabricated Resin Crown (Primary and Permanent teeth)

Neither stainless steel crowns (D2930) nor prefabricated resin crowns (D2932) are payable on primary central or lateral incisors after the 4<sup>th</sup> birthday.

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

1. Teeth B, I, L, S (1<sup>st</sup> primary molars {D’s}) for recipients 8 years of age and older; and
2. Teeth A, C, H, J, K, M, R, T (primary canines {C’s} and primary second molars {E’s}) for recipients 9 years of age and older.

Procedure codes D2930, D2931 and D2932 represent final restorations. If a non-laboratory crown is required within the first 12 months after a tooth is restored with amalgam or resin, e.g. fracture of the tooth, pulpal necrosis, etc., the reason why the tooth requires additional restoration must be documented in the recipient’s treatment record and in the “Remarks” section of the claim form submitted for prior authorization.

If in the opinion of the dental consultants, other conventional chair-side types of restoration such as complex amalgams and composite resins are unsuitable, non-laboratory or chair-side full coverage restorations such as stainless steel or polycarbonate crowns are available.

**D2930\* Prefabricated Stainless Steel Crown – primary tooth**

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

- 1) extensive caries;
- 2) significant, observable cervical decalcification;
- 3) significant, observable developmental defects, such as hypoplasia and hypocalcification.

Additional indications are:

- 4) following pulpotomy or pulpectomy;
- 5) restoring a primary tooth that is to be used as an abutment for a space maintainer; or,
- 6) fractured teeth.

A stainless steel crown may be placed on a posterior primary tooth that exhibits radiographically observable interproximal caries that penetrates into the dentin and extends beyond the line angles, when failure of other available restorative materials is likely to occur prior to the natural shedding of the tooth. Small interproximal caries that do not extend beyond line angles in an otherwise intact and non-decalcified tooth should be restored with conventional 2- and 3-surface amalgam alloys.

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

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

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

In order to aid providers during a record review to substantiate decalcifications and hypoplasia that may not be readily apparent on radiographs, photographs or other imaging media that depict the decalcification and hypoplasia are required and must be available for post-payment review.

If post-payment review discovers a practice of crowning teeth that do not conform to these stated guidelines, the providers may be sanctioned and money may be recouped.

Procedure code D2930 is reimbursable for Tooth Letters A through T. However, this procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. Prior Authorization for procedure code D2930 is required only for Tooth Letters B, I, L, and S for recipients 8 years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for recipients 9 years of age and older. 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.

**D2931\* Prefabricated Stainless Steel Crown – permanent tooth**

This procedure is reimbursable for Tooth Number 1 through 32. 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.

**D2932\* Prefabricated Resin Crown (Primary and Permanent teeth)**

This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. 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.

16.3.3.4 Other Restorative Services

**Codes**

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

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

**D2920 Re-cement crown**

The billing provider is responsible for recementation within the first 12 months after placement of the crown. This procedure does not require authorization and is limited to one recementation per tooth, per lifetime.

This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letter A through T. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

**D2950\* Core Build-Up, including any pins, in addition to crown**

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

This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

**D2951 Pin retention – per tooth, in addition to restoration**

Reimbursement for pins is limited to one per tooth, per lifetime and may only be billed in conjunction with the complex restoration codes D2160 or D2161. This procedure is reimbursable for Tooth Number 2 through 5; 12 through 15; 18 through 21; and 28 through 31. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

**D2954\* Prefabricated Post and core in addition to crown**

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

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

**D2999\* Unspecified Restorative Procedure, by report**

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

**16.3.4 Endodontic Services**

Endodontic services include those services listed below.

**Codes**

- D3110 Pulp Cap – direct (excluding final restoration)**
- D3220\* Therapeutic pulpotomy (excluding final restoration)**
- D3240\* Pulpal therapy (resorbable filling), pulpectomy – posterior, primary tooth**
- D3310\* Anterior (excluding final restoration)**
- D3320\* Bicuspid (excluding final restoration)**
- D3330\* Molar (excluding final restoration)**
- D3352\* Apexification (excluding root canal)**
- D3410\* Apicoectomy**
- D3430\* Retrograde Filling**
- D3999\* Unspecified Endodontic procedure, by report**

#### 16.3.4.1 Pulp Capping

##### **D3110 Pulp Cap – direct (excluding final restoration)**

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

This procedure is reimbursable for Tooth Number 1 through 32. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

#### 16.3.4.2 Pulpotomy

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

This service is defined as the surgical removal of the coronal portion of the pulp and completely filling the pulp chamber with a restorative material. It should not be applied to primary teeth where the roots show signs of advanced resorption (more than two-thirds of the root structure is resorbed), where there are radiographic signs of infection in the surrounding bone, or where there is mobility on clinical evaluation. Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.

In the case of a permanent tooth, prior authorization is required and will only be authorized in the case of immature teeth with incomplete root closure where the pulpotomy will allow for completion of root formation with apical closure.

This procedure is reimbursable for Tooth Number 1 through 32. 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.

#### 16.3.4.3 Endodontic Therapy on Primary Teeth

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

The Medicaid program provides for the endodontic treatment of posterior second primary molars (A, J, K or T) requiring complete extirpation of all pulpal material and filling with a resorbable filling material. This procedure is not payable on primary incisors, cuspids and first primary molars. If the endodontic pathology on these teeth cannot be treated with a pulpotomy, then extraction and space maintenance may be indicated.



Authorization will be limited to a primary second molar in an arch (maxillary or mandibular), when the first permanent molar has not erupted and when a pulpectomy will eliminate the necessity for extraction and the placement of a distal shoe space maintainer. A pulpectomy will not be approved in cases where the primary roots are more than half resorbed or when the 6-year-molar has erupted.

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

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

*16.3.4.4 Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)*

- 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 includes 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. 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. Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider, the request for prior authorization will be returned to the provider requesting additional information. Specific treatment plans for final restoration of the tooth must be submitted.

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

- A lifetime limit of one posterior root canal therapy can be reimbursed per side of the mouth (right or left). Posterior root canals will be approved only when the occlusion of that half of the arch is stable and extraction would result in destabilization.
- A lifetime maximum of four anterior root canal therapies limited to a maximum of three in either arch can be reimbursed.

