Louisiana Provider Manual

Effective Date: JanuaryMay 1, 20254

Table of Contents

1. Welcome

Dear MCNA Provider:

Managed Care of North America (MCNA) would like to take this opportunity to welcome you and your staff as part of our national network of dental providers. We are pleased that you have chosen to participate with us. Throughout your ongoing relationship with MCNA this Provider Manual will give you useful information concerning the MCNA plans in which you have chosen to participate.

MCNA was founded by a group of dentists with extensive backgrounds in the field of dental care and dental plan operations. MCNA's goal is to provide quality dental services to members and providers. MCNA recognizes the vital role the dental office plays in a successful dental plan. The purpose of this Provider Manual is to provide you with an explanation of MCNA's administrative policies and procedures, provisions, and the role you play as a dentist.

When communicating with our network providers, we make every effort to be clear and concise. Our expectation is to answer questions promptly when they arise. We strive to provide accurate and effective information that allows you and your dental team to understand which American Dental Association (ADA) Current Dental Terminology (CDT) codes are covered and what to expect from MCNA.

For the latest version of this manual in digital form, please access the MCNA Provider Portal at:

http://portal.mcna.net

or visit:

http://manuals.mcna.net/louisiana

to download a PDF version directly.

MCNA may make additions, deletions, or changes to the policies and procedures described in this Provider Manual at any time and will give providers at least 30 days advance notice before implementation. As a participating provider, your agreement requires you to comply with MCNA policies and procedures including those contained in this manual.

If you require assistance or information that is not included within this manual, please contact our Provider Hotline (See Section 2: Contact Information).

We will communicate changes in MCNA's policies and procedures as well as state and federal laws to you through the dissemination of provider bulletins.

Again, we welcome you and your staff to the growing list of MCNA providers. We look forward to a successful relationship with you and your practice.

Sincerely,
MCNA Provider Relations Department

2. Contact Information

For the quickest service, please use the contact information listed below. Please note that calls may be recorded for quality assurance purposes.

2.1. MCNA Member Hotline

Our Member Services Department is open from 7am – 7pm CST, Monday – Friday, excluding national holidays.

Main:	1-855-702-MCNA (1-855-702-6262)
TDD/TTY:	1-800-846-5277
Email:	memberhotlineLA@mcna.net

2.2. MCNA Eligibility Verification

Main:	1-855-702-MCNA (1-855-702-6262) (7:00 am CST – 7:00 pm CST)
Online:	http://portal.mcna.net (available 24 hours a day, 7 days a week.)

2.3. MCNA Provider Hotline

For provider enrollment, direct deposit issues, reporting changes and ownership, NPI, etc.

Main:	1-855-701-MCNA (1-855-701-6262)
eFax:	1-877-563-8560
email:	LA_PR_Dept@mcna.net

2.4. MCNA Credentialing

Main:	1-855-701-MCNA (1-855-701-6262)
Main Fax:	1-954-730-7131

2.5. MCNA Utilization Management (Pre-Authorizations and Referrals)

Main:	1-855-701-MCNA (1-855-701-6262)
eFax:	1-954-628-3331*(Not for pre-authorization/referral submissions.)*
Email:	umla@mcna.net *(For questions and status updates only, not for pre-authorization/referral submissions.)*

2.6. MCNA Provider Portal Helpdesk

Main:	1-855-232-MCNA (1-855-232-6262)

2.7. MCNA Hotlines

Fraud, Waste, and Abuse:	1-855-FWA-MCNA (1-855-392-6262)
Compliance:	1-855-683-MCNA (1-855-683-6262)

2.8. MCNA Corporate Headquarters

When sending mail to a specific department, please address it to the attention of that department.

Main:	1-800-494-MCNA (1-800-494-6262)
Main Fax:	1-954-730-7875
Online:	http://www.MCNA.net
Mailing Address:	**MCNA Dental** P.O. Box 740370 Atlanta, GA 30374-0370

2.9. Louisiana Recipient Eligibility Verification (REVS)

Main:	1-800-776-6323

2.10. Medicaid Eligibility Verification System (MEVS)

An automated eligibility verification system using a swipe card device or PC software through vendors.

2.11. E-Medicaid Eligibility Verification System (E-MEVS)

A web application accessed through www.lamedicaid.com

2.12. Louisiana Office of Management and Finance (Bureau of Health Services Financing) - Medicaid

For general Medicaid and ID card questions.

