

DENTAL SERVICES PROVIDER MANUAL

Chapter Sixteen of the Medicaid Services Manual

Issued March 15, 2012

**State of Louisiana
Bureau of Health Services Financing**

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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). LSU School of Dentistry, Medicaid Prior Authorization Unit, under contract to the Bureau, provides dental prior authorization services and consultation on dental policy on behalf of the Bureau.

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PROVIDER REQUIREMENTS

A dentist must enroll as a Louisiana Medicaid dental provider to receive reimbursement for covered dental services performed on eligible Medicaid recipients. 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 recipient 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 recipient population. Dental groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid recipient.

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.

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Program Guidelines

A Medicaid dental provider must offer the same services to a Medicaid recipient as those offered to a non-Medicaid recipient, provided these services are reimbursable by the Medicaid program. 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 Department of Health and Hospitals (DHH) dental consultants (LSU School of Dentistry). This address must be on file with the Louisiana State Board of Dentistry. Records documenting the services provided shall be maintained at this location.

To be eligible for reimbursement, 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 Recipients

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

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

Picking and Choosing Recipients/Services

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

Providers must bill Medicaid for all covered services performed on eligible recipients 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

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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 recipient 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 recipients for restorative, surgical and other treatment services is subject to recoupment.

Missed Appointments

Providers cannot charge recipients for missed/failed appointments.

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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 LSU School of Dentistry, 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 recipients 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 recipient's record are copies of all claim forms submitted for prior authorization including any attachments, all PA Letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs would constitute examples of additional supporting documentation. A check off list of codes and services billed is insufficient documentation.

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

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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.

Interruption 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 recipient's record, all attempts to deliver the denture and the reasons the denture was not delivered in the recipient's dental treatment record.

If due to circumstances beyond the provider's control, the recipient discontinues treatment, or loses eligibility during the course of the construction of a denture qualified under the interruption of treatment guidelines, the provider should not bill Medicaid using the procedure code as originally prior authorized.

As the original procedure has not been completed, the case must be resubmitted to the prior authorization unit at LSU so the 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
- Delivery

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to the dental consultants. If treatment is

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interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made. If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to the dental consultants. If treatment is interrupted after completion of Stage 3 (Processing), 75% of the Medicaid reimbursement fee will be paid upon submission of the denture to the dental consultants.

For further information concerning billing of interrupted services, providers may contact the dental consultants at the **LSU School of Dentistry, Dental Medicaid Program** (see Appendix J).

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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 recipient's mouth) by the provider before payment can be requested.

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

Providers cannot provide a service that has a defined 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 recipient cannot be required to pay a co-payment for Medicaid covered dental services. Also, the recipient should not be billed for any Medicaid covered services. It is the responsibility of the provider to follow up with Medicaid regarding any reimbursement issues. The provider should contact 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

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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).

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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 recipient. 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 recipient 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 recipient'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 recipient 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.

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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**.

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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 Recipient/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.

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**SECTION 16.3: EPSDT-RECIPIENT ELIGIBILITY
REQUIREMENTS**

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RECIPIENT ELIGIBILITY REQUIREMENTS

A recipient is eligible for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program only if the recipient is 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 end once the recipient reaches 19 years of age. It is the responsibility of the provider to verify recipient eligibility.

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

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SECTION 16.4: EPSDT-SECURING SERVICES**PAGE(S) 1**

SECURING SERVICES

Early and Periodic Screening, Diagnosis and Treatment (EPSDT), LaCHIP, and LaCHIP Affordable recipients are encouraged to obtain an annual oral examination, and if needed, subsequent treatment. A recipient may elect to contact a participating dentist of their choice directly to make the initial appointment. A recipient or provider needing a participating provider for purposes of making a referral may visit the website (see Appendix J).

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**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT –
COVERED SERVICES**

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

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

NOTE: Services that require prior authorization (PA) are identified by an asterisk {*}. Services requiring PA in certain situations only are identified with an underlined asterisk {*}.

Initial Dental Screening and Annual Recall Visits

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

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

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

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The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1208) is limited to once per six months.

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

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

For new and established patients, 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 the recipient has received a Medicaid-reimbursed oral examination, bitewing radiograph, prophylaxis, and fluoride. Providers must select the option for "Ancillary Services" in order to review the recipient'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 patient's chart 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 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

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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 one per six months (with noted exception) per recipient:

- One D0145 (Oral Examination for a Patient under Three Years of Age and Counseling with a Primary Caregiver; OR
- D0120 (Periodic Oral Examination –Patient of Record-3 through 20 years of age) per recipient is covered as is age appropriate.

Procedure code D0150 (Comprehensive Oral Examination-new or established patient- 3 through 20 years of age) remains the appropriate procedure code for new patients who are 3 through 20 years of age. A new patient is described as a recipient that has not been seen by this provider for at least three years; therefore, procedure code D0150 is reimbursable only once in a three year period when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider. In addition the recall visit (D0120) must be schedule at least six months after the initial visit (D0150) is rendered.

D0120 Periodic Oral Examination (established patient)

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

This procedure may be reimbursed once in a six month period.

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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, and 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 child 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 child's parent, legal guardian and/or primary caregiver.

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

Procedure code D0145 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to the same billing provider or another Medicaid provider in the same office as the billing provider within the prior 12 month period for the same recipient. In addition, procedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to the same billing provider or another Medicaid provider located in the same office as the billing provider within the prior 12 month period for the same recipient.

D0150 Comprehensive Oral Examination (new or established patient)

Medicaid recognizes this code for a new recipient only. A new patient is described as a recipient that has not been seen by this provider for at least three years. This procedure code is to be used by a general dentist and/or specialist when evaluating a patient comprehensively for the first time. This would include the examination and recording of the patient's dental and medical history and a general health assessment.

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

After the comprehensive oral examination, subsequent visits should be scheduled by the dentist to correct the dental defects that were identified. If no subsequent visit is required, the bitewing 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

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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 the recipient for future examinations and treatment, (if required).

This procedure should not be billed to Medicaid unless it has been at least three years since the recipient was seen by the specified provider or another provider in the same office. An initial comprehensive oral examination (D0150) is limited to once per three (3) years when performed by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Recipients are only allowed one exam within a six month period unless when performed by a Medicaid recognized dental specialist.

Radiographic Images (Radiographic images)**Codes**

- 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**

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

In order for the Medicaid Dental Prior Authorization Unit to be able to make necessary authorization determination, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for PA that contain radiographic images and oral/facial images that are not of good diagnostic quality will be rejected.

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

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

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

A lead 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 lead apron and thyroid shield 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 recipients six years of age or younger.
- Two cavity-detecting (bitewing) radiographic images, and 10 periapical radiographic images, for recipients age 7 through age 13.
- Two cavity-detecting (bitewing) radiographic images, and 14 periapical radiographic images, for recipients age 14 or older.

Any request for a complete series must be justified 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 in a 12 month period, except when performed by a Medicaid recognized dental specialist.

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If a full mouth x-ray (D0210) is billed within 12 months of bitewing radiographic images (D0272), the fee for the full mouth radiographic images will be cutback by the amount of the fee for the bitewing radiographic images. If bitewing radiographic images (D0272) are billed within 12 months of full mouth 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 bitewings 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 in the recipient's 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 un-extracted 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. The actual occlusal radiograph must be sent with the PA request for an occlusal film. This radiograph is reimbursable for Oral Cavity designators 01 and 02. The appropriate oral cavity designator must

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be identified in the “Area of Oral Cavity” column of the ADA Dental Claim Form when requesting prior authorization or reimbursement for this procedure.

D0272 Bitewings – two radiographic images

Bitewing radiographic images are required at the comprehensive oral examination and annually at the periodic oral examination. These radiographic images are limited to one set per year to the same billing provider or 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 recipient’s record as well as in the remarks section on any claims submitted for PA.

D0330 Panoramic film

Panoramic radiographic images are not indicated and will be considered insufficient for diagnosis in periodontics, endodontics, and restorative dentistry and it will not be reimbursed. Panoramic radiographic images are reimbursable for oral and maxillofacial surgery and orthodontic services.

This procedure code is reimbursable only once in a 12 month period, except when provided by a Medicaid recognized dental specialist.

D0350* Oral/Facial Photographic Images

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

Oral/facial photographic 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 photographic images ONLY when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated.

Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

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

This procedure is reimbursable for oral cavity designators 01, 02, 10, 20, 30 and 40.

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This procedure code requires PA.

Other Diagnostic Services**Codes**

D0470* Diagnostic Casts

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

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

D0470* Diagnostic Casts

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

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

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

For PA of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286.

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

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

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

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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
D1208	Topical Application of Fluoride
D1206	Topical Fluoride Varnish; Therapeutic application for Moderate to High Caries Risk Patients
D1351	Sealants
D1510*	Unilateral Space Maintainer
D1515*	Bilateral Space Maintainer
D1550	Recementation of Space Maintainer
D1555	Removal of Fixed Space Maintainer

Prophylaxis**D1110 Prophylaxis – Adult**

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

This procedure is limited to once in a six month period.

If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid, then procedure codeD4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis).

D1120 Prophylaxis – Child

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

This procedure is limited to once in a six month period.

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If, at the initial visit, it is determined that the Child Prophylaxis is the appropriate treatment and code D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis).

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 by Medicaid only for recipients **under six years of age**.

Procedure code D1206 is reimbursable by Medicaid to the same billing provider or another Medicaid provider located in the same office as the billing provider **once per six month period, per same recipient**.

In addition, Medicaid reimbursement of fluoride for recipients less than six years of age is limited to either of the following per six months, per recipient:

- Two D1206 (Topical Fluoride Varnish – one per six months); OR
- One D1208 (Topical Application of Fluoride – Prophylaxis Not Included-Child).

NOTE: A combination of D1208 and D1206 are NOT reimbursable in the same six month period for recipients under six years of age.

D1208 Topical Application of Fluoride

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

Topical fluoride treatment must be provided to children less than 16 years of age in order to be reimbursed under this procedure code. This procedure is limited to once in a six month period.

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Sealants**D1351 Sealants – per tooth**

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

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

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.

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 restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Space Maintenance**D1510* Space maintainer – fixed - unilateral****D1515* Space maintainer – fixed – bilateral**

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

Procedure Code D1510 is reimbursable for Oral Cavity areas 10, 20, 30, and 40. Procedure Code D1515 is reimbursable for Oral Cavity areas 01 and 02.

When requesting prior authorization, please 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).

