Louisiana Medicaid

Dental Benefit Program Manager (DBPM) Manual

Version 1: 3/1/2022

LOUISIANA DEPARTMENT OF HEALTH

Contents

PART 1: INTRODUCTION

OVERVIEW

The **Dental Benefit Program Manager (DBPM) Manual** is a compilation of policies, instructions, and guidelines established by the Louisiana Department of Health (LDH) for the administration of the Louisiana Medicaid dental program. The purpose of this Manual is to provide clarifying information and operational guidelines to support the DBPM in complying with the terms of its contract with LDH (hereinafter, the "Contract"). This Manual is intended to accompany the Contract rather than be a standalone and exhaustive compilation of contractual requirements.

This Manual applies to DBPMs contracted by LDH to provide coverage for services to Louisiana Medicaid dental program enrollees, effective March 1, 2022. This Manual also applies to major subcontractors with delegated responsibilities for the provision of all, or part, of any program area or function that relates to the delivery or reimbursement of covered services.

The DBPM is solely responsible for complying with the requirements set forth within this Manual and in the Contract whether or not subcontractors are used. In addition, the DBPM is responsible for ensuring compliance by its subcontractors. In the event of a perceived discrepancy between the Contract and this Manual, the DBPM shall seek clarification from LDH prior to taking action.

REVISIONS

This Manual may be revised at the discretion of LDH due to a variety of reasons, including, but not limited to, changes to any provisions of state and federal laws, regulations, rules, the Louisiana Medicaid State Plan, and waivers applicable to managed care, Contract amendments, internal operational changes, and requests for written guidance in a particular area.

In accordance with Louisiana Revised Statutes La. R.S. 46:460.54, prior to adopting, approving, amending, or implementing certain policies or procedures[1] contained in the Manual, LDH will publish the proposed policy or procedure on the LDH website for a period of no less than 45 calendar days for the purpose of soliciting public comments. The public comment period will not apply if LDH finds that an imminent peril[2] to the public health,

[1] Per La. R.S. 46:460.51, "Policy or procedure" shall mean a requirement governing the administration of managed care organizations specific to billing guidelines, medical management and utilization review guidelines, case management guidelines, claims processing guidelines and edits, grievance and appeals procedures and process, other guidelines or manuals containing pertinent information related to operations and pre-processing claims, and core benefits and services.

[2] Imminent peril is defined as sudden, urgent and critical situations that call for aid to the public health, safety, or welfare that require immediate approval of a proposed policy or procedure or manual revision without otherwise publishing the proposed policy or procedure or revision as required by standard timelines required under La. R.S. 46:460.53 and 46:460.54.

safety, or welfare requires immediate adoption of the proposed policy or procedure. The public comment period also will not apply for non-material[3] revisions.

Once approved by LDH, the revised Manual will be posted on the LDH website. The DBPM may subscribe via e-mail to healthy@la.gov to be notified of updates. The DBPM is responsible for notifying subcontractors and executing necessary subcontract amendments when revisions are made to the Manual.

[3] Non-material revisions are defined as typographical, grammatical, formatting, or stylistic edits only, including, but not limited to, word changes that do not impact or affect overall content. Non-material changes have no programmatic or monetary impact on providers.

PART 2: ADMINISTRATION & CONTRACT MANAGEMENT

The DBPM's business administration, organization, and oversight of all contracted responsibilities is critical to achieving LDH's goal of building a Medicaid dental benefit delivery system that improves the oral health of populations, enhances the experience of care for individuals, and effectively manages Medicaid per capita care costs.

INFORMATIONAL BULLETINS

LDH may issue Informational Bulletins (IB) when there is a need to communicate immediate guidance—particularly in temporary or emergency situations (e.g., pandemics, natural disasters). The DBPM must comply with all directives contained within IBs.

DBPMs and subcontractors can access IBs on the LDH website [https://ldh.la.gov/index.cfm/page/1198].

BUSINESS OWNERS

LDH maintains an LDH business owner listing, which is provided to the DBPMs on a monthly basis via e-mail. DBPMs should distribute this listing to its staff and use it to identify the appropriate LDH contact for questions or concerns about a specific business area or report.

LDH also maintains a DBPM business owner listing, which is provided to LDH staff. DBPMs should provide updated contact information upon request by LDH.

DBPM POLICY AND PROVIDER MANUAL SUBMISSION GUIDANCE

The DBPM shall submit all new or materially amended policies, procedures, and provider manuals to DBPMPolicies@la.gov. A brief description should be provided in the subject line. Submissions of materially amended policies, procedures, and provider manuals shall include a single document containing the existing policy, procedure, or provider manual with the proposed revisions redlined.

E-mails must not be sent to specific individuals.

In accordance with La. R.S. 46:460.54, prior to approving any policy or procedure, LDH will publish the proposed policy or procedure on the LDH website for a period of no less than 45 calendar days for the purpose of soliciting public comments. The public comment period will not apply if LDH finds that an imminent peril to the public health, safety, or welfare requires immediate adoption of the proposed policy or procedure. The public comment period also will not apply for non-material revisions. A policy or procedure proposed by a DBPM shall not be implemented unless LDH has provided its express written approval to the DBPM after the expiration of the public notice period. Additionally, the DBPM shall notify its network providers at least 30 calendar days prior to implementation of a new or revised policy or provider manual change.

LEGAL COMPLIANCE

This section provides additional information or guidance related to court-ordered requirements.

Chisholm v. LDH

Class members in *Chisholm v. LDH* (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

The DBPM shall comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the **Chisholm Compliance Guide** and accompanying **MCO User Manual**.

Monitoring of Denial Notices

LDH monitors denial and partial denial notices to ensure compliance with federal requirements regarding timely and adequate notices of benefit determinations for prior authorized services. An auditing and monitoring process was established following the *Wells v. Gee* litigation (Case 3:14-cv-00155).

As a result of the joint stipulation from the *Wells v. Gee* settlement, LDH developed multiple templates to help the DBPMs maintain compliance with federal requirements as it pertains to the development of denial and partial denial notices of prior authorized services. LDH strongly encourages continued use of these templates as a resource tool to assist with compliance. See the *Resources* section for a link to these templates.

PUBLIC RECORDS REQUEST PROTOCOL

LDH and DBPMs agree that timely responding to public records act requests ("PRR") is an important facet of the LDH/DBPM relationship. These protocols are designed to facilitate a collaborative approach aimed at allowing LDH to promptly respond to these requests in accordance with Louisiana law. PRRs may be presented that call for responses, and effort to create these responses, that range from simple to complicated. LDH and DBPMs agree that collaborative cooperation founded upon early and frequent communications between both sides can be helpful. These communications could serve to refine a request to the necessary records and to produce accurate responses. Such discussions are especially useful when such requests appear to be large, to be vague or confusing, to seek information that does not exist as requested, or to present other challenges that could impact response times. LDH and DBPMs shall utilize these Protocols to produce streamlined, accurate and timely responses to PRRs.

Receipt of Potential Public Records Request

When LDH receives a request that may be a PRR, the Department will initiate contact with the DBPM(s) that may have documents potentially responsive to the request. This will provoke a dialogue between the LDH legal team and DBPM legal representatives where questions concerning the Request and potential responses can be addressed. The Parties agree to early and frequent communications regarding PRRs. These discussions would also allow for questions as to whether the document(s) being sought is, in fact, a public record.

Public Records Requests Points of Contact for LDH and DBPMs

The DBPM shall provide LDH with the name of the individual who will serve as the point of contact for handling public records requests within seven calendar days of request. If this point of contact changes at any time, the DBPM shall provide LDH with an updated contact immediately.

LDH's point of contact for handling DBPM-related public records requests is the Medicaid Public Records Request Coordinator.

Transmission of the Public Records Request

Upon receipt of a PRR, LDH will determine if the response requires records from the DBPM. If LDH believes the DBPM has records responsive to a PRR, LDH shall notify the DBPM of the PRR, and shall forward an exact copy of the request in its entirety via email to the DBPM's point of contact for handling public records' requests within one business day of receipt.

If the DBPM receives a public records request directly from a requesting party, the DBPM shall forward the request via email to the Medicaid Public Records Request Coordinator within one business day of receipt.

In no event shall the DBPM directly respond to the requesting party to satisfy a PRR. Unless otherwise directed by a court of competent jurisdiction, LDH is the party that shall provide the response to each PRR.

If the DBPM believes the records are not public and/or meet an exception to the Louisiana Public Records law, the DBPM shall produce a log that describes each document or document type that is being withheld and shall describe the specific objection and legal basis for the withholding, pursuant to the timeline and in the requested format established by LDH. LDH and DBPM agree that the DBPM is only obligated to provide documents responsive to its Medicaid Managed Care product.

Process for LDH to Evaluate Whether Records are Subject to the Louisiana Public Records law

Upon receipt of objection from DBPMs, LDH and DBPM shall confer at a mutually convenient time with due consideration to legal restraints for compliance with Public Records Law. LDH Legal will review the objections, and confer with the Medicaid Public Records Request Coordinator, as necessary, to address DBPMs objections. LDH and DBPM will confer regarding response to the PRR, including production of documents for which no objection is made, and alternative response, if possible, for records (e.g., redaction) for which objection is made.