Main:	1-888-342-6207
TDD/TTY:	1-800-220-5404
Online:	www.healthy.la.gov
Email:	healthy@la.gov
Mailing Address:	**Bureau of Health Services Financing** P.O. Box 91030 Baton Rouge, LA 70821

2.13. Louisiana Office of Aging and Adult Services (OAAS)

Main:	1-866-758-5035
Main Fax:	1-225-219-0202
Email:	OAAS.Inquiries@la.gov
Mailing Address:	**Office of Aging and Adult Services** P.O. Box 2031 Baton Rouge, LA 70821

2.14. Health Plan Relations

Main:	1-855-229-6848
TDD/TTY:	1-800-220-5404

Main Fax:	1-225-342-9855
Online:	https://ldh.la.gov/index.cfm/subhome/6
Email:	Healthy@la.gov

Mailing Address:	**Health Plan Relations** P.O. Box 91283 Bin 32 Baton Rouge, LA 70821

2.15. Louisiana Program Integrity (PI)

Main:	1-225-219-4149
Main Fax:	1-225-219-4155
Fraud and Abuse Hotline:	1-800-488-2917

Mailing Address:	**Medicaid Program Integrity** Attention Compliance Unit Louisiana Department of Health P.O. Box 91030 Baton Rouge, LA 70821

2.16. Louisiana Division of Administrative Law (DAL)

Formerly LDH Bureau of Appeals.

Main:	1-225-342-1800
Main Fax:	1-225-219-9823
Online:	http://www.adminlaw.state.la.us/

Mailing Address:	**Division of Administrative Law** 1020 Florida Street Baton Rouge, LA 70802

2.17. Louisiana Department of Children and Family Services (DCFS)

Main:	1-855-4LA-KIDS (1-855-452-5437)
Online:	www.dcfs.la.gov

3. Revision History

Version	Date	Revision Information
1.26	1/1/25	• Made 2025 CDT editorial changes (no change to benefits). • Changed section 11.14.1 Changed form from "non-covered services" to "patient responsibility" and updated the linked form in section 33. • Added clarifying language to section 17.1 (member rights and responsibilities) to emphasize the provider's responsibility to explain before treatment anything that might not be covered by the EPSDT program. • Clarified limitation language for D0145 and D1206/D1208 in EPSDT to emphasize twice a year limitation. • Added clarifying language to all 4 programs on the documentation required (member signature) for denture claims.
1.25	5/1/24	• Revised office survey language in section 5.2 • Added D1351 coverage for the Adult Waiver and ICF/IID groups and removed age limitation for EPSDT. • Revised the VAS language for the caries risk assessment codes and the extraction codes as benefits for ADP members in section 16.3. • Removed ADP members as the population for D1354, as it was changed to a child VAS benefit and a covered service for the AWP and ICF/IID populations. • Added AAPD radiograph chart prior to the radiograph section for each program. • Removed the D4000 code limitations for D1110, D1120 and D1208 for each program. • Changed periodicity for D1351 per LDH guidance. • Changed OCD requirement to quadrant for following codes: D1510, D1533, D1556, D1575, D4210, D7285, D7286, D7291, D7310. • Language changes to D4341. • Duplicative language removed from D2330, D2331, D2332. • Added gray box language for other restorative services, and "exceptions" statement to codes in this section. • Removed PA requirement for D2950 and added requirement to submit post-operative x-rays. • D5986, D7270, D7880, D9944, D9945 and D9946 changed OCD requirement to Arch ID requirement. • Removed x-ray requirement for D7111. • Added clarifying language to D7961 and D7962. • Added language and oral surgeon exemption for codes D9222 and D9239. • Corrected dental repair limit in the Adult Denture Program. • Changed "rationale" to documentation of medical necessity throughout the manual. • Added specialist exemption language to codes D0120, D0140 and D0150 for all programs.

