Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.
# CHAPTER 16
## DENTAL SERVICES
### EPSDT AND ADULT DENTURE PROGRAMS

**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>SECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENTAL PROGRAMS OVERVIEW</strong></td>
<td>16.0</td>
</tr>
<tr>
<td><strong>DENTAL PROGRAMS PROVIDER REQUIREMENTS</strong></td>
<td>16.1</td>
</tr>
<tr>
<td>Dental Groups</td>
<td></td>
</tr>
<tr>
<td>Individual Dentists</td>
<td></td>
</tr>
<tr>
<td>Program Guidelines</td>
<td></td>
</tr>
<tr>
<td>Required Changes to Report</td>
<td></td>
</tr>
<tr>
<td>Securing Recipients</td>
<td></td>
</tr>
<tr>
<td>Picking and Choosing Recipients/Services</td>
<td></td>
</tr>
<tr>
<td>Subsequent Treatment Visits</td>
<td></td>
</tr>
<tr>
<td>General Coding Information</td>
<td></td>
</tr>
<tr>
<td>Tooth Numbering System and Oral Cavity Designators</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Missed Appointments</td>
<td></td>
</tr>
<tr>
<td>Third Party Payments</td>
<td></td>
</tr>
<tr>
<td>Record Keeping</td>
<td></td>
</tr>
<tr>
<td>Interruption of Treatment</td>
<td></td>
</tr>
<tr>
<td><strong>DENTAL PROGRAMS CLAIMS RELATED INFORMATION</strong></td>
<td>16.2</td>
</tr>
<tr>
<td>Claims Filing</td>
<td></td>
</tr>
<tr>
<td>Exceptions to Filing Dental Claim Form</td>
<td></td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI) Filing</td>
<td></td>
</tr>
<tr>
<td>Claims Documentation</td>
<td></td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td></td>
</tr>
<tr>
<td>Dental Programs Billing Instructions</td>
<td></td>
</tr>
<tr>
<td>General Reminders</td>
<td></td>
</tr>
<tr>
<td>Dental Claim Form and Instructions</td>
<td></td>
</tr>
</tbody>
</table>
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) DENTAL PROGRAM

BENEFICIARY ELIGIBILITY REQUIREMENTS  16.3
SECURING SERVICES  16.4
COVERED SERVICES  16.5
   Initial Dental Screening and Annual Recall Visits
   Diagnostic Services
   Preventive Services
   Restorative Services
   Endodontic Therapy Services
   Periodontal Services
   Removable Prosthodontics
   Maxillofacial Prosthetics
   Fixed Prosthodontics
   Oral and Maxillofacial Surgery Services
   Orthodontic Services
   Adjunctive General Services

NON-COVERED SERVICES  16.6

PRIOR AUTHORIZATION  16.7
   Prior Authorization Reminders

ADULT DENTURE PROGRAM

RECIPIENT ELIGIBILITY REQUIREMENTS  16.8

COVERED SERVICES  16.9
Diagnostic Services
  Removable Prosthodontics
  Minimum Standards for Complete and Partial Denture Prosthetics

NON-COVERED SERVICES  16.10

PRIOR AUTHORIZATION  16.11
  Prior Authorization Reminders

EPSDT DENTAL PROGRAM FEE SCHEDULE  APPENDIX A

ADULT DENTURE PROGRAM FEE SCHEDULE  APPENDIX B

DENTAL CLAIM FORM AND INSTRUCTIONS  APPENDIX C

ADJUSTMENT/VOID FORMS AND INSTRUCTIONS  APPENDIX D
  Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
    Instructions for Completing 209 Adjustment/Void Form
    Form 209
  Adult Dental Services
    Instructions for Completing 210 Adjustment/Void Form
    Form 210

DENTAL PERIODICITY SCHEDULE  APPENDIX E

CLAIM DENIAL SIMPLIFICATION PROCESS  APPENDIX F

PRIOR AUTHORIZATION CHECKLIST  APPENDIX G

PRIOR AUTHORIZATION SAMPLE LETTER  APPENDIX H

FORMS
  PEDIATRIC CONSCIOUS SEDATION FORM
  TEMPOROMANDIBULAR JOINT (TMJ) FORM

CONTACT/REFERRAL INFORMATION  APPENDIX J
OVERVIEW OF DENTAL PROGRAMS

The dental programs are governed by regulations found in the Code of Federal Regulations 42CFR 440.40 and 42CFR 440.50 which describe the services including the required services for children under the age of 21.

The Louisiana Medicaid Dental Services include the following programs:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental
- Adult Denture

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.

The fiscal intermediary (FI) provider relations staff can answer questions regarding policy and claims processing (see Appendix J for contact information).

The CDT Code and Nomenclature in this document have been obtained from Current Dental Terminology (including procedure codes, nomenclatures, descriptors and other data contained therein) (“CDT”). CDT is copyright © 2020 American Dental Association. All rights reserved.
PROVIDER REQUIREMENTS

A dentist must enroll as a Louisiana Medicaid dental provider to receive reimbursement for covered dental services performed on eligible Medicaid beneficiaries. Providers must be licensed in the state of Louisiana from the Louisiana State Board of Dentistry and must adhere to the Louisiana State Board of Dentistry requirements concerning the delivery of dental services.

Enrolled providers are not allowed to provide services to a Medicaid beneficiary beyond the intent of Medicaid guidelines, limitations and/or policies for purposes of maximizing payments. If this practice is detected, Medicaid will apply sanctions.

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.

NOTE: 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 is defined as two or more dentists offering dental services to the Louisiana Medicaid beneficiary population. Dental groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid beneficiary.

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

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.
Program Guidelines

A Medicaid dental provider must offer the same services to a Medicaid beneficiary as those offered to a non-Medicaid beneficiary, provided these services are reimbursable by the Medicaid program. A Medicaid dental provider cannot limit his/her practice to diagnostic and preventive services only. A dental provider who only offers diagnostic and preventive services in his practice does not meet the necessary criteria for participation in the Medicaid Early and Periodic Screening and Diagnosis Treatment (EPSDT) Dental or Adult Denture programs.

Medicaid enrolled dental 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 (PEU) and the Louisiana Department of Health (LDH). 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, the service must be performed in 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.

Louisiana Medicaid requires all dental providers to identify a place of treatment (service) on the 2006 American Dental Association (ADA) Claim Form. If services are to be or were provided at a location other than the address entered in Block 38 of the 2006 ADA Claim Form, use the Place of Service Codes for Professional Services to identify where the services are being rendered. The number of the corresponding location in the “other” box on the form must be entered as well as the address of the location in Box 56.

Required Changes to Report

All changes of address, group affiliation, contact information, status, and bank account information, etc. must be reported in writing to the PEU. Refer to Appendix J for contact information. For more information on required reportable changes, see chapter one, General Information and Administration of the Medicaid Manual.

Securing Beneficiaries

Eligible beneficiaries who are in need of dental services should schedule an appointment with a participating provider. It is the responsibility of the beneficiary 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 beneficiaries. 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.

**Picking and Choosing Beneficiaries and/or Services**

Providers may choose whether to accept a beneficiary as a Medicaid patient. Providers are not required to accept every Medicaid beneficiary requiring treatment. However, providers must be consistent with this practice and not discriminate against a Medicaid beneficiary based on the beneficiary’s race, religion, national origin, color or handicap.

Providers must bill Medicaid for all covered services performed on eligible beneficiaries whom the provider has accepted 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.

**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 comprehensive or periodic oral examination.

**General Coding Information**

The EPSDT Dental and Adult Denture Program Fee Schedules include a complete list of Medicaid covered procedure codes (see Appendix A and B). These codes conform to the ADA Code on Dental Procedures and Nomenclature. Fees for all procedures include local anesthesia and routine postoperative care.

**Tooth Numbering System and Oral Cavity Designators**

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

**Referrals**

Medicaid covered dental services requiring treatment by a specialist may be referred to another provider who can address the specific treatment; however, the beneficiary or guardian, as appropriate, must be advised of the referral. The reimbursement made for the examination, prophylaxis, bitewing radiographs and/or fluoride to providers who routinely refer beneficiaries for restorative, surgical and other treatment services is subject to recoupment.

**Missed Appointments**

Providers cannot charge beneficiaries for missed/failed appointments.
Third Party Liability

Medicaid is the payer of last resort. Therefore, providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. Third party insurance carrier is an individual or company who is responsible for the payment of medical services. Examples of third parties are Medicare, private health insurance, automobile, or other liability carriers. Refer to General Information and Administration, Chapter One for additional information on third party liability.

Questions regarding Dental third party payments can be directed to the LDH Medicaid Dental Prior Authorization Unit (see Appendix J).

Record Keeping

State law and Medicaid regulations require that all services provided under the EPSDT Dental and Adult Denture dental programs 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 beneficiaries under the EPSDT Dental program, records and radiographs must be maintained for at least six years from the date of the patient’s last treatment. It is strongly suggested that the Adult Denture Provider maintain records for at least eight years as the program allows for the provision of prosthetics once every eight 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 beneficiary’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 also be maintained in the beneficiary’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.

**Interuption of Treatment**

The interruption of treatment guidelines applies 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 in the beneficiary’s record, all attempts to deliver the denture and the reasons the denture was not delivered in the beneficiary’s dental treatment record.

If due to circumstances beyond the provider’s control, the beneficiary 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 LDH so the PA 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 PA 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:

- Impressions (initial impression, construction of custom dental impression tray and final impressions);
- Bite registration (wax try-in with denture teeth);
- Processing; and
- 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 Medicaid Program. 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 Medicaid Program. 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 Medicaid Program.

For further information concerning billing of interrupted services, providers may contact the LDH Medicaid Dental Prior Authorization Unit (see Appendix J).
CLAIMS RELATED INFORMATION

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, endodontic, etc. must be completed/delivered (placed in the beneficiary'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 Current Dental Terminology (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 beneficiary cannot be required to pay a co-payment for Medicaid covered dental services. Also, the beneficiary 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 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 prior authorization (PA) number.

Multiple claim forms can be submitted in the same envelope, however, do not include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program claim forms and Adult Denture Program claim forms in the same envelope.

NOTE: Dental services must not be separated or performed on different dates of services solely to enhance reimbursement.

Claims Filing

The 2006 American Dental Association (ADA) Dental Claim Form (see Appendix C) is the only hardcopy dental claim form accepted for the billing of services covered in the Medicaid Dental Program regardless of the date of service. The date of service on a claim for payment must reflect the actual date that the service was completed/delivered. Dental claims for payment received by
the fiscal intermediary (FI) on the older versions of this form will be returned to the provider. Completed claims for payment should be mailed to the FI (see Appendix J).

This section contains the process of billing for Medicaid covered dental services provided under the EPSDT Dental and Adult Denture Programs. The most current ADA Dental Claim Form is to be used. This is the only dental claim form accepted for the processing of Medicaid dental claims. These forms can be obtained through the ADA and/or dental equipment or business suppliers. A sample of the claim form, along with detailed instructions for completing the ADA Dental Claim Form, is in Appendix C.

Completed claim forms should be mailed to the FI.

**Exceptions to Filing Dental Claim Form**

Billing for Oral and Maxillofacial Surgery is accomplished by completing the professional claim form, the CMS-1500.

**Electronic Data Interchange Filing**

Providers are strongly encouraged to file claims via electronic data interchange (EDI).

The benefits of electronic submission include the following:

- Increased cash flow;
- Improved claim control;
- Decrease in time for receipt of payment;
- Improved claim reporting;
- Reduction of errors through pre-editing of claims information.

Electronic claims must be submitted for processing by telecommunications (modem). The claims must be submitted in Health Insurance Portability and Accountability Act (HIPAA) compliant 837 transactions. Providers should refer to the EDI Companion Guide on the Louisiana Medicaid website, link HIPAA Billing Instructions and Companion Guides, for details. In addition, a current list of EDI vendors, billing agents, and clearinghouses (VBC) that can provide electronic billing services is also available on the HIPAA Information Center website (see Appendix J).
Claims Documentation

The Louisiana Medicaid program is required to make payment decisions based on the information submitted on the claim form by the provider.

Third Party Liability

Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid beneficiary. When billing Medicaid after filing for payment consideration from a third party liability (TPL) (except Medicare), the provider must bill a hard copy claim with the Explanation of Benefits (EOB) from the TPL attached. The six-digit state assigned carrier code for the TPL and the amount paid by the TPL carrier (including zero [$0] payment) must be entered in the appropriate blocks on the claim form. A list identifying the various state assigned six-digit TPL carrier codes and the carrier addresses may be obtained from Provider Relations. Dental providers are not required to file dental claims with Medicare prior to billing Medicaid.

If TPL y is indicated on the Medicaid files when a claim is processed and no third party carrier information is identified on the claim and/or no EOB from the TPL is attached, Medicaid will reject or deny the claim and return it to the provider for determination of TPL for most Medicaid services.

If the provided third party coverage is found to be erroneous, providers may submit a request to update beneficiary files with correct third party information. Such requests should be made to the Provider Relations department of the FI (see Appendix J).

The request must include a cover letter stating what the provider is requesting and must attach a copy of documentation verifying the TPL information (e.g., a letter from the beneficiary’s other insurance indicating the effective coverage period). All resubmissions must be accompanied by a copy of the claim form with corrections where applicable. The FI will forward requests to update beneficiary files to the Bureau of Health Services Financing (BHSF) for correction of the files.

Dental Programs Billing Instructions

General Reminders

Providers may submit more than one hardcopy claim per envelope; however EPSDT Dental Program claims and Adult Denture Program claims should not be submitted in the same envelope.
Providers should always notify Provider Enrollment, at the address found in Appendix J, of mailing address changes when it occurs, to allow rejected claims to be returned more quickly to a provider. Many claims are returned to the FI because forwarding orders at the post office have expired.

Claims should be filed immediately after services have been rendered.

**Dental Claim Form and Instructions**

A sample of the 2006 ADA Dental Claim Form and the Medicaid instructions for completing the form is included in Appendix C. Should you have any questions regarding completion of the ADA Dental Claim Form, contact Provider Relations (see Appendix J).

**Adjusting/Voiding Claims**

Provided in this section are general reminders and specific billing instructions for adjusting or voiding an EPSDT Dental Program claim or Adult Denture Program claim. The form 209 is used to adjust/void claims in the EPSDT program and is only available upon request by contacting Provider Relations. The form 210 is used to adjust/void claims in the Adult Denture program. A sample of the adjustment/void forms 209 and 210 along with specific instructions on completion can be found in Appendix D.

Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.

If a paid claim is being voided, the provider must enter all of the information from the original claim exactly as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable.)

It is important to enter the exact Internal Control Number (ICN) and RA date for the paid claims in the appropriate block on the adjustment/void form. If the exact information is not entered, the claim will deny with error message 799 (no history for this adjustment/void).

When an Adjustment/Void form has been processed, it will appear on the RA under **Adjusted or Voided Claims**. The adjustment or void will appear first. The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims**.
An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as “Adjusted Claims”, “Previously Paid Claims”, or “Voided Claims”.

**Instructions for Adjusting/Voiding Claims**

EPSDT Dental Services Adjustment/Void Form 209 is used to adjust or void an EPSDT Dental Program claim. Adult Dental Services Adjustment/Void Form 210 is used to adjust or void an Adult Denture Program claims.

*Only a paid claim can be adjusted or voided.* The Provider Medicaid Identification Number and Beneficiary/Patient Identification Number may not be adjusted. The Adjustment/Void form allows the adjustment or voiding of only one claim line per adjustment/void form. To adjust or void more than one claim line on a multiple line claim form, a separate adjustment/void form is required for each claim line.

**NOTE:** Refer to the General Information and Administration, Chapter One, for more general claims information.
BENEFICIARY ELIGIBILITY REQUIREMENTS

A beneficiary is eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program only if Medicaid eligible AND under 21 years of age on the date of the service.

NOTE: Some categories of Medicaid, such as Louisiana Children’s Health Insurance Program (LaCHIP) and LaCHIP Affordable Plan, end once the beneficiary reaches 19 years of age. It is the responsibility of the provider to verify beneficiary eligibility.

The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain beneficiary eligibility information. The beneficiary must be eligible for each date of service. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS.
SECURING SERVICES

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), LaCHIP, and LaCHIP Affordable Plan beneficiaries are encouraged to obtain an annual oral examination, and if needed, subsequent treatment. A beneficiary may elect to contact a participating dentist of their choice directly to make the initial appointment. A beneficiary or provider needing a participating provider for purposes of making a referral may visit the website (see Appendix J).
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – COVERED SERVICES

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

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

NOTE: Services that require prior authorization (PA) are identified by an asterisk {*}. 

Initial Dental Screening and Annual Recall Visits

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

- Examination of the oral cavity and all of its structures, using a mirror and explorer, periodontal probe (if required) and necessary diagnostic or vitality tests (considered part of the examination);
- Bitewing radiographic images;
- Prophylaxis, including oral hygiene instructions; and,
- Topical fluoride varnish (beneficiaries under six years of age) or topical application of fluoride (beneficiaries under 16 years of age).