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D1550 Recementation of Space Maintainer

The billing provider is responsible for replacement within the first 12 months after placement of the space maintainer. This procedure does not require authorization and is limited to one recementation per appliance, in a five-year period.

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

D1555 Removal of Fixed Space Maintainer

This procedure code is reimbursable for the removal of Space Maintainer, Fixed, Unilateral (D1510) or the removal of a Space Maintainer, Fixed, Bilateral (D1515).

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.

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

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

Restorative Services

Restorative services include those services listed below:

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

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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
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 to be part of restorative services. Tooth and soft tissue preparation, all adhesives (including amalgam bonding agents), liners and bases, are included as part of amalgam restorations. Tooth and soft tissue preparation, all adhesives (including resin bonding agents), liners and bases and curing are included as part of resin-based composite restorations. Pins 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 (or incisal), lingual, or facial (or buccal).

The original billing provider is responsible for the replacement of the original restoration within the first twelve months after initial placement.

No restoration of any type will be payable for deciduous central or lateral incisor teeth (Tooth letters D, E, F, G, N, O, P, and Q) for recipients 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, permanent (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 or D2933).

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 patient's dental record.

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Amalgam Restorations (including polishing)**Codes**

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

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

Duplicate surfaces are not payable on the same tooth in amalgam restorations in 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 patient, 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 (see Appendix F).

Providers must utilize the Clinical Data Inquiry (e-CDI) application in order to determine whether the recipient has received a restoration within 12 months 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.

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

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

If the restoration requires a second or subsequent restoration, PA is required.

Resin-Based Composite Restorations - Direct**Codes**

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

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 D2335 or D2394 is reimbursable only once per day, same tooth, 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 patient, 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 (see Appendix F).

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Providers must utilize the Clinical Data Inquiry (e-CDI) application in order to determine whether the recipient has received a restoration within the 12 months 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 & 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 1/3 of the clinical crown of the tooth.

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

Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11 and 22 through 27 with PA; and Tooth Letters C, H, M, and R for recipients under 21 years of age. These procedures are also reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.

Procedure codes D2330, D2331, D2332, and D2390 require prior authorization for Tooth Letters C, H, M and R **only for recipients 9 years of age and older**. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

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 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.

If the restoration requires a second or subsequent restoration, PA is required.

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Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation which depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Bureau 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 payable on primary central or lateral incisors after the fifth birthday.

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

- Teeth B, I, L, S (1st primary molars {D's}) for recipients 9 years of age and older; and
- Teeth A, C, H, J, K, M, R, T (primary canines {C's} and primary second molars {E's}) for recipients 10 years of age and older.

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 only be considered 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 recipient's treatment record and in the "Remarks" section of the claim form submitted for PA.

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 recipient's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown

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services must be available for review by the Bureau or its designee upon request. Prior authorization is required.

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 2nd molar (in conjunction with a pulpectomy) prior to the eruption of the permanent 1st 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% of the root; or
- Primary teeth with insufficient tooth structure remaining so as to have a poor prognosis of success, e.g. unrestorable; or
- Incipient carious lesions.

This procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age. Prior authorization for procedure code D2930 is required only for Tooth Letters B, I, L, and S for recipients **9 years of age and older**; and for Tooth Letters A, C, H, J, K, M, R and T for recipients **10 years of age and older**.

D2931* Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32.

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D2932* Prefabricated Resin Crown (primary and permanent teeth)

This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 with prior authorization; 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. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

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 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.

Prior authorization is required for Tooth Letters C, H, M and R only for recipients 9 years of age or older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

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 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.

Prior authorization is required for Tooth Letters C, H, M and R only for recipients 9 years of age or older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.

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**

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

D2920 Re-cement Crown

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

This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter 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. Prior authorization is required and is only available for permanent teeth that have undergone endodontic treatment. A core build-up cannot be authorized in conjunction with a post and core or for primary teeth.

This procedure is reimbursable for Tooth 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 only be billed 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. Prior authorization is required and will not be authorized in combination with a core build-up.

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

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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.

Endodontic Therapy Services

Endodontic therapy includes those services listed below.

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), pulpectomy – posterior, primary tooth**
- D3310* Endodontic Therapy, Anterior Tooth (excluding final restoration)**
- D3320* Endodontic Therapy, Bicuspid Tooth (excluding final restoration)**
- D3330* Endodontic Therapy, Molar (excluding final restoration)**
- D3346* Retreatment of previous root canal therapy - anterior**
- D3352* Apexification (excluding root canal)**
- D3410* Apicoectomy**
- D3430* Retrograde Filling**
- D3999* Unspecified Endodontic Procedure, by report**

Pulp Capping

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

Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp. Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth. Pre-operative 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**

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Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure code D3220 is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under five years of age.

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 in a 12 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 and requires prior authorization.

This service is reimbursable only once a 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 payable on primary incisors, cuspids and first primary molars. If the endodontic pathology on these teeth cannot be treated with a pulpotomy, then extraction and space maintenance may be indicated.

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

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

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

Endodontic Therapy

D3310* Endodontic Therapy, anterior (excluding final restoration)

D3320* Endodontic Therapy, bicuspid (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 patient's chart 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.

Prior authorization is required. Requests for prior authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the patient. Specific treatment plans for final restoration of the tooth must be submitted. If the 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. Approval of any requested root canal will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and the past history of recipient oral care.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographic images do not adequately indicate the need for the root canal requested, the request for prior authorization will be returned to the provider requesting additional information.

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.

Final approvals for root canals require post authorization. Request for post authorization must be accompanied by the approved prior authorization request and post-operative radiographs prior to reimbursement.

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The date of service on the payment request **must** reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the root canal and must be maintained in the patient'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, bicuspid (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 payable only to a different provider or provider group than whom originally performed the initial root canal therapy, and is reimbursable with prior authorization for Medicaid eligible recipients under 21 years of age.

The PA request of procedure code D3346 by the same provider or provider group who performed the initial root canal therapy will be denied with a denial code (452) which will state: "An anterior root canal retreatment is not payable to the same dentist or dental group who performed the initial root canal. Recipients may seek the service from a different dentist (dental group) who will submit for a new prior authorization."

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 recipient's treatment records.

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Approval of any requested root canal retreatment will depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and past history of the recipient oral care. Request for PA must be accompanied by 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 recipient. Specific treatment plans for final restoration of the tooth must also be submitted.

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. 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.

Providers are reminded that if specific treatment needs are identified by the consultants and not noted by the provider or if the radiographic images do not adequately indicate the need for the retreatment of a previous root canal, the request for PA will be returned to the provider requesting additional information.

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

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

This procedure is reimbursable for Tooth 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.

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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 approved 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.

Periodontal Services

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

Codes

- D4210* Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant**
- D4341* Periodontal scaling and root planning, per quadrant**
- D4355* Full mouth debridement**
- D4999* Unspecified periodontal procedure, by report**

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,

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and to restore normal architecture when gingival enlargements or asymmetrical or unesthetic topography is evident with normal bony configuration.

This procedure requires PA. A gingivectomy may be approved by Medicaid only when the tissue growth interferes with mastication as sometimes occurs from Dilantin therapy.

Explanations or reasons for treatment must be entered in the “Remarks” section of the claim form and a photograph of the affected area(s) must be included with the request for authorization.

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

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.

This procedure requires PA. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. This service is not approved for recipients who have not progressed beyond the mixed dentition stage of development.

Only two units of periodontal scaling and root planing may be reimbursed per day. For recipients requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service if prior authorized. The claim form used to request PA or reimbursement must identify the “Place of Treatment” (Block 38) and “Treatment Location” (Block 56) if the service was performed at a location other than the primary office.

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

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

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D4355* Full Mouth Debridement

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

This service must be performed at the initial visit if 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 the same billing provider or another Medicaid provider in the same office as the billing provider within a 12 month period.**

This procedure requires prior or post authorization. When requesting prior or post authorization, bitewing radiographic images that supply evidence of significant posterior supra and/or subgingival calculus in at least two quadrants must be submitted. In the occasional instance where the bitewing 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 requesting authorization for a D4355 (Full Mouth Debridement), providers must ask their new recipients when they last received a Medicaid covered prophylaxis (D1110 or D1120) and record that information in the recipient's treatment record.

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

If the prior or post authorization request for D4355 is denied and it has been determined that Medicaid has not reimbursed a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) within the preceding 12 months for this recipient, the provider may render and bill Medicaid for a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis), whichever is applicable based on the recipient's age.

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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.

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthodontics

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

- The providers are required to obtain recipient esthetic acceptance prior to processing. This acceptance must be documented by the recipient’s signature in the treatment record.
- The denture should be flasked 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 recipient’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 recipient (not over-closed or under-closed). The proper centric relation of occlusion

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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 recipient 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 for authorization or payment is deemed insufficient documentation of services delivered.

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

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

Denture Identification Information

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

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

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Complete Dentures**Codes**

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

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

All missing teeth must be marked on the claim form. 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 recipient that no reline will be reimbursed by Medicaid within one year of the denture delivery.

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be prior authorized. 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 any conventional clasps, rests and teeth)
D5212* Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213* Maxillary cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

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D5214* Mandibular cast partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

D5820* Interim partial denture (maxillary) – Includes any necessary clasps and rests.

D5821* Interim partial denture (mandibular) – Includes any necessary clasps and rests.

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

To receive consideration for approval for cast partial dentures, providers must submit periapical 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 those recipients 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:

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- Missing one or two maxillary permanent anterior tooth/teeth, or
- 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 recipient has matured beyond the mixed dentition stage in the following cases:

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

Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On those recipients 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**

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

Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one year has elapsed since denture insertion by the same billing

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provider or another Medicaid provider located in the same office as the billing provider and the repair makes the denture fully serviceable and eliminates the need for a new denture.

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

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 recipient. This limit applies to the billing provider or another Medicaid-enrolled provider located in the same office as the requesting provider. See the EPSDT Fee Schedule on the Louisiana Medicaid website for limit.

Procedure Codes D5510 and D5610 are reimbursable for Oral Cavity Designator 01 and 02.

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

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

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

Procedure Codes D5630 and D5660 are reimbursable for Oral Cavity Designator 10, 20, 30 and 40. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the recipient’s treatment record.

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- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.
- The prosthesis must be finished in a workmanlike manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.
- The treatment record must specifically identify the location and extent of the breakage.

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

Denture Relines**Codes**

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

Reimbursement for complete and partial denture relines are allowed only if one year has elapsed since the previous complete or partial denture was constructed or last relined. If billing provider requests a complete or partial denture for the same arch within one year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in a five-year period as prior authorized by Bureau or its designee.