1.24	1/1/24	• Added D1206/D1208 coverage for AWS and ICF/IID and amended limitation for these codes in EPSDT. • Added the D1354 coverage for Adult Denture members to the VAS section. • Amended incorrect sedation limitation language. • Various formatting changes and corrections throughout manual. • Made 2024 ADA change to language for code D2335 for all programs. • Removed D1351 from the list of codes that can't be billed with the 4000 series codes. • Removed PA requirement for D9222 and D9239 for EPSDT, Adult Waiver and ICF/IID. • Revised submission requirement/Removed PA for D9223 and D9243 for EPSDT, Adult Waiver and ICF/IID. • Removed $45 comment/limitation under D2950 for EPSDT, Waiver, and ICF/IID populations. • Amended radiograph language to revise the lookback period to 15 days. • Added AAPD radiograph chart to EPSDT and Waiver populations.
1.23	7/2023	• Revised VAS to reflect changes for 2023. • Amended limitation to D0145 for EPSDT program. • Updated CDT code descriptions for D4355 and D9110. • Amended language for D0210 for EPSDT and Adult Waiver Program to reflect CDT code language change. • Revised address for provider relations complaints. • Removed PA/photo/documentation requirement for D7961 and D7962. • Revised submission requirements for D7241. • Added oral surgeon exemption language to code D7210. • Added sedation billing chart under guidelines for sedation. • Amended all fees for the EPSDT program to reflect 7/1/23 fee increase. • Amended all fees for the Adult denture program to reflect 7/1/23 fee increase. • Amended all fees for the Adult waiver program to reflect 7/1/23 fee increase. • Amended all fees for the ICF/IID program to reflect 7/1/23 fee increase.
1.22	6/2023	• Added D9222 and D9223 coverage to EPSDT, AWP, and ICF/IID programs. (and included deep sedation in references to IV sedation, removed general anesthesia from non-covered services.)
1.21	5/2023	• Added all specifics and language about the Adult ICF/IDD program, including fee schedule.
1.20	12/2022	• Added primary teeth coverage to multiple codes (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2933, D2934) and added new codes (D5213, D5214, D5820, D5821 and D7211 for the Adult Waiver Program as directed by LDH. • Formatting changes.

		• Added orthodontia criteria language to EPSDT and AWP, pages 125 and 199.
1.19	7/2022	• Color shaded the fee schedules (blue = EPSDT, pink=Adult Denture Program, green=Adult Waiver Program) for scrolling ease for providers. • Updated Periodicity chart (section 6.5.1, page 25) and included AAPD link to chart. • Corrected description language for D5110 and D5120 (for all 3 programs) to match DBPM language and CDT code description. • Corrected fee for D7111 (EPSDT, page 118) to be $64.79, was a typo in manual but being paid to providers in correct amount. • Revised CDT code description for D1354 in the Adult Denture Program (Page 144) to match description in Adult Waiver Program. • Removed concurrent code billing restriction for D0140 (EPSDT page 74 and AWP page 153). • Added language from DBPM to MCNA manual for D0150 (EPSDT and AWP) to clarify specialist exemption for the 3 year limitation. • For the restorative codes with two separate fee amounts in the AWP section (I.e.D2150), changed formatting to one row instead two on the fee schedule. • Updated MCNA mailing address and corporate address. • Corrected minor typos throughout manual.
1.18	7/2022	• Updated the pre-authorization time frame to remain valid for one year rather than 180 days. Updated the referral time frame to remain valid for one year rather than 90 days. • Clarified billing specifics on value-added services for FQHCs/IHS providers. • Removed non-applicable language regarding prosthodontics from the Adult Denture Covered Services overview. • Added all specifics and required language for the Adult Waiver Program population.
1.17	2/2022	• Added code D2929 per LDH guidance. • Replaced codes D8050 and D8060 with D8010 and D8020 per ADA changes. • Refined submission requirements for partial dentures, removed radiograph requirement. • Revised appeals procedures to delete language requiring verbal appeals to be submitted in writing. • Updated link to the pediatric conscious sedation form.
1.16	07/2021	• Removed pre-authorization requirement from D4355 – Full Mouth Debridement
1.15	05/2021	• Added link to current approved Clinical Practice Guidelines in Section 13.3 Clinical Practice Guidelines. • Revised language for D2392 to be for primary teeth only with the fee of $82.14. • Revised and added language to Section 26.1 Guidelines for Oral Surgery and Criteria
1.14	01/2021	• Updated web links, addresses, and access to care standards • Added Value-Added Services

		- Caries Risk Assessment codes for Adults (D0601, D0602, and D0603 - Silver Diamine Fluoride Treatment for Adults (D1354) - Dental Extraction for Adults (D7140) - Teledentistry for Adults (D9996) - Walmart Gift Card for $10 children under 21 - Itty Bitty Baby Teeth book and backpack for children ages 4-6
1.13	12/2020	• Added new dental rate increases for the following codes: D0145, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2931, D2934, D7230 and D7240. • Updated D1206 0-5 ages and D1208 0-15 ages. • D1510 added "Excludes a distal shoe space maintainer" per ADA code book. • Revised language to Endodontic Therapy (grey box) to support billing for diagnostic evaluation and x-rays. • Removed "Provider's Medicaid ID" requirement from denture identification. • Added language to D7220-D7240 under Benefit Limits. • Revised language for anesthesia time record. • Restored pre-authorization requirement for D9239 and D9243. • Placement of a sentence was rearranged for hospital call, D9420. • Updated information about overpayment to the Program Integrity section. • Removed the age requirement of the full mouth series x-ray (D0210). • Added "Provider and Office" sedation permit level in grey box. • Updated address for paper claims submission. Effective 1/1/2021 the following codes were replaced and/or changed: • D7960 was removed and replaced with D7961 and D7962 • Updated CDT code descriptions to reflect 2021 CDT code set changes for D5750, D5751, D5760, D5761 and D5820, D5821.
1.12	02/2020	Effective 1/1/2020 the following codes were replaced and/or changed: • D1550 was removed and replaced with D1551, D1552, and D1553 • D1555 was removed and replaced with D1556, D1557, and D1558 • D1510 and D1575 had revisions to the description adding "per quadrant" • D5213 and D5214 had editorial changes in the description
1.11	3/2019	• Updated requirements for D9944, D9945, and D9946
1.10	2/2019	• Added language to the re-credentialing process • Updated time frame for filing a member grievance • Added section about independent review process • Removed "excluding interim partial dentures" language from D5820 and D5821 • Updated requirements for D5660 and D5630 • Added language about interruption of treatment allowing balance bill to non-Medicaid members