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

*16.3.4.5 Apexification/Recalcification Procedure*

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

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

This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)”

column of the ADA Claim Form when requesting prior authorization or reimbursement for this procedure.

#### *16.3.4.6 Apicoectomy/Periradicular Services*

##### **D3410\* Apicoectomy/ periradicular surgery – anterior**

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

This procedure is reimbursable for Tooth 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.

##### **D3430\* Retrograde filling**

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

This procedure is reimbursable for Tooth 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.

#### *16.3.4.7 Other Endodontic Procedures*

##### **D3999\* Unspecified Endodontic Procedure, by report**

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

### **16.3.5 Periodontal Services**

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

#### **Codes**

##### **D4210\* Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth**

- spaces per quadrant
- D4341\*** Periodontal scaling and root planning, per quadrant
- D4355\*** Full mouth debridement
- D4999\*** Unspecified periodontal procedure, by report

*16.3.5.1 Surgical Periodontal Services*

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

A gingivectomy may be approved 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.

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.

*16.3.5.2 Non-surgical Periodontal Services*

**D4341\* Periodontal scaling and Root Planing – four or more contiguous teeth or bounded teeth spaces per quadrant**

Radiographic evidence of large amounts of supra and/or 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. 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**

This service should be requested when an adult prophylaxis is not sufficient to reestablish good gingival health and when deep scaling with curettage is not indicated. When requesting prior authorization, bitewing radiographs must be submitted that supply evidence of posterior subgingival calculus in two or more quadrants.

Only one Full Mouth Debridement is allowed per visit and it cannot be performed on the same date of service as an adult prophylaxis (D1110) or a child prophylaxis (D1120).

*16.3.5.3 Other Periodontal Services*

**D4999\* Unspecified Periodontal Procedure, by report**

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

**16.3.6 Removable Prosthodontics**

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

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

**Minimum Standards for Complete and Partial Denture Prosthodontics**

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

- The providers are required to obtain patient esthetic acceptance prior to processing. This acceptance should be documented by the patient’s signature in the treatment record.

- The denture should be flaked and processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient's treatment record.
  
- Upon delivery:
  - The denture bases should be stable on the lower and retentive on the upper.
  - The clasping should be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the patient (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion should be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and aesthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

### **Denture Identification Information**

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

- the first four letters of the recipient's last name and first initial; and
- the month and year (00/00) the denture was processed; and
- the last five digits of provider's Medicaid ID number.

#### *16.3.6.1 Complete Dentures*

##### **Codes**

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

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

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

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

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be prior authorized. Radiographs should confirm that no more than six teeth remain; or if more than 6 teeth remain, the attending dentist must certify by statement in the "Remarks" section that six or fewer teeth will remain when the final impression is taken.

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

#### *16.3.6.2 Partial Dentures*

**Codes**

- D5211\*** Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
- D5212\*** Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
- D5213\*** Maxillary cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5214\*** Mandibular cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5820\*** Interim partial denture (maxillary) – Includes any necessary clasps and rests.
- D5821\*** Interim partial denture (mandibular) – Includes any necessary clasps and rests.

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

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider should use the following symbols in Block 34 of the ADA claim form to indicate tooth status. “X” will be used to identify missing teeth and “/” will be used to identify teeth to be extracted.

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

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

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

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

The overall condition of the mouth is an important consideration in whether or not a partial denture is authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. On those recipients requiring extensive



restorations, periodontal services, extractions, etc. post-treatment radiographs may be requested prior to approval of a partial denture.

Medicaid may provide an acrylic interim partial denture in the following cases:

- Missing one maxillary permanent anterior tooth, or
- Missing two maxillary permanent anterior teeth, or
- Missing three or more permanent teeth in the same arch (of which at least one must be anterior) while in the mixed dentition or adolescent stages of eruption.

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

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

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

### *16.3.6.3 Denture Repairs*

#### **Codes**

- D5510**    **Repair broken complete denture base**  
**D5520**    **Replace missing or broken tooth – complete denture – per tooth**  
**D5610**    **Repair resin partial denture base**  
**D5630**    **Repair or replace broken clasp**  
**D5640**    **Replace missing or broken tooth – partial denture – per tooth**

**D5650 Add tooth to existing partial denture – per tooth**

**D5660 Add clasp to existing partial denture**

Reimbursement for repairs of complete and partial dentures are allowed only if more than one year has elapsed since denture insertion by the same billing provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture.

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

A total of \$125.00 in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient is allowed within a single one-year period for a single billing provider.

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designator 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

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

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

Procedures D5520, D5640 and D5650 are reimbursable for Tooth Number 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 reimbursement for this procedure.

Procedure Codes D5630 and D5660 are 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 reimbursement for these procedures. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient's treatment record.
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.
- The prosthesis must be finished in a workmanlike manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.
- The treatment record must specifically identify the location and extent of the breakage.

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

#### *16.3.6.4 Denture Relines*

##### **Codes**

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

Reimbursement for complete and partial denture relines are allowed only if one year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in a five-year period as prior authorized by Bureau or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five years. Chair-side relines (cold cure acrylics) are not reimbursable.

Minimal procedural requirements for reline services include the following:

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

- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.
- Relines must be flaked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a workmanlike manner; they must be clean; they must exhibit a high gloss; and they must be free of voids, scratches, abrasions, and rough spots.
- The denture must be fitted and adjusted for comfort and function.

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

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

#### *16.3.6.5 Other Removable Prosthodontics*

##### **D5899\* Unspecified removable prosthodontic procedure, by report**

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

#### **16.3.7 Maxillofacial Prosthetics**

##### **D5986\* Fluoride Gel Carrier**

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

This service requires prior authorization and is only available for recipients who are undergoing or who have undergone head and neck radiation therapy. Reimbursement for the fluoride gel carrier is limited to three per lifetime per arch.

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

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

### 16.3.8 Fixed Prosthodontics

#### Codes

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

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

- The patient must be at least 16 years-old.
- The abutment teeth must be caries free and restoration-free and have sound periodontal support.
- No other maxillary teeth are missing or require extraction.
- Providers must submit with the request for prior authorization periapical radiographs of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed.
- On the tooth number chart on the ADA form, “X” out the missing tooth.