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

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material.
- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.

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

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

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

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.

Maxillofacial Prosthetics**D5986* Fluoride Gel Carrier**

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

This service requires prior authorization and is only available for recipients who are undergoing or who have undergone head and neck radiation therapy.

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

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

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Fixed Prosthodontics**Codes**

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

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

- The recipient 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.
- Providers must submit with the request for prior authorization 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 authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch.

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

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

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Fixed Partial Denture Retainer**D6545* Retainer – cast metal for resin bonded fixed prosthetics**

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

Oral and Maxillofacial Surgery Services

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

NOTE: Dental providers who are qualified to bill for services using the Current Physician’s Terminology (CPT) codes, may bill for certain non-dental oral surgery services using the CPT codes which are covered under the Physician’s Program when those services are rendered to Medicaid recipients who are eligible for services provided in the Physician’s Program. Refer to the Professionals Services Manual, Chapter 38 for specific details.

Codes

- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**
- D7210* Surgical removal of erupted tooth**
- D7220* Removal of impacted tooth – soft tissue**
- D7230* Removal of impacted tooth - partial bony**
- D7240* Removal of impacted tooth - full bony**
- D7241* Removal of impacted tooth - completely bony, with unusual surgical complications**
- D7250* Surgical removal of residual tooth roots (cutting procedure)**
- D7270* Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth**
- D7280* Surgical access of an unerupted tooth**

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- 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 $\frac{3}{4}$ 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 recipient'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.

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

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

The fee for any extraction (D7210 through D7241) performed on the same tooth which previously received a surgical 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 which

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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 – deciduous 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.

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

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

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

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

Other Surgical Procedures

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

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

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

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.

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

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 orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

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

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 Designator 01, 02, 10, 20, 30 or 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.

This procedure requires post authorization. A copy of the pathology report must be submitted to the Dental Medicaid Unit when requesting post authorization.

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

D7291* Transseptal fiberotomy/supra crestal fiberotomy, by report

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

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

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

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

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

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

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**

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

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

The request for PA must include a completed TMJ Summary Form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. The TMJ Summary Form must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

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

Other Repair Procedures

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D7960* Frenulectomy (frenectomy or frenotomy) – separate procedure

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

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

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

D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar

This procedure requires PA and can only be considered 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 Designators 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.

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**

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D8220* Fixed appliance therapy**D8999* Unspecified orthodontic procedure, by report**

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

Interceptive Orthodontic Treatment**D8050* Interceptive orthodontic treatment of the primary dentition****D8060* Interceptive orthodontic treatment of the transitional dentition**

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

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

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

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

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

Recipients, who only have crowded dentitions (crooked teeth), excessive spacing between teeth, 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 recipient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

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Comprehensive orthodontic treatment is approved 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 as determined by the Medicaid dental consultants in the Medicaid Dental Prior Authorization Unit.

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

The request for PA must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, the PAU will authorize a maximum of three units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit. (See fee schedule for total maximum allowable billable fees)

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

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

Minor Treatment to Control Harmful Habits**D8220* Fixed appliance therapy**

Certain fixed habit appliances will be considered if the appliance would be beneficial to the recipient to assist in the correction of a destructive habit such as thumb sucking or tongue thrusting. The request for PA 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.*

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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.

Adjunctive General Services**Codes**

- D9110 Palliative (emergency) treatment of dental pain - minor procedure**
- D9230 Analgesia, anxiolysis, inhalation of nitrous oxide**
- D9241* Intravenous conscious sedation/analgesia – first 30 minutes**
- D9242* Intravenous conscious sedation/analgesia – each additional 15 minutes**
- D9248* Non-intravenous conscious sedation**
- D9420* Hospital call**
- D9440* Office visit – after regularly scheduled hours**
- D9920* Patient Management**
- D9940* Occlusal Guard, by report**
- D9951* Occlusal Adjustment – limited**
- D9999* Unspecified adjunctive procedure, by report**

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

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

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

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

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

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

The recipient'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).

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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.

D9241* Intravenous conscious sedation/analgesia – first 30 minutes

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

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

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

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

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

D9248* Non-intravenous conscious sedation

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

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

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

Hardcopy PAs are required only for recipients six years of age and older.

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A maximum of four non-intravenous conscious sedation/analgesia administrations, per recipient, 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 request for PA must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the patient. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration.

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

The conscious sedation form found in Appendix I, must be completed and maintained in the recipient's treatment record. If the restorative /surgical phase of the treatment is aborted after the initiation of conscious sedation, the provider must document the circumstances in the recipient'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 recipient or the dentist is not allowed.

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

PA is required only recipient six years of age and older.

The request for PA must adequately justify the need for hospitalization in the “Remarks” section of the claim form. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). If the child is physically or mentally handicapped, the particular handicap and its impact on the delivery of dental treatment in the office setting must be stated in the “Remarks” section. The request for PA must outline the entire treatment plan with the hospital code listed first or last on one of the pages.

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

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

Procedure code D9420 is reimbursable once per six month period, per recipient.

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 PA and reimbursement. A statement describing the situation must be made in the “Remarks” section of the claim form.

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

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Miscellaneous Services**D9920* Behavior Management**

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

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

Behavior management is reimbursable for recipients below the age of eight, unless documentation indicates that the recipient is physically or mentally handicapped. The particular handicap and its impact on the delivery of dental treatment in the office setting must be stated in the "Remarks" section in the request for prior authorization. Behavior management is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) on the same day, by any provider.

Hardcopy PAs are required only for recipients eight years of age and older.

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

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SECTION 16.5: EPSDT- COVERED SERVICES**PAGE(S) 54**

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

D9940* Occlusal Guard, by report

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

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

The request for prior authorization must include a completed TMJ summary form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

This procedure is reimbursable for Oral Cavity Designator 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 recipient must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The request for prior authorization must include a completed TMJ summary form (see Appendix I); a copy of this form must be retained in the recipient's treatment record. 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.

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SECTION 16.6: EPSDT-NON-COVERED SERVICES**PAGE(S) 1**

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.

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SECTION 16.7: EPSDT-PRIOR AUTHORIZATION**PAGE(S) 4**

PRIOR AUTHORIZATION

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 dental consultants at the LSU School of Dentistry 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 recipient.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the recipient 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 need be issued per recipient.

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 dental consultants at the LSU School of Dentistry before payment will be made.

It is the provider’s responsibility to utilize the appropriate procedure code in a request for 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 dental consultants reviewing the case to fully understand the general dental health and condition of the recipient for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the “Remarks” section of the claim form. If the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the recipient’s name, the recipient’s Medicaid ID #, the provider’s name and the provider’s Medicaid ID #.

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A copy of this cover sheet, along with a copy of the request for PA, must be kept in the recipient's treatment record. Without the complete treatment plan, appropriate radiographs, or explanations it may not be possible for the consultant to approve isolated services.

Prior Authorization Requirements for Multiple Permanent Tooth Restorations

Providers must use their recipient records in order to determine if the second or subsequent restoration performed on the same recipient, 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.

If the requested code is eligible for reimbursement as a second or subsequent restoration due to pulpal necrosis (root canal), traumatic injury for the same permanent tooth, or in the event of failed restorations, a PA is required. The PA request must provide the following:

- An indication in the "Remarks" section of the ADA Dental Claim Form (Block 35) that this is the second or subsequent restoration in a 12-month period, same tooth (provide tooth number); and
- An indication in the "Remarks" section of the ADA Dental Claim Form (Block 35) as to whether the restoration is necessary due to pulpal necrosis (root canal), traumatic injury, failed restorations; and
- Submit a copy of the entire treatment record.

NOTE: The reason that the tooth requires a second or subsequent restoration must be well documented in the recipient's record; and

- Submit all pertinent radiographs that were taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

Prior Authorization Reminders

All codes that are to be submitted for payment as a second or subsequent restoration in a 12-month period for the same recipient and same permanent tooth, requires PA 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.

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If the above-referenced guidelines are not followed when the PA request is submitted, the claim will receive a 515 or 630 denial and the provider will be responsible for resubmitting the required information to the Medicaid Dental PAU (see Appendix K for contact information) in order to have the claim reconsidered for payment.

If you have questions regarding this policy, you may contact the LSU Dental School, 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 recipient 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 recipient'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 dental consultants with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the "Remarks" section of the claim form.

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

The dental consultants review the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

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SECTION 16.7: EPSDT-PRIOR AUTHORIZATION**PAGE(S) 4**

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 dental consultants at the LSU School of Dentistry. If the claim form is returned to the provider but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the LSU School of Dentistry. All contacts with the LSU School of Dentistry must be documented in the recipient'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 recipient number corrections, date of service changes, etc., a copy of the PA Letter with the requested changes noted, may be sufficient.

If the provider proceeds with treatment before receiving 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 recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization of services becomes void.

All dental PA requests should be sent to the **LSU School of Dentistry Medicaid Dental Prior Authorization Unit (PAU)** (see Appendix K for contact information).

The checklist available in Appendix H 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 K for contact information).

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**SECTION 16.8: ADULT DENTURE PROGRAM- RECIPIENT
ELIGIBILITY REQUIREMENTS****PAGE(S) 1**

RECIPIENT 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. LSU School of Dentistry, under contract to the Bureau, provides dental prior authorization services and consultation on dental policy.

Recipients 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 recipients who are certified for Medicaid in the "Medically Needy Program" (MNP) or as "Qualified Medicare Beneficiary Only" (QMB Only) are NOT eligible to receive services in the Adult Denture Program. It is the responsibility of the provider to verify recipient eligibility. Recipient eligibility should be verified prior to providing services to the recipient. The recipient must be eligible for each date of service.

The Recipient Eligibility Verification System (REVS) or the Medicaid Eligibility Verification System (MEVS) should be used to obtain recipient eligibility information. It is advisable that providers keep on file hardcopy proof of eligibility from MEVS.

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**SECTION 16.9: ADULT DENTURE PROGRAM- COVERED
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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
- 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 recipient who is in need of a complete denture.

Reimbursement for this procedure code requires that radiographs be taken and submitted with the request for PA. The comprehensive oral examination can only be prior authorized in conjunction with the appropriate radiographs.

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

Any request that does not have the required number/type of radiographs attached will be denied.

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The request for PA must also include all of the other Adult Denture Program procedures scheduled for the recipient.