The visit should also include preparation and/or updating the beneficiary’s treatment record, development of a current treatment plan, and the completion of reporting forms.
The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical fluoride varnish (D1206) or topical application of fluoride (D1208) are limited to once per six-month period. In cases where the provider considers radiographic images, prophylaxis or fluoride to be medically contraindicated, a narrative stating the contraindication must be documented in the beneficiary’s treatment record.

The provider must ask a new patient when he/she last received a Medicaid-covered oral examination, prophylaxis, bitewing radiograph, and fluoride and record that information in the beneficiary’s treatment record. A new patient is described as a beneficiary that has not received active treatment from the provider for at least three years. For an established patient, the provider must check the beneficiary’s treatment record to ensure that it has been at least six months since the beneficiary received these services. If it is determined that it has been less than six months, the beneficiary must schedule for a later date. An established patient is one who has received active treatment from the provider within the past three years. The dental provider should maintain a recall system of beneficiaries for future examinations and treatment, if required.

For all (new and established) beneficiaries, dental providers must utilize the electronic Clinical Data Inquiry (e-CDI) application which is available in the provider restricted area of the Louisiana Medicaid website (see Appendix J) in order to determine whether each beneficiary has received a Medicaid-reimbursed oral examination, bitewing radiographic images, prophylaxis, and fluoride within the preceding six-month period. Providers must select the option for “Ancillary Services” in order to review the beneficiary’s dental claims history. The e-CDI application provides up to 12 months of history information. A printout of the dental claims history from the e-CDI application must be placed in the beneficiary’s treatment record prior to each initial or recall visit.

**Diagnostic Services**

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

**Codes**

- **D0120** Periodic Oral Examination (established patient)
- **D0145** Oral Examination for a Patient under Three Years of Age and Counseling with Primary Caregiver
- **D0150** Comprehensive Oral Examination (new or established patient)
- **D0210** Intraoral - complete series of radiographic images
- **D0220** Intraoral – periapical first radiographic image
- **D0230** Intraoral – periapical each additional radiographic image
- **D0240** Intraoral – occlusal radiographic image
- **D0272** Bitewings – two radiographic images
D0330  Panoramic radiographic image
D0350  Oral/Facial Images
D0470  Diagnostic Casts
D0473  Accession of tissue, gross and microscopic examination, preparation and transmission of written report
D0474  Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report

Examinations

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

Codes

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

The following EPSDT Dental Program Services are limited to once per six-month period (with noted exception) per beneficiary, as is age appropriate:

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

- D0120 (Periodic Oral Examination – established patient) - 3 through 20 years of age).

Procedure code D0150 remains the appropriate procedure code for new patients who are 3 through 20 years of age. D0150 is reimbursable once in a three-year period when performed by the same or another Medicaid rendering general dentist located in the same office as the billing provider. However, a recognized dental specialist within the same office (group) may perform a D0150 prior to the expiration of the three-year period.

In addition, the appropriate recall visit (D0120 or D0145) must be scheduled at least six months after the initial visit (D0150) is rendered.
D0120 Periodic Oral Examination (established patient)

An examination performed on an established patient to determine any changes in the beneficiary’s dental and medical health status since a previous comprehensive or periodic examination.

This procedure is limited to once per six-month period and is reimbursable for beneficiaries age three through age 20.

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

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

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

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

Procedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to any provider, excluding a Medicaid-recognized dental specialist, within the prior six-month period for the same beneficiary.

D0150 Comprehensive Oral Examination (new or established patient)

Procedure code D0150 is to be used for a comprehensive evaluation performed on a beneficiary age three through 20 years of age by a Medicaid-recognized dentist and/or dental specialist. This would include the examination and recording of the beneficiary’s dental and medical history and a general health assessment.

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

After the comprehensive oral examination, subsequent visits should be scheduled by the provider to correct the dental defects that were identified. If no subsequent visit is required, the bitewing
radiographic images, prophylaxis, and fluoride must be provided at the time of the initial comprehensive or periodic oral examination. If subsequent treatment is required, these services must be provided at the first treatment visit if they were not provided at the initial comprehensive periodic oral examination.

The dental provider should maintain a recall of beneficiaries for future examinations and treatment, if required.

Procedure code D0150 is reimbursable once per three years when performed by the same or another Medicaid general dentist located in the same office (group) as the billing provider. However, a Medicaid-recognized dental specialist within the same office (group) may perform a D0150 prior to the expiration of the three-year period.

Beneficiaries are allowed only one examination per six-month period except when the subsequent examination is performed by a Medicaid-recognized dental specialist.

**Radiographic Images**

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral – complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral – periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral – periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral – occlusal radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – two radiographic images</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
</tr>
<tr>
<td>D0350</td>
<td>Oral / Facial Images</td>
</tr>
</tbody>
</table>

Radiographic images and/or oral/facial images must be of **good diagnostic quality**. Radiographic mounts and panoramic-type radiographic images should indicate the date taken, the name of the beneficiary, and the provider. Radiographic copies should indicate the same information as well as be marked to indicate the left and right sides of the beneficiary’s mouth.

Scanned radiographic images should be of an adequate resolution to be diagnostically acceptable and must indicate the right and left sides of the beneficiary’s mouth. Scanned images that are not diagnostically acceptable will be returned for new images.

According to the accepted standards of dental practice, the provider should limit the number of images obtained to the minimum necessary to obtain essential diagnostic information.
In cases where the provider considers radiographic images to be medically contraindicated, a narrative stating the contraindication must be documented both in the beneficiary’s treatment record and on the claim form submitted.

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

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

**D0210 Intraoral- complete series of radiographic images**

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

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

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

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

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

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

Payment for periapical radiographic images (D0220 and D0230) taken in addition to bitewing radiographic images (D0272) is limited to a total of five and is payable when the purpose is to obtain information in regard to a specific pathological condition other than caries (ex. periapical pathology or serious doubt regarding the presence of the permanent dentition).

Under the following circumstances, periapical radiographic images must be taken or written documentation as to why the radiograph(s) was contraindicated must be noted in the beneficiary’s treatment record:

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

These radiographic images are reimbursable for, and must be associated with, a specific 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 American Dental Association (ADA) Dental Claim Form when requesting reimbursement for this procedure.

D0240   Intraoral – Occlusal radiographic image

A #2 size film taken in an occlusal orientation will be considered an anterior periapical radiograph for payment. The fee for an occlusal radiograph will be paid only when a true occlusal film (2" x 3") is used to evaluate the maxillary or mandibular arch. This radiograph is reimbursable for Oral Cavity Designation areas 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Dental Claim Form when requesting reimbursement for this procedure.
D0272    Bitewings – two radiographic images

Bitewing radiographic images (D0272) are required at the comprehensive oral examination and annually at the periodic oral examination. These radiographic images are limited to one set per year when performed by the same billing provider, except when performed by a Medicaid-recognized dental specialist. If radiographic images cannot be obtained, a narrative explaining the reason why they could not be taken must be documented both in the beneficiary’s treatment record, as well as in the remarks section of the claim form submitted.

D0330    Panoramic radiographic images

This procedure code is reimbursable only once per day by any provider, facility or group and is limited to one service every 12-months by the same provider. Rationale is required for members less than 3 years of age.

Panoramic radiographic images (D0330) are not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed.

Panoramic radiographic images (D0330) are not allowed on emergency claims unless third molars or a traumatic condition is involved. Rationale for use is needed when panoramic images are warranted during palliative care.

D0350    Oral/Facial Images

Oral/facial images (D0350) means photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images must be a part of the beneficiary’s treatment record. Oral/facial images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations:

- Prior to gingivectomy;
- Prior to frenulectomy; or
- With the presence of a fistula prior to retreatment of previous endodontic therapy, anterior.

The provider should bill Medicaid for oral/facial images ONLY when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated.
Oral/facial images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

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

Procedure code D0350 is reimbursable for Oral Cavity Designation areas 01, 02, 10, 20, 30, and 40.

**Other Diagnostic Services**

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470</td>
<td>Diagnostic Casts</td>
</tr>
<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and transmission of written report</td>
</tr>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic Casts</td>
</tr>
<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and transmission of written report</td>
</tr>
</tbody>
</table>

Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not bill procedure code D0473 on the pathologist’s behalf.

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report</td>
</tr>
</tbody>
</table>

Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not bill procedure code D0474 on the pathologist’s behalf.

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

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

Codes

D1110  Adult Prophylaxis
D1120  Child Prophylaxis
D1206  Topical Fluoride Varnish; Therapeutic application for Moderate to High Caries Risk Patients
D1208  Topical Application of Fluoride – excluding varnish
D1351  Sealants
D1510  Unilateral Space Maintainer
D1516  Bilateral Space Maintainer – fixed, maxillary
D1517  Bilateral Space Maintainer – fixed, mandibular
D1551  Recementation of space maintainer-maxillary
D1552  Recementation of space maintainer-mandibular
D1553  Recementation or re-bound unilateral space maintainer – per quadrant
D1556  Removal of fixed unilateral space maintainer
D1557  Removal of fixed bilateral space maintainer-maxillary
D1558  Removal of fixed bilateral space maintainer- mandibular
D1575  Distal shoe space maintainer – fixed, unilateral per quadrant

Prophylaxis

D1110 Adult Prophylaxis

Prophylaxis for beneficiary’s age 12 through 20 years of age includes removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. Qualified dental personnel must perform any prophylaxis.

This procedure is limited to once per six-month period.

Procedure code D4355 (Full Mouth Debridement) is not reimbursable if procedure code D1110 (Adult Prophylaxis) has been reimbursed within the prior twelve-month period for the same beneficiary.
D1120 Child Prophylaxis

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

This procedure is limited to once per six-month period.

Procedure code D4355 (Full Mouth Debridement) is not reimbursable if procedure code D1120 (Child Prophylaxis) has been reimbursed within the prior twelve-month period for the same beneficiary.

Fluoride Treatment

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

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

Procedure code D1206 is reimbursable once per six-month period, for the same beneficiary.

In addition, reimbursement of fluoride treatment for beneficiaries under six years of age is limited to either of the following within a six-month period, per beneficiary:

- D1206 (Topical Fluoride Varnish); or
- D1208 (Topical Application of Fluoride).

NOTE: A combination of D1208 and D1206 are NOT reimbursable in the same six-month period.

D1208 Topical Application of Fluoride – excluding varnish

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

Procedure code D1208 is reimbursable for beneficiaries under 16 years of age. This procedure is limited to once per six-month period.
Sealants

D1351 Sealants – per tooth

A sealant is a mechanically and/or chemically prepared enamel surface seal applied to the occlusal surface to prevent decay. Sealants are limited to six and 12-year molars only. Sealants are further limited to one application per tooth per 24 months.

Six-year molar sealants are reimbursable for beneficiaries under 10 years of age only. Twelve-year molar sealants are reimbursable for beneficiaries under 16 years of age only.

All sealants must be performed on a single date of service, unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services. If there are circumstances that would not allow sealants to be applied in this manner, the contraindication(s) must be documented in the beneficiary's treatment record.

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

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

Space Maintenance

D1510 Space maintainer – fixed – unilateral – per quadrant
D1516 Space maintainer – fixed – bilateral, maxillary
D1517 Space maintainer – fixed – bilateral, mandibular
D1551 Recementation of space maintainer-maxillary
D1552 Recementation of space maintainer-mandibular
D1553 Recementation or re-bound unilateral space maintainer – per quadrant
D1556 Removal of fixed unilateral space maintainer – per quadrant
D1557 Removal of fixed bilateral space maintainer -- maxillary
D1558 Removal of fixed bilateral space maintainer -- mandibular
D1575 Distal shoe space maintainer – fixed -- unilateral -- per quadrant
Fixed-space maintainers 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 covered.

Procedure codes D1510 (Space maintainer – fixed – unilateral – per quadrant) and D1575 (Distal shoe space maintainer – fixed – unilateral – per quadrant) are reimbursable for Oral Cavity areas 10, 20, 30, and 40. Procedure code D1516 (Space maintainer – fixed – bilateral, maxillary) is reimbursable for Oral Cavity area 01 and procedure code D1517 (Space maintainer – fixed – bilateral, mandibular) is reimbursable for Oral Cavity area 02.

The beneficiary’s treatment records must indicate the tooth/teeth that have been or will be extracted in Block 34 of the ADA Dental Claim Form (“X” for missing teeth and “/” for teeth to be extracted).

**D1551 Recementation of space maintainer-maxillary**

The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. This procedure is limited to one recementation per appliance, in a five-year period.

**D1552 Recementation of space maintainer-mandibular**

The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. This procedure is limited to one recementation per appliance, in a five-year period.

**D1553 Recemot or rebound unilateral space maintainer–per quadrant**

The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. This procedure is limited to one recementation per appliance, in a five-year period.

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

**D1556 Removal of fixed unilateral space maintainer–per quadrant**

This procedure code is reimbursable for the removal of Space maintainer - fixed - unilaterally (D1510 & D1575).

This procedure is NOT reimbursable to the same billing provider who placed the appliance or another Medicaid provider located in the same office (group) as the billing provider who placed the appliance.
This procedure is reimbursable for Oral Cavity Designation areas 10, 20, 30, and 40.

**D1557   Removal of fixed bilateral space maintainer-maxillary**

This procedure code is reimbursable for the removal of a Space maintainer - fixed - bilaterally (D1516 or deleted code D1515 (01).

This procedure is NOT reimbursable to the same billing provider who placed the appliance or another Medicaid provider located in the same office (group) as the billing provider who placed the appliance.

**D1558   Removal of fixed bilateral space maintainer- mandibular**

This procedure code is reimbursable for the removal of a Space maintainer - fixed - bilaterally (D1517 or deleted code D1515 (02).

This procedure is NOT reimbursable to the same billing provider who placed the appliance or another Medicaid provider located in the same office (group) as the billing provider who placed the appliance.

**D1575   Distal shoe space maintainer – fixed – unilateral – per quadrant**

This procedure code is reimbursable for placement of a distal shoe space maintainer which extending subgingivally and distally to guide the eruption of the first permanent molar. The provider is responsible for replacement and recementation within the first 12 months of initial placement. However, this service does not include ongoing follow-up, adjustments, or replacement appliance once the permanent tooth has erupted. It is limited to fixed appliances. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months.

This procedure is reimbursable for Oral Cavity Designation areas 10, 20, 30, and 40.
Restorative Services

Codes

D2140  Amalgam – one surface, primary or permanent
D2150  Amalgam – two surfaces, primary or permanent
D2160  Amalgam – three surfaces, primary or permanent
D2161  Amalgam – four or more surfaces, permanent
D2330  Resin-based composite, one surface, anterior
D2331  Resin-based composite, two surfaces, anterior
D2332  Resin-based composite, three surfaces, anterior
D2335  Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390  Resin-based composite crown, anterior
D2391  Resin-based composite, one surface, posterior
D2392  Resin-based composite, two surfaces, posterior
D2393  Resin-based composite, three surfaces, posterior
D2394  Resin-based composite, four or more surfaces, posterior
D2920  Re-cement crown
D2930  Prefabricated Stainless Steel Crown – primary tooth
D2931  Prefabricated Stainless Steel Crown – permanent tooth
D2932  Prefabricated Resin Crown (primary and permanent teeth)
D2933  Prefabricated stainless steel crown with resin window
D2934  Prefabricated esthetic coated stainless steel crown primary
D2950  Core Buildup, including any pins, in addition to crown
D2951  Pin retention – per tooth, in addition to restoration
D2954  Prefabricated post in addition to crown
D2999*  Unspecified Restorative Procedure, by report

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

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

The original billing provider is responsible for the replacement of the original restoration within the first 12 months after initial placement.
No restoration of any type will be reimbursable for deciduous central or lateral incisor teeth (Tooth letters D, E, F, G, N, O, P, and Q) for beneficiaries who have reached their fifth birthday.

Laboratory processed crowns are not covered.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four or more surfaces, posterior (D2161); resin-based composite, four or more surfaces, posterior (D2394); resin-based composite, four or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932, D2933 or D2934).

Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. This allows the dentist to complete all restorative treatment in the area of the mouth that is anesthetized. In addition, if there is a simple restoration required in a second quadrant, the simple restorative procedure in the second quadrant must also be performed at the same appointment. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the beneficiary's treatment record.

**Amalgam Restorations (including polishing)**

**Codes**

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

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

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

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

The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of non-duplicated surfaces when performed within a 12-month period. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In
addition, Medicaid policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal), traumatic injury to the tooth, or in the event of failed restoration which must be indicated in the beneficiary’s treatment records (see Appendix F).

Providers must utilize the e-CDI application to determine whether the beneficiary has received a restoration within the preceding 12-month period from the date of original restoration.

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

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

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

**Resin-Based Composite Restorations - Direct**

**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2330</td>
<td>Resin-based composite, one surface, anterior</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite, two surfaces, anterior</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite, three surfaces, anterior</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite – four or more surfaces or involving incisal angle, anterior</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite, one surface, posterior</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite, two surfaces, posterior</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite, three surfaces, posterior</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite, four or more surfaces, posterior</td>
</tr>
</tbody>
</table>

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two restorations are placed on the same tooth, a maximum fee for
resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum fee for the combined number of surfaces when performed within a 12-month period, by any provider.