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

Only one Maryland-type bridge can be authorized for a recipient per lifetime.

#### *16.3.8.1 Fixed Partial Denture Pontic*

**D6241\* Pontic – porcelain fused to predominantly base metal**

This code is only reimbursable when submitted in conjunction with code D6545. Procedure code D6241 is limited to one per recipient, per lifetime.

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

#### *16.3.8.2 Fixed Partial Denture Retainer*

##### **D6545\* Retainer – cast metal for resin bonded fixed prosthetics**

This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two per recipient, per lifetime.

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

#### *16.3.8.3 Other Fixed Partial Denture Services*

##### **D6999\* Unspecified, fixed prosthodontic procedure, by report**

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

### **16.3.9 Oral and Maxillofacial Surgery Services**

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

Note: Dental providers who are qualified to bill for services using the Current Physician’s Terminology (CPT) codes, may bill for certain non-dental oral surgery services using the CPT codes which are covered under the Physician’s Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Physician’s Program. Refer to the Oral and Maxillofacial Surgery Program section of the 1995 Dental Services Manual for specific details.

#### **Codes**

- D7140**     **Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**
- D7210\***   **Surgical removal of erupted tooth**
- D7220\***   **Removal of impacted tooth – soft tissue**
- D7230\***   **Removal of impacted tooth - partial bony**
- D7240\***   **Removal of impacted tooth - full bony**
- D7241\***   **Removal of impacted tooth - Completely Bony, with unusual surgical complications**

ISSUE DATE

MAY 1, 2003

REVISION DATE

MAY 1, 2003

- D7250\*** Surgical removal of residual tooth roots (cutting procedure)
- D7270\*** Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
- D7280\*** Surgical access of an unerupted tooth
- D7281\*** Surgical exposure of impacted or unerupted tooth to aid eruption
- D7285\*** Biopsy of oral tissue – hard (bone, tooth)
- D7286\*** Biopsy of oral tissue – soft (all others)
- D7291\*** Transseptal fiberotomy/supra crestal fiberotomy, by report
- D7310\*** Alveoloplasty, in conjunction with extractions – per quadrant
- D7510** Incision and drainage of abscess – intraoral soft tissue
- D7880\*** Occlusal orthotic device, by report
- D7910** Suture of recent small wound up to 5 cm
- D7960\*** Frenulectomy (frenectomy or frenotomy) – separate procedure
- D7999\*** Unspecified oral surgery procedure, by report

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

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

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

The fee for any extraction (D7210 through D7241) performed on the same tooth which previously received a surgical exposure of impacted or unerupted tooth to aid eruption (D7281) will be cut back to the maximum fee for the extraction. The fee for code D7140 performed on the same tooth which previously received a surgical exposure of impacted or unerupted tooth to aid eruption (D7281) will be paid at \$0 since the fee for D7281 exceeds the maximum fee for the extraction.

Procedure codes D7140, D7210, D7220, D7230, D7240, D7241, and D7250 are reimbursable for Tooth Number 1 through 32 and A through T. ADA codes for Supernumerary Teeth 51 through 82 and AS through TS should be used when needed. The appropriate tooth number or letter must be identified in the “Tooth Number(s) or Letter(s)” column of the ADA Claim Form when requesting reimbursement for this procedure.

#### *16.3.9.1 Non-surgical Extractions*

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

Includes routine removal of tooth structure and closure, as necessary. This code should be used for all routine extractions as well as uncomplicated root tip removal

*16.3.9.2 Surgical Extractions*

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

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

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

If the radiographic evidence does not clearly demonstrate the need for the cutting of gingiva and removal of bone or tooth structure the prior authorization request will be returned unprocessed. After the tooth is removed, the provider may resubmit the prior authorization request (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 and the radiographs which will be used by the dental consultants in the authorization determination.

**D7220\* Removal of impacted tooth - Soft Tissue**

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

**D7230\* Removal of impacted tooth - Partial Bony**

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

**D7240\* Removal of impacted tooth - Complete or Full Bony**

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

**D7241\* Removal of impacted tooth - Completely Bony, with unusual surgical complications**

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

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



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

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

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

*16.3.9.3 Other Surgical Procedures*

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

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

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

**D7280\* Surgical access of an unerupted tooth**

This procedure includes an incision, the reflection of tissue, the removal of bone as necessary to expose the crown. This procedure includes the placement of any orthodontic attachment(s) to facilitate eruption.

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

Procedure Code D7280 is reimbursable for Tooth Number 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 includes the reflection of dense fibrous tissue and the removal of any overlying bone from an impacted or unerupted tooth. This procedure is available in cases of delayed eruption. This procedure is not available for third molars or in other cases where extraction is indicated.

This procedure is reimbursable for Tooth Number 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.

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

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

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

**D7286\* Biopsy of oral tissue – soft (all others)**

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

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.

**D7291\* Transseptal fiberotomy/supra crestal fiberotomy, by report**

This procedure is only reimbursable in conjunction with a Medicaid-approved comprehensive orthodontic treatment plan and reimbursement is limited to one per lifetime per arch.

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

*16.3.9.4 Alveoloplasty*

**D7310\* Alveoloplasty in conjunction with extractions - Per Quadrant**

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

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

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

*16.3.9.5 Surgical Incision*

**D7510 Incision and Drainage of abscess – intraoral soft tissue**

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

This procedure is reimbursable for Tooth Number 1 through 32. 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

*16.3.9.6 Temporomandibular Joint (TMJ) Procedure*

**D7880\* Occlusal orthotic device, by report**

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

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

The request for prior authorization must include a completed TMJ Summary Form; a copy of this form must be retained in the patient’s treatment record. The TMJ Summary Form must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. A copy of the TMJ Summary Form may be found in Appendix C.