		• Made correction to number of units and updated language for D9243 Updated age limit for child D1120 and adult prophylaxis D1110 • Updated requirement for anesthesia time record Effective 1/1/2019 the following codes were replaced and/or changed: • CDT code D1515 was removed and replaced with D1516 and D1517 • CDT code D1575 (distal shoe) was added • Descriptor change for D5211, D5212, D5630, and D7283 • CDT code D9940 was removed and replaced with D9944, D9945, and D9946
1.9	4/18/2018	• Effective 1/1/2018 the following codes were replaced and/or changed: o CDT code D5510 was replaced with D5511 and D5512 o CDT code D5610 was replaced with D5611 and D5612 o CDT code D9239 (intravenous moderate conscious sedation/analgesia – first 15 minutes) has been added • Descriptor change on the following codes: D3320, D3330, D4355, and D7111 • Added language under Section 26.1 Oral Surgery Guidelines "Extractions performed within a six-month period of a prior placement of restorations on the same tooth are subject to be recouped." • Removed the requirement of a panoramic film (D0330) from the full mouth series D0210 • Updated the language for D0272 and D0330 • Updated the language for D2932 • Updated time frame for State Fair Hearing request • Revised Forms section, and added a revised Member Outreach form
1.8	6/28/2017	Changed age limit for D9920 (behavior management) from 6 to 8 years.
1.7	6/01/2017	Code description change effective 1/1/2017 for CDT codes D7210, D7250, and D7280. Added primary teeth eruption and shed age chart in the Oral and Maxillofacial Surgery Services section. Added language for post authorization in EPSDT and Adult Denture Program in the Pre-Authorization section. Revised turnaround time for referrals
1.6	10/11/2016	Clarification for emergency dental services.
1.5	7/26/2016	Updated the pre-authorization time frame to remain valid for 180 days rather than 90 days. Revised the claims timely filing time frame from 180 days to 365 days from the date of service. Noted in the Third Party Liability section that all claims must be finalized in 24 months. Clarified the prompt payment standard is business rather than calendar days. Added contact number for Case Management Department. Extended date to file reconsideration from 60 to 365 days. Included language about ability to file consolidated complaints and in person complaints. Clarified that replacement and recementation of space maintainers is the provider's

		responsibility for the first 12 months. Added language about cutback for restorations.
1.4	1/28/2015	Edits to timely filing requirements and reconsideration timeframe. Clarification to the requirement for recementation of space maintainers.
1.3	9/15/2014	Edits to emergency treatment authorizations.
1.2	7/2/2014	Change to Radiographs section in Adult Denture Program Covered Services.
1.1	6/30/2014	Update to Pediatric Dentistry Conscious Sedation Form.
1.0	6/20/2014	Initial Version.

4. Program Overview

Dental programs are governed by regulations found in the Code of Federal Regulations 42CFR 440.40 and 42CFR 440.50 that describe the services available through the programs, including the required services for children under the age of 21.

The Louisiana Medicaid Dental Services include the following programs:

- EPSDT Dental
- Adult Denture Program
- Adult Waiver Program
- Adult ICF/IID

Louisiana Medicaid refers to Children's Medicaid and LaCHIP together as the "EPSDT Dental Program."

5. Criteria for Network Participation

The Dentist Participation Criteria lists a variety of requirements that a participating provider must meet. These requirements include standards regarding dental office physical attributes, practice coverage, member access, office procedures, office records, insurance and professional qualifications, and staff work history. The criteria are used in our credentialing and re-credentialing process and a full listing is attached to our current Provider Agreement.