Procedure code D2335 or D2394 is reimbursable only once per day for the same tooth when performed by any billing provider.

In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, Medicaid policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal), traumatic injury to the tooth, or in the event of failed restoration which must be indicated in the beneficiary’s treatment records (see Appendix F).

Providers must utilize the e-CDI application to determine whether the beneficiary has received a restoration within the preceding 12-month period from the date of original restoration.

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

The resin-based composite – four or more surfaces or involving incisal angle (D2335 and D2394) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least one-third 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 (Resin-based composite, three surfaces, anterior) restorations would not adequately restore the tooth or in cases where two D2335 (Resin-based composite – four or more surfaces or involving incisal angle, anterior) would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Tooth Letters C, H, M, and R for beneficiaries under 21 years
of age. These procedures are also reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

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

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

Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation that depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Louisiana Department of Health (LDH) or its designee upon request.

Codes

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

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

Procedure codes D2930, D2931, D2932, D2933, and D2934 represent final restorations. These restorations must be in direct contact with the periodontally affected gingival tissue. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should be considered only when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable.

If a non-laboratory crown is required within the first 12 months after a tooth is restored with amalgam or resin, e.g. fracture of the tooth, pulpal necrosis, etc., the reason why the tooth requires additional restoration must be documented in the beneficiary’s treatment record.
Crown services require radiographic images (unless contraindicated). Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the beneficiary’s treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by LDH or its designee upon request.

D2930  Prefabricated Stainless Steel Crown – primary tooth

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

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

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

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

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

D2931  Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32.

D2932  Prefabricated Resin Crown (primary and permanent teeth)

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and Letters C, H, M and R. This procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

D2933  Prefabricated Stainless Steel Crown with Resin Window

A prefabricated stainless steel crown with resin window is an open-face stainless steel crown with aesthetic resin facing or veneer.

This procedure is reimbursable for Tooth Letters C, H, M, and R. This procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

D2934  Prefabricated Esthetic Coated Stainless Steel Crown – primary tooth

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

This procedure is reimbursable for Tooth Letters C, H, M, and R. This procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

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

Procedure codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.
Adequate documentation describing the situation requiring treatment and the treatment proposed must be recorded in the beneficiary’s treatment record.

**D2920 Re-cement Crown**

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

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

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

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

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

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

Reimbursement for pins is limited to one per tooth, within a 12-month period and may be billed only in conjunction with the complex restoration codes D2160 or D2161.

This procedure is reimbursable for Tooth Numbers 2 through 5, 12 through 15, 18 through 21, and 28 through 31.

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

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

This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.
D2999* Unspecified Restorative Procedure, by report

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

Endodontic Therapy Services

Codes

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

Pulp Capping

D3110 Pulp Cap – direct (excluding final restoration)

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

D3220 Therapeutic Pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament
Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

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

This procedure is limited to once every 24-month period, per tooth.

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

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

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

**Endodontic Therapy on Primary Teeth**

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

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

This procedure is not reimbursable 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.

This procedure code is 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 should not be
provided in cases where the primary roots are more than half-resorbed or when the six-year molar has erupted.

Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the pulpal therapy and must be maintained in the beneficiary’s treatment record. This procedure is reimbursable for Tooth Letters A, J, K, and T.

**Endodontic Therapy**

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

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

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

The beneficiary’s treatment records should include a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the beneficiary. Specific treatment plans for final restoration of the tooth must be indicated. If the radiographic images do not indicate the need for a root canal, the provider must include a written statement as to why the root canal is necessary. Root canal therapy should depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of the beneficiary’s oral care.

Providers are reminded that if specific treatment needs are identified during post payment review and not noted by the provider or if the radiographic images do not adequately indicate the need for the root canal requested, recoupment will be initiated.

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 beneficiary’s treatment record. Written
documentation must also include the type of filling material used as well the notation of any
complications encountered which may compromise the success of the endodontic treatment.

D3310 Endodontic Therapy, anterior (excluding final restoration)

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

D3320 Endodontic Therapy, premolar (excluding final restoration)

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

D3330 Endodontic Therapy, molar (excluding final restoration)

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

Endodontic Retreatment

D3346 Retreatment of previous root canal therapy – anterior

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

An anterior root canal retreatment is not payable to the same dentist or dental group who performed
the initial root canal. Beneficiaries may seek the service from a different dentist (dental group).

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

Consideration of root canal retreatment should depend on the prognosis of the affected tooth, the
condition of the other teeth in the mouth, and history of the beneficiary oral care. The beneficiary’s
treatment records should include sufficient readable, most current bitewings and current periapical
radiographic images, as applicable, to judge the general oral health status of the beneficiary.
Specific treatment plans for final restoration of the tooth should also be included.
If the radiographic images do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary in the treatment records. If a fistula is present, a clear oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographic images do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

There will be a recoupment of money paid for all unnecessary root canal treatments if specific treatment needs are identified during post payment review and not noted by the provider in the beneficiary’s treatment records or if the radiographic images do not adequately indicate the need for the retreatment of a previous root canal.

**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 should be considered when the tooth fulfills all requirements for a root canal, as well as an open apex, which cannot be sealed using conventional endodontic technique. In order to obtain optimal results for these services, a three-month period must elapse between start of the root canal, each step in the treatment as well as the final endodontic fill.

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

**Apicoectomy/Periradicular Services**

**D3410  Apicoectomy/ periradicular surgery – anterior**

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

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

**D3430  Retrograde filling**
This procedure is to be reported for placement of retrograde filling material during periradicular surgery procedures on anterior teeth only. This procedure will be reimbursed only in conjunction with code D3410.

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

Other Endodontic Procedures

D3999* Unspecified Endodontic Procedure, by report

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

Periodontal Services

Periodontal services include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures. Local anesthesia is considered 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 to enable a comprehensive oral evaluation and diagnosis
D4999* Unspecified periodontal procedure, by report

Surgical Periodontal Services

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

This procedure involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, and to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.
A gingivectomy is only allowed when the tissue growth interferes with mastication as sometimes occurs from Dilantin therapy.

Explanations or reasons for treatment and a photograph of the affected area(s) must be indicated in the beneficiary’s treatment records.

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

Non-surgical Periodontal Services

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

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

Radiographic evidence of bone loss indicating a true periodontal disease state must be maintained in the beneficiary’s treatment for review with bitewings and/or posterior/anterior periapicals. This service is not allowable for beneficiaries 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 beneficiaries requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service. The claim form used to request 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 Designation areas 10, 20, 30, and 40.

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

**D4355  Full Mouth Debridement to enable a comprehensive oral evaluation and diagnosis**

This procedure involves full mouth debridement involving the preliminary removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This procedure is not to be completed on the same day as a comprehensive oral evaluation (D0150).
This service must be performed at the initial visit if this service is indicated.

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

Only one full mouth debridement is allowed in a 12-month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to any provider.

Bitewing radiographic images that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be maintained in the beneficiary’s treatment record. In the occasional instance where the bitewing radiographic images do not supply evidence of significant calculus in at least two quadrants, Oral/facial photographic images that provide evidence of significant plaque and calculus are required.

Prior to a Full Mouth Debridement, providers must ask their new beneficiaries when they last received a Medicaid covered prophylaxis (D1110 or D1120) and record that information in the beneficiary’s treatment record.

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

Other Periodontal Services

D4999* Unspecified Periodontal Procedure, by report

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

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

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

- The denture should be flanked 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 beneficiary’s treatment record.

- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasping must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion should be comfortable to the beneficiary (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.
  - The denture must be fitted and adjusted for comfort, function, and aesthetics.
  - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

The dentist is responsible for all necessary adjustments for a period of six months.
Records must include a chronological (dated) narrative account of each beneficiary visit indicating what treatment was performed/provided or what conditions were present on those visits. A check off list of codes for services billed as well as copies of claim forms submitted is deemed insufficient documentation of services delivered.

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

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

**Denture Identification Information**

All full and partial dentures (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 beneficiary’s last name and first initial;
- The month and year (00/00) the denture was processed; and
- The last five digits of provider’s Medicaid ID number.

**Complete Dentures**

**Codes**

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

Only one prosthesis per beneficiary 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 beneficiary becomes 21 years of age, the rules of the Adult Denture Program apply.**

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

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

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

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

Partial Dentures

Codes

D5211* Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5212* Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5213* Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5214* Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, 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 beneficiary 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 beneficiary becomes 21 years of age, the rules of the Adult Denture Program apply.

To receive consideration for approval for cast partial dentures, providers must submit periapical radiographic images of the abutment teeth and bitewings with the treatment plan.
A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider must use the following symbols in Block 34 of the ADA Dental Claim Form to indicate tooth status:

- “X” will be used to identify missing teeth; and
- “/” will be used to identify teeth to be extracted.

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

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

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

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

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

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

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

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

- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- 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);
• 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 beneficiaries who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

Denture Repairs

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken tooth – complete denture – per tooth</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken retentive/ clasping materials – per tooth</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace missing or broken tooth – per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture – per tooth</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
</tr>
</tbody>
</table>

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

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

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

Procedure Codes D5511, D5512, D5611, D5612 are reimbursable for Oral Cavity Designation areas 01 or 02.

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 the EPSDT Fee Schedule (Appendix A).

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

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designation areas 10, 20, 30, and 40.

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 beneficiary’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 skillful 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, including the side of the prosthesis involved (right or left).

Failure to provide adequate documentation of services billed as repaired when requested by LDH or its authorized representative will result in recoupment of monies paid by the program for the repair.
CHAPTER 16: DENTAL SERVICES

SECTION 16.5: EPSDT- COVERED SERVICES

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.

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

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material.
- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.
- Relines must be flasked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a skillful 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 LDH or its authorized representative will result in recoupment of the fee paid for the reline.
Other Removable Prosthodontics

D5899*  Unspecified removable prosthodontic procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. Adequate documentation describing the situation requiring treatment and the treatment proposed must be indicated in the beneficiary’s treatment record.

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 is only available for beneficiaries who are undergoing or who have undergone head and neck radiation therapy.

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

This procedure is reimbursable for Oral Cavity Designation areas 01 and 02.

Fixed Prosthodontics

Codes

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

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

- The beneficiary must have attained the age of sixteen.
- The abutment teeth must be caries free and restoration-free and have sound periodontal support.
• No other maxillary teeth are missing or require extraction.
• Periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed.
• On the tooth number chart on the ADA form, “X” out the missing tooth.

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

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

**Fixed Partial Denture Pontic**

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

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

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

**Fixed Partial Denture Retainer**

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

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

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

**Other Fixed Partial Denture Services**

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

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

**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 certain non-dental oral surgery services using the CPT codes, which are covered under the Professional Services Program when those services are rendered to Medicaid beneficiaries who are eligible for services provided in the Professional Services Program. Refer to the Professionals Services Provider Manual, Chapter 5, Section 5.1 for specific details.

**Codes**

D7111  Extraction, coronal remnants – primary tooth  
D7140  Extraction, erupted tooth or exposed root (elevation and/or forceps removal)  
D7210  Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated  
D7220  Removal of impacted tooth – soft tissue  
D7230  Removal of impacted tooth - partial bony  
D7240  Removal of impacted tooth - completely bony  
D7241  Removal of impacted tooth - completely bony, with unusual surgical complications  
D7250  Removal of residual tooth roots (cutting procedure)  
D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth  
D7280  Exposure of an unerupted tooth  
D7283  Placement of device to facilitate eruption of impacted tooth  
D7285  Biopsy of oral tissue – hard (bone, tooth)  
D7286  Biopsy of oral tissue – soft (all others)  
D7291  Transseptal fiberotomy/supra crestal fiberotomy, by report  
D7310  Alveoloplasty, in conjunction with extractions – per quadrant  
D7510  Incision and drainage of abscess – intraoral soft tissue  
D7880  Occlusal orthotic device, by report  
D7910  Suture of recent small wound up to 5 cm  
D7960  Frenulectomy (frenectomy or frenotomy) – separate procedure  
D7997  Appliance removal (not by dentist who placed appliance), includes removal of archbar  
D7999*  Unspecified oral surgery procedure, by report

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

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

Removal of third molars are reimbursable only if symptomatic, and the symptoms must be noted in the beneficiary’s records.

The radiographic findings determine the degree of impaction. The claim should list the tooth numbers and will correspond to the Current Dental Terminology (CDT) definitions.

The fee for any extraction (D7210 through D7241) performed on the same tooth which previously received a surgical access of an unerupted tooth (D7280) will be cut back to the maximum fee for the extraction. The fee for code D7140 performed on the same tooth that previously received a surgical access of an unerupted tooth (D7280) will be paid at $0 since the fee for D7280 exceeds the maximum fee for the extraction.

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

Non-surgical Extractions

D7111 Extraction, Coronal Remnants – primary tooth

Removal of soft tissue-retained coronal remnants for deciduous teeth only. This procedure code is reimbursable for Tooth Letters A through T and AS through TS. All primary teeth within six months of the ADA’s shed age chart requires an x-ray.
D7140 Extraction erupted tooth or exposed root (elevation and/or forceps removal)

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

Surgical Extractions

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

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

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

D7220 Removal of impacted tooth - soft tissue

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

D7230 Removal of impacted tooth - partial bony

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

D7240 Removal of impacted tooth - complete or full bony

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

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

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

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

A copy of the post-surgical operative report and/or treatment record describing the unusual surgical complications, and the radiographic images, must be maintained in the beneficiary’s record, and must be furnished to post-payment review if requested.
D7250  Surgical removal of residual tooth roots (cutting procedure)
This procedure includes the cutting of soft tissue and bone, removal of tooth structure, and closure.

Other Surgical Procedures

D7270  Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth
This procedure includes splinting and/or stabilization. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, recorded in the beneficiary’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 Designation areas 01 and 02.

D7280  Surgical access of an unerupted tooth
This procedure includes an incision, the reflection of tissue, and the removal of bone as necessary to expose the crown of an impacted tooth not intended to be extracted.

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

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

D7283  Placement of Device to Facilitate Eruption of Impacted Tooth
This procedure involves the placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

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

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

D7285  Biopsy of oral tissue – hard (bone, tooth)
This procedure is for the removal of specimen only. It involves the biopsy of osseous lesions and is not to be used for apicoectomy/periradicular surgery.
This procedure is reimbursable for Oral Cavity Designation areas 01, 02, 10, 20, 30, and 40.

**D7286  **  Biopsy of Oral Tissue – Soft

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

A copy of the pathology report must be maintained in the beneficiary’s treatment records.

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

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

This procedure is only reimbursable in conjunction with Medicaid covered comprehensive orthodontic treatment plan.

This procedure is reimbursable for Oral Cavity Designation areas 01 and 02.

**Alveoloplasty – Surgical Preparation of Ridge for Dentures**

**D7310  **  Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaced, 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 recorded and maintained in the beneficiary’s treatment record.

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

**Surgical Incision**

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

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

This procedure is reimbursable for Tooth Numbers 1 through 32.
Temporomandibular Joint (TMJ) Procedure

**D7880 Occlusal orthotic device, by report**

Medicaid reimburses only hard acrylic splints for the treatment of temporomandibular joint dysfunction.

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

The beneficiary’s treatment record must include a completed TMJ Summary Form (see Appendix I). The TMJ Summary Form must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

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

Repair of Traumatic Wounds

**D7910 Suture recent small wound up to 5cm**

Post-operative color photos and rationale is to be documented and maintained within the beneficiary’s treatment record.

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 and/or to recession of the gingival tissue.

An explanation of the circumstances and the specific dental reason must be recorded in the beneficiary’s treatment record.

This procedure is reimbursable for Oral Cavity Designation areas 01, 02, 10, 20, 30, and 40.
D7997   Appliance removal (not by dentist who placed appliance), includes removal of archbar
This procedure is for the removal of appliances due to interrupted or discontinued treatment cases.

This procedure is not reimbursable to the same billing provider who placed the appliance or another Medicaid provider located in the same office as the billing provider who placed the appliance. This procedure is reimbursable for Oral Cavity Designation areas 01 and 02.

D7999* Unspecified oral surgical procedure, by report

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

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 beneficiaries meeting specified criteria. Providers are reminded that Medicaid reimbursement is payment in full for that procedure code.

Interceptive Orthodontic Treatment

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

Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate.
The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.

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

**Comprehensive Orthodontic Treatment**

- **D8070** Comprehensive orthodontic treatment of the transitional dentition
- **D8080** Comprehensive orthodontic treatment of the adolescent dentition
- **D8090** Comprehensive orthodontic treatment of the adult dentition

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

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

This code is used to report the coordinated diagnosis and treatment leading to the improvement of a beneficiary’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 allowable by Medicaid only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crozon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities that result in a physically handicapping malocclusion.

Providers are reminded that Medicaid reimbursement is payment in full for the procedure code and should a beneficiary 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 beneficiary’s treatment records must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case.