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

*16.3.9.7 Other Repair Procedures*

**D7960\* Frenulectomy (frenectomy or frenotomy) – separate procedure**

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

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

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

**D7999\* Unspecified oral surgical procedure, by report**

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

**16.3.10 Orthodontic Services**

**Codes**

- D8050\* Interceptive orthodontic treatment of the primary dentition**
- D8060\* Interceptive orthodontic treatment of the transitional dentition**
- D8070\* Comprehensive orthodontic treatment of the transitional dentition**
- D8080\* Comprehensive orthodontic treatment of the adolescent dentition**
- D8090\* Comprehensive orthodontic treatment of the adult dentition**
- D8220\* Fixed appliance therapy**
- D8999\* Unspecified orthodontic procedure, by report**

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

*16.3.10.1 Interceptive Orthodontic Treatment*

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

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

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

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

*16.3.10.2 Comprehensive Orthodontic Treatment*

**D8070\* Comprehensive orthodontic treatment of the transitional dentition**

**D8080\* Comprehensive orthodontic treatment of the adolescent dentition**

**D8090\* Comprehensive orthodontic treatment of the adult dentition**

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

Recipients, who only have crowded dentitions (crooked teeth), excessive spacing between teeth, or having horizontal/vertical (overjet/overbite) discrepancies, are not eligible to receive comprehensive orthodontic treatment.

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

Comprehensive orthodontic treatment is provided only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy, or other craniofacial deformities that result in a physically handicapping malocclusion.

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

The request for prior authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, the prior authorization unit will authorize a maximum of three units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (total maximum allowable fee for all units is \$2,500.00).

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

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

In order for the provider to be reimbursed for the services, the recipient must be Medicaid-eligible on each of the individual dates of service.

#### *16.3.10.3 Minor Treatment To Control Harmful Habits*

##### **D8220\* Fixed appliance therapy**

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

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

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

#### *16.3.10.4 Other Orthodontic Services*

##### **D8999\* Unspecified orthodontic procedure, by report**

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

### **16.3.11 Adjunctive General Services**

#### **Codes**

**D9110 Palliative (emergency) treatment of dental pain - minor procedure**

**D9230 Analgesia, anxiolysis, inhalation of nitrous oxide**

**D9241\* Intravenous conscious sedation/analgesia – first 30 minutes**

**D9242\* Intravenous conscious sedation/analgesia – each additional 15 minutes**

**D9248\* Non-intravenous conscious sedation**

**D9420\* Hospital call**

**D9440\* Office visit – after regularly scheduled hours**

**D9920\* Patient Management**

**D9940\* Occlusal Guard, by report**

**D9951\* Occlusal Adjustment – limited**  
**D9999\* Unspecified adjunctive procedure, by report**

*16.3.11.1 Palliative (Emergency) Treatment*

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

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

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

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

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

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

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

If root canal therapy is anticipated and the provider has not already obtained bitewing radiographs, bitewing radiographs should be taken for inclusion with the request for prior authorization of the root canal, in addition to any periapical radiographs taken for diagnosis of the affected tooth.

*16.3.11.2 Anesthesia*

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

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

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

**D9241\* Intravenous conscious sedation/analgesia – first 30 minutes**

**D9242\* Intravenous conscious sedation/analgesia – each additional 15 minutes**

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

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

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

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

**D9248\* Non-intravenous conscious sedation**

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



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

This service is only reimbursable for children with behavioral problems under the age of 6 or for older children who are physically or mentally handicapped.

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

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

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

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

### *16.3.11.3 Professional Visits*

#### **D9420\* Hospital call**

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

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

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

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

section. The request for prior authorization must outline the entire treatment plan with the hospital code listed first or last on one of the pages.

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

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

**D9440 \* Office Visit – after regularly scheduled hours**

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

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

*16.3.11.4 Miscellaneous Services*

**D9920\* Behavior Management**

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

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

Behavior management is reimbursable for recipients below the age of eight, unless documentation indicates that the recipient is physically or mentally handicapped. The particular handicap and its impact on the delivery of dental treatment in the office setting must be stated in the "Remarks" section in the request for prior authorization.

Providers must indicate on the request for prior authorization which dental treatment services are scheduled to be delivered at each treatment visit for which a management fee is requested. Behavior management is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed.

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

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

**D9940\* Occlusal Guard, by report**

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

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

The request for prior authorization must include a completed TMJ summary form; a copy of this form must be retained in the patient's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. A copy of the TMJ Summary Form may be found in Appendix C.

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

**D9951\* Occlusal Adjustment – limited**

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

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

The request for prior authorization must include a completed TMJ summary form; a copy of this form must be retained in the patient's treatment record. Indicate whether the condition is acute

or chronic and if any other services are to be provided. A copy of the TMJ Summary Form may be found in Appendix C.

**D9999\* Unspecified adjunctive procedure, by report**

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

### **16.4 NON-COVERED SERVICES**

Non-covered services include but are not limited to the following:

- Procedure codes not included in Appendix A of this manual
- Plaque control
- Routine post-operative services (these services are covered as part of the fee for the initial treatment provided)
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- General anesthesia
- Administration of in-office pre-medication

## **16.5 ADULT DENTURE PROGRAM**

Federal regulations found at 42CFR 440.120 describe the services which may be furnished at the states option. The fiscal intermediary's provider relations staff can answer questions regarding policy and claims processing. LSU School of Dentistry, under contract to the Bureau, provides dental prior authorization services and consultation on dental policy.

Providers enrolled as a group or individual providers who are not enrolled as a group but are located in the same office as another Medicaid provider are responsible for checking office records to assure that Medicaid established guidelines, limitations, and/or policies are not exceeded.

Providers are not allowed to provide services to a Medicaid recipient beyond the intent of Medicaid guidelines, limitations and/or policies for the purpose of maximizing payments or circumventing Medicaid guidelines, limitations, and/or policies. If this practice is detected, Medicaid will apply sanctions.

### **16.5.1 General Coding Information**

The Adult Denture Program Fee Schedule, a complete list of Medicaid covered procedure codes, can be found in Appendix B of this manual. These codes conform to the American Dental Association (ADA) Code on Dental Procedures and Nomenclature.

### **16.5.2 Tooth Numbering System and Oral Cavity Designators**

Specific tooth numbers/letters and/or oral cavity designators may be required when requesting Medicaid prior authorization or reimbursement for certain procedure codes. Services requiring specific tooth numbers/letters and/or oral cavity designators are identified in the dental services manual and in Appendix B.