5.1. Applicability

The participation criteria apply to each new applicant for participation in MCNA's network, and to all providers currently participating. They shall be enforced by MCNA as required by the EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program. Any provider applying to join MCNA's network must be licensed in the State of Louisiana from the Louisiana State Board of Dentistry and must adhere to the Louisiana State Board of Dentistry Requirements concerning the delivery of dental services.

An applicant must satisfactorily document evidence meeting the criteria listed for at least six (6) months prior to application unless that provider has entered clinical practice or completed a residency or a fellowship program within the past six (6) months, or currently participates with Louisiana EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program.

The following additional requirements for continued participation in MCNA's network apply to all participating providers:

- All MCNA participating providers in a group practice must meet MCNA credentialing criteria. If one or more of the providers in the group fail to meet the criteria, the entire group cannot participate.
- All MCNA participating providers must be credentialed, execute a Provider Agreement, and agree to provide all services to EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program members as set forth by the EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program. Providers who offer only diagnostic and preventive services do not meet the necessary criteria for participation.
- All MCNA participating providers must apply for re-credentialing every three (3) years.

5.2. Office Survey

Office surveys are conducted on an ongoing basis for participating offices, either in-person or virtually. These surveys focus on essential areas of office management and dental care delivery. The provider shall allow MCNA authorized agents or representatives access to their premises during normal business hours. Provider shall allow similar access or availability to their premises to assist in internal and external quality assessment review, utilization management, and grievance procedures established by MCNA and provide adequate space on the premises to reasonably accommodate the quality review personnel conducting the audit, investigation, or inspection effort. The provider shall produce all records, documents, or other data requested as part of such review, investigation, or audit. The survey, which may or may not be scheduled in advance, may cover the following areas:

1. **General Information** – the name of the practice, address, name of principal owner and all associates, license numbers, staffing information, office hours, list of foreign languages spoken in the office,

availability of appointments, method of providing 24 hour coverage (e.g., answering machine or answering services), and the name of the covering dentist when a provider is unavailable (e.g., office closed or provider on vacation).

2. **Practice History** – information regarding malpractice suits, settlements, and disciplinary actions, if applicable.
3. **Office Profile** – overview of services routinely performed.
4. **Facility Information** – description of location, accessibility (including handicap accessibility), interior office and the reception area, operatories and lab, type of infection control, general equipment, and radiographic equipment.
5. **Risk Management** – review of personal protective equipment (e.g., gloves, masks, equipment to handle waste disposal, equipment and methods to handle sterilization and disinfection), training programs for staff, radiographic procedures and safety, occupational hazard control regarding amalgam, nitrous oxide, and hazardous chemicals, and medical emergency preparedness training and equipment.
6. **Recall System** – review of procedures for assuring members are scheduled for recall examinations and follow-up treatment.
7. **Provider Credentials** – verification that all MCNA participating dental providers in a group practice are credentialed by MCNA.

5.3. Credentialing/Re-Credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a dental care professional who seeks acceptance into MCNA's provider network. Our Credentialing Program follows the recommended CMS categories, which include:

- **Initial Credentialing** – written application, verification of information from primary and secondary sources, confirmation of eligibility for payment under Medicaid and site visits, as appropriate.
- **Monitoring** – monitoring of lists of practitioners who have been sanctioned and/or had grievances filed against them, and of practitioners who opt-out of accepting federal reimbursement from Medicaid. Monitoring is conducted on a regular basis between credentialing and re-credentialing cycles.
- **Re-credentialing** – re-evaluation of Provider's credentials at least once every three (3) years through a process that updates the information obtained during initial credentialing. Re-credentialing considers performance indicators such as those collected through the Quality Improvement (QI) program, the Utilization Management system, the Grievance and Appeal system, enrollee satisfaction surveys, and other activities of the organization. Following the initial credentialing process with MCNA, all of our network providers who enter into the re-credentialing cycle are considered approved unless otherwise notified. If you have any questions regarding re-credentialing with MCNA, please call our Provider Hotline at 1-855-701-6262.
- **Expedited Credentialing** – records for a select provider (or provider group) are given priority status.
- **Temporary Credentialing** – provisional credentialing where MCNA runs basic verifications. If no adverse information is initially found, the provider is granted network privileges while MCNA completes all the credentialing elements. If the provider does not meet the full set of credentialing criteria, network participation privileges are rescinded and recoupment efforts ensue.

Additionally, MCNA will:

- Verify Louisiana license through appropriate licensing agency

- Review state and federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and State Medicaid Agencies)
- Review monthly reports released by the Office of Inspector General and local Medicaid Agencies for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid

All providers are required to complete the Dental Credentialing Form.