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three claim 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. The
reimbursement for each claim will not exceed one third of the maximum allowable billable fee in the EPSDT Dental Fee Schedule (Appendix A).

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

**Minor Treatment to Control Harmful Habits**

**D8220**  
Fixed appliance therapy

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

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

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

**Other Orthodontic Services**

**D8999**  
Unspecified orthodontic procedure, by report

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

**Adjunctive General Services**

**Codes**

- **D9110**  
Palliative (emergency) treatment of dental pain - minor procedure
- **D9230**  
Inhalation of nitrous oxide/analgesia, anxiolysis
- **D9239**  
Intravenous moderate conscious sedation/analgesia – first 15 minutes
- **D9243**  
Intravenous moderate conscious sedation/analgesia – each additional 15 minutes
- **D9248**  
Non-intravenous conscious sedation
- **D9420**  
Hospital call
- **D9440**  
Office visit – after regularly scheduled hours
- **D9920**  
Behavior Management, by report
CHAPTER 16: DENTAL SERVICES
SECTION 16.5: EPSDT- COVERED SERVICES

D9944 Occlusal Guard – hard appliance, full arch
D9945 Occlusal Guard – soft appliance, full arch
D9946 Occlusal Guard – hard appliance, partial arch
D9951 Occlusal Adjustment – limited
D9999* Unspecified adjunctive procedure, by report

Palliative (Emergency) Treatment

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

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

On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) in addition to this procedure code. Panoramic images (D0330) are not allowed on emergency claims unless third molars or a traumatic complaint is involved.

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

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

- Procedures used to control bleeding;
- Procedures used to relieve pain;
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen;
- 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;
- 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 beneficiary’s treatment record must contain a narrative of the specific treatment rendered (tooth number, temporization, opened tooth for drainage, etc.). The treatment provided must not be one that the program lists as non-covered nor can it be a treatment that would be covered under a specific dental service code.

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

Anesthesia

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

Nitrous oxide inhalation analgesia is only payable to providers who possess a personal permit for its administration from the Louisiana State Board of Dentistry and administer it in a State Board approved facility. Nitrous oxide is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. Nitrous oxide, if provided, must be billed on the same claim form as the restorative and/or surgical service(s) and may not be submitted more than once per member per day.

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

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

D9239 Intravenous moderate conscious sedation/analgesia – first 15 minutes
D9243 Intravenous moderate 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 beneficiary. Anesthesia services are considered completed when the beneficiary 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 performed by doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

These procedures are only allowable in conjunction with difficult impactions or other extensive surgical procedures done in the office setting.

A maximum of three units of D9243 are available per beneficiary per visit; if requested, each must be listed on a separate claim line for payment.

Anesthesia time record is required when billing D9239 and the three-unit maximum for D9243.

D9248 Non-intravenous conscious sedation

Non-intravenous conscious sedation is a medically controlled state of depressed consciousness while maintaining the beneficiary’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 performed by doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

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

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

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

The beneficiary’s treatment records must adequately 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 the drug(s) anticipated to be used and route(s) of administration in the treatment records.

The use of conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the dentist or staff from administration through the time of discharge.
The conscious sedation form found in Appendix I, must be completed and maintained in the beneficiary’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 beneficiary’s treatment record. Administration of oral pre-medication is not a covered service.

**Professional Visits**

**D9420 Hospital call**

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

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

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

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

The notes in the beneficiary’s treatment record must adequately justify the need for hospitalization. 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 records must indicate the particular handicap and its impact on the delivery of dental treatment in the office setting. The beneficiary’s treatment records 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 beneficiary must also document the justification for hospitalization including accurate dental charting. A copy of the operative report must be maintained in the beneficiary’s dental office treatment record.

Procedure code D9420 is reimbursable once per six-month period, per beneficiary.
D9440  Office Visit – after regularly scheduled hours

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

Miscellaneous Services

D9920  Behavior Management

Additional compensation paid for behavior management is intended to help offset the additional cost of providing care to beneficiaries 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 beneficiaries receiving similar treatment who do not demonstrate negative or disruptive behavior;
- Use of an additional dental personnel/assistant(s); or
- Use of restraint devices such as a papoose board.

Behavior management is reimbursable for beneficiaries below the age of eight, unless documentation indicates that the beneficiary is physically or mentally handicapped. The particular handicap and its impact on the delivery of dental treatment in the office setting must be recorded in the beneficiary’s treatment record. Behavior management is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) on the same day, by any provider.

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

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

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

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

D9944 Occlusal Guard – hard appliance, full arch
D9945 Occlusal Guard – soft appliance, full arch
D9946 Occlusal Guard – hard appliance, partial arch

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

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

The beneficiary’s treatment record must include a completed TMJ summary form (see Appendix I). Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

This procedure is reimbursable for Oral Cavity Designation areas 01 and 02.

**D9951 Occlusal Adjustment – limited**

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

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

The beneficiary’s treatment record must include a completed TMJ summary form (see Appendix I). Indicate whether the condition is acute or chronic and if any other services are to be provided.
D9999*  Unspecified adjunctive procedure, by report

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

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

- Procedure codes not included in Appendix A of this manual chapter;
- 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; and
- Administration of in-office pre-medication.
Requests for prior authorization (PA) are made on the ADA Dental Claim Form, the same claim form used for billing. Providers should complete this form for prior authorization following the instructions found within this chapter. When requesting prior authorization, two identical copies of the 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 Louisiana Department of Health (LDH) Medicaid Dental Prior Authorization Unit (PAU) will return all requests for PA 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 PA and documented in the treatment record as well.

Providers should staple together all claim forms and radiographs for a single beneficiary.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the beneficiary’s record and provide that information to the PAU.

For ease of billing, it is preferable to group services requiring authorization on a single claim form so that only one complete PA is issued per beneficiary.

EPSDT Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided in Appendix A. The procedure codes for services requiring PA are marked with an asterisk (*) and must be authorized by the Medicaid Dental PAU before payment will be made.

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

When requesting PA, the provider should list all services that are anticipated, even those not requiring authorization, in order for the PAU to fully understand the general dental health and condition of the beneficiary 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 beneficiary’s name, the beneficiary’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 PA, must be kept in the beneficiary’s treatment record. Without the complete treatment plan, appropriate radiographs, or explanations it may not be possible for the PAU to approve isolated services.

Prior Authorization Reminders

If you have questions regarding this policy, you may contact the Medicaid Dental Prior Authorization Unit.

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

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 PAU. The FI will send a PA letter to the provider detailing the services that have been prior authorized. A prior authorization number will be furnished on the PA letter to allow the provider to bill for services as they are completed. The beneficiary also receives a copy of the PA letter. An example of a PA Letter can be found at the end of this section. The returned copy of the claim form and the PA letter must be filed in the beneficiary’s treatment record.

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 PAU with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the “Remarks” section of the claim form.

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, the FI will send a PA 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 beneficiary also receives a copy of the PA letter and in the case of a denial, the explanation of denied benefits will advise beneficiaries of their appeal rights. The returned copy of the claim form and the PA letter must be filed in the beneficiary’s treatment record.
Provider should be certain that both copies of the claim form submitted for prior authorization are identical so that there is an accurate copy in the beneficiary’s treatment record.

The Medicaid PAU reviews the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

Failure to receive the returned claim form and radiographs and/or a Prior Authorization Letter within two weeks’ time should alert the provider that the claim form might have been misdirected. In these instances, please contact the Medicaid Dental Prior Authorization Unit. 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 PAU. All contacts with the PAU must be documented in the beneficiary’s record.

To amend or request reconsideration of a PA, the provider should submit a copy of the PA letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single PA Letter should match the services originally requested on a single page of the claim submitted for PA. Requests for additional treatment must be submitted as a new claim for which a new PA will be issued. For administrative changes only, e.g. provider number or beneficiary identification 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 PA, 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 PA while awaiting PA of those services that do.

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

All dental PA requests should be sent to the LDH Medicaid Dental PAU (see Appendix J for contact information).

The checklist available in Appendix G is provided to help prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. We recommend that you print this form and use when completing Medicaid dental PA requests.

NOTE: Claim forms for payment should be submitted to the FI (see Appendix J for contact information).
BENEFICIARY ELIGIBILITY REQUIREMENTS

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.

Beneficiaries may be eligible for the Adult Denture Program if they are Medicaid eligible, 21 years of age or older, AND missing all teeth in the maxillary and/or mandibular arches. Adult beneficiaries who are certified for Medicaid in “Qualified Medicare Beneficiary Only” (QMB Only) are NOT eligible to receive services in the Adult Denture Program. It is the responsibility of the provider to verify eligibility. Beneficiary eligibility should be verified prior to providing services to the beneficiary. The beneficiary 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 beneficiary eligibility information. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS.
COVERED SERVICES

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

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

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

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

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

Diagnostic Services

Examination

D0150 Comprehensive oral examination - new or established patient

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

Reimbursement for this procedure code requires that radiographs be taken and maintained in the beneficiary’s record and must be furnished to post-payment review if requested. The comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs.

Procedure code D0150 should be entered on the first line of the Dental Claim Form followed on the second line by the procedure code for radiographs D0210.
Code D0150 is reimbursable once every eight years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

**Examinations in Anticipation of Denture Construction**

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

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

**Minimum Examination Requirements for the Clinical Examination**

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

**Examination of Ineligible Beneficiaries**

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

**Examination in Conjunction with a Denture Repair**

Radiographs are not required in conjunction with a denture repair; therefore the fees for the examination and radiographs are not reimbursable. Claims for eligible denture repairs should be forwarded directly to the fiscal intermediary (FI) for payment.
CHAPTER 16: DENTAL SERVICES

SECTION 16.9: ADULT DENTURE PROGRAM- COVERED SERVICES

Examination in Conjunction with a Denture Reline

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

Radiographs

D0210 Intraoral – complete series

A complete series consists of:

- 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);
- An occlusal film (only for an edentulous arch); or
- A panoramic radiograph.

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

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

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

The comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs. The comprehensive oral examination will be denied if post payment review discovers the radiographs and/or oral/facial images were not provided prior to the delivery of dentures.
CHAPTER 16: DENTAL SERVICES
SECTION 16.9: ADULT DENTURE PROGRAM- COVERED SERVICES

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthetics

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

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

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

- Upon delivery:
  - The denture bases must be stable on the lower and retentive on the upper.
  - The clasping must be appropriately retentive for partial dentures.
  - The vertical dimension of occlusion must be comfortable to the patient (not over or under-closed). The proper centric relation of occlusion must be established for complete dentures or partial dentures opposing full dentures.
• For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.

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

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

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

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

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

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

**Denture Identification Information**

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

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

**Complete Dentures**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5110*</td>
<td>Complete Denture - maxillary</td>
</tr>
<tr>
<td>D5120*</td>
<td>Complete Denture - mandibular</td>
</tr>
<tr>
<td>D5130*</td>
<td>Immediate Denture - maxillary</td>
</tr>
<tr>
<td>D5140*</td>
<td>Immediate Denture – mandibular</td>
</tr>
</tbody>
</table>
Only one complete or partial denture per arch is allowed in an eight-year period. The eight-year period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in an eight-year period as prior authorized by Medicaid.

All missing teeth or teeth to be extracted must be marked in Block 34 of the ADA Dental Claim Form in the following manner: “X” out missing teeth and “/” out teeth to be extracted. Immediate dentures are not considered temporary. The provider must inform the beneficiary that no reline will be reimbursed by Medicaid within one year of the denture delivery.

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

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

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

Partial Dentures

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

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

The Adult Dental Program only provides for acrylic partials to oppose a full denture and does not provide for two partial dentures in the same oral cavity.
CHAPTER 16: DENTAL SERVICES

SECTION 16.9: ADULT DENTURE PROGRAM– COVERED SERVICES

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

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

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

Denture Repairs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
</tr>
<tr>
<td>D5520</td>
<td>Replace missing or broken tooth – complete denture – per tooth</td>
</tr>
<tr>
<td>D5611</td>
<td>Repair resin partial denture base, mandibular</td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin partial denture base, maxillary</td>
</tr>
<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
</tr>
<tr>
<td>D5640</td>
<td>Replace missing or broken tooth – partial denture – per tooth</td>
</tr>
<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture – per tooth</td>
</tr>
<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
</tr>
</tbody>
</table>
Repairs to partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Beneficiaries who do not have a complete denture are not eligible for the partial denture repair services of the Adult Denture Program.

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

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

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

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

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

The request for payment for procedure codes D5511, D5512, D5611 and D5612 must include the location and description of the fracture in the “Remarks” section of the claim form.

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

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

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designator 10, 20, 30 and 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 beneficiary’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; 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 Medicaid or its authorized representative will result in recoupment of monies paid by the program for the repair.

Denture Relines

D5750* Reline complete maxillary Denture - 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. Beneficiaries who do not have a complete denture are not eligible for the partial denture relines 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 an eight-year period as prior authorized by Medicaid or its designee. The eight-year period begins from the date the previous complete or partial denture for the same arch was delivered.

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

If the same billing provider (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture for the same arch within one 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 an eight-year period as prior authorized by Medicaid 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 eight years.

**NOTE:** 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 flanked and processed under heat and pressure in a commercial or office laboratory.

- Relines must be finished in a workmanlike manner; clean; exhibit a high gloss; and 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 Medicaid or its authorized representative will result in recoupment of the fee paid for the reline.

**Other Removable Prosthodontics**

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

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Please describe the situation requiring treatment and the treatment proposed in the “Remarks” section of the claim form.
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 Current Procedural Terminology (CPT) codes that are covered under the Professional Services Program when these services are rendered to Medicaid beneficiaries who are eligible for services provided in the Professional Services Program.
PRIOR AUTHORIZATION

Requests for Prior Authorization (PA) are made on the American Dental Association (ADA Claim Form, the same claim form used for billing. Providers should complete this form for PA following the instructions found in this chapter. When requesting PA two identical copies of this 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 Medicaid Prior Authorization Unit (PAU) will return all requests for PA 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 PA and documented in the treatment record as well.

Staple together all claim forms and radiographs for a single beneficiary.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the beneficiary’s record and provide that information to the PAU.

For ease of billing it is preferable to group services requiring authorization on a single claim form so that only one PA number need be issued per beneficiary.

All Adult Denture Program services (except for repairs) require PA. Adult Denture Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided in Appendix B. The procedure codes for services requiring PA are marked with an asterisk (*) and must be authorized by the Medicaid Dental PAU before payment will be made.

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

When requesting PA, the provider should list all services that are anticipated, even those not requiring authorization, in order for the Medicaid PAU to fully understand the general dental health and condition of the beneficiary 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, be certain it includes the date of the request, the beneficiary’s name, the beneficiary’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 PA, must be kept in the beneficiary’s treatment
record. Without the complete treatment plan, appropriate radiographs, or explanations, it may not be possible for the Medicaid PAU to determine approval of the isolated services.

Prior Authorization Reminders

If you have questions regarding this policy, you may contact the LDH Medicaid Dental Prior Authorization Unit (see appendix J).

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

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 PAU. The FI will send a PA letter to the provider detailing the services that have been prior authorized. A PA number will be furnished on the PA letter to allow the provider to bill for services as they are completed. The beneficiary also receives a copy of the PA letter. An example of a PA letter can be found in Appendix I. The returned copy of the claim form and the PA letter must be filed in the beneficiary’s treatment record.

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 PA process, they must be returned to the Medicaid PAU with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the “Remarks” section of the claim form.

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, the FI will send a PA 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 beneficiary also receives a copy of the PA letter and in the case of a denial, the explanation of denied benefits will advise beneficiaries of their appeal rights. The returned copy of the claim form and the PA letter must be filed in the beneficiary’s treatment record.

Provider should be certain that both copies of the claim form submitted for prior authorization are identical so that there is an accurate copy in the beneficiary’s treatment record.

The Medicaid PAU reviews the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

NOTE: 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 (see Appendix I) within three-weeks time should alert the provider that the claim form might have been misdirected. In these instances, contact the Medicaid Dental PAU. 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 Medicaid Dental PAU. All contacts with the PAU must be documented in the beneficiary’s record.

To amend or request reconsideration of a PA, the provider should submit a copy of the PA letter and copies of the original claim form and supporting documentation with a statement of what is requested. The services indicated on a single PA letter should match the services originally requested on a single page of the claim submitted for PA. Requests for additional treatment must be submitted as a new claim for which a new PA will be issued. For administrative changes only, e.g., provider number or beneficiary identification 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 PA, 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 PA while awaiting PA of those services that do.

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

All PA requests should be sent to the Louisiana Department of Health Medicaid Dental PAU (see Appendix J for contact information).

The checklist available in Appendix G is provided to help prevent errors frequently made when completing a Medicaid dental PA request. We recommend that you print this form and use when completing Medicaid dental PA requests.
DENTAL PROGRAM FEE SCHEDULE

The tables on the following pages contain the reimbursable dental procedure codes and fees for the Louisiana Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program.

All procedures listed in the EPSDT Dental Program Fee Schedule are subject to the guidelines, policies and limitations of the Medicaid Program and 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 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 and on the prior authorization request when prior authorization is 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.