Notice to DBPMs of Impending Release of Records DBPM has Deemed Not Public and/or Meet an Exception to the Public Records Law

If LDH and DBPM cannot agree to the response to the PRR, LDH will provide DBPM with written notice that LDH will respond to the PRR over DBPM's objections, specifying the date on which LDH will respond, which shall not be less than seven business days from the written notice. DBPM has the right to seek injunctive or other judicial

or administrative relief to prohibit LDH's response. If DBPM elects to file a Petition for Injunctive Relief, Declaratory Judgment or other process for judicial or administrative relief, DBPM will promptly deliver a copy of the petition or other pleading to LDH, and thereafter shall keep LDH notified of any significant developments that would impact LDH's obligations under Public Records laws. LDH and DBPM shall cooperate as necessary any such judicial or administrative proceeding, and shall comply with the final judgment or other ruling or determination regarding PRR. If DBPM does not file a Petition for Injunctive Relief or seek such judicial or administrative relief as specified above, LDH may respond to the PRR in the manner LDH determines appropriate.

PART 3: ELIGIBILITY & ENROLLMENT

LDH is responsible for determining eligibility for enrollment in the DBPM, and the DBPM is required to accept these enrollees for the provision of covered services.

The Contract identifies the populations that are eligible for enrollment in a DBPM and the service offerings available to them.

Additional guidance regarding special populations and enrollment processes are provided in this section.

CERTIFICATE OF CREDITABLE COVERAGE

Certificates of Creditable Coverage, or portability letters, are written certificates issued by a health plan or health insurance issuer to show prior healthcare coverage. LDH determines the eligibility of individuals for enrollment into an DBPM; therefore, the DBPM shall direct any requests for a Certificate of Creditable Coverage to LDH.

The DBPM should route enrollees to the Medicaid Recovery and Premium Assistance Unit at 225-342-8662 to request the certificate.

ELIGIBILITY UPDATES

The enrollment broker shall make available to the DBPM, via electronic media (i.e., ASC X12N 834 Benefit Enrollment and Maintenance transaction), daily updates on new enrollees in the format specified in the **834 Systems Companion Guide**.

In addition to the daily file, the enrollment broker shall transmit to the DBPM files containing retroactive updates to enrollment. These files will be available to download via the enrollment broker's EDI site.

Medicaid Eligibility Determinations Based on SSI

When Supplemental Security Income (SSI) determinations are obtained by LDH from the Social Security Administration, they may be retroactive and LDH will alter eligibility periods with the appropriate aid category/type case information. This eligibility process may cause overlaps with existing eligibility periods for the impacted enrollees, resulting in a need for reconciliation between LDH, the fiscal intermediary, the enrollment broker, and the DBPM.

The overlapping certification will be transmitted daily from the Louisiana Medicaid Eligibility Determination System (LaMEDS) to the fiscal intermediary. The fiscal intermediary will send the overlapping eligibility information to the enrollment broker via daily enrollee files and/or weekly full reconciliation files, and the enrollment broker will distribute to the DBPMs via 834 full reconciliation file in the 2700 Loop. All historical eligibility will be present on the file.

The fiscal intermediary will conduct a retrospective SSI cleanup on a monthly basis, with a 12-month look back period from the beginning of the month. DBPMs can identify impacted enrollees by reviewing the associated 820 file.

ADMINISTRATIVE RETROACTIVE CORRECTIONS

Administrative retroactive corrections to enrollee linkages may be necessary to ensure compliance with internal policies and the approved Louisiana Medicaid State Plan. These corrections may address multiple months and significantly impact paid claims and PMPMs.

Each month, LDH and its fiscal intermediary will review all changes made by the enrollment broker in the prior month to identify retroactively enrolled or disenrolled individuals, claims paid within this retroactive period, and associated adjustments needed to PMPMs.

LDH, or its designee, will send a monthly report of impacted enrollees to the DBPMs with detailed information to assist in anticipating claims which should be billed to them for their retroactively enrolled enrollees.

Retroactive Enrollment

An enrollee may be retroactively enrolled with a DBPM up to 12 months prior to the enrollee's DBPM linkage add date. Providers have up to 365 calendar days from the date of service or 180 calendar days from the enrollee's DBPM linkage add date, whichever is later, to submit claims to the DBPM for dates of service during the retrospective enrollment period. The DBPM linkage add date is reported on the 834 file header.

DBPMs shall not deny these claims for timely filing or prior authorization or precertification edits. The provider shall not be required to submit the enrollee's eligibility determination award letter. Instead, the DBPM shall develop a process to bypass timely filing or prior authorization, and precertification edits using the enrollee's DBPM linkage add date.

DBPMs may conduct post-service reviews for medical necessity, and if the DBPM determines the service was not medically necessary, the DBPM may deny the claim. The provider will have the right to appeal the denial.

Retroactive Disenrollment

The DBPM shall review the daily 834 files and any manual special processing files provided by the enrollment broker on a daily basis to identify whether any of its enrollees were retroactively disenrolled. The DBPM shall identify all associated claims which were paid for these enrollees.

If the enrollee was retroactively disenrolled for any other reason, the DBPM shall:

- Initiate recoupments of reimbursements to providers, via written notice, within 60 days of the date LDH notifies the DBPM of the change.
- Require providers to submit paper/hard copy claims to the correct entity, unless the DBPM has established other means of identifying these claims.
    - Providers shall not be required to obtain prior authorization or pre-certification for these claims.
    - Providers must attach documentation supporting the void. This may be the remittance advice (RA) indicating the void.
    - The DBPM shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within 180 days from the enrollee's linkage to the DBPM.

- The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to the DBPM by the latter of 365 calendar days from the date of service or 180 days from the enrollee's linkage to the DBPM.

❖ Submit encounters for voided claims to the fiscal intermediary.

Refer to the Contract for additional requirements related to provider recoupments, including provider notification requirements.

ENROLLEE RETROACTIVE REIMBURSEMENT

The DBPM is responsible for processing retroactive reimbursement requests submitted by Medicaid enrollees. Medicaid enrollees may be directly reimbursed for part or all of any medical expenses paid by them to any Medicaid provider for dental services delivered during the period of retroactive eligibility and prior to the expected date of receipt of the DBPM's ID card and/or expected date of receipt of notification of linkage to the DBPM. Value-added benefits offered by the DBPMs are not eligible for reimbursement.

The DBPM must have written policies and procedures for receiving, processing, and issuing payment for enrollee retroactive reimbursement requests and a tracking system that can be accessed by its member services staff.

The DBPM shall provide customer service to enrollees who seek explanations and/or education regarding retroactive reimbursement issues.

The DBPM must use claims payment business processes that deny or approve requests for retroactive reimbursement. For approved requests, the business processes must be able to do the following: edit, adjudicate, adjust, void, pay, and audit the request for reimbursement of covered Medicaid services. In cases of a retroactive reimbursement involving third party liability, the DBPM may instruct the provider to resubmit the unpaid portion of the claims to the DBPM for payment, if applicable.

DBPMs must provide written notice of eligibility for retroactive reimbursement information in an enrollee welcome letter. The welcome letter must include the following policies and provide the date the request is due:

❖ Enrollees are eligible for reimbursement of medical expenses paid three months prior to the month of application if they requested retroactive coverage on their application and received approval.

❖ Enrollees are given 30 calendar days from the date of the welcome letter to contact the DBPM to request consideration for reimbursement and provide the required documentation.

❖ An extension of up to 10 calendar days shall be granted if the extension is requested on or before the deadline. A second extension of no more than 10 additional calendar days should be granted if the extension is requested before the deadline of the first extension. No extensions shall be granted beyond this timeframe.

Changes to existing documents (e.g., policies, welcome letter templates) must be reviewed and approved by LDH in advance.

Reimbursement Criteria

Reimbursement shall be provided only under the following conditions:

❖ The enrollee is Medicaid eligible for the date of service.

- The DBPM has verified that the provider is enrolled with the DBPM on the date on which the enrollee received the service and is approved to provide the service rendered.
- The bills must be for services received on or after the Medicaid effective date through receipt of the initial Medicaid eligibility card (MEC) or reactivation of the MEC. Reactivation of the MEC would take place when an enrollee of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program. The certification period is usually twelve months.
- The enrollee has not received reimbursement from Medicaid or the Medicaid provider or received payment in full by a third-party entity.
- The bills must be for dental services covered by Medicaid at the time that the service was delivered.
- The enrollee must provide proof of payment to the DBPM. Bills which were paid in full by a third party (e.g., Medicare, an insurance company, charitable organization, family, or friend) cannot be considered for reimbursement unless the enrollee remains liable to the third party. It is a requirement that continuing liability of the enrollee be verified.

Bills Not Eligible for Reimbursement

- Unpaid bills - the enrollee should present his or her MEC to the provider along with the unpaid bill so that the provider can file a claim.
- Bills paid by the enrollee after receipt of the initial MEC or reactivation of the MEC.
- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.
- Value-added benefits offered by the DBPM.

Reimbursements Involving Third Party Liability

The DBPM should use a cost comparison method for enrollee reimbursement requests involving third-party liability (TPL). The claim must first be processed by the primary payer. The TPL payment amount is provided on the explanation of benefits (EOB) sent by the primary payer. The reimbursement to the enrollee shall be the Medicaid allowed amount minus the TPL payment. If the TPL payment is greater than the Medicaid allowed amount, the reimbursement to the enrollee would be zero.

The DBPM shall require enrollees to submit all of the required documentation listed below within the timeframes specified above.

Required Documentation

An enrollee seeking reimbursement must provide to the DBPM a copy of the bill(s) or other acceptable verification which include(s) the following:

- Name of the individual who received the service,
- Name, address and phone number of the dentist or facility providing the service,
- Date of service,
- Procedure and Diagnosis codes per tooth,
- Amount of billed charges and verification of payment,
- Receipts or other acceptable proof showing that the bill was paid by the Medicaid enrollee or someone else. If paid by someone else, proof that the eligible is still liable for repayment to the individual who paid the bill,

- ❖ Proof of payment by any Private Insurance - EOB, and, **if applicable**,

If the DBPM determines that additional information is needed from the enrollee, the DBPM shall mail a Recipient Verification Request Form to the enrollee within three business days of the receipt of the initial request.