Medicaid uses Tooth Numbers 1 through 32 and A through T when identifying specific teeth. Certain Oral Surgery procedure codes may be billed for Supernumerary Teeth. The Supernumerary teeth are identified with Tooth Numbers 51 through 82 and AS through TS as per ADA policy. Only one tooth number or letter is allowed per claim line.

The following ADA oral cavity designators are used to report areas of the oral cavity:

00 – entire oral cavity  
01 – maxillary area  
02 – mandibular area

03 – upper right sextant  
04 – upper anterior sextant

05 – upper left sextant  
06 – lower left sextant  
07 – lower anterior sextant  
08 – lower right sextant

10 – upper right quadrant  
20 – upper left quadrant  
30 – lower left quadrant  
40 – lower right quadrant.

Only one oral cavity designator is allowed per claim line.

## **16.6 COVERED SERVICES**

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

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

- Examination (only in conjunction with denture construction)
- Radiographs (only in conjunction with denture construction)
- Complete dentures
- Denture relines
- Denture repairs
- Acrylic partial dentures (only in conjunction with an opposing full denture).

Although similar services are available under the EPSDT Dental Program, different program guidelines apply to the Adult Denture Program.

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

## 16.6.1 Diagnostic Services

### 16.6.1.1 Examination

#### Code

#### **D0150 Comprehensive oral examination - new or established patient**

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

Reimbursement for this procedure code requires that radiographs be taken and submitted with the request for prior authorization. The comprehensive oral examination can only be prior authorized in conjunction with the appropriate radiographs. Procedure code D0150 should be entered on the first line of the Dental Claim Form followed on the second line by the procedure code for radiographs D0210.

Any request that does not have the required number/type of radiographs attached will be denied. The request for Prior Authorization must also include all of the other Adult Denture Program procedures scheduled for the recipient.

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

#### **Examinations in Anticipation of Denture Construction**

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

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

#### **Minimum Examination Requirements for the Clinical Examination**

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

#### **Examination of Ineligible Recipients**

If the recipient is not eligible for Medicaid denture services or if the provider perceives that the recipient does not require a complete denture; e.g. the recipient does not have an edentulous

arch; the provider should not continue with the examination or take radiographs. In addition, the provider should not submit a claim for authorization or for payment of the examination code D0150 or the code for radiographs.

#### **Examination in Conjunction with a Denture Repair**

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

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

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

#### *16.6.1.2 Radiographs*

#### **D0210\* Intraoral – complete series**

A complete series consisting of:

- Minimum of five mounted periapical radiographs of each edentulous or partially edentulous arch for which a prosthesis is requested (three periapical radiographs if the arch does not require a prosthesis); or,
- An occlusal film (only for an edentulous arch); or,
- A Panoramic radiograph

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

Poor radiographs (or radiographic images) that are not of diagnostic quality will be denied. As the comprehensive oral examination can only be prior authorized in conjunction with the appropriate radiographs, the comprehensive oral examination will also be denied.

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



### **16.6.2 Removable Prosthodontics**

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

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

#### **Minimum Standards for Complete and Partial Denture Prosthetics**

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

- The providers are required to obtain patient esthetic acceptance prior to processing. This acceptance should be documented by the patient's signature in the treatment record.
- The denture should be flaked and processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient's treatment record.
- Upon delivery:
  - The denture bases should be stable on the lower and retentive on the upper.
  - The clasping should be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the patient (not over or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion should be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and aesthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

### **Denture Identification Information**

All full and partial dentures reimbursed under the Medicaid Adult Denture Program must have the following unique identification information processed into the acrylic base:

- The first four letters of the recipient's last name and first initial; and
- The month and year (mm/yy) the denture was processed; and
- The last five digits of provider's Medicaid ID number.

#### *16.6.2.1 Complete Dentures*

### **Codes**

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

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

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

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

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be prior authorized. Radiographs should confirm that no more than six teeth remain; or if more than 6 teeth remain, the attending dentist must certify by statement in the “Remarks” section that six or fewer teeth will remain when the final impression is taken.

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

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

#### *16.6.2.2 Partial Dentures*

- D5211\*** Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)  
**D5212\*** Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)

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

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

- Missing two or more maxillary anterior teeth; or
- Missing three or more mandibular anterior teeth; or
- Missing at least four posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion.

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

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

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. On the tooth number chart on the ADA form, “X” out missing teeth, “/” out teeth to be extracted or if only a few teeth are present “O” teeth that are to be retained when the partial is delivered. The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

### *16.6.2.3 Denture Repairs*

#### **Codes**

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

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

Reimbursement for repairs of complete and partial dentures are allowed only if more than one year has elapsed since denture insertion by the same billing provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture unit.

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

A total of \$125.00 in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same recipient is allowed within a single one-year period for the same billing provider (or another Medicaid-enrolled provider located in the same office as the requesting provider).

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designator 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

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

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

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

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designator 10, 20, 30, and 40. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the patient’s treatment record.
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.
- The prosthesis must be finished in a workmanlike manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.
- The treatment record must specifically identify the location and extent of the breakage.

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

*16.6.2.4 Denture Relines*

**Codes**

- D5750\* Reline complete maxillary Denture - Laboratory Reline**
- D5751\* Reline complete mandibular Denture - Laboratory Reline**
- D5760\* Reline maxillary Partial denture - Laboratory Reline**
- D5761\* Reline mandibular Partial denture - Laboratory Reline**

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

A combination of two complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in a seven-year period as prior authorized by BHSF or its designee. The seven-year period begins from the date the previous complete or partial denture for the same arch was delivered.

Reimbursement for complete and partial denture relines are allowed only if one year has elapsed since the previous complete or partial denture was constructed or last relined.

If the same billing provider (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture for the same arch within one year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in a seven-year period as prior authorized by the Bureau or its designee. Reline of existing dentures must be given priority over the construction of new dentures if the reline will result in a serviceable denture for at least seven years. Chair-side relines (cold cure acrylics) are not reimbursable.

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material.
- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.
- Relines must be flaked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a workmanlike manner; they must be clean; they must

exhibit a high gloss; and they must be free of voids, scratches, abrasions, and rough spots.