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

The CDT Code and Nomenclature below have been obtained from Current Dental Terminology (including procedure codes, nomenclatures, descriptors and other data contained therein) (“CDT”). CDT is copyright © 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
The following fee schedule is effective January 1, 2016:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral examination – Patient of Record</td>
<td>27.24</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral examination for a patient under 3 years of age and counseling with primary caregiver</td>
<td>38.49</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral examination – New Patient</td>
<td>47.37</td>
</tr>
</tbody>
</table>

Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 3 years) only.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - Complete series of radiographic images</td>
<td>60.17</td>
</tr>
<tr>
<td>#D0220</td>
<td>Intraoral – Periapical first radiographic image</td>
<td>14.69</td>
</tr>
<tr>
<td>#D0230</td>
<td>Intraoral – Periapical each additional radiographic image</td>
<td>12.42</td>
</tr>
<tr>
<td>+D0240</td>
<td>Intraoral - Occlusal radiographic image</td>
<td>20.41</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings – 2 Radiographic images</td>
<td>21.43</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic radiographic image</td>
<td>57.05</td>
</tr>
<tr>
<td>+D0350</td>
<td>Oral/facial images</td>
<td>27.42</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>47.44</td>
</tr>
<tr>
<td>D0473</td>
<td>Accession of tissue, gross and microscopic examination, preparation and transmission of written report</td>
<td>74.49</td>
</tr>
<tr>
<td>D0474</td>
<td>Accession of tissue, gross and microscopic examination; including assessment of surgical margins for presence of disease, preparation and transmission of written report</td>
<td>77.03</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>FEE</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis – Adult (12 through 20 years of age)</td>
<td>48.01</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis – Child (under 12 years of age)</td>
<td>35.02</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish; therapeutic application for moderate to high caries risk patients (under 6 years of age)</td>
<td>24.29</td>
</tr>
<tr>
<td>D1208</td>
<td>Topical application of fluoride</td>
<td>19.50</td>
</tr>
<tr>
<td>#D1351</td>
<td>Sealant, per tooth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6-year molar sealant – under 10 years of age)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(12-year molar sealant – 10 through 15 years of age)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2, 3, 14, 15, 18, 19, 30, and 31.</td>
<td></td>
</tr>
<tr>
<td>+D1510</td>
<td>Space maintainer, fixed, unilateral</td>
<td>151.52</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 10, 20, 30, and 40.</td>
<td></td>
</tr>
<tr>
<td>+D1515</td>
<td>Space maintainer, fixed, bilateral</td>
<td>206.61</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td>+D1550</td>
<td>Recementation of space maintainer</td>
<td>38.77</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30, and 40.</td>
<td></td>
</tr>
<tr>
<td>D1555</td>
<td>Removal of fixed space maintainer</td>
<td>38.26</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>FEE</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>#D2140</td>
<td>Amalgam, one surface, primary or permanent</td>
<td>64.79</td>
</tr>
<tr>
<td></td>
<td>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 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2150</td>
<td>Amalgam, two surfaces, primary or permanent</td>
<td>82.14</td>
</tr>
<tr>
<td></td>
<td>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 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2160</td>
<td>Amalgam, three surfaces, primary or permanent</td>
<td>99.48</td>
</tr>
<tr>
<td></td>
<td>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 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2161</td>
<td>Amalgam, four or more surfaces, permanent</td>
<td>117.34</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32.</td>
<td></td>
</tr>
<tr>
<td>#D2330</td>
<td>Resin-based composite, one surface, anterior</td>
<td>76.01</td>
</tr>
<tr>
<td></td>
<td>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 for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2331</td>
<td>Resin-based composite, two surfaces, anterior</td>
<td>94.38</td>
</tr>
<tr>
<td></td>
<td>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 for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>FEE</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>#D2332</td>
<td>Resin-based composite, three surfaces, anterior</td>
<td>114.79</td>
</tr>
<tr>
<td></td>
<td>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 for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2335</td>
<td>Resin-based composite, four or more surfaces, anterior</td>
<td>143.87</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6 through 11 and 22 through 27; and tooth letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2390</td>
<td>Resin-based composite crown, anterior</td>
<td>210.70</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6 through 11 and 22 through 27; and tooth letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2391</td>
<td>Resin-based composite, one surface, posterior</td>
<td>64.79</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and tooth letters A, B, I, J, K, L, S and T.</td>
<td></td>
</tr>
<tr>
<td>#D2392</td>
<td>Resin-based composite, two surface, posterior</td>
<td>82.14</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and tooth letters A, B, I, J, K, L, S and T.</td>
<td></td>
</tr>
</tbody>
</table>
## EPSDT DENTAL PROGRAM
### RESTORATIVE PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D2393</td>
<td>Resin-based composite, three surface, posterior</td>
<td>99.48</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and tooth letters A, B, I, J, K, L, S and T.</td>
<td></td>
</tr>
<tr>
<td>#D2394</td>
<td>Resin-based composite, four or more surfaces, posterior</td>
<td>117.34</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and tooth letters A, B, I, J, K, L, S and T.</td>
<td></td>
</tr>
<tr>
<td>#D2920</td>
<td>Recement crown</td>
<td>50.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32 and tooth letter A through T.</td>
<td></td>
</tr>
<tr>
<td>#D2930</td>
<td>Prefabricated stainless steel crown, primary tooth</td>
<td>127.54</td>
</tr>
<tr>
<td></td>
<td>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 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2931</td>
<td>Prefabricated stainless steel crown, permanent tooth</td>
<td>152.03</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32.</td>
<td></td>
</tr>
<tr>
<td>#D2932</td>
<td>Prefabricated resin crown</td>
<td>165.80</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6 through 11 and 22 through 27; and tooth letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
</tbody>
</table>
### EPSDT DENTAL PROGRAM

#### RESTORATIVE PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D2933</td>
<td>Prefabricated stainless steel crown with resin window</td>
<td>168.86</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age and for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2934</td>
<td>Prefabricated esthetic coated stainless steel crown- primary tooth</td>
<td>168.86</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age and for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D2950</td>
<td>Core buildup, including any pins</td>
<td>128.56</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td>#D2951</td>
<td>Pin retention, per tooth, in addition to restoration</td>
<td>35.20</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 5; 12 through 15; 18 through 21; and 28 through 31.</td>
<td></td>
</tr>
<tr>
<td>#D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>160.70</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td>#*D2999</td>
<td>Unspecified restorative procedure, by report</td>
<td>*****</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32 and tooth letter A through T.</td>
<td></td>
</tr>
</tbody>
</table>
## EPSDT DENTAL PROGRAM
### ENDODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D3110</td>
<td>Pulp cap – direct (excluding final restoration)</td>
<td>38.26</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32.</td>
<td></td>
</tr>
<tr>
<td>#D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration)</td>
<td>94.38</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth letter A through T. However, this</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedure is reimbursable for tooth letters D, E, F, G, N, O, P and Q only if</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the recipient is under 5 years of age.</td>
<td></td>
</tr>
<tr>
<td>#D3222</td>
<td>Partial pulpotomy for apexogenesis</td>
<td>94.38</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth numbers 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td>#D3240</td>
<td>Pulpal therapy (resorbable filling), posterior, primary tooth</td>
<td>152.03</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth letter A, J, K, and T.</td>
<td></td>
</tr>
<tr>
<td>#D3310</td>
<td>Root canal therapy, anterior (excluding final restoration)</td>
<td>336.71</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.</td>
<td></td>
</tr>
<tr>
<td>#D3320</td>
<td>Root canal therapy, bicuspid (excluding final restoration)</td>
<td>395.37</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 4, 5, 12, 13, 20, 21, 28 and 29.</td>
<td></td>
</tr>
<tr>
<td>#D3330</td>
<td>Root canal therapy, molar (excluding final restoration)</td>
<td>474.45</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2, 3, 14, 15, 18, 19, 30 and 31.</td>
<td></td>
</tr>
<tr>
<td>D3346</td>
<td>Retreatment of previous root canal therapy, anterior</td>
<td>391.29</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.</td>
<td></td>
</tr>
</tbody>
</table>
# EPSDT DENTAL PROGRAM
## ENDODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D3352</td>
<td>Apexification/recalcification, Interim Medication Replacement, This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td>121.42</td>
</tr>
<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery, anterior, This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.</td>
<td>323.44</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling, per root, This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.</td>
<td>128.56</td>
</tr>
<tr>
<td>D3999</td>
<td>Unspecified endodontic procedure, by report, This procedure is reimbursable for tooth number 1 through 32 and tooth letter A through T.</td>
<td>****</td>
</tr>
</tbody>
</table>

# EPSDT DENTAL PROGRAM
## PERIODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D4210</td>
<td>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.</td>
<td>295.38</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planning, four or more teeth per quadrant, This procedure is reimbursable for oral cavity designator 10, 20, 30, and 40.</td>
<td>117.34</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>86.73</td>
</tr>
<tr>
<td>D4999</td>
<td>Unspecified periodontal procedure, by report</td>
<td>****</td>
</tr>
</tbody>
</table>
## EPSDT DENTAL PROGRAM
### REMOVABLE PROSTHODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>*D5110</td>
<td>Complete denture, maxillary</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5120</td>
<td>Complete denture, mandibular</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5130</td>
<td>Immediate denture, maxillary</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5140</td>
<td>Immediate denture, mandibular</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5211</td>
<td>Maxillary partial denture, resin base (including clasps)</td>
<td>470.00</td>
</tr>
<tr>
<td>*D5212</td>
<td>Mandibular partial denture, resin base (including clasps)</td>
<td>470.00</td>
</tr>
<tr>
<td>*D5213</td>
<td>Maxillary partial denture, cast metal (including clasps)</td>
<td>688.00</td>
</tr>
<tr>
<td>*D5214</td>
<td>Mandibular partial denture, cast metal (including clasps)</td>
<td>688.00</td>
</tr>
<tr>
<td>+D5510</td>
<td>Repair broken complete denture base</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Total of $175.00 limit in denture repairs per arch, see manual for details.</em></td>
<td></td>
</tr>
<tr>
<td>#D5520</td>
<td>Replace missing or broken tooth, complete denture, per tooth</td>
<td>65.00/33.00</td>
</tr>
<tr>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; Tooth = $65.00; Each additional tooth = $33.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Total of $175.00 limit in denture repairs per arch, see manual for details.</em></td>
<td></td>
</tr>
<tr>
<td>+D5610</td>
<td>Repair resin denture base, partial denture</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Total of $175.00 limit in denture repairs per arch, see manual for details.</em></td>
<td></td>
</tr>
</tbody>
</table>
## EPSDT DENTAL PROGRAM
### PERIODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+D5630</td>
<td>Repair or replace broken clasp – per tooth</td>
<td>119.00</td>
</tr>
<tr>
<td>#D5640</td>
<td>Replace broken teeth, partial denture, per tooth</td>
<td>65.00/33.00</td>
</tr>
<tr>
<td>+D5660</td>
<td>Add clasp to existing partial denture – per tooth</td>
<td>119.00</td>
</tr>
<tr>
<td>*D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>238.00</td>
</tr>
<tr>
<td>*D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>238.00</td>
</tr>
<tr>
<td>*D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>208.00</td>
</tr>
<tr>
<td>*D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>208.00</td>
</tr>
</tbody>
</table>

This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.

Total of $175.00 limit in denture repairs per arch, see manual for details.
### EPSDT DENTAL PROGRAM
#### PERIODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>*D5820</td>
<td>Interim partial denture (maxillary), includes clasps</td>
<td>375.00</td>
</tr>
<tr>
<td>*D5821</td>
<td>Interim partial denture (mandibular), includes clasps</td>
<td>375.00</td>
</tr>
<tr>
<td>*D5899</td>
<td>Unspecified removable prosthodontic procedure, by report</td>
<td>****</td>
</tr>
</tbody>
</table>

#### MAXILLOFACIAL PROSTHETIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+D5986</td>
<td>Fluoride gel carrier</td>
<td>98.76</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
</tbody>
</table>

#### FIXED PROSTHODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D6241</td>
<td>Pontic - porcelain fused to predominantly base metal</td>
<td>486.69</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 7, 8, 9, and 10.</td>
<td></td>
</tr>
<tr>
<td>#D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>394.35</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 6, 7, 8, 9, 10 and 11.</td>
<td></td>
</tr>
<tr>
<td>*D6999</td>
<td>Unspecified, fixed porothodontic procedure, by report</td>
<td>****</td>
</tr>
</tbody>
</table>
**EPSDT DENTAL PROGRAM**

**ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D7111</td>
<td>Extraction, Coronal Remnants – Deciduous Tooth</td>
<td>64.79</td>
</tr>
<tr>
<td></td>
<td>Includes soft tissue-retained coronal remnants. This procedure code is reimbursable for tooth letters A through T and AS through TS.</td>
<td></td>
</tr>
<tr>
<td>#D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>79.07</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D7210</td>
<td>Surgical removal of erupted tooth</td>
<td>130.09</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>#D7220</td>
<td>Removal of impacted tooth – soft tissue</td>
<td>150.50</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>#D7230</td>
<td>Removal of impacted tooth – partially bony</td>
<td>188.76</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>#D7240</td>
<td>Removal of impacted tooth – completely bony</td>
<td>232.12</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
## Chapter 16: Dental Services

### Appendix A: EPSDT Dental Program Fee Schedule

### Page(s) 17

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D7241</td>
<td>Removal of impacted tooth – completely bony, with unusual surgical complications</td>
<td>278.04</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>#D7250</td>
<td>Surgical removal of residual tooth roots (cutting procedure)</td>
<td>144.38</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>+D7270</td>
<td>Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>*****</td>
</tr>
<tr>
<td></td>
<td>Maximum Fee $255.05</td>
<td>$255.05</td>
</tr>
<tr>
<td>#D7280</td>
<td>Surgical access of an unerupted tooth</td>
<td>229.57</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15; and 18 through 31.</td>
<td></td>
</tr>
</tbody>
</table>

### EPSDT Dental Program

#### Oral and Maxillofacial Surgery Procedure Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>#D7283</td>
<td>Placement of device to facilitate eruption of impacted tooth</td>
<td>245.90</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15; and 18 through 31 for Medicaid approved comprehensive orthodontic cases only.</td>
<td></td>
</tr>
<tr>
<td>+D7285</td>
<td>Biopsy of oral tissue – hard (bone, tooth)</td>
<td>*****</td>
</tr>
<tr>
<td></td>
<td>Maximum Fee $194.88</td>
<td>$194.88</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30 or 40.</td>
<td></td>
</tr>
<tr>
<td>+D7286</td>
<td>Biopsy of oral tissue - soft (all others)</td>
<td>152.54</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30 and 40.</td>
<td></td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>FEE</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>+D7291</td>
<td>Transseptal fiberotomy/supra crestal fiberotomy, by report</td>
<td>152.03</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02 for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid approved comprehensive orthodontic cases only.</td>
<td></td>
</tr>
<tr>
<td>+D7310</td>
<td>Alveoloplasty in conjunction with extractions – per quadrant</td>
<td>140.29</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.</td>
<td></td>
</tr>
<tr>
<td>#D7510</td>
<td>Incision and drainage of abscess – intraoral soft tissue</td>
<td>109.68</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 1 through 32.</td>
<td></td>
</tr>
<tr>
<td>+D7880</td>
<td>Occlusal orthotic device, by report</td>
<td>461.69</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
<td>140.80</td>
</tr>
<tr>
<td>+D7960</td>
<td>Frenulectomy (frenectomy or frenotomy) – separate procedure</td>
<td>211.21</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and 40.</td>
<td></td>
</tr>
</tbody>
</table>

**EPSDT DENTAL PROGRAM**

**ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+D7997</td>
<td>Appliance removal (not by dentist who placed appliance), includes removal of</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td>archbar</td>
<td>$240.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td>*D7999</td>
<td>Unspecified oral surgery procedure, by report</td>
<td>*****</td>
</tr>
</tbody>
</table>
### EPSDT Dental Program

#### Orthodontic Procedure Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+D8050</td>
<td>Interceptive orthodontic treatment of the primary dentition</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30 and 40.</td>
<td>$438.00</td>
</tr>
<tr>
<td>+D8060</td>
<td>Interceptive orthodontic treatment of the transitional dentition</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30 and 40.</td>
<td>$438.00</td>
</tr>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional dentition</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$4,182.00</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$4,281.00</td>
</tr>
<tr>
<td>D8090</td>
<td>Comprehensive orthodontic treatment of the adult dentition</td>
<td>***** Maximum Fee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$4,515.00</td>
</tr>
<tr>
<td>D8220</td>
<td>Fixed appliance therapy</td>
<td>534.71</td>
</tr>
<tr>
<td>*D8999</td>
<td>Unspecified orthodontic procedure, by report</td>
<td>*****</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
<td>FEE</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain</td>
<td>58.67</td>
</tr>
<tr>
<td>D9230</td>
<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
<td>36.73</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>1st 15 Minute Increment = $109.17; Each Additional 15 Minute Increments = $73.98</strong></td>
<td>109.17/73.98</td>
</tr>
<tr>
<td>D9242</td>
<td>Intravenous conscious sedation/analgesia – each additional 15 minutes</td>
<td>73.98</td>
</tr>
<tr>
<td>D9248</td>
<td>Non-intravenous conscious sedation</td>
<td>125.45</td>
</tr>
<tr>
<td>D9420</td>
<td>Hospital call</td>
<td>106.18</td>
</tr>
<tr>
<td>D9440</td>
<td>Office visit – after regularly scheduled hours</td>
<td>79.59</td>
</tr>
<tr>
<td>D9920</td>
<td>Behavior management, by report</td>
<td>68.87</td>
</tr>
<tr>
<td>+D9940</td>
<td>Occlusal guard, by report</td>
<td>280.08</td>
</tr>
<tr>
<td></td>
<td>This procedure reimbursable for oral cavity designator 01 and 02.</td>
<td></td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment – limited</td>
<td>85.71</td>
</tr>
<tr>
<td>*D9999</td>
<td>Unspecified adjunctive procedure, by report</td>
<td>*****</td>
</tr>
</tbody>
</table>

**Note:** Dental prior authorization requests and dental claims for payment must indicate tooth surface(s) when the procedure code directly involves one or more tooth surfaces.
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. 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. *If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator on the claim form for payment or on the prior authorization request when prior authorization is 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. *If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter on the claim form for payment.*

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

The CDT Code and Nomenclature below have been obtained from Current Dental Terminology (including procedure codes, nomenclatures, descriptors and other data contained therein) (“CDT”).