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

Examinations in Anticipation of Denture Construction

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

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

Minimum Examination Requirements for the Clinical Examination

The recipient's oral cavity 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 Recipients

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

Examination in Conjunction with a Denture Repair

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

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

If radiographs are unobtainable, e.g. the recipient is physically unable to receive this service or the recipient is a resident of a long- term care facility where radiographic equipment is unavailable, the reason for the lack of radiographs must be recorded in the treatment record and on all claims submitted for PA and in the recipient'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. Those requests for PA that contain radiographs and oral/facial images that are not of good diagnostic quality will be rejected.

A lead 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.

As the comprehensive oral examination can only be prior authorized in conjunction with the appropriate radiographs, the comprehensive oral examination will be denied if the radiographs are rejected/denied.

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.

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Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthetics

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

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

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- 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 recipient'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 recipient refuses delivery of the complete or partial denture, it cannot be considered delivered.

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

Denture Identification Information

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

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

Complete Dentures

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

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

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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 recipient that no reline will be reimbursed by Medicaid within one year of the denture delivery.

If there will be teeth remaining on the date of denture delivery, only the immediate full denture codes (D5130 and/or D5140) may be prior authorized. Radiographs 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 recipient 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 conventional clasps, rests and teeth)

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

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

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

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

Only one complete or partial denture per arch is allowed in 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

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

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

Denture Repairs

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

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

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

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

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allowed in conjunction with a reline on the same recipient 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 recipient 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 D5510 and D5610 are reimbursable for Oral Cavity Designator 01 and 02. The appropriate oral cavity designator must be identified in the “Area of Oral Cavity” column of the ADA Claim Form when requesting reimbursement for these procedures.

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

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

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

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

Minimal procedural requirements for repair services include the following:

- The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the recipient’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.

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- 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. Recipients who do not have a complete denture are not eligible for the partial denture reline services of the Adult Denture Program.

A combination of two complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in 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.

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- Occlusal vertical dimensions and centric relationships must be retained or re-established if lost.
- Relines must be flaked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a workmanlike manner; 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.

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**SECTION 16.10: ADULT DENTURE PROGRAM- NON-COVERED
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NON-COVERED SERVICES

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

NOTE: Dental providers may request compensation for certain services using the Current Physician's Terminology (CPT) codes which are covered under the Professional Services Program when these services are rendered to Medicaid recipients who are eligible for services provided in the Professional Services Program.

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**SECTION 16.11: ADULT DENTURE PROGRAM- PRIOR
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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 dental consultants at the Louisiana State University (LSU) School of Dentistry 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 recipient.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the recipient 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 recipient.

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 dental consultants at the Medicaid Dental PA Unit 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 dental consultants reviewing the case to fully understand the general dental health and condition of the recipient for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be entered in the “Remarks” section of the claim form. If the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, be certain it includes the date of the request, the recipient’s name, the recipient’s Medicaid ID) #, the provider’s name and the provider’s Medicaid ID #. A copy of

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this cover sheet, along with a copy of the request for PA, must be kept in the recipient's treatment record. Without the complete treatment plan, appropriate radiographs, or explanations, it may not be possible for the consultant to determine approval of the isolated services.

Prior Authorization Reminders

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

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 recipient 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 recipient'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 dental consultants with the requested information. If necessary, the provider may provide further explanations or reasons for treatment in the "Remarks" section of the claim form.

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

The dental consultants review the dental PA requests in an expedient manner. However, some requests are held over for additional consultation.

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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 dental consultants at the LSU School of Dentistry. If the claim form is returned to the provider but the radiographs that were included with the claim are not returned, the provider must immediately contact the dental consultants at the LSU School of Dentistry. All contacts with the LSU School of Dentistry must be documented in the recipient'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 recipient number corrections, date of service changes, etc., a copy of the PA letter with the requested changes noted, may be sufficient.

If the provider proceeds with treatment before receiving 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 recipient Medicaid eligibility. When a recipient loses Medicaid eligibility, any authorization of services becomes void.

All PA requests should be sent to the **LSU School of Dentistry Medicaid Dental PA Unit** (see Appendix K for contact information).

The checklist available in Appendix H 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.

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DENTAL PROGRAM FEE SCHEDULE

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

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

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

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

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

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

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The following fee schedule is effective August 1, 2013:

EPSDT DENTAL PROGRAM DIAGNOSTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
D0120	Periodic Oral Examination – Patient of Record	26.83
D0145	Oral Examination for a Patient Under Three Years of Age and Counseling with Primary Caregiver	37.91
D0150	Comprehensive Oral Examination – New Patient Note: Medicaid requires use of this code to report new patients (patients not seen by the billing provider within 3 years) only.	46.66
*D0210	Intraoral - Complete Series of Radiographic Images	59.27
#D0220	Intraoral – Periapical First Radiographic Image	14.47
#D0230	Intraoral – Periapical Each Additional Radiographic Image	12.23
+*D0240	Intraoral - Occlusal Radiographic Image	20.10
D0272	Bitewings – Two Radiographic Images	21.11
*D0330	Panoramic Radiographic Image	56.19
+D0350	Oral/Facial Images	27.01
*D0470	Diagnostic Casts	46.73
*D0473	Accession of Tissue, Gross and Microscopic Examination, Preparation and Transmission of Written Report	73.37
*D0474	Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report	75.87

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EPSDT DENTAL PROGRAM PREVENTIVE PROCEDURE CODES		
CODE	DESCRIPTION	FEE
D1110	Prophylaxis – Adult (12 through 20 years of age)	47.29
D1120	Prophylaxis – Child (under 12 years of age)	34.49
D1206	Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients (under 6 years of age)	23.93
D1208	Topical Application of Fluoride	19.21
#D1351	Sealant, Per Tooth (6-year molar sealant – under 10 years of age; 12-year molar sealant – 10 through 15 years of age.) This procedure is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30, and 31.	25.13
+*D1510	Space Maintainer, Fixed, Unilateral This procedure is reimbursable for Oral Cavity Designator 10, 20, 30, and 40.	149.25
+*D1515	Space Maintainer, Fixed, Bilateral This procedure is reimbursable for Oral Cavity Designator 01 and 02.	203.51
+D1550	Recementation of Space Maintainer This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30, and 40.	38.19
D1555	Removal of Fixed Space Maintainer This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30, and 40.	37.69

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EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D2140	Amalgam, One Surface, Primary or Permanent This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under <u>5 years of age</u> .	63.82
#D2150	Amalgam, Two Surfaces, Primary or Permanent This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under <u>5 years of age</u> .	80.91.
#D2160	Amalgam, Three Surfaces, Primary or Permanent This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letters A through T. However, this Procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under <u>5 years of age</u> .	97.99
#D2161	Amalgam, Four or More Surfaces, Permanent This procedure is reimbursable for Tooth Number 1 through 32.	115.58
#D2330	Resin-based Composite, One Surface, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letter C, H, M and R 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 <u>5 years of age</u> .	74.87
#D2331	Resin-based Composite, Two Surfaces, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R 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 <u>5 years of age</u> .	92.96

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EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D2332	Resin-based Composite, Three Surfaces, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27. This procedure is reimbursable for Tooth Letters C, H, M and R 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 <u>5 years of age.</u>	113.07
#D2335	Resin-based Composite, Four or More Surfaces, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 <u>with prior authorization</u> ; 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 <u>5 years of age. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.</u>	141.71
#*D2390	Resin-based Composite Crown, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 with prior authorization; 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 <u>5 years of age. Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.</u>	207.54
#D2391	Resin-based Composite, One Surface, Posterior 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.	63.82
#D2392	Resin-based Composite, Two Surface, Posterior 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.	80.91

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EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D2393	Resin-based Composite, Three Surface, Posterior 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.	97.99
#D2394	Resin-based Composite, Four or More Surfaces, Posterior 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.	115.58
#D2920	Recement Crown This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letter A through T.	49.25
#_D2930	Prefabricated Stainless Steel Crown, Primary Tooth This procedure is reimbursable for Tooth Letters A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under <u>5 years of age</u> . <u>Prior Authorization is required only for Tooth Letters B, I, L, and S for recipients 8 years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for recipients 9 years of age and older.</u>	125.63
#*D2931	Prefabricated Stainless Steel Crown, Permanent Tooth This procedure is reimbursable for Tooth Number 1 through 32.	149.75
#_D2932	Prefabricated Resin Crown This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27 with prior authorization; 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 <u>5 years of age</u> . <u>Prior authorization for Tooth Letters C, H, M and R is required only for recipients 9 years of age and older. Prior authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.</u>	163.31

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EPSDT DENTAL PROGRAM RESTORATIVE PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#*D2933	<p>Prefabricated Stainless Steel Crown with Resin Window</p> <p>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. <u>Prior authorization is required for Tooth Letters C, H, M and R only for recipients 9 years of age and older.</u> Prior authorization is <u>not</u> required for Tooth Letters D, E, F, G, N, O, P and Q.</p>	166.33
#*D2934	<p>Prefabricated Esthetic Coated Stainless Steel Crown- Primary Tooth</p> <p>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 <u>is under 5 years of age.</u> <u>Prior authorization is required for Tooth Letters C, H, M and R only for recipients 9 years of age and older.</u> Prior authorization is <u>not</u> required for Tooth Letters D, E, F, G, N, O, P and Q.</p>	166.33
#*D2950	<p>Core Buildup, Including Any Pins</p> <p>This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.</p>	126.63
#D2951	<p>Pin Retention, Per Tooth, In Addition To Restoration</p> <p>This procedure is reimbursable for Tooth Number 2 through 5; 12 through 15; 18 through 21; and 28 through 31.</p>	34.67
#*D2954	<p>Prefabricated Post And Core In Addition To Crown</p> <p>This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.</p>	158.29
#*D2999	<p>Unspecified Restorative Procedure, By Report</p> <p>This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letter A through T.</p>	*****

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EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D3110	Pulp Cap – Direct (excluding final restoration) This procedure is reimbursable for Tooth Number 1 through 32.	37.69
##_D3220	Therapeutic Pulpotomy (excluding final restoration) This procedure is reimbursable for Tooth Letter A through T. However, this procedure is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under <u>5 years of age</u> .	92.96
##_D3222	Partial Pulpotomy for Apexogenesis This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	92.96
##_D3240	Pulpal Therapy (Resorbable Filling), Posterior, Primary Tooth This procedure is reimbursable for Tooth Letter A, J, K, and T.	149.75
##_D3310	Root Canal Therapy, Anterior (excluding final restoration) This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	331.66
##_D3320	Root Canal Therapy, Bicuspid (excluding final restoration) This procedure is reimbursable for Tooth Number 4, 5, 12, 13, 20, 21, 28 and 29.	389.44
##_D3330	Root Canal Therapy, Molar (excluding final restoration) This procedure is reimbursable for Tooth Number 2, 3, 14, 15, 18, 19, 30 and 31.	467.33
##_D3346	Retreatment of Previous Root Canal Therapy, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	385.42