The enrollee shall be allowed 15 days to provide the additional documentation and, upon request for additional time, be granted an extension. If an extension is requested, no more than 15 additional days shall be granted. Enrollees who fail to provide the requested documentation or fail to request an extension shall have the request for reimbursement denied.

Processing Timeframes

DBPMs must follow established timeframes as required by the Contract. A reimbursement request is considered clean when the enrollee has timely submitted all requested documentation within the established timeframe; therefore, the DBPM shall process the request within three months from the date of the request and mail a Notice of Decision Letter to the enrollee. If the request is denied, the notice must include a clear explanation of the reason(s) for ineligibility for reimbursement.

PART 4: SERVICES

The Louisiana Medicaid State Plan establishes the services covered as well as reimbursement methodologies for Medicaid FFS. State Plan services are broad categories, and the Medicaid FFS fee schedule operationalizes that coverage. In accordance with 42 C.F.R. § 438.210, the Prepaid Ambulatory Health Plan (PAHP) must provide for coverage of services that is no more restrictive in amount, scope, and duration than is covered in Medicaid FFS.

Compared with Medicaid FFS, the DBPM has the flexibility to cover services in a *greater* amount, scope, or duration, or to an *expanded* patient group, if deemed medically necessary. Nothing herein shall be construed by the DBPM to limit coverage to only those procedure codes, fees or limitations listed on the Medicaid FFS fee schedules. Within the broad State Plan categories, the DBPM has the flexibility to reimburse for procedure codes not on the Medicaid FFS fee schedules when medically necessary. For those services not covered under the State Plan, the Contract identifies requirements for value-added benefits that the DBPM may offer. The DBPM shall consult LDH with any questions about these requirements.

Further, federal law mandates that enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical conditions (Section 1905(r) of the Social Security Act). The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan. The DBPM shall consult LDH with any questions about these requirements.

This section defines minimum coverage and reimbursement policies for select services only and does not represent an exclusive list of covered services. Unless otherwise agreed to by the DBPM and its contracted providers, the Medicaid FFS fee schedule establishes the minimum reimbursement rates for services rendered to enrollees. Any references herein to a minimum reimbursement rate shall include the exception that the DBPM may contract with its providers to reimburse the service at a lower rate, if the contracting parties agree.

The DBPM shall develop and maintain comprehensive provider manuals customized to the Louisiana Medicaid dental program that are in alignment with this Manual and inclusive of all applicable DBPM-established policies. The DBPM shall not include references to the **Medicaid Services Manual** or this Manual in lieu of maintaining its own comprehensive provider manuals. The DBPM shall make coverage decisions in alignment with its own provider manuals, with the policies in this section, and with the Contract.

The DBPM shall update its provider manuals in a timely manner and be responsive to provider questions or concerns.

DBPM Covered Services

The Louisiana Medicaid Dental Program is governed by regulations found in the Code of Federal Regulations 42 C.F.R. § 440.40 and 42 C.F.R. § 440.50 which describe services including the required services for children under the age of 21.

Louisiana Medicaid Dental Services include the following programs:

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

The CDT Code and Nomenclature in this document have been obtained from *Current Dental Terminology* (including procedure codes, nomenclatures, descriptors and other data contained therein) ("CDT"). CDT is copyright © 2021 American Dental Association. All rights reserved.

EPSDT Dental Program

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT – COVERED SERVICES

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

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

Diagnostic Services

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

Examinations

D0120 Periodic oral examination – established patient
D0145 Oral examination for a patient under 3 years of age and counseling with primary caregiver
D0150 Comprehensive oral examination – new or established patient

The DBPM shall cover one periodic oral examination in a six-month period. The periodic oral examination shall be at least six months after the comprehensive oral examination, when applicable. The DBPM shall require providers to use the appropriate CDT code based on the age of the enrollee when submitting claims for this service.

The DBPM shall cover one comprehensive oral examination in a three-year period when performed by the same or another Medicaid rendering general dentist located in the same office as the billing provider. However, a recognized dental specialist within the same office (group) may be reimbursed for another comprehensive oral examination prior to the expiration of the three-year period.

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

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

Radiographic Images

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

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

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

of the complete series of radiographic images (D0210), the bitewing radiographic images (D0272) will be cutback to $0.

D0220 Intraoral – periapical first radiographic image

D0230 Intraoral – periapical each additional radiographic image

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

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

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

These radiographic images are reimbursable for, and must be associated with, a specific 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.

D0240 Intraoral – Occlusal radiographic image

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

D0272 Bitewings – two radiographic images

Bitewing radiographic images (D0272) are required at the comprehensive oral examination and annually at the periodic oral examination. These radiographic images are limited to one set per year when performed by the same billing provider, except when performed by a Medicaid-recognized dental specialist

D0330 Panoramic radiographic images

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

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

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

D0350 Oral/Facial Images

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

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

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

Other Diagnostic Services

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

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

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 bill procedure code D0474 on the pathologist's behalf.

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

Preventive Services

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

Prophylaxis

D1110 Adult Prophylaxis

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

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

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

D1120 Child Prophylaxis

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

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

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

Fluoride Treatment

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

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

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

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

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

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

D1208 Topical Application of Fluoride – excluding varnish

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

Sealants

D1351 Sealants – per tooth

Sealants are limited to six and 12-year molars only. Sealants are further limited to one application per tooth per 24 months.

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

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

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

In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous occlusal restoration.

Space Maintenance

Removable, maxillary anterior or active space maintainers are not covered.

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

D1551 Recementation of space maintainer-maxillary

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

D1552 Recementation of space maintainer-mandibular

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

D1553 Recement or rebound unilateral space maintainer –per quadrant

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

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

D1556 Removal of fixed unilateral space maintainer –per quadrant

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

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

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

D1557 Removal of fixed bilateral space maintainer-maxillary

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

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

D1558 Removal of fixed bilateral space maintainer- mandibular

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

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

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

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

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

Restorative Services

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

The original billing provider is responsible for the replacement of the original restoration within the first 12 months after initial placement.

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); a prefabricated porcelain/ceramic crown, anterior (D2929) or a prefabricated stainless steel crown (D2930, D2931, D2932, D2933 or D2934).

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

Amalgam Restorations (including polishing)

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

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

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

The fee for any additional restorative service(s) on the same tooth shall 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 shall not exceed the maximum fee of the larger restoration. In addition, policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal), traumatic injury to the tooth, or in the event of failed restoration which must be indicated in the beneficiary’s treatment records.

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

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

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

Resin-Based Composite Restorations - Direct

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 shall be cut back to the maximum fee for the combined number of surfaces when performed within a 12-month period, by any provider.

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

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

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

The resin-based composite – four or more surfaces or involving incisal angle (D2335 and D2394) is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least one-third of the clinical crown of the tooth.

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

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

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

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

Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation that depict the pretreatment condition. The documentation that supports the need for crown services must be available for review by the Louisiana Department of Health (LDH) or its designee upon request. Porcelain/ceramic (D2929), stainless steel crowns (D2930 and D2933) nor prefabricated resin crowns (D2932) are reimbursable on primary central or lateral incisors after the **fifth** birthday.

Procedure codes D2929, D2930, D2931, D2932, D2933, and D2934 represent final restorations. These restorations must be in direct contact with the periodontally affected gingival tissue. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should be considered only when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable.

If a non-laboratory crown is required within the first 12 months after a tooth is restored with amalgam or resin, e.g. fracture of the tooth, pulpal necrosis, etc., the reason why the tooth requires additional restoration must be documented in the beneficiary's treatment record.

Crown services require radiographic images (unless contraindicated). Indications such as extensive caries, extensive cervical caries, fractured teeth, replacing a missing cusp, etc. must be radiographically evident and/or documented in the beneficiary's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by LDH or its designee upon request.

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

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

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

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

- Primary teeth with abscess or bone resorption; or

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

D2929 Prefabricated Porcelain/Ceramic Crown – anterior tooth

This procedure is reimbursable for tooth letters C, H, M, and R for EPSDT beneficiaries. This procedure is also reimbursable for tooth letters D, E, F, G, N, O, P and Q for beneficiaries under five years of age.

D2930 Prefabricated Stainless Steel Crown – primary tooth

Procedure code D2930 is reimbursable for Tooth Letters A, B, C, H I, J, K, L, M, R, and S. Procedure code D2930 is reimbursable for Tooth Letters D, E, F, G, N, O, P, and Q for beneficiaries under five years of age only.

D2931 Prefabricated Stainless Steel Crown – permanent tooth

This procedure is reimbursable for Tooth Numbers 1 through 32.

D2932 Prefabricated Resin Crown (primary and permanent teeth)

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

D2933 Prefabricated Stainless Steel Crown with Resin Window

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

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

D2934 Prefabricated Esthetic Coated Stainless Steel Crown – primary tooth

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

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

Other Restorative Services

Procedure codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.

Adequate documentation describing the situation requiring treatment and the treatment proposed must be recorded in the beneficiary's treatment record.

D2920 Re-cement Crown

The billing provider is responsible for recementation within the first 12 months after placement of the crown. This procedure is reimbursable for Tooth Numbers 1 through 32 and Letters A through T.

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

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

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

D2951 Pin Retention – per tooth, in addition to restoration

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

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

D2954 Prefabricated Post and core in addition to crown

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

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

D2999 Unspecified Restorative Procedure, by report

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

Endodontic Therapy Services

Pulp Capping

D3110 Pulp Cap – direct (excluding final restoration)

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

D3220 Therapeutic Pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament

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

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

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

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

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

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

Endodontic Therapy on Primary Teeth

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

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

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

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

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

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

Endodontic Therapy

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

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

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

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

In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable.