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

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

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

#### *16.6.2.5 Other Removable Prosthodontics*

#### **D5899\* Unspecified removable prosthodontic procedure, by report**

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

### **16.7 NON-COVERED SERVICES**

Non-covered services in the Adult Denture Program are any codes not listed in the Adult Denture Program fee schedule located in Appendix B of this manual.

**NOTE: Dental providers may request compensation for certain services using the Current Physician's Terminology (CPT) codes which are covered under the Physician's Program when these services are rendered to Medicaid recipients who are eligible for services provided in the Physician's Program. Refer to the Oral and Maxillofacial Surgery Program section of the 1995 Dental Services manual.**

---

**APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE**

Provided in the table on the following pages are the reimbursable dental procedure codes and fees for the Medicaid of Louisiana, EPSDT Dental Program.

All procedures listed in the EPSDT Dental Program Fee Schedule are subject to the guidelines, policies and limitations of the Medicaid of Louisiana, EPSDT Dental Program. Please refer to the EPSDT Dental Program section of the Dental Services Manual for complete guidelines, policies and limitations for each procedure.

All services marked with an asterisk (\*) in the code column require prior authorization.

All services marked with an underscored asterisk (\*) in the code column requires partial prior authorization. Prior authorization requirements for these procedures are based on tooth number or age of recipient.

All services marked with a number sign (#) in the code column for the EPSDT Dental Program require a tooth number or letter to be specified on the claim form for payment requests and prior authorization requests if required.

All services marked with a plus sign (+) in the code column for the EPSDT Dental Program require an oral cavity designator to be specified on the claim form for payment requests and prior authorization requests if required.

Fees marked with a check mark (✓) in the fee column denotes fee for permanent tooth.

All fees marked with 5 asterisks (\*\*\*\*\* ) in the fee column will be priced manually by the dental consultant.



**EPSDT DENTAL PROGRAM FEE SCHEDULE**

<b>EPSDT DENTAL PROGRAM DIAGNOSTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
<b>D0120</b>	Periodic Oral Examination – Patient of Record	16.00
D0150	Comprehensive Oral Examination – New Patient Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 2 years) only.	16.00
*D0210	Radiographs – Complete Series (including bitewings)	35.00
#D0220	Radiograph – Periapical, First Film This procedure is reimbursable for Tooth Number 1 through 32; and Tooth Letter A through T.	6.00
#D0230	Radiograph – Periapical, Each Additional Film This procedure is reimbursable for Tooth Number 1 through 32; and Tooth Letter A through T.	5.00
+*D0240	Radiograph – Occlusal Film This procedure is reimbursable for Oral Cavity Designator 01 and 02.	10.00
D0272	Radiograph – Bitewings, Two Films	12.00
*D0330	Radiograph – Panoramic Film	35.00
+D0350	Oral/Facial Images This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	4.00
*D0470	Diagnostic Casts	25.00
*D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	80.00

**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

<b>EPSDT DENTAL PROGRAM DIAGNOSTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	80.00

<b>EPSDT DENTAL PROGRAM PREVENTIVE PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
<b>D1110</b>	Prophylaxis – Adult (12 through 20 years of age)	27.00
D1120	Prophylaxis – Child (under 12 years of age)	12.00
D1203	Topical Application of Fluoride (prophylaxis not included) – Child (under 12 years of age)	11.00
D1204	Topical Application of Fluoride (prophylaxis not included) – Adult (12 through 15 years of age)	11.00
#D1351	Sealant, Per Tooth (6-year molar sealant – under 10 years of age; 12-year molar sealant – 10 through 15 years of age.) This procedure is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30, and 31.	16.00
+*D1510	Space Maintainer, Fixed, Unilateral This procedure is reimbursable for Oral Cavity Designator 10, 20, 30, and 40.	78.00
+*D1515	Space Maintainer, Fixed, Bilateral This procedure is reimbursable for Oral Cavity Designator 01 and 02.	123.00
+D1550	Recementation of Space Maintainer This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30, and 40.	20.00

<b>EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#D2140	Amalgam, One Surface, Primary or Permanent  This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	35.00/42.00√
#D2150	Amalgam, Two Surfaces, Primary or Permanent  This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	50.00/53.00√
#D2160	Amalgam, Three Surfaces, Primary or Permanent  This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	60.00/64.00√
#D2161	Amalgam, Four or More Surfaces, Permanent  This procedure is reimbursable for Tooth Number 1 through 32.	75.00
#D2330	Resin-based Composite, One Surface, Anterior  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	45.00

<b>EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#D2331	Resin-based Composite, Two Surfaces, Anterior  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	55.00
#D2332	Resin-based Composite, Three Surfaces, Anterior  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	65.00
##D2335	Resin-based Composite, Four or More Surfaces, Anterior  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	75.00
##D2390	Resin-based Composite Crown, Anterior  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	75.00
#D2920	Recement Crown  This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letter A through T.	20.00

<b>EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#*D2930	Prefabricated Stainless Steel Crown, Primary Tooth  This procedure is reimbursable for Tooth Letters A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. <u>Prior Authorization is required only for Tooth Letters B, I, L, and S for recipients 8 years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for recipients 9 years of age and older.</u>	80.00
#*D2931	Prefabricated Stainless Steel Crown, Permanent Tooth  This procedure is reimbursable for Tooth Number 1 through 32.	80.00
#*D2932	Prefabricated Resin Crown  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27; and Tooth Letters C, H, M and R regardless of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age.	75.00
#*D2950	Core Buildup, Including Any Pins  This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31	55.00
#D2951	Pin Retention, Per Tooth, In Addition To Restoration  This procedure is reimbursable for Tooth Number 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	15.00
#*D2954	Prefabricated Post And Core In Addition To Crown  This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31	75.00
#*D2999	Unspecified Restorative Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#D3110	Pulp Cap – Direct (excluding final restoration) This procedure is reimbursable for Tooth Number 1 through 32.	15.00
##_D3220	Therapeutic Pulpotomy (excluding final restoration) This procedure is reimbursable for Tooth Number 1 through 32; and Tooth Letter A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 4 years of age. <u>Prior authorization required for Tooth Number 1 through 32 only.</u>	40.00
##_D3240	Pulpal Therapy (Resorbable Filling), Posterior, Primary Tooth This procedure is reimbursable for Tooth Letter A, J, K, and T.	50.00
##_D3310	Root Canal Therapy, Anterior (excluding final restoration) This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	212.00
##_D3320	Root Canal Therapy, Bicuspids (excluding final restoration) This procedure is reimbursable for Tooth Number 4, 5, 12, 13, 20, 21, 28 and 29.	241.00
##_D3330	Root Canal Therapy, Molar (excluding final restoration) This procedure is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30 and 31.	306.00
##_D3352	Apexification/Recalcification, Interim Medication Replacement This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	50.00
##_D3410	Apicoectomy/Periradicular Surgery, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	100.00