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EPSDT DENTAL PROGRAM ENDODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#*D3352	Apexification/Recalcification, Interim Medication Replacement This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	119.60
#*D3410	Apicoectomy/Periradicular Surgery, Anterior This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	318.59
#*D3430	Retrograde Filling, Per Root This procedure is reimbursable for Tooth Number 6 through 11 and 22 through 27.	126.63
#*D3999	Unspecified Endodontic Procedure, By Report This procedure is reimbursable for Tooth Number 1 through 32 and Tooth Letter A through T.	*****

EPSDT DENTAL PROGRAM PERIODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
+*D4210	Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	290.95
+*D4341	Periodontal Scaling and Root Planning, Four or More Teeth Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30, and 40.	115.58
*D4355	Full Mouth Debridement To Enable Comprehensive Evaluation and Diagnosis	85.43
*D4999	Unspecified Periodontal Procedure, By Report	*****

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EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
*D5110	Complete Denture, Maxillary	495.00
*D5120	Complete Denture, Mandibular	495.00
*D5130	Immediate Denture, Maxillary	495.00
*D5140	Immediate Denture, Mandibular	495.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	470.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	470.00
*D5213	Maxillary Partial Denture, Cast Metal (including clasps)	688.00
*D5214	Mandibular Partial Denture, Cast Metal (including clasps)	688.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designator 01 and 02.	125.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	65.00/33.00
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designator 01 and 02.	125.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	119.00

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EPSDT DENTAL PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	65.00/33.00
#D5650	Add Tooth to Existing Partial Denture <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31.	65.00/33.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	119.00
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5820	Interim Partial Denture (Maxillary), Includes Clasps	375.00
*D5821	Interim Partial Denture (Mandibular), Includes Clasps	375.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	

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EPSDT DENTAL PROGRAM MAXILLOFACIAL PROSTHETIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
+*D5986	Fluoride Gel Carrier This procedure is reimbursable for Oral Cavity Designator 01 and 02.	97.28

EPSDT DENTAL PROGRAM FIXED PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#*D6241	Pontic - Porcelain Fused to Predominantly Base Metal This procedure is reimbursable for Tooth Number 7, 8, 9, and 10.	479.39
#*D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis This procedure is reimbursable for Tooth Number 6, 7, 8, 9, 10 and 11.	388.43
*D6999	Unspecified, Fixed Prosthodontic procedure, By Report	*****

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#D7111	Extraction, Coronal Remnants – Deciduous Tooth Includes soft tissue-retained coronal remnants. This procedure code is reimbursable for Tooth Letters A through T and AS through TS.	63.82
#D7140	Extraction, Erupted Tooth or Exposed Root This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	77.88

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EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#*D7210	Surgical Removal of Erupted Tooth This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	128.14
#*D7220	Removal of Impacted Tooth – Soft Tissue This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	148.24
#*D7230	Removal of Impacted Tooth – Partially Bony This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	185.93
#*D7240	Removal of Impacted Tooth – Completely Bony This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	228.64
#*D7241	Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	273.87
#*D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure) This procedure is reimbursable for Tooth Number 1 through 32 and A through T; and for Supernumerary Teeth 51 through 82 and AS through TS.	142.21
+*D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth This procedure is reimbursable for Oral Cavity Designator 01 and 02.	***** Maximum Fee \$ 251.22
#*D7280	Surgical Access of an Unerupted Tooth This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31.	226.13

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EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	DESCRIPTION	FEE
#*D7283	Placement of Device to Facilitate Eruption of Impacted Tooth This procedure is reimbursable for Tooth Number 2 through 15; and 18 through 31 for Medicaid approved comprehensive orthodontic cases only.	242.21
+*D7285	Biopsy of Oral Tissue – Hard (bone, tooth) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 or 40.	***** Maximum Fee \$ 191.96
+*D7286	Biopsy of Oral Tissue - Soft (all others) This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	150.25
+*D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02 for Medicaid approved comprehensive orthodontic cases only.	149.75
+*D7310	Alveoloplasty in Conjunction with Extractions – Per Quadrant This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40.	138.19
#D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue This procedure is reimbursable for Tooth Number 1 through 32.	108.03
+*D7880	Occlusal Orthotic Device, By Report This procedure is reimbursable for Oral Cavity Designator 01 and 02.	454.76
D7910	Suture of Recent Small Wounds up to 5 cm	138.69
+*D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	208.04

CHAPTER 16: DENTAL SERVICES**APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE****PAGE(S) 16**

EPSDT DENTAL PROGRAM ORAL AND MAXILLOFACIAL SURGERY PROCEDURE CODES		
CODE	DESCRIPTION	FEE
+*D7997	Appliance Removal (not by dentist who placed appliance), includes removal of archbar This procedure is reimbursable for Oral Cavity Designator 01 and 02.	***** Maximum Fee \$ 236.40
*D7999	Unspecified Oral Surgery Procedure, By Report	*****

EPSDT DENTAL PROGRAM ORTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
+*D8050	Interceptive Orthodontic Treatment of the Primary Dentition This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	***** Maximum Fee \$438.00
+*D8060	Interceptive Orthodontic Treatment of the Transitional Dentition This procedure is reimbursable for Oral Cavity Designator 01, 02, 10, 20, 30 and 40.	***** Maximum Fee \$438.00
*D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	***** Maximum Fee \$4,182.00
*D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	***** Maximum Fee \$4,281.00
*D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	***** Maximum Fee \$4,515.00

CHAPTER 16: DENTAL SERVICES**APPENDIX A: EPSDT DENTAL PROGRAM FEE SCHEDULE****PAGE(S) 16**

EPSDT DENTAL PROGRAM ORTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
*D8220	Fixed Appliance Therapy	526.69
*D8999	Unspecified Orthodontic Procedure, By Report	*****

EPSDT DENTAL PROGRAM ADJUNCTIVE GENERAL SERVICES		
CODE	DESCRIPTION	FEE
D9110	Palliative (Emergency) Treatment of Dental Pain	57.79
D9230	Analgesia, Anxiolysis, Inhalation of Nitrous Oxide	36.18
*D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	180.40
*D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	72.87
*D9248	Non-intravenous Conscious Sedation	123.57
*D9420	Hospital Call	104.51
*D9440	Office Visit – After Regularly Scheduled Hours	78.40
*D9920	Behavior Management, By Report	67.84
+*D9940	Occlusal Guard, By Report This procedure reimbursable for Oral Cavity Designator 01 and 02.	275.88
*D9951	Occlusal Adjustment – Limited	84.42
*D9999	Unspecified Adjunctive Procedure, By Report	*****

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.

CHAPTER 16: DENTAL SERVICES

APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE PAGE(S) 4

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 requests and prior authorization requests if required. *If an oral cavity designator is required by Medicaid, do not enter a tooth number or letter on the claim form for payment or on the prior authorization request when prior authorization is required.*

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

CHAPTER 16: DENTAL SERVICES**APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE PAGE(S) 4**

The following fee schedule is effective August 1, 2013:

ADULT DENTURE PROGRAM DIAGNOSTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
*D0150	Comprehensive Oral Examination (Adult Oral Examination)	\$ 40.22
*D0210	Intraoral Radiographs, Complete Series	\$ 59.58

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
*D5110	Complete Denture, Maxillary	495.00
*D5120	Complete Denture, Mandibular	495.00
*D5130	Immediate Denture, Maxillary	495.00
*D5140	Immediate Denture, Mandibular	495.00
*D5211	Maxillary Partial Denture, Resin Base (including clasps)	470.00
*D5212	Mandibular Partial Denture, Resin Base (including clasps)	470.00
+D5510	Repair Broken Complete Denture Base This procedure is reimbursable for Oral Cavity Designator 01 and 02. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	125.00
#D5520	Replace Missing or Broken Tooth, Complete Denture, Per Tooth <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	65.00/33.00

CHAPTER 16: DENTAL SERVICES**APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE PAGE(S) 4**

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
+D5610	Repair Resin Denture Base, Partial Denture This procedure is reimbursable for Oral Cavity Designator 01 and 02. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	125.00
+D5630	Repair or Replace Broken Clasp, Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40. <i>Total of \$175.00 limit in denture repairs per arc, see manual for details.</i>	119.00
#D5640	Replace Broken Teeth, Partial Denture, Per Tooth <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	65.00/33.00
#D5650	Add Tooth to Existing Partial Denture <u>1st Tooth = \$65.00; Each Additional Tooth = \$33.00</u> This procedure is reimbursable for Tooth Number 2 through 15 and 18 through 31. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	65.00/33.00
+D5660	Add Clasp to Existing Partial Denture This procedure is reimbursable for Oral Cavity Designator 10, 20, 30 and 40. <i>Total of \$175.00 limit in denture repairs per arch, see manual for details.</i>	119.00

CHAPTER 16: DENTAL SERVICES

APPENDIX B: ADULT DENTURE PROGRAM FEE SCHEDULE PAGE(S) 4

ADULT DENTURE PROGRAM REMOVABLE PROSTHODONTIC PROCEDURE CODES		
CODE	DESCRIPTION	FEE
*D5750	Reline Complete Maxillary Denture (Laboratory)	238.00
*D5751	Reline Complete Mandibular Denture (Laboratory)	238.00
*D5760	Reline Maxillary Partial Denture (Laboratory)	208.00
*D5761	Reline Mandibular Partial Denture (Laboratory)	208.00
*D5899	Unspecified Removable Prosthodontic Procedure, By Report	*****

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11****2006 ADA DENTAL CLAIM FORM AND INSTRUCTIONS**

The 2006 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 2006 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).