The date of service on the payment request **must** reflect the final treatment date. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the root canal and must be maintained in the beneficiary's treatment record. Written documentation must also include the type of filling material used as well the notation of any complications encountered which may compromise the success of the endodontic treatment.

D3310 Endodontic Therapy, anterior (excluding final restoration)

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

D3320 Endodontic Therapy, premolar (excluding final restoration)

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

D3330 Endodontic Therapy, molar (excluding final restoration)

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

Endodontic Retreatment

D3346 Retreatment of previous root canal therapy – anterior

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

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

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

Consideration of root canal retreatment should depend on the prognosis of the affected tooth, the condition of the other teeth in the mouth, and history of the beneficiary oral care. The beneficiary's treatment records should include sufficient readable, most current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the beneficiary. Specific treatment plans for final restoration of the tooth should also be included.

If the radiographic images do not indicate the need for a root canal, the provider must include a written statement as to why the root canal retreatment is necessary in the treatment records. If a fistula is present, a clear oral/facial image (photograph) is required and will be reimbursable in situations where dental radiographic images do not adequately indicate the necessity for the requested retreatment of previous root canal therapy.

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

Apexification/Recalcification Procedure

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

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

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

Apicoectomy/Periradicular Services

D3410 Apicoectomy/ periradicular surgery – anterior

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

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

D3430 Retrograde filling

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

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

Other Endodontic Procedures

D3999 Unspecified Endodontic Procedure, by report

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

Periodontal Services

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

Surgical Periodontal Services

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

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

A gingivectomy is only allowed when the tissue growth interferes with mastication as sometimes occurs from Dilantin therapy.

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

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

Non-surgical Periodontal Services

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

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

Radiographic evidence of bone loss indicating a true periodontal disease state must be maintained in the beneficiary's treatment for review with bitewings and/or posterior/anterior periapicals. This service is not allowable for beneficiaries who have not progressed beyond the mixed dentition stage of development.

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

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

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

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

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

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

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

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

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

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

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

Other Periodontal Services

D4999 Unspecified Periodontal Procedure, by report

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthodontics

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

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

- The denture should be 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 beneficiary's treatment record.

- Upon delivery:

    - The denture bases must be stable on the lower and retentive on the upper.

    - The clasping must be appropriately retentive for partial dentures.

    - The vertical dimension of occlusion should be comfortable to the beneficiary (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch.

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

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

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

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

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

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

Complete Dentures

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

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

Immediate dentures are not considered temporary. The provider must inform the beneficiary that no reline will be reimbursed 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 will not be reimbursed, nor will Medicaid reimburse any payment under the interruption of treatment guidelines (see Part 5).

Partial Dentures

Only one prosthesis (excluding interim partial dentures) per beneficiary per arch is allowed in a five-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid under the Louisiana Medicaid program. **Once the beneficiary turns 21, 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 shall be authorized. For partial dentures, abutment teeth must be caries free or have been completely restored and have sound periodontal support. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post-treatment radiographic images may be requested prior to approval of a partial denture.

An acrylic interim partial dentur (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages may be provided in the following cases:

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

A partial denture may be provided in cases where the beneficiary has matured beyond the mixed dentition stage in the following cases:

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

Cast partials (D5213 and D5214) shall be considered only for those beneficiaries who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining

teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

Denture Repairs

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

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

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

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

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

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

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

Minimal procedural requirements for repair services include the following:

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

- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.

- The prosthesis must be finished in a skillful manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

- The treatment record must specifically identify the location and extent of the breakage, including the side of the prosthesis involved (right or left).

Failure to provide adequate documentation of services billed as repaired when requested by LDH or its designee shall result in recoupment of monies paid by the program for the repair.

Denture Relines

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 shall be deducted from the new prosthesis fee. A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in a five-year period.

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

Minimal procedural requirements for reline services include the following:

- All tissue bearing areas of the denture or saddle areas of the partial must be properly relieved to allow for the reline material.
- Occlusal vertical dimensions and centric relationships must be retained or re- established if lost.
- Relines must be flasked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a skillful manner; they must be clean; they must exhibit a high gloss; and they must be free of voids, scratches, abrasions, and rough spots.
- The denture must be fitted and adjusted for comfort and function.

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

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

Other Removable Prosthodontics

D5899 Unspecified removable prosthodontic procedure, by report

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

Maxillofacial Prosthetics

D5986 Fluoride Gel Carrier

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

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

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

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

Fixed Prosthodontics

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

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

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

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

Fixed Partial Denture Pontic

D6241 Pontic – porcelain fused to predominantly base metal

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

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

Fixed Partial Denture Retainer

D6545 Retainer – cast metal for resin bonded fixed prosthetics

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

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

Other Fixed Partial Denture Services

D6999 Unspecified, fixed prosthodontic procedure, by report

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

Oral and Maxillofacial Surgery Services

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

NOTE: Dental providers who are qualified to bill for services using the Current Physician's Terminology (CPT) codes, may bill certain non-dental oral surgery services using the CPT codes, which are covered under the Professional Services Program when those services are rendered to Medicaid beneficiaries who are eligible for services provided in the Professional Services Program. Refer to the Professionals Services Provider Manual, Chapter 5, Section 5.1 for specific details.

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

Primary teeth that are being lost naturally must not be billed as an extraction. If a practice is noted during post-payment review of billing for the extraction of primary teeth that are shown radiographically to be in the advanced stages of root resorption (more than ¾ of the root resorbed), i.e., exfoliating naturally, there shall be a recoupment of money paid for all such therapeutically unnecessary extractions.

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

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

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

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

Non-surgical Extractions

D7111 Extraction, Coronal Remnants – primary tooth

Removal of soft tissue-retained coronal remnants for deciduous teeth only. This procedure code is reimbursable for Tooth Letters A through T and AS through TS. All primary teeth within six months of the ADA's shed age chart requires an x-ray.

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

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

Surgical Extractions

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

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

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

D7220 Removal of impacted tooth - soft tissue

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

D7230 Removal of impacted tooth - partial bony

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

D7240 Removal of impacted tooth - complete or full bony

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

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

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

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

A copy of the post-surgical operative report and/or treatment record describing the unusual surgical complications, and the radiographic images, must be maintained in the beneficiary's record.

D7250 Surgical removal of residual tooth roots (cutting procedure)

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

Other Surgical Procedures

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

This procedure includes splinting and/or stabilization. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, recorded in the beneficiary's treatment record. This procedure is not reimbursable for periodontal splinting.

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

D7280 Surgical access of an unerupted tooth

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

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

D7283 Placement of Device to Facilitate Eruption of Impacted Tooth

This procedure involves the placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.

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

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

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

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

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

D7286 Biopsy of Oral Tissue – Soft

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

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

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

D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report

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

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

Alveoloplasty – Surgical Preparation of Ridge for Dentures

D7310 Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaced, per quadrant

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

The date of service and an explanation of the circumstances and procedures performed, including the teeth involved recorded and maintained in the beneficiary's treatment record.

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

Surgical Incision

D7510 Incision and Drainage of abscess – intraoral soft tissue

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Temporomandibular Joint (TMJ) Procedure

D7880 Occlusal orthotic device, by report

Only hard acrylic splints for the treatment of temporomandibular joint dysfunction are reimbursable.

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

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

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

Repair of Traumatic Wounds

D7910 Suture recent small wound up to 5cm

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

record.

Other Repair Procedures

D7961 Buccal/labial frenectomy (frenulectomy)

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

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

D7962 Lingual frenectomy (frenulectomy)

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

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

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

This procedure is for the removal of appliances due to interrupted or discontinued treatment cases.

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

D7999 Unspecified oral surgical procedure, by report

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

Orthodontic Services

Orthodontic treatment is available to beneficiaries meeting specified criteria. Reimbursement is payment in full for that procedure code.

Limited Orthodontic Treatment

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition

Orthodontic treatment utilizing any therapeutic modality with a limited objective or scale of treatment. 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 objective may be limited by:

- not involving the entire dentition
- not attempting to address the full scope of the existing or developing orthodontic problem
- mitigating an aspect of a greater malocclusion (i.e. crossbite, overjet, overbite, arch length, anterior alignment, one phase of multi-phase treatment, treatment prior to the permanent dentition, etc.)
- a decision to defer or forego comprehensive treatment

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

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

Comprehensive Orthodontic Treatment

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

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

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

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

Comprehensive orthodontic treatment is allowable 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.

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

The beneficiary's treatment records must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case.

Reimbursement includes the brackets/appliance and all visits and adjustments.

Minor Treatment to Control Harmful Habits

D8220 Fixed appliance therapy

Certain fixed habit appliances shall be considered if the appliance would be beneficial to the beneficiary to assist in the correction of a destructive habit such as thumb sucking or tongue thrusting. The beneficiary's treatment records must include sufficient documentation to substantiate the need for and the utility of the appliance.
For approval of procedure code D8220, the following must apply:

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

Other Orthodontic Services

D8999 Unspecified orthodontic procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA.

Adjunctive General Service

Palliative (Emergency) Treatment

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

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

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

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

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

- Procedures used to control bleeding;
- Procedures used to relieve pain;

- ❖ Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen;

- ❖ Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings;

- ❖ Complaint where assessment is provided, or diagnosis is determined, or referral is made; or

- ❖ Palliative therapy for pericoronitis associated with partially erupted/impacted teeth.