MCNA's Credentialing Program establishes the selection criteria for qualification as a participating provider. The criteria are reviewed and approved by the Credentialing Committee. The full set of criteria is clearly outlined by the credentialing application.

Additionally, current copies of the following documents must be attached to an application for initial credentialing as well as for re-credentialing. These documents are required as components of the selection criteria and will be verified through primary and secondary sources.

- Louisiana Dental License
- National Provider Identifier (NPI)
- Controlled Substance Registration Certificate from the Drug Enforcement Agency (DEA)
- Professional Liability Insurance Face Sheet
- Curriculum Vitae
- Board Certificate or Evidence of adequate training
- Completed W-9 Form
- Signed Provider Agreement/Contract
- Signed Provider Application

It is the provider's responsibility to submit any renewal certification documentation or changes in information to MCNA within 10 business days of any change. MCNA encourages all eligible providers to seek applicable Board Certification.

MCNA will send a letter to a provider with a license nearing expiration, according to the most current information received from the provider.

5.4. Credentialing Committee Appeals

In the event an applicant is credentialed with restrictions or denied, the Credentialing Committee offers an opportunity to appeal. An appeal must be requested in writing and must be reviewed by the committee within 30 days of the date the committee gave notice of its decision.

A copy of MCNA's credentialing policies can be obtained by contacting the Credentialing department (See Section 2: Contact Information).

5.5. Practice Requirements

Each dentist's office must:

- Have a sign containing the names of all dentists practicing at the office. The office sign must be visible when the office is open.

- Have a mechanism for notifying members if a dental hygienist or other non-dentist dental professional may provide care.
- Be accessible to all members in all areas, including but not limited to, the entrance, parking, and bathroom facilities.
- Have offices that are clean, presentable, and professional in appearance.
- Be a non-smoking facility and have a no-smoking sign prominently displayed in the waiting room.
- Have clean and properly equipped non-staff toilet and hand-washing facilities.
- Have a waiting room that will accommodate at least four (4) members.
- Have treatment rooms that are clean, properly equipped, and contain functional, adequately supplied hand washing facilities.
- Have at least one (1) staff person (in addition to the provider) on duty during normal office hours.
- Provide a copy of current licenses and certificates for all providers, dental hygienists, and other non-dentist dental professionals practicing in the office, including state professional licenses and certificates, Federal Drug Enforcement, and State Controlled Drug Substance licenses and certification (where applicable).
- Keep a file and make available to MCNA any state-required practices and protocols or supervising agreements for dental hygienists and other non-dentist dental professionals practicing in the office.
- Have appropriate, safe x-ray equipment. Radiation protection devices including, but not limited to, lead aprons shall be available and used according to professionally recognized guidelines, such as Food and Drug Administration guidelines. Signs warning pregnant women of potential exposure must be prominently displayed.
- Use appropriate sterilization procedures for instruments and use gloves and disposable needles. All staff shall maintain the standards and techniques of safety and sterility in the dental office required by applicable federal, state, and local laws and regulations including, but not limited to, those mandated by OSHA, and as advocated by the American Dental Association (ADA) and state and local societies.
- Comply with all applicable federal, state, and local laws and regulations regarding the handling of sharps and environmental waste, including the disposal of waste and solutions.
- Make appointments in an appointment book or the electronic equivalent accepted by MCNA. Appointments should be made in a manner that will prevent undue member waiting time and in compliance with the access criteria listed in this manual.
- Have documented emergency procedures, including procedures addressing treatment, evacuation, and transportation plans to provide for the safety of members.
- Upon request, provide members with the MCNA Member Services Hotline number to receive a copy of their rights and responsibilities as listed in the Member Handbook.
- Provide translation assistance services to any member whose native language is different from English.
- Have a functional recall system in place to notify members of the need to schedule dental appointments. The recall system must meet the following requirements for all enrolled members:
    - The system must include either written or verbal notification
    - The system must have procedures for scheduling and notifying members of routine checkups, follow-up appointments, and cleaning appointments
    - The system must have procedures for the follow-up and rescheduling of missed appointments

MCNA encourages its providers to attempt to decrease the number of “no shows." Provider offices should contact the member prior to a scheduled appointment either by phone or in writing to remind them of the time and place of

the appointment. Follow-up phone calls or written information should be provided encouraging the member to reschedule the appointment in the event the appointment is missed.

5.6. Sterilization and Infection Control

Members and all office staff must be protected from infectious and environmental contaminants.