Locator #	Description	Instructions	Alerts
1	Type of Transaction	<p>Required -- Check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.</p> <p>Situational – Check box marked “EPSDT Title XIX” if patient is Medicaid eligible and under 21 years of age.</p> <p>If block is not checked, the claim will be processed as an adult claim.</p>	
2	Predetermination / Preauthorization Number	<p>Situational – Enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.</p>	
3	Company / Plan Name, Address, City, State, Zip Code	<p>Situational – Enter the primary payer information if applicable.</p>	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

Locator #	Description	Instructions	Alerts
4	Other Dental or Medical Coverage?	Situational – If yes, complete Block 9.	
5	Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)	Situational.	
6	Date of Birth (MM/DD/CCYY)	Situational.	
7	Gender	Situational.	
8	Policyholder/Subscriber ID	Situational.	
9	Plan/Group Number	<p>Situational – 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, www.lamedicaid.com under the link Forms/Files.</p> <p>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.</p>	
10	Patient's Relationship to Person Named in #5	Situational.	
11	Other Insurance Company / Dental Benefit Plan Name, Address, City, State, Zip Code	Situational.	
12	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	<p>Required -- Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS.</p> <p>Recipient's address is optional.</p>	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

Locator #	Description	Instructions	Alerts
13	Date of Birth (MM/DD/CCYY)	Required -- Enter the recipient'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.	
14	Gender	Optional – Check appropriate block.	
15	Policyholder/Subscriber ID	Required -- 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 recipient's Medicaid card.	
16	Plan / Group Number	Situational.	
17	Employer Name	Situational.	
18	Relationship to Policyholder/Subscriber in #12 above.	Situational.	
19	Student Status	Situational.	
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Situational. This field should be used only when other private insurance is primary. Note: The Medicaid recipient's name is required to be entered in Block 12.	
21	Date of Birth (MM/DD/CCYY)	Situational.	
22	Gender	Situational.	
23	Patient ID / Account # (Assigned by Dentist)	Optional – 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.	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS** **PAGE(S) 11**

Locator #	Description	Instructions	Alerts
24	Procedure Date (MM/DD/CCYY)	Required -- 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.	
25	Area of Oral Cavity	Situational – 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.	
26	Tooth System	Leave Blank	
27	Tooth Number(s) or Letter(s)	Situational – 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. <u>If a tooth number or letter is required by Medicaid, do not enter an oral cavity designator in Block 25.</u>	
28	Tooth Surface	Situational – 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.	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS** **PAGE(S) 11**

Locator #	Description	Instructions	Alerts
29	Procedure Code	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.	
30	Description	Required – Enter the description of the service performed.	
31	Fee	Required -- Enter the dentist's full (usual and customary) fee for the dental procedure reported.	
32	Other Fee(s)	Leave Blank	
33	Total Fee	Required – Total of all fees listed on the claim form.	
34	(Place an 'X' on each missing tooth)	<p>Situational – Complete if applicable. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with an "/".</p> <p>In the following circumstances, this information is required:</p> <p>If the claim is for the Adult Denture Program.</p> <p>If the claim is for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy.</p>	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

Locator #	Description	Instructions	Alerts
35	Remarks	<p>Situational – Enter the amount paid by the primary payor if block 9 is completed. If no TPL, leave blank. (RANDY – PLEASE DELETE)</p> <p>Write the words “Carrier Paid” and the amount that was paid by the carrier (including zero [\$0] payment) in this block.</p> <p>Enter any additional information required by Medicaid regarding requested services (including description of the patient management techniques used for which a patient management fee is billed; reason for hospitalization requests, or any additional information that the provider needs to include).</p> <p>For prior authorization requests, 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 sure it includes the date of the request, the recipient’s name and Medicaid ID # and the provider’s name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient’s treatment record.</p>	
36	Authorizations	Optional.	
37	Authorizations	Optional.	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

Locator #	Description	Instructions	Alerts
38	Place of Treatment	<p>Situational – Check the applicable box if services are to be or were provided at a location other than the address entered in Block 48.</p> <p>If services were provided at a location other than the address entered in Block 48, completion of this block and Block 56 is required.</p>	
39	Number of Enclosures	<p>Situational – Enter 00 to 99 in applicable boxes.</p> <p>Claims submitted for prior authorization are required to contain the identified attachments.</p> <p>Claims submitted for payment should not contain any of the attachments listed in Block 39.</p>	
40	Is Treatment for Orthodontics?	<p>Situational – Complete if applicable.</p> <p>Claims requesting comprehensive orthodontic services are required to enter information in this block.</p> <p>Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.</p>	
41	Date Appliance Placed	Situational.	
42	Months of Treatment Remaining.	Situational.	
43	Replacement of Prosthesis	Situational – Check appropriate box if applicable; if checked, complete Block 44 if known.	

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

Locator #	Description	Instructions	Alerts
44	Date Prior Placement	Situational – If Block 43 is checked and if known, enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).	
45	Treatment Resulting from	Situational – If the claim is the result of Occupational Illness / Injury, Auto Accident, or Other Accident, then this Block is required . Check the appropriate box.	
46	Date of Accident (MM/DD/CCYY).	Situational. If Block 45 is completed, then this block is required . Enter the eight-digit date in month, day and year (MM/DD/CCYY).	
47	Auto Accident State	Situational. If Auto Accident is checked in Block 45, this block is required . Enter the state in which the auto accident occurred.	
48	Billing Dentist Name, Address, City, State, Zip Code	Required. Enter the name of the individual dentist if the payment is being made to an individual dentist. Enter the group name if the payment is being made to a dental group. Enter the full address, including city, state and zip code, of the dentist or dental group to whom payment is being made.	
49	NPI	Required – Enter the 8-digit NPI of the billing dental provider.	
50	License Number	Optional.	
51	SSN or TIN	Optional.	
52	Phone Number	Required -- Enter the phone number for the billing dental provider.	
52A	Additional Provider ID	Required – Enter the 7-digit Medicaid Provider ID of the billing dental provider.	

CHAPTER 16: DENTAL SERVICES

APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS **PAGE(S) 11**

Locator #	Description	Instructions	Alerts
53	Signature	Required – Enter the signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider’s assistant.	
54	NPI	Required – Enter the 8-digit NPI of the treating dental provider.	
55	License Number	Required – Enter the license number of the treating (attending) dental provider.	
56	Address, City, State, Zip Code	Situational – Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dental provider, if different from Block 48.	
56A	Provider Specialty Code	Optional.	
57	Phone Number	Situational – Enter the phone number for the treating (attending) dental provider, if different from Block 52.	
58	Additional Provider ID	Required – Enter the 7-digit Medicaid ID of the treating (attending) dental provider.	

CHAPTER 16: DENTAL SERVICES

APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11

ADA Dental Claim Form

HEADER INFORMATION																			
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Presubmital <input type="checkbox"/> EPSDT/Title XIX																			
2. Predetermination/Presubmital Number																			
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																			
3. Company/Plan Name, Address, City, State, Zip Code																			
OTHER COVERAGE																			
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																			
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																			
6. Date of Birth (MM/DD/YYYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)															
9. Plan/Group Number		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																			
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																			
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																			
13. Date of Birth (MM/DD/YYYY)			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)														
16. Plan/Group Number			17. Employer Name																
PATIENT INFORMATION																			
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																			
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																			
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																			
21. Date of Birth (MM/DD/YYYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)														
RECORD OF SERVICES PROVIDED																			
24. Procedure Date (MM/DD/YYYY)		25. Area of Oral Cavity		26. Tooth System		27. Tooth Number(s) or Letter(s)		28. Tooth Surface		29. Procedure Code		30. Description		31. Fee					
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
MISSING TEETH INFORMATION										32. Other Fee(s)									
34. (Place an 'X' on each missing tooth)										33. Total Fee									
35. Remarks																			
AUTHORIZATIONS										ANCILLARY CLAIM/TREATMENT INFORMATION									
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.										38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other									
X _____ Patient/Guardian signature Date										39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)									
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity										40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)									
X _____ Subscriber signature Date										41. Date Appliance Placed (MM/DD/YYYY)									
										42. Months of Treatment Remaining 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)									
										44. Date Prior Placement (MM/DD/YYYY)									
										45. Treatment Resulting from <input type="checkbox"/> Occupational Illness/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident									
										46. Date of Accident (MM/DD/YYYY) 47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)										TREATING DENTIST AND TREATMENT LOCATION INFORMATION									
48. Name, Address, City, State, Zip Code										53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.									
										X _____ Signed (Treating Dentist) Date									
49. NPI 50. License Number 51. SSN or TIN										54. NPI 55. License Number									
										56. Address, City, State, Zip Code 56A. Provider Specialty Code									
52. Phone Number () - 52A. Additional Provider ID										57. Phone Number () - 58. Additional Provider ID									

CHAPTER 16: DENTAL SERVICES**APPENDIX C: DENTAL CLAIM FORM/ INSTRUCTIONS PAGE(S) 11**

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

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 #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
- B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
- C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
- D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
- E. All dates must include the four-digit year.
- F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Identifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web site: www.ada.org/goto/npi

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

- 56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

PAGE(S) 10

ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

Early and Periodic Screening, Diagnosis and Treatment

Instructions for Completing 209 Adjustment/Void Form

Molina 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 |

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

PAGE(S) 10

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|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15. Patient ID/Account Number
(Assigned By Dentist) | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 16. Pay to Dentist or Group | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 17. Pay to Dentist or Group Provider No. | 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. |
| 18. Are X-Rays Enclosed | Not required. |
| 19. Treatment Necessitated By | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 20. Payment Source Other Than Title XIX | Adjust - 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.