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

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

Anesthesia

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

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

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

D9239 Intravenous moderate conscious sedation/analgesia – first 15 minutes

D9243 Intravenous moderate conscious sedation/analgesia – each additional 15 minutes

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

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

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

A maximum of three units of D9243 are available per beneficiary per visit.

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

D9248 Non-intravenous conscious sedation

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

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

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

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

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

The beneficiary's treatment records must adequately document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the patient. The provider must indicate the drug(s) anticipated to be used and route(s) of administration in the treatment records.

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

A conscious sedation form must be completed and maintained in the beneficiary's treatment record. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation, the provider must document the circumstances in the beneficiary's treatment record.

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

Professional Visits

D9420 Hospital call

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

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 claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the hospital call, the payment for the hospital call will be denied.

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

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

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

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

For more information on billing for hospital claims payment for dental services by an oral surgeon please refer to Informational Bulletin 12-25.

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. A statement describing the situation must be recorded in the beneficiary's treatment records.

Miscellaneous Services

D9920 Behavior Management

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

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

Behavior management is reimbursable for beneficiaries below the age of eight, unless documentation indicates that the beneficiary is physically or mentally handicapped. The particular handicap and its impact on the delivery of dental treatment in the office setting must be recorded in the beneficiary's treatment record. Behavior

management is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) on the same day, by any provider.

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

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

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

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

D9944 Occlusal Guard – hard appliance, full arch

D9945 Occlusal Guard – soft appliance, full arch

D9946 Occlusal Guard – hard appliance, partial arch

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

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

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

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

D9951 Occlusal Adjustment – limited

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

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

The beneficiary's treatment record must include a completed TMJ summary form.

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. Providers must describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form when submitting for prior authorization.

ADULT DENTURE PROGRAM

The dental services that are covered under the Adult Denture Program are divided into two categories; Diagnostic Services and Removable Prosthodontics**.**

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

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

Although similar services are available under the Early and Periodic Screening, Diagnostic 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

Reimbursement for this procedure code requires that radiographs be taken and maintained in the beneficiary's record. The comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs.

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

Examinations in Anticipation of Denture Construction

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

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

Minimum Examination Requirements for the Clinical Examination

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

Examination of Ineligible Beneficiaries

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

Examination in Conjunction with a Denture Repair

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

Examination in Conjunction with a Denture Reline

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

Radiographs

D0210 Intraoral – complete series

A complete series consists of:

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

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

Radiographs must be maintained in the beneficiary's record.

The comprehensive oral examination is only reimbursable in conjunction with the appropriate radiographs.

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthetics

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

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

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

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

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

Records must include a chronological (dated) narrative account of each beneficiary's visit indicating what treatment was performed/provided or what conditions were present on those visits. A check off list of codes for

services billed as well as copies of claim forms sent in for authorization or payment is deemed insufficient documentation of services delivered.

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

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

Complete Dentures

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.

Immediate dentures are not considered temporary. The provider must inform the beneficiary that no reline will be reimbursed 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 that six or fewer teeth will remain when the final impression is taken.

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

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

Partial Dentures

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

An acrylic partial denture may be provided 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.

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.

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

Denture Repairs

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

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

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

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

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 on the Fee Schedule.

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

Minimal procedural requirements for repair services include the following:

- The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the beneficiary's treatment record.
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion.
- The prosthesis must be finished in a workmanlike manner; clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.
- The treatment record must specifically identify the location and extent of the breakage. Failure to provide adequate documentation of services billed as repaired when requested by Medicaid or its authorized representative will result in recoupment of monies paid by the program for the repair.

Denture Relines

Relines for partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Beneficiaries who do not have a complete denture are not eligible for the partial denture 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.
- Occlusal vertical dimensions and centric relationships must be retained or re- established if lost.
- Relines must be flasked and processed under heat and pressure in a commercial or office laboratory.
- Relines must be finished in a 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. Providers must describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.

Out-of-State Dental Care

The DBPM shall cover medically necessary services to enrollees provided outside of the state when any of the following conditions are met:

- Dental services are needed due to an emergency;

Prohibited and Non-Covered Services

The DBPM shall ensure that dentists and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

In general, services that are not approved by the Food and Drug Administration or the Louisiana State Board of Dentistry or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

The following non-exhaustive list of services excluded from DBPM covered services and/or otherwise limited by Louisiana Medicaid shall be reflected in the DBPM's coverage policy:

- Any service (device, procedure, or equipment) that is not medically necessary;
- Experimental/investigational, devices, procedures, or equipment, unless approved by the Secretary of LDH;
- Cosmetic devices, procedures, or equipment;
- Surgical procedures discontinued before completion;
- Provider preventable conditions.

Coordination of Care

The DBPM shall maintain written care coordination and continuity of care procedures that include the following minimum functions:

- Appropriate referral and scheduling assistance for enrollees needing specialty dental care;
- A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;
- Coordination with the enrollee's MCO for oral health issues exceeding the coverage of the Contract;
- Coordination with the enrollee's MCO for transportation to and from covered dental services; and

- ❖ Coordination with the enrollee's MCO regarding value-added dental benefits offered by the enrollee's MCO.

AMBULATORY SURGICAL SERVICES

The member's health plan shall cover ambulatory surgical services, defined as surgical services where patients do not require hospitalization and in which the expected duration of services would not exceed 24 hours. Ambulatory surgical services can be provided in non-hospital ambulatory surgical centers and outpatient hospitals.

The DBPM is responsible for Coordination of Care with the member's MCO or FFS Medicaid for oral health issues exceeding the coverage of the Contract. This includes dental services requiring anesthesia performed in an outpatient facility. The DBPM will be responsible for payment for all covered dental services rendered in non-hospital ambulatory surgical centers and outpatient hospitals.

MEDICAL TRANSPORTATION

The DBPM is responsible for coordination with the enrollee's MCO for transportation to and from covered dental services.

EPSDT

Early and Periodic Screening, Diagnostic, and Treatment Preventive Services Program

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is a comprehensive and preventive child health program for individuals under the age of 21. The program consists of two mutually supportive, operational components: (1) ensuring the availability and accessibility of required healthcare services; and (2) helping Medicaid enrollees and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

Enrollees under 21 years of age are entitled to receive all medically necessary health care, screening, diagnostic services, treatment, and other measures to correct or improve physical or mental conditions (Section 1905(r) of the Social Security Act). The EPSDT benefit is comprehensive in nature and includes coverage of all services described in federal Medicaid statutes and regulations including those that are not covered for adults, not explicitly described in the Contract, not included in the Medicaid FFS fee schedules, and not covered in the Louisiana Medicaid State Plan. The DBPM shall consult LDH with any questions about these requirements.

The DBPM shall have written procedures for EPSDT preventive services in compliance with 42 C.F.R. Part 441 Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible enrollees are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that

tracking or follow-up occurs to ensure all necessary services were provided to all of the DBPM's enrollees under the age of 21.

Screening

The DBPM policy shall include the following EPSDT screening guidelines, as age appropriate. The DBPM shall ensure that these guidelines are followed by its providers.

Periodic Screening

In accordance with 42 C.F.R. § 441.56(b)(1)(vi) and periodicity charts posted on Louisiana Medicaid's website at www.lamedicaid.com, the DBPM shall provide dental screening services furnished by direct referral to a dentist for children beginning at the eruption of the first tooth and no later than twelve (12) months of age and within ninety (90) days of the effective date of enrollment for all other enrollees. The DBPM shall provide dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

The DBPM shall ensure that providers have access to the most current periodicity schedule and that EPSDT enrollees receive services according to this schedule.

Off-Schedule Screening

If a child misses a regular periodic screening, that child may be screened off-schedule in order to bring the child up to date at the earliest possible time. However, all screenings performed on children who are under two years of age must be at least 30 days apart, and those performed on children age two through six years of age must be at least six months apart.

PART 5: PROVIDER CLAIMS & REIMBURSEMENT

The DBPM shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are fulfilled within the timeframes specified in the Contract and the Manual.

LDH is responsible for setting and defining minimum provider rates for Medicaid covered services. The DBPM shall reimburse providers at an amount that is no less than the published Medicaid FFS rate or that is contained on the weekly procedure file sent to the DBPM by the fiscal intermediary in effect on the date of service unless mutually agreed to by both the DBPM and the provider. Nothing herein shall restrict the DBPM from reimbursing at a higher rate than would be reimbursed by Medicaid FFS.

EXCEPTIONS TO CLAIMS TIMELY FILING GUIDELINES

DBPMs must comply with the following exceptions to the 365-day timely filing guidelines:

- **Administrative Error:** This is where the failure to meet the filing deadline is caused by error or misrepresentation of the DBPM, its subcontractor, or LDH. In these cases, the DBPM shall extend the

timely filing through the last day of the sixth month following the month in which the enrollee, provider, or supplier received notice from the DBPM that an error or misrepresentation was corrected.

- **Retroactive Medicaid entitlement or retroactive DBPM enrollment:** This is where a beneficiary receives notification of Medicaid entitlement and/or DBPM enrollment retroactive to or before the date the service was furnished. In these cases the DBPM shall extend timely filing to 365 calendar days from the date of service or 180 calendar days from the enrollee's linkage add date in the enrollee's 834 eligibility file, whichever is later.

PAYMENT RECOUPMENTS

The DBPM may recoup provider payments for a variety of reasons, including, but not limited to, the following:

- Retroactive enrollment or disenrollment due to Medicaid or Medicare eligibility changes;
- Discovery of improper payments through either of the following reviews:
  - Automated review (i.e., analysis of paid claims) up to one year from the date of payment;
  - Complex review (i.e., requires review of medical, financial, and/or other records) up to five years from date of service; or
- Third party liability.