The following OSHA requirements must be met, without exception:

- All personnel should wash with anti-bacterial soap before all oral procedures.
- Dental gloves, facemask, and eye protection should be worn.
- All instruments should be thoroughly scrubbed before sterilization.
- All instruments and equipment that cannot be sterilized, including operating light chair switches, hand pieces, cabinet working surfaces, and water/air syringes and their tips, should be disinfected, using approved techniques, after each use.
- ADA-approved sterilization solutions should be utilized.
- All equipment should be monitored using process indicators with each load and spore testing on a weekly basis.
- Handling of all environmental waste, including the disposal of waste and solutions, must be completed in compliance with all applicable federal, state, and local laws and regulations.

5.7. Medical Emergencies

All office staff shall be prepared to deal with any medical emergency through the implementation of the following guidelines:

- The provider and at least one other staff member must be currently certified in CPR procedures.
- The dental office must have a formal medical emergency plan and staff members must understand their individual responsibilities. All emergency numbers must be posted.
- Members with medical risk shall be identified in advance.
- All dental offices must have a portable source of oxygen with a positive demand valve, blood pressure cuff, and stethoscope.

6. Provider Roles and Responsibilities

6.1. Provider Rights

Each MCNA contracted provider that furnishes services to MCNA members shall be assured of the following rights:

1. A dental provider, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
    a. Member health status, medical care, or treatment options, including any alternative treatment that may be self-administered
    b. Any information the member needs in order to decide between all relevant treatment options
    c. The risks, benefits, and consequences of treatment or non-treatment
    d. Member right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
2. The right to receive information on the Grievance, Appeal, and State Fair Hearing procedures.
3. The right to access MCNA's policies and procedures covering the authorization of services.
4. The right to be notified of any decision by MCNA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
5. The right to challenge, at the request of a Medicaid EPSDT member and on their behalf, the denial of coverage of, or payment for, medical assistance.
6. The right to be free from discrimination with regard to MCNA's provider selection policies and procedures based on a provider's service to high-risk populations or specialization in conditions that require costly treatment.
7. The right to be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification.

6.2. Primary Care Dentist Role and Responsibilities

Louisiana defines a Primary Care Dentist as the provider of primary dental services. Establishment of a member's Primary Care Dentist begins no later than six (6) months of age and includes referrals to dental specialists for EPSDT Dental Program members under the age of 21, when appropriate.

Louisiana defines primary dental services as dental services and laboratory services customarily furnished by or through a Primary Care Dentist for the evaluation, diagnosis, prevention, and treatment of diseases, disorders, or conditions of the oral cavity, maxillofacial areas, or the adjacent and associated structures. Primary dental services should be delivered through direct service to the member when possible or through the appropriate referral to specialists and/or ancillary providers.

MCNA must develop a network of Primary Care Dentists consisting of general or pediatric dentists that practice in solo or group practices. Primary Care Dentists may also practice in a clinic (Federally Qualified Health Centers or Rural Health Care Clinics). They provide preventive care to EPSDT Dental members and complete referrals for specialty care as needed. When an EPSDT member does not select a Primary Care Dentist, DentalTrac™ will auto-assign to a Primary Care Dentist (general dentist or pediatric specialist) based on the following considerations:

1. Providers who are not in good standing are not considered during the auto-assignment methodology.

2. MCNA strives to keep families together. If a member of a family is assigned to a PCD, other members of the same family will be assigned to the same PCD. However, if the PCD has age restrictions that would prevent a family member from being assigned, we will assign that family member to another PCD in the same office that meets the age restrictions if possible.

3. If there is historical claims data that identifies a dentist that performed dental services on the member, we will assign the member to such dentist, as long as the dentist is a participating PCD that meets the age restrictions and travel distance requirement for the member.

4. For each member that needs to be auto-assigned to a PCD, we will generate a pool of participating PCDs that meet the age restrictions of the member and who are located near the member's residence address. The search radius will be increased until a PCD is located for assignment within the time and distance requirements of the plan. Once a pool of providers is generated, members living within that radius needing auto-assignment will be assigned to PCDs from this pool in a random sequence in order to equalize the patient load amongst providers within such radius.

Louisiana's EPSDT Dental, the Adult Denture program, the Adult Waiver Program, and the Adult ICF/IID Program participating providers must offer the same services to a Medicaid member as those offered to a non-Medicaid patient provided these services are reimbursable by the Medicaid program. In addition, participating providers have the responsibility to develop a provider-member relationship based on trust and cooperation. Coordination of care strengthens the positive relationship between the member and provider and is a critical tool for achieving positive oral health outcomes.

Primary Care Dentists must assess the dental needs of members for referral to specialty care providers and complete referrals as needed. Referrals must be made through MCNA. Providers can send referral requests through the online Provider Portal or via mail. Please contact the Provider Hotline for assistance with submitting a referral. Primary Care Dentists are responsible for coordinating care with specialty providers after referral.