Void - Enter the information exactly as it appeared on the original invoice. |
| 21-22. | Leave these spaces blank. |
| 23. Diagram | Not required. |

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

PAGE(S) 10

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|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 appeared on the original invoice. |
| 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 Molina 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

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FOR PREAUTHORIZATION
MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT
REMIT TO:
Molina
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES

FOR OFFICE USE ONLY

1. ADJ. ☐ VOID ☐

2. PATIENT'S LAST NAME (PRINT) _____ 3. FIRST NAME _____ 4. MI _____ 5. MEDICAL ASSISTANCE I.D. NUMBER _____

6. PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.) _____ 7. DATE OF BIRTH _____ 8. SEX ☐ M ☐ F

9. REFERRING AGENCY NO. _____ 10. DATE OF REFERRAL _____ 11. REFERRED FOR:
☐ EMERGENCY
☐ BASIC SCREENING

12. DENTIST OR GROUP REFERRED TO: NAME _____ ADDRESS _____ TEL. NO. _____

13. REFERRED BY: (SIGNATURE) _____ 14. TELEPHONE NO. _____ 15. PATIENT ID. / ACCOUNT # ASSIGNED BY DENTIST _____

16. PAY TO: DENTIST OR GROUP NAME _____ ADDRESS _____ CITY _____ ST. _____ ZIP _____

17. PAY TO: DENTIST OR GROUP PROVIDER NO. _____ 18. ARE X-RAYS ENCLOSED?
☐ YES ☐ NO

19. TREATMENT NECESSITATED BY:
A. EMPLOYMENT ☐ YES ☐ NO
B. ACCIDENT/INJURY ☐ YES ☐ NO

20. PAYMENT SOURCE OTHER THAN TITLE XIX
IPL CARRIER CODE:
1. _____
2. _____
3. _____

21. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? ☐ YES ☐ NO

22. IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM ☐

23. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	E. UNITS	F. DATE SERVICE PERFORMED MO. DAY YR.	G. ADJUSTED FEE (FOR STATE USE ONLY)	H. USUAL AND CUSTOMARY FEE
H. ORAL CAVITY							

24. CONTROL NUMBER _____

25. REASONS FOR ADJUSTMENT

☐ 01 THIRD PARTY LIABILITY RECOVERY
☐ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN _____

26. REASONS FOR VOID

☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN _____

27. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: _____

28. REMARKS FOR UNUSUAL SERVICE: _____

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

29. REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM

ATTENDING DENTIST'S SIGNATURE _____
PROVIDER NUMBER _____ DATE _____

30. APPROVED - YES ☐ NO ☐ W/EXCEPTIONS ☐

AUTHORIZED SIGNATURE _____ DATE _____

31. REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)

ATTENDING DENTIST'S SIGNATURE _____
PROVIDER NUMBER _____

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

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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.

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

PAGE(S) 10

Adult Dental Services**Instructions for Completing 210 Adjustment/Void Form**Molina 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 |

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

PAGE(S) 10

- | | |
|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15. Patient ID/Account Number
(Assigned By Dentist) | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 16. Pay to Dentist or Group | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 17. Pay to Dentist or Group Provider No. | 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. |
| 18. Are X-Rays Enclosed | Not required. |
| 19. Treatment Necessitated By | Adjust - Enter the information exactly as it appeared on the original invoice.

Void - Enter the information exactly as it appeared on the original invoice. |
| 20. Payment Source Other Than Title XIX | Adjust - 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.

Void - Enter the information exactly as it appeared on the original invoice. |
| 21. | Not required. |
| 22. | Leave blank. |

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS**PAGE(S) 10**

- | | | |
|--------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 Molina 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

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FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
Molina
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

1. ADJ. ☐ VOID ☐

2. PATIENT'S LAST NAME (PRINT) 3. FIRST NAME 4. MI 5. MEDICAL ASSISTANCE I.D. NUMBER

6. PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL. NO.) 7. DATE OF BIRTH 8. SEX ☐ M ☐ F

9. REFERRING AGENCY NO. 10. DATE OF REFERRAL 11. DENTIST OR GROUP REFERRED TO: NAME ADDRESS TEL. NO.

12. REFERRED BY: (SIGNATURE) 13. TELEPHONE NO. 14. PATIENT I.D. / ACCOUNT # ASSIGNED BY DENTIST

15. PAY TO: DENTIST OR GROUP NAME ADDRESS CITY ST. ZIP

16. PAY TO: DENTIST OR GROUP PROVIDER NO. 17. ARE X-RAYS ENCLOSED? ☐ YES ☐ NO NUMBER OF X-RAYS

18. TREATMENT NECESSITATED BY: A. EMPLOYMENT ☐ YES ☐ NO B. ACCIDENT/INJURY ☐ YES ☐ NO

19. PAYMENT SOURCE OTHER THAN TITLE XIX TPL CARRIER CODE: 1. 2. 3.

20. IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? ☐ YES ☐ NO

21. A. PROCEDURE CODE B. DESCRIPTION OF SERVICE C. DATE SERVICE PERFORMED MO. DAY YEAR D. ADJUSTED FEE (FOR STATE USE ONLY) E. USUAL AND CUSTOMARY FEE

22. F. ORAL CAVITY G. TOOTH # 23. PAID OR PAYABLE BY OTHER CARRIER \$

24. (1) IS THE PATIENT EDENTULOUS? MAXILLARY: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS / / MANDIBULAR: NO ☐ YES ☐ DATE OF LAST EXTRACTIONS / /

25. (2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT: MAXILLARY: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. YR. MANDIBULAR: NO ☐ YES ☐ FULL ☐ PARTIAL ☐ MO. YR.

COMMENTS:

INFORMATION FROM PATIENT (1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER LOWER (2) NAME AND ADDRESS OF DENTIST (3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES ☐ NO ☐

26. CONTROL NUMBER 27. THIS IS FOR CHANGING OR VOIDING A PAID ITEM (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED) 28. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

29. REASONS FOR ADJUSTMENT 01 THIRD PARTY LIABILITY RECOVERY 02 PROVIDER CORRECTIONS 03 FISCAL AGENT ERROR 90 STATE OFFICE USE ONLY - RECOVERY 99 OTHER - PLEASE EXPLAIN

30. REASONS FOR VOID 10 CLAIM PAID FOR WRONG RECIPIENT 11 CLAIM PAID TO WRONG PROVIDER 99 OTHER - PLEASE EXPLAIN

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

31. REQUEST FOR AUTHORIZATION - SEND TO OPS DENTAL PROGRAM 32. REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY) APPROVED YES ☐ NO ☐ W/EXCEPTIONS ☐

ATTENDING DENTIST'S SIGNATURE PROVIDER NUMBER DATE

ATTENDING DENTIST'S SIGNATURE PROVIDER NUMBER

Molina 210 10/04

CHAPTER 16: DENTAL SERVICES

APPENDIX D: ADJUSTMENT/VOID FORMS AND INSTRUCTIONS

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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.

CHAPTER 16: DENTAL SERVICES**APPENDIX E: DENTAL PERIODICITY SCHEDULE****PAGE(S) 2****DENTAL PERIODICITY SCHEDULE**

The Louisiana Department of Health and Hospitals Medicaid Program recommends enrolled dental providers to follow the Dental Periodicity Schedule. The Centers for Medicare and Medicaid Services (CMS) requires that dental services be provided at intervals determined to meet reasonable standards of dental practice.

The Louisiana Medicaid Program follows the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule oral health recommendations. These recommendations are designed for care of children who have no contributing medical conditions are developing normally. These recommendations may require modification for children with special health needs.

The Louisiana Department of Health and Hospitals Medicaid Program follows the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule oral health recommendations in consultation with local dental communities. These recommendations are designed for care of children who have no contributing medical conditions are developing normally. These recommendations may require modification for children with special health needs.					
AGE	6-12 MTHS	12-24 MTHS	2-6 YEARS	6-12 YEARS	12 YEARS AND OLDER
Clinical oral exam including but not limited to the following: ¹	x	x	x	x	x
❖ Assess oral growth & development	x	x	x	x	x
❖ Caries-risk assessment	x	x	x	x	x
❖ Anticipatory guidance/counseling ⁵	x	x	x	x	x
❖ Oral hygiene counseling	x	x	x	x	x
❖ Dietary counseling	x	x	x	x	x
❖ Assessment for the need of fluoride supplementation	x	x	x	x	x
❖ Injury prevention counseling ⁸	Parent	Parent	Patient/Parent	Patient/Parent	Patient
❖ Counseling for non-nutritive habits ⁹	x	x	x	x	x
❖ Assessment for the need of substance abuse counseling				x	x
❖ Counseling for intraoral/perioral piercing				x	x
❖ Assessment for pit and fissure sealants ¹¹				x	x
❖ Assessment of developing malocclusion ¹⁰			x	x	x
Radiographic assessment ²	x	x	x	x	x
Prophylaxis and topical fluoride ^{2,4}	x	x	x	x	x
Assessment and/or removal of third molars					x
Transition to adult dental care					x

- (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.
- (2) Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
- (3) Fluoride supplementation as indicated including a topical fluoride varnish, as indicated by the child's risk for caries and periodontal disease and the water source
- (4) Repeat every 6 months or as indicated by child's risk status
- (5) Appropriate discussion and counseling should be an integral part of each visit for care.
- (6) Initially, responsibility of parent; as child develops, jointly with parent; then when indicated, only child.

CHAPTER 16: DENTAL SERVICES

APPENDIX E: DENTAL PERIODICITY SCHEDULE**PAGE(S) 2**

- (7) At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
- (8) Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouth guards.
- (9) 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.
- (10) For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
- (11) For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

CHAPTER 16: DENTAL SERVICES

APPENDIX F: CLAIM DENIAL SIMPLIFICATION PROCESS PAGE(S) 5

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 LSU Medicaid Dental Unit 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 LSU Medicaid Dental Unit 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 PA Unit) and the provider is required to submit a 515 override request along with certain documentation to the LSU Medicaid Dental Unit 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.

CHAPTER 16: DENTAL SERVICES**APPENDIX F: CLAIM DENIAL SIMPLIFICATION PROCESS PAGE(S) 5**

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.

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: <u>The code must be reimbursable by Medicaid for the specific tooth number.</u>	
Code	Anterior Permanent Teeth	Posterior Permanent Teeth
D2140	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2150	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2160	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931
D2161	D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	D2931 or D2950/D2931 or D2954/D2931

CHAPTER 16: DENTAL SERVICES**APPENDIX F: CLAIM DENIAL SIMPLIFICATION PROCESS PAGE(S) 5**

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: <u>The code must be reimbursable by Medicaid for the specific tooth number.</u>	
Code		Anterior Permanent Teeth	Posterior Permanent Teeth
D2330		D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2331		D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2332		D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2335		D2390 or D2931 or D2932 or D2950/D2931 or D2950/D2932 or D2954/D2931 or D2954/D2932	
D2390		D2140 or D2330 or D2335 or D2390	
D2931		D2140 or D2330 or D2931 or D2932	D2140 or D2931
D2932		D2140 or D2330 or D2931 or D2932	D2140 or D2931

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.

CHAPTER 16: DENTAL SERVICES

APPENDIX F: CLAIM DENIAL SIMPLIFICATION PROCESS PAGE(S) 5

If the requested code is eligible for reimbursement as a second or subsequent restoration due to pulpal necrosis (root canal) or traumatic injury for the same permanent tooth, a prior authorization is required. The prior authorization request must provide the following:

- An indication in the “Remarks” section of the ADA Claim Form (Block 35) that this is the second or subsequent restoration in a 12-month period, same tooth (provide tooth number); and
- An indication in the “Remarks” section of the ADA Claim Form (Block 35) as to whether the restoration is necessary due to pulpal necrosis (root canal) or traumatic injury; and
- Submit a copy of the entire treatment record. Note: The reason that the tooth requires a second or subsequent restoration must be well documented in the patient’s record; and
- Submit all pertinent radiographs that were taken. If radiographic copies are sent, they must be labeled right/left and be of good diagnostic quality.