The DBPM shall not recoup payments simply on the basis of an encounter being denied. The DBPM may submit inquiries about encounter denials using the MMIS Inquiry Form as outlined in the **DBPM System Companion Guide**. The DBPM should refer to the *Eligibility and Enrollment* and *Third Party Liability* sections of this Manual as well as the Contract for additional requirements, including provider notification requirements.

INTERRUPTION OF TREATMENT (DENTURES)

The interruption of treatment guidelines applies to codes D5110, D5120, D5211, D5212, D5213 and D5214, if due to circumstances beyond the provider's control, the beneficiary discontinues treatment, or loses eligibility during the course of the construction of a denture. No other codes are eligible for payment under the interruption of treatment guidelines.

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

<u>An immediate denture that is not delivered cannot be reimbursed nor any payment under the interruption of treatment guidelines for an immediate denture.</u>

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

- Impressions (initial impression, construction of custom dental impression tray and final impressions);

- Bite registration (wax try-in with denture teeth);

- ❖ Processing; and

- ❖ Delivery.

1. If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid.
2. If treatment is interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made.
3. If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid. If treatment is interrupted after completion of Stage 3 (Processing), 75% of the reimbursement fee will be paid.

If a provider chooses to proceed with delivering the completed dentures to the member while they are no longer Medicaid eligible, the provider would be allowed to bill the member the remaining "contract rate" amount only under these circumstances.

PART 6: ENCOUNTERS

The DBPM shall submit encounter data according to specifications, including data elements and reporting requirements, outlined in the **DBPM System Companion Guide**

The DBPM shall submit paid, denied, adjusted, and voided claims with the appropriate identifiers established in the **DBPM System Companion Guide** to indicate these claims as encounters.

The DBPM should refer to the **DBPM System Companion Guide** for a list of encounter edit codes.

PART 7: PROVIDER SERVICES

The DBPM must engage with its network providers to enhance service delivery, improve provider and enrollee satisfaction, promote data sharing strategies, and enable regular provider participation in clinical policy development and provider operations. This section provides additional information on ways in which the DBPM interacts and supports its providers to ensure that providers receive timely reimbursement and appropriate support over the course of the Contract.

PROVIDER ISSUE RESOLUTION

The DBPM shall provide options to providers for pursuing resolution of issues. Providers should first seek resolution with the DBPM directly prior to engaging LDH or other third parties, except when the DBPM has demonstrated a pattern of the same issue reoccurring.

Claim Reconsideration, Appeal, and Arbitration

The DBPM shall maintain, in accordance with Informational Bulletin 21-22 or as otherwise approved by LDH, claim dispute procedures for providers who wish to file formal claim reconsideration requests and claim appeals. Procedures should include submission instructions and timelines.

In any instance where a provider claim is denied, the consent of the enrollee who received services shall not be required in order for the provider to dispute the denial of the claim. The provider may pursue a claim dispute on the basis of nonpayment for rendered services under the terms and conditions outlined in their provider contract with the DBPM or as otherwise provided by Louisiana law. The enrollee who received the services shall not be required to sign an authorized representative form, or provide other forms of written consent, for the provider to dispute the denied claim for payment. For each denied claim, providers must be notified of the amount and reason for the denial.

In any case where a provider is required to obtain a service authorization on a concurrent or post-service basis, the consent of the enrollee who received the service shall not be required in order for the provider to dispute the denied authorization for service.

Providers may escalate claim disputes to LDH via e-mail to Kevin.Guillory@la.gov or Andrea.Perry@la.gov.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

Independent Review

Independent review is another option for resolution of claim disputes. The Independent Review process may be initiated after claim denial.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

- The Independent Review process was established by La. RS 46:460.89, *et seq*. to resolve claims disputes when a provider believes a DBPM has partially or totally denied claims incorrectly. A DBPM's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the DBPM's receipt of the claim is considered a claims denial.
- Independent Review is a two-step process which may be initiated by submitting an Independent Review Reconsideration Request Form to LDH within 180 calendar days of the Remittance Advice paid, denial, or recoupment date.
- There is a $250 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the DBPM is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the DBPM, the provider is responsible for paying the fee.
- Additional detailed information and copies of above referenced forms are available on the LDH website [https://ldh.la.gov/index.cfm/page/3284].

Provider Issue Escalation and Resolution

A provider may desire to escalate an issue to the attention of the DBPM's executive team. This may apply to claim or non-claim related issues.

The DBPM is required to maintain a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or administrative functions. This system should include contacts for filing a formal complaint and then for escalating to management and executive levels. Providers should first seek resolution with the DBPM, using these contacts. If a provider is unable to reach satisfactory resolution or get a timely response through the DBPM escalation process, direct contact with LDH is also an option.

If the DBPM, LDH, or its subcontractors discover errors made by the DBPM when a claim was adjudicated, the DBPM shall make corrections and reprocess the claim within 30 calendar days of discovery, or if circumstances exist that prevent the DBPM from meeting this time frame, a specified date shall be approved by LDH. The DBPM shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

PART 8: ENROLLEE SERVICES

This section provides information related to services provided by the DBPM to its enrollees. Additional information may be found in the **Marketing and Member Education Companion Guide**.

AUTHORIZED REPRESENTATIVES OR LEGAL REPRESENTATIVES

Medicaid enrollees may appoint an authorized representative (AR) to accompany, assist, and represent them in matters related to their Medicaid coverage. In addition, parents are generally authorized to speak on their minor child's behalf regarding the child's Medicaid without an executed AR form, as long as the parent has been verified to hold such parental authority. Also, an enrollee may have a legal representative who is designated by operation of law or by the action of a court. For example, an unemancipated minor child will have someone with parental authority to act on his or her behalf; usually it will be the parent(s), although in some cases it may be another person (e.g., legal guardian/curator) or entity who has been appointed by a court (e.g., DCFS when it has legal custody of a child in foster care).

The case record maintained by LDH is the definitive source of the identity of an enrollee's AR or legal representative. The DBPM may contact LDH to obtain verification of who is authorized to speak and act on behalf of the enrollee.

If the DBPM needs assistance determining whether a caller is an AR for an enrollee, the DBPM should contact the Medicaid Customer Service Unit (CSU) for a verbal verification. The DBPM may conduct the verification through a three-way call with the AR if preferred. DBPMs may call the CSU hotline at 888-342-6207 from 8:00 a.m. to 4:30 p.m. to reach an LDH representative.

The DBPM should accept this verification as the source of truth in confirming or denying who is authorized to speak on behalf of the enrollee. The DBPM should not require any additional documents from Medicaid or the enrollee.

In some cases, a DBPM may learn of an actual or potential change in an enrollee's AR or legal representative before Medicaid does. If that happens, the DBPM should be proactive in educating the enrollee/caller to report changes to Louisiana Medicaid within 10 days and provide direction on contacting Louisiana Medicaid for assistance.

Nothing in this guidance should be interpreted as creating a barrier to access to treatment for enrollees who are unable to speak for themselves. If a minor child is brought to a network provider by an adult who does not have verified parental authority or an AR designation in the child's record, a reasonable effort should be made to contact the AR, or the person with verified parental authority over the minor child, to obtain the appropriate consent for treatment; however, even if that attempt is unsuccessful, it is still legally possible for the provider to furnish necessary treatment to the child, particularly in emergency situations.

This guidance does not affect the ability of a duly designated AR to sign an authorization permitting the disclosure of an enrollee's protected health information to a third person. Medicaid does not seek to dictate the precise authorization forms to be used by DBPMs and their providers, other than to require that they be HIPAA compliant. Generally, Medicaid will honor any valid, HIPAA compliant authorization that permits it to disclose the requested information, but will no longer honor the HIPAA authorization when the person who signed it ceases to be the enrollee's AR or is otherwise unauthorized to speak and act on behalf of the enrollee. The DBPM should follow the same policy.

A disclosure authorization of the type discussed in the preceding paragraph is not the same thing as a written consent for a provider to file a grievance or appeal or to request a state fair hearing on behalf of an enrollee. If an enrollee, an enrollee's AR, or an enrollee's verified legal representative wishes to permit a provider to take such action on the enrollee's behalf, a disclosure authorization by itself will not be sufficient for that purpose.

ENROLLEE RIGHTS AND RESPONSIBILITIES

Each enrollee is guaranteed the following rights:

- To be treated with respect and with due consideration for his or her dignity and privacy.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his or her medical records (one copy free of charge) and request that they be amended or corrected.
- To receive dental services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition. To receive all information (e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives) in a manner and format that may be easily understood as defined in the Contract between LDH and the DBPM.
- To receive assistance from both LDH and the enrollment broker in understanding the requirements and benefits of the DBPM.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information on the DBPM's services, to include, but not limited to:
    - Benefits covered;
    - Procedures for obtaining benefits, including any authorization requirements;
    - Any cost sharing requirements;
    - Service area;
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care dentist, specialists, and hospitals ;
    - Any restrictions on enrollee's freedom of choice among network providers;
    - Providers not accepting new patients; and

- Benefits not offered by the DBPM but available to enrollees and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.
- To receive information on grievance, appeal, and state fair hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not be limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services;
  - That emergency services do not require prior authorization;
  - The process and procedures for obtaining emergency services;
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Contract;
  - Enrollee's right to use any hospital or other setting for emergency care; and
  - Post-stabilization care services rules as detailed in 42 C.F.R. § 422.113(c).
- To receive the DBPM's policy on referrals for specialty care and other benefits not provided by the enrollee's Primary Dental Provider.
- To have his or her privacy protected in accordance with the privacy requirements in 45 C.F.R. Part 160 and Part 164, Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the DBPM, its providers or LDH treat the enrollee.

GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS

Continuation of Benefits

An enrollee is only entitled to a continuation of benefits pending resolution of an appeal or state fair hearing when a previously authorized benefit is terminated, suspended, or reduced prior to the expiration of the current service authorization.

Expiration of an approved number of visits does not constitute a termination for purposes of notice and continuation of benefits. The cessation of services because the authorization expired is not cause for a continuation of benefits, since the enrollee had no right to expect the services to continue beyond the "previously authorized" quantity, period, or duration.

RETURNED MAIL PROCEDURES

When the DBPM receives returned enrollee-related mail, the DBPM should first identify whether a forwarding address has been received.

If a forwarding address is received, the DBPM shall:

- For out-of-state addresses, follow procedures in place for reporting an enrollee disenrollment request to the enrollment broker.

- ❖ For in-state addresses, attempt to contact (including, but not limited to, by phone, mail, e-mail, text) the enrollee to verify that the newly received address is correct.

If no forwarding address is received, the DBPM shall attempt to contact the enrollee as described above.

PART 9: THIRD PARTY LIABILITY

Pursuant to federal and state law, the Medicaid program is intended to be the payer of last resort. This means all other available third party liability (TPL) resources must meet their legal obligation to pay claims before the DBPM pays for the care of an individual eligible for Medicaid.

The DBPM shall take reasonable measures to determine third party liability. The DBPM shall coordinate benefits so that costs for services otherwise payable by the DBPM are cost avoided or recovered from a liable party.

The two methods used are cost avoidance and post-payment recovery. The DBPM shall use these methods as described in federal and state law.

If the probable existence of third party liability cannot be established then the DBPM must adjudicate the claim. The DBPM must then utilize post-payment recovery as outlined in the Contract.

The DBPM may require subcontractors or providers to be responsible for coordination of benefits for services provided pursuant to the Contract.

The DBPM's system shall identify and track potential collections. The system must produce reports indicating open receivables, closed receivables, amounts collected, amounts written off and amounts avoided. Collection reports shall be available to LDH for inspection within three (3) business days of request.

When an enrollee has other insurance, the enrollee must follow any and all requirements of that insurance since it is primary. If the enrollee does not follow private insurance rules and regulations, the DBPM will not be responsible for considering reimbursement of those services. Thus, the enrollee will be responsible for the payment of the services.

Providers must determine, prior to providing services, to which commercial plan the enrollee belongs and if the provider of service is a part of the network of that particular plan. Enrollees must be informed prior to the service that they will be responsible for payment if they choose to obtain services from an out-of-network provider and their commercial plan does not offer out-of-network benefits.

When an enrollee has other insurance, the provider shall first seek authorization from the primary payer; if authorized by the primary payer, the provider shall bill the DBPM as secondary payer. If not authorized by the primary payer, the provider may seek authorization from the DBPM for evaluation of medical necessity.

The DBPM shall process these claims as they were processed by the primary payer. The payment information indicated on the primary payer's EOB will be used to process the claim.

Cost Avoidance

Except for "pay and chase" claims identified in this section, the DBPM shall cost-avoid a claim if it establishes the probable existence of a Third Party Liability at the time the claim is filed. The DBPM shall deny the claim for coordination of benefits (COB) and return it back to the provider noting the third party the DBPM believes to be legally responsible for payment.

If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to the DBPM for payment of the balance up to the maximum allowable Medicaid reimbursement amount.

Post-Payment Recoveries

Post-payment recovery shall be necessary in cases where the DBPM has not established the probable existence of Third Party Liability at the time services were rendered or paid for, or was unable to cost avoid. The following sets forth requirements for DBPM recovery:

- The DBPM must have established procedures for recouping post-payments. The DBPM must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the DBPM must submit replacement encounters.

- The DBPM shall identify the existence of potential Third Party Liability to pay for covered dental benefits and services.

- The DBPM must report the existence of Third Party Liability in a weekly file to the LDH Fiscal Intermediary in the format to be specified by the Fiscal Intermediary and approved by LDH.

- The DBPM shall be required to seek payment in accident/trauma related cases when claims in the aggregate equal or exceed five hundred dollars ($500) as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines, and may seek payment when claims in the aggregate are less than five-hundred dollars ($500).

- The amount of any recoveries collected by the DBPM outside of the claims processing system shall be treated by the DBPM as offsets to dental expenses for the purposes of reporting.

Managing Third Party Liability File Exchanges and Enrollee Updates

The LDH TPL contractor discovers, verifies, and adds/updates insurance coverage leads for all Medicaid enrollees. The TPL contractor completes all insurance coverage lead update requests from DBPMs, LDH, providers, and enrollees within four business hours for urgent requests, and within five business days for non-urgent requests. Additionally, the TPL contractor performs a monthly data match against all Medicaid enrollees and deliver verified insurance data to the fiscal intermediary within 30 days of the match.

LDH defines urgent TPL requests as the inability of an enrollee to have a prescription filled or the inability of an enrollee to access immediate care because of incorrect third party insurance coverage.

The LDH TPL contractor is the sole source for electronic TPL resource file add/updates. Responsibilities for each entity are as follows:

- The TPL contractor sends daily TPL file exchanges to the fiscal intermediary.
- The fiscal intermediary sends daily incremental TPL files to the DBPMs every business day.
- Every Monday, the fiscal intermediary sends weekly TPL full reconciliation files to the DBPMs.

Encounters for Post-Payment Recoveries

The DBPM shall adjust both the provider claim record and the encounter record to include the other payer payment information and report the adjusted DBPM payment amount.

TPL Scope Of Coverage

The type of enrollee's other health insurance coverage is defined by LDH as scope of coverage. Scope of coverage codes with associated definitions are specified in the **DBPM System Companion Guide**.

The DBPM must accept scope of coverage codes from LDH's fiscal intermediary in daily and weekly TPL file transmittals. The fiscal intermediary's TPL file transmittal schedule and file layout are specified in the **DBPM System Companion Guide**.

Liens

Approval Guidelines for Lien Settlements Equal to or Greater Than $25,000

The process for obtaining LDH approval for settlements on liens equal to or greater than $25,000 is as follows:

- The LDH subject matter expert (SME)/business owner for the TPL Trauma Recovery process is the point of contact for these submissions. The DBPM must provide LDH with its contact for this process.
- The DBPM (not its subrogation vendor) must submit these requests directly to LDH via e-mail, marked with High Importance, using the following subject format: "[DBPM Name], Settlement Request".
- At minimum, the DBPM must include the following in the body of the e-mail and/or in the corresponding attachment(s):
    - Enrollee's identifying information (name, SSN, Medicaid ID#);
    - DOA/DOI (Date of Accident/Date of Incident);
    - Third party (i.e., liable party/insurance companies, defense and plaintiff attorneys), with contact information;
    - DBPM's lien amount;
    - Case settlement amount;
    - Requested settlement amount (suggested reduced amount);
    - Description of incident and injuries;

- Reason for request and DBPM's recommendation;
- Other liens to be considered; and
- Attorney's fees and expenses.

❖ Once received, the LDH SME/business owner will consult with LDH Bureau of Legal Services and provide its decision to the DBPM's contact via secure e-mail.

PART 10: QUALITY

LDH's **Medicaid Managed Care Quality Strategy** ("Quality Strategy") defines and drives the overall vision for advancing health outcomes and quality of care provided to Louisiana Medicaid enrollees. The DBPM must have an overall quality management and quality improvement approach with specific strategies that advance the Quality Strategy and LDH's incentive-based quality measures.

LDH has also developed an **MCO Quality Companion Guide** that focuses on core quality improvement activities. The DBPM shall refer to this companion guide for clarification of contract requirements and external quality review organization (EQRO) activities and processes. This includes timeline and format specifications for performance measure and Performance Improvement Project (PIP) reporting.

See the *Resources* section for links to the Quality Strategy and **MCO Quality Companion Guide**.

PART 11: PROGRAM INTEGRITY

Preventing and detecting Medicaid fraud, waste, and abuse requires a collaborative effort by various parties.

LDH, the Louisiana Legislative Auditor's Office, and the Office of the Attorney General are responsible for identifying and reviewing suspected incidents of fraud, waste, and abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with federal and state regulations. The Office of the Attorney General conducts criminal investigation and prosecution of fraud and abuse by providers, via its Medicaid Fraud Control Unit (MFCU), and by enrollees based on LDH and DBPM referrals and complaints received from the public.

The DBPM is responsible for quality review, compliance, and fraud and abuse investigation. Subjects may be DBPM employees, subcontractors, providers, and enrollees. The DBPM has no criminal review authority, although it may pursue civil damages, so the DBPM is required to report suspected and confirmed fraud and abuse to LDH and MFCU. A summary of responsibilities is provided below.

INVESTIGATIONS

All complex reviews shall be completed within eight (8) months (two hundred-forty (240) calendar days) of the date the case was opened unless an extension is authorized by LDH. Requests for extensions to investigations are to be e-mailed to LDH as needed.

REFERRALS/NOTICES

All provider and enrollee fraud and abuse must be reported to the appropriate agencies as follows:

Type	Reported To	Reporting Template
Provider (confirmed)	LDH and MCFU	MCE Fraud Referral Template
Provider (suspected)	LDH and MCFU	MCE Fraud Notice Template
Enrollee (confirmed or suspected)	LDH and local law enforcement	MCE Member Fraud Referral Template

LDH and MFCU screen all referrals for potential payment suspension. MFCU may choose to open its own investigation, or it may use the information to expand an existing investigation. For this reason, the DBPM must refrain from contacting the subject of the fraud referral until LDH confirms the DBPM may continue its review. There is no such prohibition on contacting the subject of a fraud notice.