<b>EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#*D3430	Retrograde Filling, Per Root  This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	56.00
#*D3999	Unspecified Endodontic Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM PERIODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+*D4210	Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	125.00
+*D4341	Periodontal Scaling And Root Planing, Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant  This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	56.00
*D4355	Full Mouth Debridement To Enable Comprehensive Evaluation and Diagnosis	46.00
*D4999	Unspecified Periodontal Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D5110	Complete Denture, Maxillary	470.00
*D5120	Complete Denture, Mandibular	470.00
*D5130	Immediate Denture, Maxillary	470.00
*D5140	Immediate Denture, Mandibular	470.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	425.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	425.00

<b>EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D5213	Maxillary Partial Denture, Cast Metal (including clasps)	550.00
*D5214	Mandibular Partial Denture, Cast Metal (including clasps)	550.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designator 01 and 02.	72.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designator 01 and 02.	72.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	93.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00
#D5650	Add Tooth to Existing Partial Denture <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00



**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

<b>EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+D5660	Add Clasp to Existing Partial Denture  This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	93.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	200.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	200.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	175.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	175.00
*D5820	Interim Partial Denture (Maxillary), Includes Clasps	185.00
*D5821	Interim Partial Denture (Mandibular), Includes Clasps	185.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM MAXILLOFACIAL PROSTHETIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+#D5986	Fluoride Gel Carrier  This procedure is reimbursable for Oral Cavity Designator 01 and 02.	30.00

<b>EPSDT DENTAL PROGRAM FIXED PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
##D6241	Pontic - Porcelain Fused to Predominantly Base Metal  This procedure is reimbursable for Tooth Number 7, 8, 9, and 10.	300.00
##D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis  This procedure is reimbursable for Tooth Number 6, 7, 8, 9, 10 and 11.	150.00
*D6999	Unspecified, Fixed Prosthodontic procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
<b>#D7140</b>	Extraction, Erupted Tooth or Exposed Root  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	38.00
<b>##D7210</b>	Surgical Removal of Erupted Tooth  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00
<b>##D7220</b>	Removal of Impacted Tooth – Soft Tissue  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	75.00
<b>##D7230</b>	Removal of Impacted Tooth – Partially Bony  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	125.00
<b>##D7240</b>	Removal of Impacted Tooth – Completely Bony  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	150.00
<b>##D7241</b>	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications  This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	175.00

**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

<b>EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#*D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure) This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	57.00
+#*D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth This procedure is reimbursable for Oral Cavity Designator 01 and 02.	***** Maximum Fee \$150.00
#*D7280	Surgical Access of an Unerupted Tooth This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31 for Medicaid approved comprehensive orthodontic cases only.	***** Maximum Fee \$300.00
#*D7281	Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31.	50.00
+#*D7285	Biopsy of Oral Tissue – Hard (bone, tooth) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.	***** Maximum Fee \$200.00
+#*D7286	Biopsy of Oral Tissue - Soft (all others) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	50.00
+#*D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02 for Medicaid approved comprehensive orthodontic cases only.	60.00

<b>EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+*D7310	Alveoloplasty in Conjunction with Extractions – Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	54.00
#D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue This procedure is reimbursable for Tooth Number 1 through 32.	38.00
+*D7880	Occlusal Orthotic Device, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02.	250.00
D7910	Suture of Recent Small Wounds up to 5 cm	50.00
+*D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	90.00
*D7999	Unspecified Oral Surgery Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM ORTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+*D8050	Interceptive Orthodontic Treatment of the Primary Dentition This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	***** Maximum Fee \$200.00
+*D8060	Interceptive Orthodontic Treatment of the Transitional Dentition This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	***** Maximum Fee \$200.00

**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

<b>EPSDT DENTAL PROGRAM ORTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	***** Maximum Fee \$2,500.00
*D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	***** Maximum Fee \$2,500.00
*D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	***** Maximum Fee \$2,500.00
*D8220	Fixed Appliance Therapy	\$150.00
*D8999	Unspecified Orthodontic Procedure, By Report	*****

<b>EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
<b>D9110</b>	Palliative (Emergency) Treatment of Dental Pain	23.00
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	7.00
*D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	63.00
*D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	31.00
*D9248	Non-intravenous Conscious Sedation	50.00
*D9420	Hospital Call	125.00
*D9440	Office Visit – After Regularly Scheduled Hours	75.00
*D9920	Behavior Management, By Report	30.00

<b>EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
+*D9940	Occlusal Guard, By Report This procedure reimbursable for Oral Cavity Designator 01 and 02.	50.00
*D9951	Occlusal Adjustment – Limited	68.00
*D9999	Unspecified Adjunctive Procedure, By Report	*****

**APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE**

Provided in the table on the following pages are the reimbursable dental procedure codes and fees for the Medicaid of Louisiana, Adult Denture Program.

All procedures listed in the Adult Denture Program Fee Schedule are subject to the guidelines, policies and limitations of the Medicaid of Louisiana, Adult Denture Program. Please refer to the Adult Denture Program section of the Dental Services Manual for complete guidelines, policies and limitations for each procedure.

All services marked with an asterisk (\*) in the code column require prior authorization.

All services marked with a number sign (#) in the code column require a tooth number to be specified on the claim form for payment requests and prior authorization requests if required.

All services marked with a plus sign (+) in the code column require an oral cavity designator to be specified on the claim form for payment requests and prior authorization requests if required.

All fees marked with 5 asterisks (\*\*\*\*\*) in the fee column will be priced manually by the dental consultant.