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 Dental Medicaid Unit in order to have the claim reconsidered for payment.

If you have questions regarding this policy, you may contact the LSU Dental School, Dental Medicaid Unit.

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.

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APPENDIX F: CLAIM DENIAL SIMPLIFICATION PROCESS PAGE(S) 5

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 LSU Dental School, Dental Medicaid Unit.

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APPENDIX G: PRIOR AUTHORIZATION CHECKLIST**PAGE(S) 2**

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.)

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APPENDIX G: PRIOR AUTHORIZATION CHECKLIST**PAGE(S) 2**

- ☐ 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 LSU School of Dentistry, Medicaid Dental PA Unit, P.O. Box 19085, New Orleans, LA 70179-9085?**

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.

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APPENDIX H: PRIOR AUTHORIZATION SAMPLE LETTER PAGE(S) 1

PRIOR AUTHORIZATION (PA) SAMPLE LETTER

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

DATE 04/01/2003 RECIPIENT NAME xxxxxx xxxxx
PRIOR AUTH. NBR 999999999 RECIPIENT NUMBER 9999999999999

xxxxxxxxxx xxxxx xxxx *
xxxx xxxxxxxxx
xxxxxxxxxxxxxx xx 99999

PROVIDER NUMBER 9999999

DEAR PROVIDER,

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

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

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

PAGE(S) 3

FORMS

- 1. PEDIATRIC CONSCIOUS SEDATION FORM**
- 2. TEMPOROMANDIBULAR JOINT (TMJ) FORM**

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APPENDIX I: FORMS

PAGE(S) 3

PEDIATRIC DENTISTRY CONSCIOUS SEDATION

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

Preoperative Health Evaluation _____ ASA 1 ☐ 2 ☐ 3 ☐ 4 ☐

NPO Status _____

Preoperative Behavior Evaluation _____

Frankl Scale: ☐ 1 – definitely negative ☐ 3 – positive **North Carolina Scale:** Head Movement ☐ Crying ☐
☐ 2 negative ☐ 4 – definitely positive Physical Resistance ☐ Hands ☐ Legs ☐

Restraints: Papoose Board ☐ Pediwrap ☐ Velcro Seatbelts ☐ Mouth Prop ☐ Other: _____

Preprocedural Drug: _____ Route: _____ Dose (mg): _____ Time: _____ Administered by: _____

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

Route of Administration ☐ Oral ☐ Intramuscular ☐ Submucosal ☐ Other _____

Monitoring Devices ☐ B.P. Cuff ☐ P.C. Steth ☐ Dynamap ☐ Pulse Oximeter Other: _____

[illegible]

NOTE: ATTACH PRINTOUT OF MONITORING DEVICE, IF AVAILABLE.

Treatment: Time Started: _____ Completed: _____ Elapsed time: _____ hr. _____ min.

LEVEL OF SEDATION <input type="checkbox"/> No behavioral change <input type="checkbox"/> Sedated but disruptive when stimulated <input type="checkbox"/> Sedated but responsive to verbal command <input type="checkbox"/> Sedated – slept but responsive to verbal command <input type="checkbox"/> Sedated – slept, responsive only to physical stimulation <input type="checkbox"/> Slept and unresponsive to verbal or physical stimulation <input type="checkbox"/> Unconscious and unresponsive <input type="checkbox"/> Other	EFFECTIVENESS OF SEDATION <input type="checkbox"/> Ineffective <input type="checkbox"/> Effective <input type="checkbox"/> Very Effective <input type="checkbox"/> Over-Sedated SIDE EFFECTS <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Respiration Depression <input type="checkbox"/> Vertigo <input type="checkbox"/> Headache <input type="checkbox"/> Prolonged Recovery
Postoperative Course and Discharge Evaluation <input type="checkbox"/> Alert <input type="checkbox"/> Talking/Crying <input type="checkbox"/> Ambulatory <input type="checkbox"/> CV Stable <input type="checkbox"/> Airway Stable <input type="checkbox"/> Sit Unaided	

Disposition: _____
Signature: _____ Time of Discharge: _____

CHAPTER 16: DENTAL SERVICES

APPENDIX I: FORMS

PAGE(S) 3

TMJ SUMMARY

Patient's Name: _____ Age: _____ M F

Recipient Number: _____

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

Chief Complaints:

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

Clinical Findings:

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

Radiographic Findings:

Impressions:

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

Etiology:

Trauma, Bruxism, Missing teeth, malocclusion, etc.

Recommendations:

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

CHAPTER 16: DENTAL SERVICES**APPENDIX J: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT/REFERRAL INFORMATION****Fiscal Intermediary: Molina Medicaid Solutions (formerly UNISYS Corporation)**

Name of Contact	Address/Telephone/Website
Electronic Data Interchange (EDI) Electronic claims sign up and testing	P.O. Box 91025 Baton Rouge, LA 70898-0159 Phone: 225-216-6303 Fax: 225-216-6336
Pharmacy Point of Sale (POS) Pharmacy Help Desk	P.O. Box 91019 Baton Rouge, LA 70821 Phone: 800-648-0790 (Toll Free) Phone: 225-216-6381 (Local) Phone: 225-237-3381 (Local) Fax: 225-216-6334 <i>*After hours please call REVS line</i>
Pre-Certification Unit (Hospital) Pre-certification issues and forms	P.O. Box 14849 Baton Rouge, LA 70898-4849 Phone: 800-877-0666 Fax: 800-717-4329
Prior Authorization Unit (PAU) Prior authorization issues, forms, etc. <i>*See LSU School of Dentistry below in "Other Helpful Numbers" for more information.</i>	P.O. Box 14919 Baton Rouge, LA 70898-4919 Phone: 800-807-1320 (<i>Home Health</i>) Phone: 866-263-6534 (<i>Dental</i>) Phone: 800-488-6334 (<i>DME & All Other</i>) Fax: 225-216-6478
Provider Enrollment Unit (PEU) Provider Enrollment, direct deposit problems, reporting of changes and ownership, NPI	P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370 Fax: 225-216-6392
Provider Relations (PR) Billing and training questions	P.O. Box 91024 Baton Rouge, LA 70821 Phone: 225-924-5040 (Local) Phone: 800-473-2783 (Toll Free) Fax: 225-216-6334 http://www.lamedicaid.com
Recipient Eligibility Verification (REVS)	Phone: 225-216-7387 (Local) Phone: 800-776-6323 (Toll Free)
Web Technical Support	Phone: 877-598-8753 (Toll Free)

CHAPTER 16: DENTAL SERVICES**APPENDIX J: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****Department of Health and Hospitals (DHH)**

Name of Contact	Address/Telephone/Website
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821-1811 Phone: 225-342-0138 Fax: 225-342-5292
Louisiana's Medicaid and Louisiana Children's Health Insurance Program (LaCHIP) General Medicaid and card questions	General Medicaid Hotline Phone: 888-342-6207 (Toll Free) http://www.lamedicaid.com/provweb1/default.htm LaCHIP: 225-342-0555 (Local) LaCHIP: 877-252-2447 (Toll Free) http://bhsfweb.dhh.louisiana.gov/LaCHIP/
Office of Aging and Adult Services (OAAS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: 866-758-5035 Fax: 225-219-0202 E-mail: MedWeb@dhh.la.gov http://www.dhh.louisiana.gov/offices/?ID=105
Office for Citizens with Developmental Disabilities (OCDD)	P. O. Box 3117 Baton Rouge, LA 70821-3117 Phone: 225-342-0095 (Local) Phone: 866-783-5553 (Toll Free) Fax: 225-342-8823 E-mail: ocddinfo@la.gov http://www.dhh.louisiana.gov/offices/?ID=191
Office of Emergency Preparedness (OEP) Required Emergency Preparedness HH Model	http://gohsep.la.gov/modelhmlthpln.aspx

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Department of Health and Hospitals (DHH)	
Name of Contact	Address/Telephone/Website
Office of Management and Finance (Bureau of Health Services Financing – MEDICAID)	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-5774 Fax: 225-342-3893 E-mail: medweb@la.gov http://www.medicaid.la.gov
Program Integrity (PI)	628 N. 4 th Street; 7 th Floor Baton Rouge, LA 70821 Phone: 225-219-4149 Fax: 225-219-4155 Fraud and Abuse Hotline: 800-488-2917 http://new.dhh.louisiana.gov/
Rate and Audit (R&A)	P.O. Box 546 Baton Rouge, LA 70821-0546 Phone: 225-342-6116 Fax: 225-342-1831 http://www.dhh.louisiana.gov/offices/?ID=111
Recipient Assistance for Authorized Services	Phone: 1-888-342-6207 (Toll Free)
Take Charge (Family Planning Waiver)	P.O. Box 91278 Baton Rouge, LA 70821 Phone: (888) 342-6207 Fax: (877) 523-2987 Email: medweb@la.gov http://new.dhh.louisiana.gov/index.cfm/page/232
Recovery and Premium Assistance Formally: Third Party Liability (TPL) TPL Recovery, Trauma	P.O. Box 3558 Baton Rouge, LA 70821 Phone: 225-342-8662 Fax: 225-342-1376

CHAPTER 16: DENTAL SERVICES**APPENDIX J: CONTACT/REFERRAL INFORMATION****PAGE(S) 4**

Other Helpful Contact Information	
Name of Contact	Address/Telephone/Website
American Dental Association	211 East Chicago Ave. Chicago, IL 60611-2678 Phone: 312-440-2500 www.ada.org
Centers for Medicare and Medicaid Services (CMS) Place of Service Codes	https://www.cms.gov/place-of-service-codes/
Division of Administrative Law (DAL) Formerly DHH Bureau of Appeals	P.O. Box 4189 Baton Rouge, LA 70821 Phone: 225-342-0263 Fax: 225-219-9823 http://www.adminlaw.state.la.us/
LSU School of Dentistry, Medicaid Dental Prior Authorization Unit Dental Prior Authorizations ONLY	P. O. Box 19085 New Orleans, LA 70179-9085 Phone: 504-941-8206 (Local) Phone: 866-263-6534 (Toll Free) Fax: 504-941-8209