CDT is copyright © 2020 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
The following fee schedule is effective January 1, 2016:

**ADULT DENTURE PROGRAM
DIAGNOSTIC PROCEDURE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>*D0150</td>
<td>Comprehensive oral examination (adult oral examination)</td>
<td>$47.37</td>
</tr>
<tr>
<td>*D0210</td>
<td>Intraoral radiographs, complete series</td>
<td>$60.49</td>
</tr>
</tbody>
</table>

**ADULT DENTURE PROGRAM
REMOVABLE PROSTHODONTIC PROCEDURE CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>*D5110</td>
<td>Complete denture, maxillary</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5120</td>
<td>Complete denture, mandibular</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5130</td>
<td>Immediate denture, maxillary</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5140</td>
<td>Immediate denture, mandibular</td>
<td>495.00</td>
</tr>
<tr>
<td>*D5211</td>
<td>Maxillary partial denture, resin base (including retentive/clasping materials, rests and teeth)</td>
<td>470.00</td>
</tr>
<tr>
<td>*D5212</td>
<td>Mandibular partial denture, resin base (including retentive/clasping materials, rests and teeth)</td>
<td>470.00</td>
</tr>
<tr>
<td>D5511</td>
<td>Repair broken complete denture base, mandibular</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>*Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>D5512</td>
<td>Repair broken complete denture base, maxillary</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>*Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>#D5520</td>
<td>Replace missing or broken tooth, complete denture, per tooth</td>
<td>65.00/33.00</td>
</tr>
<tr>
<td></td>
<td>1st Tooth = $65.00; each additional tooth = $33.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
</tbody>
</table>
## ADULT DENTURE PROGRAM
### REMOVABLE PROSTHODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5611</td>
<td>Repair resin denture base, partial denture, mandibular</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>D5612</td>
<td>Repair resin denture base, partial denture, maxillary</td>
<td>125.00</td>
</tr>
<tr>
<td></td>
<td>Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>+D5630</td>
<td>Repair or replace broken retentive/clasping materials, partial denture – per tooth</td>
<td>119.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>#D5640</td>
<td>Replace broken teeth, partial denture, per tooth</td>
<td>65.00/33.00</td>
</tr>
<tr>
<td></td>
<td>1st Tooth = $65.00; Each additional tooth = $33.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
<tr>
<td>#D5650</td>
<td>Add tooth to existing partial denture</td>
<td>65.00/33.00</td>
</tr>
<tr>
<td></td>
<td>1st Tooth = $65.00; each additional tooth = $33.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of $175.00 limit in denture repairs per arch, see manual for details.</td>
<td></td>
</tr>
</tbody>
</table>
## ADULT DENTURE PROGRAM
### REMOVABLE PROSTHODONTIC PROCEDURE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>+D5660</td>
<td>Add clasp to existing partial denture – Per tooth</td>
<td>119.00</td>
</tr>
<tr>
<td></td>
<td>This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Total of $175.00 limit in denture repairs per arch, see manual for details.</em></td>
<td></td>
</tr>
<tr>
<td>*D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
<td>238.00</td>
</tr>
<tr>
<td>*D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
<td>238.00</td>
</tr>
<tr>
<td>*D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
<td>208.00</td>
</tr>
<tr>
<td>*D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
<td>208.00</td>
</tr>
<tr>
<td>*D5899</td>
<td>Unspecified removable prosthodontic procedure, by report</td>
<td>*****</td>
</tr>
</tbody>
</table>
ADA DENTAL CLAIM FORM AND INSTRUCTIONS

The most current American Dental Association (ADA) Dental Claim Form is required when submitting hardcopy claims to Medicaid and will be the only dental claim form accepted for prior authorization and payment of dental services.

The numbered line-by-line billing instructions below correspond with the same numbered block of the 2019 ADA Dental Claim Form. **Required** information must be entered to ensure claims processing. **Situational** information may be required only in certain situations as detailed in each instruction item. Information on the claim form may be handwritten or computer generated and must be legible and completely contained in the designated area of the claim form. **Only one tooth number/letter or oral cavity designator is allowed per claim line.** Refer to the applicable dental program policy and/or dental program fee schedule for specific requirements regarding tooth number/letter or oral cavity designator.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental Program and Adult Denture Program **claims for payment** should be submitted to the fiscal intermediary (refer to Appendix J for contact information).

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Transaction</td>
<td><strong>Required</strong> -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization. <strong>Situational</strong> – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age. If block is not checked, the claim will be processed as an adult claim.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Predetermination / Preauthorization Number</td>
<td><strong>Situational</strong> – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Company / Plan Name, Address, City, State, Zip Code</td>
<td><strong>Situational</strong> – Enter the primary payer information if applicable.</td>
<td></td>
</tr>
</tbody>
</table>
## Locator #
<table>
<thead>
<tr>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Other Dental or Medical Coverage?</td>
<td><strong>Situational</strong> – If yes, complete Block 9.</td>
<td></td>
</tr>
<tr>
<td>5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>6 Date of Birth (MM/DD/CCYY)</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>7 Gender</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>8 Policyholder/Subscriber ID</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>9 Plan/Group Number</td>
<td><strong>Situational</strong> – Enter the third party’s carrier code if a third party is involved. A list of codes identifying various carriers may be obtained from the Louisiana Medicaid website, <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> under the link Forms/Files. If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.</td>
<td></td>
</tr>
<tr>
<td>10 Patient’s Relationship to Person Named in #5</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>11 Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code</td>
<td><strong>Situational.</strong></td>
<td></td>
</tr>
<tr>
<td>12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code</td>
<td><strong>Required</strong> -- Enter the beneficiary’s last name, first name, and middle initial exactly as verified through REVS or MEVS. Beneficiary’s address is <strong>optional.</strong></td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>13</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td><strong>Required</strong> -- Enter the beneficiary’s eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.</td>
</tr>
<tr>
<td>14</td>
<td>Gender</td>
<td><strong>Optional</strong> – Check appropriate block.</td>
</tr>
<tr>
<td>15</td>
<td>Policyholder/Subscriber ID</td>
<td><strong>Required</strong> -- Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the sixteen-digit Card Control Number (CCN) from the beneficiary’s Medicaid card.</td>
</tr>
<tr>
<td>16</td>
<td>Plan / Group Number</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>17</td>
<td>Employer Name</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>18</td>
<td>Relationship to Policyholder/Subscriber in #12 above.</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>19</td>
<td>Student Status</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>20</td>
<td>Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code</td>
<td><strong>Situational.</strong> This field should be used only when other private insurance is primary. <strong>Note:</strong> The Medicaid beneficiary’s name is required to be entered in Block 12.</td>
</tr>
<tr>
<td>21</td>
<td>Date of Birth (MM/DD/CCYY)</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>22</td>
<td>Gender</td>
<td><strong>Situational.</strong></td>
</tr>
<tr>
<td>23</td>
<td>Patient ID / Account # (Assigned by Dentist)</td>
<td><strong>Optional</strong> – Enter a Patient ID/Account Number if one has been assigned by the dentist. If entered, this identifier will appear on the Remittance Advice. The Patient ID/Account Number may consist of letters and/or numbers, and it may be a maximum of 20 characters.</td>
</tr>
</tbody>
</table>
## Appendix C: Dental Claim Form/Instructions

<table>
<thead>
<tr>
<th>Locator #</th>
<th>Description</th>
<th>Instructions</th>
<th>Alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Procedure Date (MM/DD/CCYY)</td>
<td><strong>Required</strong> -- Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. A service must have been performed/delivered before billing Medicaid for payment.</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Area of Oral Cavity</td>
<td><strong>Situational</strong> – Enter the oral cavity designator when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator. If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter in Block 27.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Tooth System</td>
<td><strong>Leave Blank</strong></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Tooth Number(s) or Letter(s)</td>
<td><strong>Situational</strong> – Enter a tooth number or letter when applicable for a specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter. If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25.</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Tooth Surface</td>
<td><strong>Situational</strong> – Enter tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal; D = Distal; F = Facial; I = Incisal; L = Lingual; M = Mesial; and O = Occlusal. Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.</td>
<td></td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
<td>Instructions</td>
<td>Alerts</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>29</td>
<td>Procedure Code</td>
<td>Required – Enter the appropriate dental procedure code from the current version of Code on Dental Procedures and Nomenclature. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.</td>
<td></td>
</tr>
<tr>
<td>29a</td>
<td>Diagnosis Code Pointer</td>
<td>Situational – This field is optional and is only utilized if diagnosis will be listed in 34a. If diagnosis codes are being used, enter the letter(s) from item 34 that identify the diagnosis code(s) applicable to the specific dental procedure. List primary diagnosis pointer first.</td>
<td></td>
</tr>
<tr>
<td>29b</td>
<td>Quantity</td>
<td>Required – Enter the number of times (01-99) the procedure identified in block 29 was delivered to the beneficiary on the date of service shown in block 24. The default value for the field is “01”.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Description</td>
<td>Required – Enter the description of the service performed.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Fee</td>
<td>Required -- Enter the dentist’s full (usual and customary) fee for the dental procedure reported.</td>
<td></td>
</tr>
<tr>
<td>31a</td>
<td>Other Fee(s)</td>
<td>Leave Blank</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Total Fee</td>
<td>Required – Total of all fees listed on the claim form.</td>
<td></td>
</tr>
</tbody>
</table>
### Missing Teeth Information

<table>
<thead>
<tr>
<th>33</th>
<th>Missing Teeth Information (Place an ‘X’ on each missing tooth)Total Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Situational</strong> – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an “X”. Indicate teeth to be extracted with an “/”.</td>
</tr>
<tr>
<td></td>
<td>In the following circumstances, this information is <strong>required</strong>:</td>
</tr>
<tr>
<td></td>
<td>If the claim is for the Adult Denture Program.</td>
</tr>
<tr>
<td></td>
<td>If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy. <strong>Required</strong> – Total of all fees listed on the claim form.</td>
</tr>
</tbody>
</table>

### Diagnosis Code List Qualifier

<table>
<thead>
<tr>
<th>34</th>
<th>Diagnosis Code List Qualifier (Place an ‘X’ on each missing tooth)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Situational</strong> – Required if field 29a (diagnosis pointer) is completed.</td>
</tr>
<tr>
<td></td>
<td>Diagnosis qualifier “AB” indicates an ICD-10 diagnosis will be entered in field 34a. <strong>Situational</strong> – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an “X”. Indicate teeth to be extracted with an “/”.</td>
</tr>
<tr>
<td></td>
<td>In the following circumstances, this information is <strong>required</strong>:</td>
</tr>
<tr>
<td></td>
<td>If the claim is for the Adult Denture Program.</td>
</tr>
<tr>
<td></td>
<td>If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.</td>
</tr>
</tbody>
</table>

### Diagnosis Code(s)

<table>
<thead>
<tr>
<th>34a</th>
<th>Diagnosis Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Situational</strong> – This information is only needed when the diagnosis may affect claim adjudication due to specific dental procedures being authorized to minimize risks associated with the connection between the patient’s oral and systemic health conditions.</td>
</tr>
<tr>
<td></td>
<td>Supports up to 4 diagnosis codes per dental procedure. The primary diagnosis should be noted in line A.</td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>35</td>
<td>Remarks</td>
</tr>
<tr>
<td>36</td>
<td>Authorizations</td>
</tr>
<tr>
<td>37</td>
<td>Authorizations</td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>38</td>
<td>Place of Treatment</td>
</tr>
<tr>
<td>39</td>
<td>Number of Enclosures</td>
</tr>
<tr>
<td>40</td>
<td>Is Treatment for Orthodontics?</td>
</tr>
<tr>
<td>41</td>
<td>Date Appliance Placed</td>
</tr>
<tr>
<td>42</td>
<td>Months of Treatment Remaining.</td>
</tr>
<tr>
<td>43</td>
<td>Replacement of Prosthesis</td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>44</td>
<td>Date Prior Placement</td>
</tr>
<tr>
<td>45</td>
<td>Treatment Resulting from</td>
</tr>
<tr>
<td>46</td>
<td>Date of Accident (MM/DD/CCYY)</td>
</tr>
<tr>
<td>47</td>
<td>Auto Accident State</td>
</tr>
<tr>
<td>48</td>
<td>Billing Dentist Name, Address, City, State, Zip Code</td>
</tr>
<tr>
<td>49</td>
<td>NPI</td>
</tr>
<tr>
<td>50</td>
<td>License Number</td>
</tr>
<tr>
<td>51</td>
<td>SSN or TIN</td>
</tr>
<tr>
<td>52</td>
<td>Phone Number</td>
</tr>
<tr>
<td>52a</td>
<td>Additional Provider ID</td>
</tr>
<tr>
<td>Locator #</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>53</td>
<td>Signature</td>
</tr>
<tr>
<td>54</td>
<td>NPI</td>
</tr>
<tr>
<td>55</td>
<td>License Number</td>
</tr>
<tr>
<td>56</td>
<td>Address, City, State, Zip Code</td>
</tr>
<tr>
<td>56a</td>
<td>Provider Specialty Code</td>
</tr>
<tr>
<td>57</td>
<td>Phone Number</td>
</tr>
<tr>
<td>58</td>
<td>Additional Provider ID</td>
</tr>
</tbody>
</table>
# Appendix C: Dental Claim Form/Instructions

## Dental Claim Form

### Header Information

1. **Type of Transaction (Mark all applicable boxes):**
   - Statement of Account
   - Request for Preauthorization/Authorization
   - Other (please specify):

2. **Preauthorization/Authorization Number:**

### Dental Benefit Plan Information

3. **Company Name:**

4. **Plan/Group Number:**

### Other Coverage

5. **Name of Policyholder/Subscriber in Plan:**

6. **Date of Birth (MM/DD/YYYY):**

7. **Policyholder/Subscriber ID (Assigned by Plan):**

### Patient Information

8. **Relationship to Policyholder/Subscriber in #2 Above:**
   - Self
   - Spouse
   - Dependent
   - Other

9. **Number and Address:**

10. **Name:**

11. **City, State, Zip Code:**

### Record of Services Provided

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diagnosis Code

12. **Diagnosis Code(s):**

### Auxiliary Claim Information

13. **Place of Treatment:**

14. **Diagnosis Code(s):**

### Authorization

15. **Signature:**

16. **Date:**

### Billing Dentist or Dental Entity

17. **Name:**

18. **Address:**

19. **City, State, Zip Code:**

### Treatment and Treatment Location Information

20. **Treator/Operator (锹 or Dentist):**

21. **Address:**

22. **City, State, Zip Code:**

### Additional Information

23. **Name:**

24. **Address:**

25. **City, State, Zip Code:**

### Additional Information

26. **Name:**

27. **Address:**

28. **City, State, Zip Code:**

### ADA American Dental Association Dental Claim Form

©2015 American Dental Association

J422 (Same as ADA Dental Claim Form — J421, J422, J432, J433, J434, J435C)
The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/edf/ada-dental-claim-form).

**GENERAL INSTRUCTIONS**

A. The form is designed so that the name and address (item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 envelope window (window to the left). Please fold the form using the `tick-marks` printed in the margin.

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

F. GENDER Codes (items 7, 14 and 22) – M = Male; F = Female; U = Unknown

**COORDINATION OF BENEFITS (COB)**

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the “Remarks” field (item 35).