**ADULT DENTURE PROGRAM FEE SCHEDULE**

<b>ADULT DENTURE PROGRAM DIAGNOSTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D0150	Comprehensive Oral Examination (Adult Oral Examination)	\$5.00
*D0210	Intraoral Radiographs, Complete Series	\$35.00

<b>ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
*D5110	Complete Denture, Maxillary	470.00
*D5120	Complete Denture, Mandibular	470.00
*D5130	Immediate Denture, Maxillary	470.00
*D5140	Immediate Denture, Mandibular	470.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	425.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	425.00
+D5510	Repair Broken Complete Denture Base  This procedure is reimbursable for Oral Cavity Designator 01 and 02.	72.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u>  This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00
+D5610	Repair Resin Denture Base, Partial Denture  This procedure is reimbursable for Oral Cavity Designator 01 and 02.	72.00
+D5630	Repair or Replace Broken Clasp, Partial Denture  This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	93.00



**ISSUE DATE**

**MAY 1, 2003**

**REVISION DATE**

**MAY 1, 2003**

<b>ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES</b>		
<b>CODE</b>	<b>DESCRIPTION</b>	<b>FEE</b>
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00
#D5650	Add Tooth to Existing Partial Denture <u>1<sup>st</sup> Tooth = \$46.00; Each Additional Tooth = \$12.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	46.00/12.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	93.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	200.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	200.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	175.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	175.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

**APPENDIX C: CONSCIOUS SEDATION FORM/TMJ SUMMARY**

**PEDIATRIC DENTISTRY CONSCIOUS SEDATION**

Child's Name \_\_\_\_\_ Sex \_\_\_\_ Race \_\_\_\_ Date \_\_\_\_  
 Child's Medicaid ID# \_\_\_\_\_  
 Weight \_\_\_\_\_ lb. \_\_\_\_\_ kg. Operating Dentist(s) \_\_\_\_\_  
 Age \_\_\_\_\_ yr. \_\_\_\_\_ mo. Assistants \_\_\_\_\_

Preoperative Health Evaluation \_\_\_\_\_ ASA 1  2  3  4

NPO Status \_\_\_\_\_

Preoperative Behavior Evaluation \_\_\_\_\_

Frankl Scale:  1 – definitely negative  2 negative  3 – positive  4 – definitely positive

North Carolina Scale: Head Movement  Crying   
 Physical Resistance  Hands  Legs

Restraints: Papoose Board  Pediwrap  Velcro Seatbelts  Mouth Prop  Other: \_\_\_\_\_

Preprocedural Drug: \_\_\_\_\_ Route: \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Time: \_\_\_\_\_ Administered by: \_\_\_\_\_

Sedation Medication Drug: \_\_\_\_\_ Route: \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Time: \_\_\_\_\_ Administered by: \_\_\_\_\_

Route of Administration  Oral  Intramuscular  Submucosal  Other \_\_\_\_\_

Monitoring Devices  B.P. Cuff  P.C. Steth  Dynamap  Pulse Oximeter Other: \_\_\_\_\_

MONITOR/AGENT	DOSE	TIME → (Base Line)																		
Respiration rate/min.																				
Pulse rate/min.																				
Oxygen Saturation																				
Blood Pressure	Systolic																			
	Diastolic																			
2% Xylo _____ epi.	(4.0 mg/kg)	mg.																		
Nitrous Oxide	(N <sub>2</sub> O-02%)																			
Hydroxyzine (Vistaril)	(1.0-2.0 mg/kg)	mg.																		
Promethazine (Phenergan)	(1.0mg/kg)	mg.																		
Meperidine (Demerol)	(1.0-2.0 mg/kg)	mg.																		
Diazepam (Valium)	(0.25-0.5 mg/kg)	mg.																		
Midazolam (Versed)	(0.3-0.7 mg/kg)	mg.																		
Chloral Hydrate(Noctec)	(25-50mg/kg)	mg.																		
Naloxone (Narcan)	(0.01 mg/kg)	mg.																		
Flumazenil (Romazicon)	(0.01 mg/kg)	mg.																		

NOTE: ATTACH PRINTOUT OF MONITORING DEVICE, IF AVAILABLE.

Treatment: Time Started: \_\_\_\_\_ Completed: \_\_\_\_\_ Elapsed time: \_\_\_\_ hr. \_\_\_\_ min.

**LEVEL OF SEDATION**  
 No behavioral change  
 Sedated but disruptive when stimulated  
 Sedated but responsive to verbal command  
 Sedated – slept but responsive to verbal command  
 Sedated – slept, responsive only to physical stimulation  
 Slept and unresponsive to verbal or physical stimulation  
 Unconscious and unresponsive  
 Other \_\_\_\_\_

**EFFECTIVENESS OF SEDATION**  
 Ineffective  Effective  Very Effective  Over-Sedated

**SIDE EFFECTS**  
 Nausea  Vomiting  Respiration Depression  
 Vertigo  Headache  Prolonged Recovery

**Postoperative Course and Discharge Evaluation**  
 Alert  Talking/Crying  Ambulatory  
 CV Stable  Airway Stable  Sit Unaided

Disposition: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Time of Discharge: \_\_\_\_\_

## TMJ SUMMARY

---

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ M F

Recipient Number: \_\_\_\_\_

< The items written in small print, in each category are not inclusive  
and should be used only as guides >

### Chief Complaints:

Facial Pain: headaches, TMJ pain,  
TMJ sounds, cervical pain, oral pain,  
dental pain, decrease in jaw ROM,  
ringing in ears, jaw locking, closed  
or open, duration

### Clinical Findings:

Palpation of: TMJ, masticator muscles,  
cervical muscles; functional manipulation;  
jaw and neck ROM; TMJ sounds: occlusion

### Radiographic Findings:

### Impressions:

Myofacial Pain: masticatory muscles, cervical muscles,  
TMJ capsules, TMJ disc displacement or dislocation,  
Hyper-mobility, osteoarthritis, headaches, myofacial  
tension, missing teeth, malocclusion, chronic pain, etc.

### Etiology:

Trauma, Bruxism, Missing teeth, malocclusion, etc.

### Recommendations:

If splints are requested please state if it will be a hard or soft splint.