REPORTING

The DBPM must report all audits, overpayments identified, and recoveries by the DBPM and its subcontractors, including subcontractors that pay claims using the LDH report template.

The DBPM must adjust encounters when it discovers the data is incorrect or no longer valid or that some element of the claim needs to be changed.

When overpayments associated with fraud, waste, and abuse are identified, the DBPM shall start the process of voiding or adjusting claims and encounters within 14 calendar days of being considered final, regardless of recovery status. Overpayments are considered final when all appeals and grievances have been exhausted. All voids should be completed within 45 calendar days of the overpayment being considered final. A 45 calendar day extension will be allowed for those overpayments involving 500 or more claim lines.

TIPS

All tips regarding any potential billing or claims issue identified through complaints or internal review shall be reported to LDH by the 20th of the month.

The DBPM shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse, including tips shared with the DBPM by LDH in the monthly tips reports.

FWA COMPLIANCE PROGRAM

The DBPM is required to implement and maintain arrangements to detect and prevent fraud, waste, and abuse. The FWA Compliance Plan is due to LDH annually and prior to changes.

LDH Program Integrity may initiate reviews of the DBPM's FWA detection and prevention activities.

PROGRAM INTEGRITY MEETINGS

LDH Program Integrity hosts regular meetings to discuss fraud, abuse, waste, neglect, and overpayment issues with the DBPMs and the state's Office of Attorney General MFCU, which the DBPM Program Integrity Officer and CEO or COO are required to attend. The DBPM's SIU investigators are encouraged to participate.

EXCLUSIONS & PROHIBITED AFFILIATIONS

The DBPM may not employ or contract with an individual or entity that is debarred, suspended, or excluded from participating in any federal health care program, or with any individual or entity that is an affiliate of such an individual or entity. This includes:

- Any person with an ownership or control interest; and
- DBPM staff, DBPM owners, subcontractors, and network providers.

The DBPM must conduct all required exclusion screenings monthly. The Exclusion Database Attestation is due to LDH by the 15th of every month. The attestation confirms that the monthly screening of providers, employees and subcontractors has been completed as required in the contract and 42 C.F.R. § 455.436.

In the event payments were paid to an excluded provider, LDH may recover those funds directly from the DBPM via deduction from their capitation payment. Upon identification by the state, the DBPM will be given 30 days to respond and/or provide documentation that disputes the findings.

Sampling of Paid Claims

On a monthly basis, the DBPM must provide individual explanation of benefits (EOB) notices to a sample group of enrollees to verify that services were received by the enrollees as billed.

The DBPM shall track and investigate any complaints received from enrollees that the billed services were not rendered as stated.

The sampling of paid claims report is due 30 days after the end of the calendar year quarter.

Overpayments

DBPMs may recover any overpayments identified by the DBPM; however, the DBPM must confer with LDH before initiating recoupment or withhold on providers previously identified through audit coordination to ensure that the recovery is permissible, meaning the funds are not already set for recovery under an open LDH or MFCU review.

Unless prior approval is obtained from LDH, the DBPM must not employ extrapolation methods to derive an overpayment in a provider audit. LDH follows published CMS guidelines used by Medicare recovery contractors to determine whether an extrapolation is permissible.

Audit Coordination

Surveillance and Utilization Review Audit Coordination

Preliminary Review of Data

- LDH Program Integrity (PI) in conjunction with Surveillance and Utilization Review (SURS) reviews encounter data of all of the DBPMs on a regular basis.
- If a potential overpayment is identified for a provider within the DBPM's network, SURS will send a secure e-mail to the DBPM for vetting.

Contact with the DBPMs

- The e-mail to the DBPMs will contain information pertaining to the potential overpayment. The following information may be sent depending on the information available:
  - A description of the issue(s) and provider information.
  - An attachment with the encounter data and the preliminary results of each encounter audited.
  - A copy of the draft letter containing each area of review.
- The DBPM is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted, or audited.

Audit Clearance

- If the issues or data anomalies relating to the providers were audited or are in the process of being audited by the DBPM, SURS will need a copy of results in order for the SURS case to be closed with "no action".
- If the providers were not previously audited by the DBPMs, SURS will proceed with the audits (i.e., contacting the providers, requesting records, sending recoupment letters, etc.).

Audit

- Records will be requested for the SURS analyst and/or consultants to review or encounters will be given for the provider to do a self-audit.
- All letters from LDH's Program Integrity section or SURS will have the contact information of the analyst who is performing the audit who the provider may contact for additional information or clarification as needed.
- If an overpayment is identified, a recoupment letter containing each area of review and the encounter-level detail will be sent.

Conclusion of the Audit

- The provider has informal and appeal rights (refer to the SURS Rule and the Medical Assistance Program Integrity Law (MAPIL) for detailed information).
- If a recoupment is identified, SURS will collect the amount owed from the DBPM via a deduction from the DBPM's capitation payment. The DBPM may pursue recovery from the provider as a result of the State-identified overpayment.
- The DBPM will receive an e-mail notification from the SURS analyst that the review is complete and provide the timing of the capitation deduction.

Unified Program Integrity Contractor Audit Coordination

Preliminary Review of Data

- Program Integrity (PI) in conjunction with the Unified Program Integrity Contractor (UPIC) reviews encounter data of all of the MCEs on a regular basis.
- If a potential overpayment is identified for a provider within the DBPM's network, PI will send a secure e-mail to the DBPM for vetting.

Contact with the DBPMs

- The e-mail to the DBPM will contain information pertaining to the type/scope of the audit.
- The DBPM is given a deadline to indicate whether the encounter data has been or is in the process of being corrected, adjusted or audited.

Audit Clearance

- If the issues or data anomalies relating to the providers were audited or is in the process of being audited by the DBPM, those DBPM claims are removed from the potential universe of claims for the UPIC case.
- If the providers were not previously audited by the DBPMs, UPIC will proceed with the audit (request records, question providers/recipients, produce a final report, etc.).

Audit

- Records will be requested for UPIC to review.
- If an overpayment is identified, UPIC will produce a final report to the PI Unit. PI will draft/mail all correspondence to the provider, and enclose the final report.

Conclusion of the Audit

- The provider has informal and appeal rights. Refer to the SURS Rule and the Medical Assistance Program Integrity Law (MAPIL) for detailed information.
- If a recoupment is identified, PI will collect the amount owed from the DBPM via a deduction from the DBPM's capitation payment. The DBPM may pursue recovery from the provider as a result of the State-identified overpayment.
- The DBPM will receive an e-mail notification from the UPIC analyst that the review is complete and provide the timing of the capitation deduction.

PART 12: PAYMENT & FINANCIAL PROVISIONS

CAPITATED PAYMENTS

Capitated payments (also referred to as "PMPM payments") are the fixed payments that LDH makes to the DBPM for each enrollee covered under the Contract for provision of DBPM covered services. This payment is made regardless of whether the enrollee receives any DBPM covered services during the period covered by the payment.

DBPM PAYMENT SCHEDULE

The DBPM should refer to the payment schedule established by LDH and published on www.lamedicaid.com.

WITHHOLD OF CAPITATED PAYMENT AND RETURN OF FUNDS

LDH withholds 2% of the DBPM's monthly capitated payments to incentivize quality and health outcomes.

A withhold of the aggregate capitation rate payment shall be applied to provide an incentive for DBPM compliance with the requirements of the Contract. If LDH has not identified any DBPM deficiencies, LDH will pay to the DBPM the withhold of the DBPM's payments withheld in the month subsequent to the withhold.

MEDICAL LOSS RATIO

In accordance with the Financial Reporting Guide, the DBPM shall provide an annual Medical Loss Ratio (MLR) report following the end of the MLR reporting year.

RISK SHARING

The Dental Benefit program is a full risk-bearing, Pre-Paid Ambulatory Health Plan delivery system responsible for providing specified Medicaid covered services included in the Louisiana Medicaid State Plan to Medicaid enrollees.

A DBPM assumes full risk for the cost of covered services under the Contract and incurs loss if the cost of furnishing these covered services exceeds the payment received for providing these services.

Determination of DBPM Rates

LDH shall establish actuarially sound capitation rates for enrollees assigned to the DBPM to ensure that DBPM covered services under this Contract are provided. Rates are set using available and appropriate sources, including, encounter data, and financial data and supplemental ad hoc data and analyses, and adjusted based on factors such as utilization trend, unit cost trend, TPL recoveries, and administrative costs.

RESOURCES

Manuals and Guides

Links to manuals and guides referenced in this Manual are provided below. Additional DBPM resources are posted on the LDH website [https://ldh.la.gov/index.cfm/page/37].

- Chisholm Compliance Guide and MCO User Manual
- DOJ Agreement Compliance Guide
- LDH Dental Services Homepage
- Financial Reporting Guide
- Louisiana Quality Management Strategy for the Louisiana Medicaid Managed Care Program (Quality Strategy)
- Marketing and Member Education Companion Guide
- Medicaid 834 Benefit and Enrollment EDI Transaction Set Companion Guide (834 Systems Companion Guide)
- Medicaid Services Manual
- Provider Network Companion Guide
- Quality Companion Guide
- Reinstatement and Implementation of LAHIPP Third Party (TPL) Claims Payment
- DBPM System Companion Guide
- State Fair Hearing Companion Guide

Fee Schedules

Louisiana Medicaid fee schedules are posted on https://www.lamedicaid.com.

Forms and Templates

Most forms referenced in this Manual may be located at https://www.lamedicaid.com.

Additional forms referenced in this Manual may be located using the following links:

- Denial and Partial Denial Notice Templates
- Dental Benefit Plan Reporting Templates