**DIAGNOSIS CODING**

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 28a – Diagnosis Code Pointer (“A” through “D” as applicable from item 34a)
- Item 34 – Diagnosis Code List Qualifier (AB for ICD-10-OCM)
- Item 34a – Diagnosis Code Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter “A”)

**PLACE OF TREATMENT**

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office
- 12 = Home
- 21 = Inpatient Hospital
- 22 = Outpatient Hospital
- 31 = Skilled Nursing Facility
- 32 = Nursing Facility

The full list is available online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

**PROVIDER SPECIALTY**

This code is entered in item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as “Dentist” may be used instead of any of the other codes.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>12230000DX</td>
</tr>
<tr>
<td>General Practice</td>
<td>12236001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>12230000DX</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223ED00X</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1223ED00X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223E000X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P900X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P000X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P010X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D000X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S012X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at: http://www.wpo-edi.com/reference/code lists/healthcare/health-care-provider-taxonomy-code-set
ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

Early and Periodic Screening, Diagnosis and Treatment

Instructions for Completing 209 Adjustment/Void Form

DXC Form 209 Instructions
Revised 10/04

1. Adj/Void
   Check the appropriate box.

2.-4. Patient’s Last Name, First Name, MI
   Adjust – Enter the information exactly as it appeared on the original invoice.
   Void – Enter the information exactly as it appeared on the original invoice.

5. Medical Assistance ID Number
   Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.
   Void - Enter the information exactly as it appeared on the original invoice.

6. Patient's Address
   Adjust - Enter the information exactly as it appeared on the original invoice.
   Void - Enter the information exactly as it appeared on the original invoice.

7. Date of Birth
   Adjust - Enter the information exactly as it appeared on the original invoice.
   Void - Enter the information exactly as it appeared on the original invoice.

8. Sex
   Adjust - Enter the information exactly as it appeared on the original invoice.
   Void - Enter the information exactly as it appeared on the original invoice.

9.-14. Not required
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Adjust</th>
<th>Void</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Patient ID/Account Number</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
</tr>
<tr>
<td></td>
<td>(Assigned By Dentist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Pay to Dentist or Group</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
</tr>
<tr>
<td>17</td>
<td>Pay to Dentist or Group Provider No.</td>
<td>Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
</tr>
<tr>
<td>18</td>
<td>Are X-Rays Enclosed</td>
<td>Not required</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Treatment Necessitated By</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
</tr>
<tr>
<td>20</td>
<td>Payment Source Other Than Title XIX</td>
<td>Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
</tr>
<tr>
<td>21-22</td>
<td></td>
<td>Leave these spaces blank.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Diagram</td>
<td>Not required</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix D: Adjustment/Void Forms and Instructions

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| 24.     | Examination and Treatment Plan  
**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted.  
**Void** - Enter the information exactly as it appeared on the original invoice. |
| 25.     | Paid or Payable by Other Carrier  
**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0).  
**Void** - Enter the information exactly as it appeared on the original invoice. |
| 26.     | Control Number |
| 27.     | Date of Remittance Advice |
| 28-29.  | Reasons for Adjustment/Void  
Check the appropriate box and give a written explanation, when applicable. |
| 30-31.  | Leave these spaces blank. |
| 32.     | Attending Dentist's Signature-Provider Number  
All adjustment forms must be signed, and the provider number must be entered. |

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to DXC for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.
## Chapter 16: Dental Services

### Appendix D: Adjustment/Void Forms and Instructions

**Page(s) 10**

---

**State Form 2090**

**For Office Use Only**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Payment Information**

- **State of Louisiana**
- **Department of Health**
- **Bureau of Health Services Financing**
- **Medical Assistance Program**
- **Provider Billing for Special Dental Services**

**Diagnosis**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Employment</td>
<td>Yes/No</td>
</tr>
<tr>
<td>B. Accident/Injury</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Payment Receipted By**

- **Yes**
- **No**

**Exceeding Frequency**

- **Yes**
- **No**

**If Adult Emergency Service, Credit allure and send to DSH Dental Program**

**Examination and Treatment Plan**

**Deficiency**

- **A. NKG INHIBIT (A)**
- **B. WEIGHING TEETH THROUGH ANX**
- **C. INHIBIT GROWING WITH AND**
- **D. INHIBIT TEETH TO BE EXTRACTED WITH U/**

**Reasons for Adjustment**

- **01. Third Party Liability Recovery**
- **02. Provider Overcharges**
- **03. Local Agency Error**
- **05. State Office Use Only - Recovery**
- **06. Other - Please Explain**

**Reasons for Void**

- **10. Claim Paid for Wrong Recipient**
- **12. Claim Paid to Wrong Provider**
- **00. Other - Please Explain**

**Control Number**

- **This is for charging of void**

**Use of Remittance Only**

- **Yes**
- **No**

**Equipment**

- **U.S. Lavender...**

**Authorization**

- **Approved - Yes**
- **No**
- **W/Exceptions**

**Attending Dentist Signature**

- **Provider #**
- **Authorization Signature**
- **Date**

**References**

- **Attending Dentist Information**
MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTSCLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.
Adult Dental Services

Instructions for Completing 210 Adjustment/Void Form

DXC Form 210 Instructions
Revised 10/04

1. Adj/Void
   Check the appropriate box.

2. -4. Patient’s Last Name, First Name, MI

   Adjust – Enter the information exactly as it appeared on the original invoice.

   Void – Enter the information exactly as it appeared on the original invoice.

5. Medical Assistance ID Number

   Adjust – Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.

   Void – Enter the information exactly as it appeared on the original invoice.

6. Patient's Address

   Adjust – Enter the information exactly as it appeared on the original invoice.

   Void – Enter the information exactly as it appeared on the original invoice.

7. Date of Birth

   Adjust – Enter the information exactly as it appeared on the original invoice.

   Void – Enter the information exactly as it appeared on the original invoice.

8. Sex

   Adjust – Enter the information exactly as it appeared on the original invoice.

   Void – Enter the information exactly as it appeared on the original invoice.

9.-14.

   Not required
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Adjust</th>
<th>Void</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Patient ID/Account Number (Assigned By Dentist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Pay to Dentist or Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Pay to Dentist or Group Provider No.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Are X-Rays Enclosed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Treatment Necessitated By</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Payment Source Other Than Title XIX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice.
### Chapter 16: Dental Services

#### Appendix D: Adjustment/Void Forms and Instructions

<table>
<thead>
<tr>
<th>Page(S) 10</th>
</tr>
</thead>
</table>

23. **A-G**  
**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted.  
**Void** - Enter the information exactly as it appeared on the original invoice.

24. **Paid or Payable by Other Carrier**  
**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0).

25. **Other Information**  
**Leave blank**

26. **Control Number**  
Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied the claim.

27. **Date of Remittance Advice**  
Enter the date of the Remittance Advice that paid or denied claim.

28-29. **Reasons for Adjustment/Void**  
Check the appropriate box and give a written explanation, when applicable.

30-31.  
**Leave these spaces blank.**

32. **Attending Dentist's Signature-Provider Number**  
All adjustment forms must be signed, and the provider number must be entered.

---

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to DXC for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.
MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.
The Louisiana Department of Health follows the American Academy of Pediatric Dentistry’s (AAPD) oral health recommendations in consultation with local dental professionals. These recommendations are designed for care of children who have no contributing medical conditions and are developing normally. These recommendations may require modification for children with special health needs or if disease or trauma manifests variations from normal.

<table>
<thead>
<tr>
<th>AGE</th>
<th>6-12 MTHS</th>
<th>12-24 MTHS</th>
<th>2-6 YEARS</th>
<th>6-12 YEARS</th>
<th>12 YEARS AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical oral exam</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Assess oral growth &amp; development</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Caries-risk assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Radiographic Assessment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Prophylaxis and topical fluoride</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Fluoride supplementation</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Anticipatory guidance/counseling</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Oral hygiene counseling</td>
<td>Parent</td>
<td>Parent</td>
<td>Patient/Parent</td>
<td>Patient/Parent</td>
<td>Patient</td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Injury prevention counseling</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Counseling for non-nutritive habits</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Counseling for speech/language development</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Assessment and treatment of developing malocclusion</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Assessment for pit and fissure sealants</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Substance abuse counseling</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Counseling for intraoral/perioral piercing</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Assessment and/or removal of third molars</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Transition to adult dental care</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

(1) First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child’s risk status/susceptibility to disease. Includes assessment of pathology and injuries.
(2) By clinical examination.
(3) Must be repeated regularly and frequently to maximize effectiveness.
(4) Timing, selection, and frequency determined by child’s history, clinical findings, and susceptibility to oral disease.
(5) Consider when systemic fluoride is suboptimal, up to at least 16 years of age.
(6) Appropriate discussion and counseling should be an integral part of each visit for care.
(7) Initially, responsibility of parent; as child matures, jointly with parent; then when indicated, only child.
(8) At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
(9) Initially play objects, pacifiers, car seats; then learning to walk, sports and routine playing, including the importance of mouth guards.

(10) At first, discuss the need for additional sucking; digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

(11) For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2020 American Dental Association. The CDT Code and Nomenclature used throughout this document have been obtained from Current Dental terminology (including procedure codes, nomenclatures, descriptors and other data contained therein) (“CDT”). CDT is copyright © 2020 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.
ERROR CODE 515 CLAIM DENIAL SIMPLIFICATION PROCESS

The restoration policy which is provided below applies to multiple restorations on the same patient, same tooth within 12 months from the date of the original restoration by the same billing provider or another Medicaid provider located in the same office as the billing provider. Providers should note that the policy differs between permanent and primary teeth. Currently, providers who receive a claim denial for error code 515 must resubmit the request for payment to the Louisiana Department of Health Medicaid Dental Prior Authorization Unit (PAU) (see Appendix J for contact information) along with certain documentation and a request to override the claim denial. By following the guidelines on Page 3 of this document, providers will not have to resubmit their 515 claim denials to the Medicaid Dental PAU for reconsideration of payment. Failure to follow the guidelines on Page 3 will continue to result in a 515 claim denial and the provider will be responsible for resubmitting the required information.

Permanent Tooth Restorations

Medicaid currently performs a cutback in the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same recipient, same permanent tooth when billed within 12 months from the date of the original restoration. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same permanent tooth will not exceed the maximum fee of the larger restoration.

In addition, Medicaid policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same recipient, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. The chart on Page 2 of this document identifies the specific procedure codes for permanent teeth that are eligible for full reimbursement as a second or subsequent restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury.

Currently, the second and subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee due to pulpal necrosis (root canal) or traumatic injury are denied by Medicaid with a 515 claim denial (Override Required-Send to Dental PAU) and the provider is required to submit a 515 override request along with certain documentation to the Medicaid Dental PAU in order to have the claim reconsidered for payment.

If no additional payment is made by Medicaid for a second or subsequent restoration for a permanent tooth for the same patient, same permanent tooth within a 12 month period, the provider is responsible for the restoration.
Procedure Codes Available for Reimbursement at the Full Fee for Multiple Restorations on the Same Permanent Tooth Within 12 Months Due to pulpal necrosis or traumatic injury.

The chart below will identify the specific restoration procedure codes that are available for reimbursement at the full fee when billed as a second or subsequent restoration for the same patient, same permanent tooth within 12 months from the date of the original restoration due to pulpal necrosis (root canal) or traumatic injury. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury require prior authorization including codes D2140 and D2330 which usually does not require Medicaid prior authorization. The prior authorization unit must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The PA number must be entered in the appropriate block on the claim for payment.

<table>
<thead>
<tr>
<th>Code Previously Reimbursed Within 12 Months for the Same Patient, Same Permanent Tooth</th>
<th>Code</th>
<th>Anterior Permanent Teeth</th>
<th>Posterior Permanent Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932</td>
<td>D2931 or D2950/D2931 or D2954/D2931</td>
<td></td>
</tr>
<tr>
<td>D2150</td>
<td>D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932</td>
<td>D2931 or D2950/D2931 or D2954/D2931</td>
<td></td>
</tr>
<tr>
<td>D2160</td>
<td>D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932</td>
<td>D2931 or D2950/D2931 or D2954/D2931</td>
<td></td>
</tr>
<tr>
<td>D2161</td>
<td>D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932</td>
<td>D2931 or D2950/D2931 or D2954/D2931</td>
<td></td>
</tr>
</tbody>
</table>
Code Previously Reimbursed Within 12 Months for the Same Patient, Same Permanent Tooth | Codes Available for Reimbursement at the Full Fee When Billed as a Second or Subsequent Restoration for the Same Patient, Same Permanent Tooth, Within 12 Months Due to pulpal necrosis (root canal) or traumatic injury (PA required). NOTE: The code must be reimbursable by Medicaid for the specific tooth number.

<table>
<thead>
<tr>
<th>Code</th>
<th>Anterior Permanent Teeth</th>
<th>Posterior Permanent Teeth</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2330</td>
<td>D2390 or D2931 or D2932 or D2950/D2931 or D2954/D2932</td>
<td>or D2950/D2932 or D2954/D2932</td>
</tr>
<tr>
<td>D2331</td>
<td>D2390 or D2931 or D2932 or D2950/D2931 or D2954/D2932</td>
<td>or D2950/D2932 or D2954/D2932</td>
</tr>
<tr>
<td>D2332</td>
<td>D2390 or D2931 or D2932 or D2950/D2931 or D2954/D2932</td>
<td>or D2950/D2932 or D2954/D2932</td>
</tr>
<tr>
<td>D2335</td>
<td>D2390 or D2931 or D2932 or D2950/D2931 or D2954/D2932</td>
<td>or D2950/D2932 or D2954/D2932</td>
</tr>
<tr>
<td>D2390</td>
<td>D2140 or D2330 or D2335 or D2390</td>
<td></td>
</tr>
<tr>
<td>D2931</td>
<td>D2140 or D2330 or D2931 or D2932</td>
<td>D2140 or D2931</td>
</tr>
<tr>
<td>D2932</td>
<td>D2140 or D2330 or D2931 or D2932</td>
<td>D2140 or D2931</td>
</tr>
</tbody>
</table>

Prior Authorization Requirements for Multiple Permanent Tooth Restorations (Same Tooth) that are Reimbursable within 12 Months Due to pulpal necrosis or traumatic injury.

Providers must use their patient records and the chart on Page 2 of this document in order to determine if the second or subsequent restoration performed on the same patient, same permanent tooth within 12 months from the date of the original restoration due to pulpal necrosis (root canal) or traumatic injury is eligible for reimbursement by Medicaid. This policy applies to the same billing provider or another Medicaid provider located in the same office as the billing provider.
Reminders:

All codes that are to be submitted for payment as a second or subsequent restoration in a 12-month period for the same patient, same permanent tooth requires prior authorization including codes D2140 and D2330 which normally does not require PA. The PA number must be entered in the appropriate block on the claim for payment.

If the above-referenced guidelines are not followed when the prior authorization request is submitted, the claim will receive a 515 denial and the provider will be responsible for resubmitting the required information to the Medicaid Dental PAU in order to have the claim reconsidered for payment.

If you have questions regarding this policy, you may contact the Medicaid Dental PAU.

Primary Tooth Restorations

Currently, Medicaid performs a cutback in the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150 and D2160); and a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same patient, same primary tooth when the date of service of the second restoration is within 12 months from the date of the original restoration. In these situations, the maximum combined fee for the two or more restorations within a 12-month period on the same primary tooth will not exceed the maximum fee of the larger restoration.

Effective September 13, 2007 (regardless of the date of service), Medicaid will also perform a cutback in the payment of other second or subsequent primary restorations that are rendered within a 12-month period for the same patient, same primary tooth. In these situations, the maximum combined fee for two or more restorations within a 12-month period on the same primary tooth, same recipient will not exceed the maximum fee of the higher reimbursed restoration. These services will no longer receive an error code 515 and will no longer require additional action by the provider.

If no additional payment is made by Medicaid for a second or subsequent restoration for a primary tooth for the same patient, same primary tooth within a 12 month period, the provider is responsible for the restoration.

Providers should refer to the EPSDT Dental Program Fee Schedule to determine whether the procedure code is reimbursable for the specific tooth letter and requires Medicaid prior authorization based on the specific age of the patient.

If you have questions regarding this policy, you may contact the, Medicaid Dental PAU.
Check List for Use Prior to Mailing a Medicaid Dental Prior Authorization Request
(Print or copy this page for your convenience)

The information provided below will help you prevent errors frequently made when completing a Medicaid dental prior authorization (PA) request. For complete dental prior authorization guidelines, see the Prior Authorization section for the dental services program that applies.

☐ Are you using the 2006 American Dental Association (ADA) Claim Form when submitting a request to Medicaid for dental prior authorization? (Only this version is accepted.)

☐ Have you provided two identical copies of each ADA claim form being submitted?

☐ Has any information been placed in the upper right-hand corner of the claim (above the box labeled “Primary Subscriber Information”)? (This area is for Medicaid use only and must be left blank.)

☐ Are you certain that the claim form is properly completed with provider name, group, and individual provider number, current provider address and phone number, recipient name and date of birth, etc.? (Each claim form submitted for dental prior authorization should be fully completed using the ADA Claim Form instructions within this chapter. If a service has not been delivered at the time of the request, leave the date of service blank. If a service has already been delivered, enter the correct date of service on the claim form.

☐ Have you grouped together on the first lines of the claim form all services requiring prior authorization? (Procedures that will be rendered and do not require prior authorization should be listed on the ADA claim form after those services requiring prior authorization so that the reviewer understands the full treatment plan.)

☐ Have you provided an explanation or reason for treatment in the remarks section of the claim form if the reason is not obvious from the radiographs? (Be certain to include the remarks on the same ADA claim form in which the treatment is being requested.)

☐ Have you included bitewing radiographs and any other required radiographs?

☐ Are the radiographs mounted so that each individual film is readily viewable and does the doctor’s name, patient’s name, and the date of the films appear on the mounting? (Radiographs MUST be mounted and MUST contain the identified information.)

☐ Are the mounted radiographs on the top of the EPSDT Dental Program the Adult Denture Program claims?

(The mounted radiographs MUST be on the top of the claim for prior authorization for these programs.)
☐ Have you submitted the panoramic radiograph, if one has been taken, along with the request for post authorization of the radiograph and included any additional services requiring prior authorization on the same claim form?

☐ Have you stapled all pages (and the mounted radiographs) for a single recipient with a SINGLE staple in the upper left-hand corner? (Using a single staple will expedite the request. Paper clips should be not used.)

☐ Have you separated the dental prior authorization requests by program type (EPSDT Dental Program, and Adult Denture Program and placed each program type in a separate package/envelope?

☐ Are you mailing to Louisiana Department of Health Medicaid Dental Program, P.O. Box 91030, Baton Rouge, LA 70821-9030?

**NOTE:** It is the dental provider’s responsibility to obtain a dental PA on behalf of the recipient. If a dental provider has not received a PA decision (or other related correspondence from the Dental Medicaid Unit) within 25 days from the date of submission, it is the provider’s responsibility to contact the Medicaid Dental PA Unit to inquire on the status of the PA request. The provider should NEVER instruct the recipient to contact Medicaid regarding the dental PA request.
PRIOR AUTHORIZATION (PA) SAMPLE LETTER

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

DATE 04/01/2003                               RECIPIENT NAME xxxxx      xxxxx
PRIOR AUTH. NBR     999999999     RECIPIENT NUMBER    9999999999999
xxxxxxxxx    xxxxx      xxxx *
xxxx xxxxxxxx
xxxxxxxxxxxx          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.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>UVS</th>
<th>AMOUNT</th>
<th>DATES OF SERVICE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2930-STAINLESS STEEL CROWN</td>
<td>2</td>
<td>.00</td>
<td>01/01/2003-01/01/2004</td>
<td>APPROVED</td>
</tr>
<tr>
<td>D3310-ENDODONTIC 1 CANAL</td>
<td>1</td>
<td>.00</td>
<td>01/01/2003-01/01/2004</td>
<td>DENIED-460</td>
</tr>
</tbody>
</table>

THE REASON FOR DENIED PRIOR AUTHORIZATION REQUESTS IS LISTED BELOW,
460 – ENDODONTIC 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.

SINCERELY,

BUREAU OF HEALTH SERVICES FINANCING
CHAPTER 16: DENTAL SERVICES

APPENDIX I: FORMS

FORMS

1. PEDIATRIC CONSCIOUS SEDATION FORM
2. TEMPOROMANDIBULAR JOINT (TMJ) FORM
PEDiatric DENTISTRY CONSCIOUS SEDATION FORM

Patient Selection Criteria

Patient: ___________ Date: ___________

M ☐ F ☐ Age: ___ yr ___ mo Weight: ___ lb Physician: ___________

Indication for sedation:
☐ Fearful/anxious patient for whom basic behavioral guidance techniques have not been successful.
☐ Patient unable to cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability.
☐ To protect patient's developing psyche.
☐ To reduce patient's medical risk.

Medical history/review of systems (ROS)

<table>
<thead>
<tr>
<th>Allergies &amp; or previous adverse drug reactions</th>
<th>NONE ☐ YES* ☐</th>
<th>Describe positive findings: ___________</th>
<th>Airway Assessment</th>
<th>NONE ☐ YES* ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current medications (including OTC)</td>
<td>☐ ☐ ☐</td>
<td>Obesity</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Relevant diseases, physical/neurologic impairment</td>
<td>☐ ☐ ☐</td>
<td>Limited neck mobility</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Previous sedation/general anesthetics</td>
<td>☐ ☐ ☐</td>
<td>Microtia/nasal obstruction</td>
<td>☐ ☐ ☐</td>
<td></td>
</tr>
<tr>
<td>Snoring, obstructive sleep apnea, mouth breathing</td>
<td>☐ ☐ ☐</td>
<td>Maxillofacial obstruction (%) ☐ ☐ ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other significant findings (eg, family history)</td>
<td>☐ ☐ ☐</td>
<td>Tonsillar obstruction (%) ☐ ☐ ☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| ASA classification | I ☐ II ☐ III* ☐ IV* ☐ E ☐ | Medical consultation indicated? ☐ ☐ ☐ ☐ | Date requested: ___________

Comments: ___________

Is this patient a candidate for in-office sedation? ☐ YES ☐ NO Doctor's signature: ___________ Date: ___________

Plan

Informed consent obtained from: ____________________________
Pre-op instructions reviewed with: ____________________________
Post-op precautions reviewed with: ____________________________

Assessment on Day of Sedation

Accompanied by: ____________________________ Relationship(s) to patient: ____________________________

<table>
<thead>
<tr>
<th>Medical Hx &amp; ROS update</th>
<th>NO ☐ YES ☐</th>
<th>NPO status</th>
<th>Airway assessment</th>
<th>NO ☐ YES ☐</th>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in medical Hx/ROS</td>
<td>☐ ☐ ☐</td>
<td>Clear liquids ___ hrs</td>
<td>Upper airway clear</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Change in medications</td>
<td>☐ ☐ ☐</td>
<td>Milks, other liquids ___ hrs</td>
<td>Lungs clear</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Recent respiratory illness</td>
<td>☐ ☐ ☐</td>
<td>&amp; or foods ___ hrs</td>
<td>Tonsillar obstruction (%)</td>
<td>☐ ☐ ☐</td>
<td>☐ ☐ ☐</td>
</tr>
<tr>
<td>Weight: ___ kg</td>
<td>☐ ☐ ☐</td>
<td>Medications ___ hrs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vital signs (If unable to obtain, check ☐ and document reason: ___________

Blood pressure: ___ / ___ mm Hg Resp: ___ / ___ min Puls: ___ / ___ min Temp: ___ °F SpO₂: ___ %

Comments: ___________

Pre-sedation cooperation level:
☐ Unable/unwilling to cooperate ☐ Rarely follows requests ☐ Cooperates with prompting ☐ Cooperates freely

Behavioral interaction:
☐ Defensively shy and withdrawn ☐ Somewhat shy ☐ Approachable

Guardian was provided an opportunity to ask questions, appeared to understand, and reaffirmed consent for sedation? ☐ YES ☐ NO

Drug Dosage Calculations

Sedatives

Agent: ___________ Route: ___________ mg/kg X ___ kg = ___ mg = ___ mg/mL = ___ mL

Emergency reversal agents

For narcotics: NALOXONE IV, IM, or subQ Dose: 0.1 mg/kg X ___ kg = ___ mg (Maximum dose: 2 mg may repeat) For benzodiazepine: FLUMAZENIL IV (preferred), IM Dose: 0.01 mg/kg X ___ kg = ___ mg (Maximum dose: 0.2 mg may repeat up to 4 times)

Local anesthetics (maximum dosage based on weight)

Lidocaine 2% (34 mg/1.7 mL cartridge) 4.4 mg/kg X ___ kg = ___ mg (not to exceed 300 mg total dose)
Articaine 4% (68 mg/1.7 mL cartridge) 7 mg/kg X ___ kg = ___ mg (not to exceed 500 mg total dose)
Mepivacaine 3% (51 mg/1.7 mL cartridge) 4.4 mg/kg X ___ kg = ___ mg (not to exceed 300 mg total dose)
Pentacaine 4% (68 mg/1.7 mL cartridge) 6 mg/kg X ___ kg = ___ mg (not to exceed 400 mg total dose)
Bupivacaine 0.5% (8.5 mg/1.7 mL cartridge) 1.3 mg/kg X ___ kg = ___ mg (not to exceed 90 mg total dose)
**CHAPTER 16: DENTAL SERVICES**

**APPENDIX I: FORMS**

**Intraoperative Management and Post-Operative Monitoring**

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Observation</th>
<th>Pulse oximeter</th>
<th>Preoperative/perineal arterioscope</th>
<th>Blood pressure cuff</th>
<th>Capnograph</th>
<th>EKG</th>
<th>Thermometer</th>
<th>Protective restraints/devices</th>
<th>Pajamas</th>
<th>Head positioner</th>
<th>Manual hold</th>
<th>Neck/shoulder roll</th>
<th>Mouth prop</th>
<th>Rubber dam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMS telephone number:**

**TIME**

<table>
<thead>
<tr>
<th>Baseline</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
</table>

**Sedatives**

- **N₂O/O₂ (%)**
- **Local (mg)**

**Procedure**

**Procedure component**

**Comments**

**Sedation level**

- **A**
- **B**
- **C**
- **D**

**Behavior**

1. **Agent**
2. **Local anesthetic agent**
3. **Record dental procedure start and completion times, transfer to recovery area, etc.**
4. **Enter letter on chart and corresponding comments (e.g., complications/side effects, airway intervention, reversal agent, analgesia) below:**
   - **A**
   - **B**
   - **C**
   - **D**

**Discharge Vital Signs**

- **Pulse:** _/min_
- **SpO₂:** _%_
- **BP:** _/ _/ _mmHg_
- **Temp:** _°F_
- **Resp:** _/min_

**Discharge Process**

- **Post-operative instructions reviewed with**
  - **Transportation**
  - **Airway protection/observation**
  - **Activity**
  - **Diet**
  - **Nausea/vomiting**
  - **Fever**
  - **Rx**
  - **Anesthetized tissues**
  - **Dental treatment rendered**
  - **Posts**
  - **Wound**
  - **Emergency contact**
  - **Next appointment time**

**I have received and understand these discharge instructions. The patient is discharged into my care at ______ AM/PM**

**Post-op call**

- **Date:**
- **Time:**
- **By:**
- **Spoke to:**
- **Comments:**

**Page 3 of 4**

**Appendix I**
TEMPOROMANDIBULAR JOINT (TMJ) FORM

<table>
<thead>
<tr>
<th>Patient's Name: ___________________________</th>
<th>Age: _____ □ M □ F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Number: _________________________</td>
<td>&lt;The items written in small print, in each category are not inclusive and should be used only as guides&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chief Complaints:</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Findings:</td>
<td>Palpation of: TMJ, masticatory muscles, cervical muscles, functional manipulation; jaw and neck ROM: TMJ sounds; occlusion</td>
</tr>
<tr>
<td>Radiographic Findings:</td>
<td></td>
</tr>
<tr>
<td>Impressions:</td>
<td>Myofacial Pain: masticatory muscles, cervical muscles, TMJ capsule, TMJ disc displacement or dislocation, Hypermobility, osteoarthritis, headaches, myofacial tension, Missing teeth, malocclusion, chronic pain, etc.</td>
</tr>
<tr>
<td>Etiology:</td>
<td>Trauma, Bruxism, Missing teeth, malocclusion, etc</td>
</tr>
<tr>
<td>Recommendations:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is a splint requested?</th>
<th>□ Yes □ No □ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>If splint requested please indicated type:</td>
<td>□ Hard Splint □ Soft Splint □ N/A</td>
</tr>
</tbody>
</table>
## CONTACT INFORMATION

**DXC Technology**

The Medicaid Program’s fiscal intermediary, DXC Technology can be contacted for assistance with the following:

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-CDI technical support</td>
<td>DXC Technology</td>
</tr>
<tr>
<td></td>
<td>Phone: (877) 598-8753 (Toll Free)</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td></td>
</tr>
<tr>
<td>Electronic Claims testing and assistance</td>
<td>P.O. Box 91025</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70898</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 216-6000</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 216-6335</td>
</tr>
<tr>
<td>Pre-Certification Unit (Hospital)</td>
<td></td>
</tr>
<tr>
<td>Pre-certification issues and forms</td>
<td>P.O. Box 14849</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70809-4849</td>
</tr>
<tr>
<td></td>
<td>Phone: (800) 877-0666</td>
</tr>
<tr>
<td></td>
<td>Fax: (800) 717-4329</td>
</tr>
<tr>
<td>Pharmacy Point of Sale (POS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 91019</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td></td>
<td>Phone: (800) 648-0790 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 216-6381 (Local)</td>
</tr>
<tr>
<td></td>
<td>*After hours, please call REVS</td>
</tr>
<tr>
<td>Prior Authorization Unit (PAU)</td>
<td>DXC Technology – Prior Authorization</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 14919</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70898-4919</td>
</tr>
<tr>
<td></td>
<td>Phone: (800) 488-6334</td>
</tr>
<tr>
<td>Provider Enrollment Unit (PEU)</td>
<td>DXC Technology – Provider Enrollment Provider Enrollment</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 80159</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70898-0159</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 216-6370</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 216-6392</td>
</tr>
<tr>
<td>Provider Relations Unit (PR)</td>
<td>DXC Technology – Provider Relations Unit</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 91024</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA 70821</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 924-5040 or (800) 473-2783</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 216-6334</td>
</tr>
<tr>
<td>Recipient Eligibility Verification (REVS)</td>
<td>Phone: (800) 766-6323 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 216-7387 (Local)</td>
</tr>
</tbody>
</table>
Louisiana Department of Health (LDH)

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicaid Hotline</td>
<td>Phone: (888) 342-6207 (Toll Free)</td>
</tr>
<tr>
<td>Health Standards Section (HHS)</td>
<td>P.O. Box 3767</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA  70821</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 342-0128</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 5292</td>
</tr>
<tr>
<td>Louisiana Children’s Health Insurance Program (LaCHIP)</td>
<td>Phone: (225) 342-0555 (Local)</td>
</tr>
<tr>
<td></td>
<td>Phone: (877) 252-2447 (Toll Free)</td>
</tr>
<tr>
<td>Office of Aging and Adult Services (OAAS)</td>
<td>P.O. Box 2031</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA  70821</td>
</tr>
<tr>
<td></td>
<td>Phone: (866) 758-5038</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 219-0202</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:OAAS.Inquiries@la.gov">OAAS.Inquiries@la.gov</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://ldh.la.gov/index.cfm/subhome/12">http://ldh.la.gov/index.cfm/subhome/12</a></td>
</tr>
<tr>
<td>Office for Citizens with Developmental Disabilities (OCDD)</td>
<td>628 N. Fourth Street</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA  70802</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 342-0095 (Local)</td>
</tr>
<tr>
<td></td>
<td>Phone: (866) 783-5553 (Toll free)</td>
</tr>
<tr>
<td></td>
<td>E-mail: <a href="mailto:ocddinfo@la.gov">ocddinfo@la.gov</a></td>
</tr>
<tr>
<td>Governor’s Office of Homeland Security and Emergency Preparedness (GOSHEP)</td>
<td><a href="https://gohsep.la.gov/">https://gohsep.la.gov/</a></td>
</tr>
<tr>
<td>Rate Setting and Audit Hospital Services</td>
<td>P.O. Box 91030</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA  70821</td>
</tr>
<tr>
<td></td>
<td>Phone: 225-342-0127</td>
</tr>
<tr>
<td></td>
<td>225-342-9462</td>
</tr>
<tr>
<td>Recipient Assistance for Authorized Services</td>
<td>Phone: (888) 342-6207 (Toll Free)</td>
</tr>
<tr>
<td>Recovery and Premium Assistance TPL Recovery, Trauma</td>
<td>P.O. Box 3588</td>
</tr>
<tr>
<td></td>
<td>Baton Rouge, LA  70821</td>
</tr>
<tr>
<td></td>
<td>Phone: (225) 342-1376</td>
</tr>
<tr>
<td></td>
<td>Fax: (225) 342-5292</td>
</tr>
</tbody>
</table>
**Fraud hotline**

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| To report fraud    | Program Integrity (PI) Section  
P.O. Box 91030  
Baton Rouge, LA 70821-9030  
Fraud and Abuse Hotline: (800) 488-2917  
Fax: (225) 219-4155  

**Appeals**

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| To file an appeal  | Division of Administrative Law (DAL) -  
Health and Hospitals Section  
Post Office Box 4189  
Baton Rouge, LA 70821-4189  
Phone: (225) 342-0443  
Fax: (225) 219-9823 |

**Other Helpful Contact Information**

<table>
<thead>
<tr>
<th>TYPE OF ASSISTANCE</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
</table>
| American Dental Association                        | 211 East Chicago Ave.  
Chicago, IL  60611-2678  
Phone: (312) 440-2500  
www.ada.org |
Place for Service Codes |
| LDH Medicaid Dental Prior Authorization Unit       | P.O. Box 91030  
Baton Rouge, LA  70821-9030  
Phone: (225) 342-7476 (Local)  
Fax: (225) 389-8109 |
| Dental Prior Authorization ONLY                    |                     |