If a referral is not submitted to MCNA, the treating dentist's claims for services will be denied. In order to receive appropriate payment for services rendered, the treating dentist must include the referral number in Box 2 of the ADA Claim Form, or in the "Pre-Authorization Number" field of the form in MCNA's Provider Portal. Failure to include the referral number may result in denial of the claim.

6.3. Specialist Role and Responsibilities

The role of the specialist (Endodontist, Orthodontist, Oral Surgeon, Pedodontist, Periodontist, and Prosthodontist) is to provide covered services to members for medically necessary treatment. Once treatment is complete, the specialist discharges the member back to their Primary Care Dentist for follow-up. MCNA allows Pedodontists to serve as Primary Care Dentists for our pediatric members.

6.4. Medically Necessary Services

Medically necessary services are those healthcare services that are delivered in accordance with generally accepted, evidence-based medical standards, or are considered by most dentists (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction.
- Those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the member.

Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. They may be neither more nor less than what the member requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." Medical Necessity determinations do not apply to Adult Denture members. In the Adult Denture program all services are subject to clinical review as noted in this manual. Service limitations apply. Please refer to the Adult Denture Program Covered Services section for more detail.

6.5. Preventive Treatment

EPSDT Dental members should be encouraged to return for a recall visit as frequently as indicated by their individual oral status and within plan time parameters. It is important that each dental office has a recall procedure in place. The following should be accomplished at each recall visit:

- Update medical history
- Review of oral hygiene practices and necessary instruction provided
- Complete prophylaxis and periodontal maintenance procedures
- Topical application of fluoride, if indicated
- Sealant application, if indicated

Please refer to the Louisiana Medicaid recommendations for treatment of pediatric members by age on the next page.

6.5.1. Periodicity and Anticipatory Guidance Recommendations

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this best practice for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assessment developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal-risk assessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/ vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2 By clinical examination.
3 Must be repeated regularly and frequently to maximize effectiveness.
4 Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6 Appropriate discussion and counseling should be an integral part of each visit for care.
7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.
9 At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
10 Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.
11 Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.
12 Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.
13 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
14 Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

Source: https://www.aapd.org/globalassets/media/policies_guidelines/bp_recdentperiodschedule.pdf

6.6. Access Requirements

6.6.1. Availability and Accessibility

Providers must provide the same availability to MCNA members as is done for all other patients as stated in the MCNA Dental Provider Agreement.

Appropriate access to care is an essential part of MCNA's Quality Improvement Program. Access to care is monitored by the Provider Relations department. Periodically, a written inquiry or phone call may be generated by a Provider Services Representative to obtain information concerning the next available appointment.

In order to be a PCD for EPSDT Dental Program members, a provider must deliver comprehensive care. A provider who serves as a PCD to MCNA members, including a provider who delivers services at locations other than his or her physical office location such as school based or mobile dental services, shall demonstrate to the satisfaction of MCNA that he or she has the requisite skill and facilities to deliver comprehensive care to MCNA members. Comprehensive care means that the provider or group must provide all of the covered restorative and therapeutic services described in this Provider Manual. Programs that are sealant only or preventive only will not be permitted. Services in a mobile setting or school based setting must be within 20 miles of the provider's principal place of practice for urban areas, and 40 miles of the provider's principal place of practice for rural areas.

Adult Denture Program providers conducting business at locations other than their principal place of practice shall provide the physical address where services are rendered to MCNA's Credentialing Department. This address must be on file with both MCNA and the Louisiana State Board of Dentistry. Records documenting the services provided shall be maintained at this location. To be eligible for reimbursement under the Adult Denture Program, the service must be performed within 75 miles of the provider's principal place of practice.

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

6.6.2. Missed Appointments

Providers cannot charge members for missed or failed appointments. For assistance with members who routinely break appointments, please use the Member Outreach Form located in the Forms section of this manual. In addition to the Member Outreach Form, providers have the option to report the code D9986 (missed appointment) via claim submission. MCNA will use the reported D9986 data to provide outreach and education to members on the importance of keeping appointments and/or canceling with notice when appropriate.

6.6.3. After Hours Standards

When a provider's office is closed the office should have an answering service or answering machine that offers the following information:

- Instructions for contacting someone who can render clinical decisions or someone who can reach a dentist for clinical decisions
- Instructions for emergency services (including directing the member to dial 9-1-1 if necessary)
- List of the office hours
- Instructions for the caller to leave a message so that someone can return their call

The answering service or machine must also offer all of the information listed above in any additional languages based on cultural population.

6.6.4. Appointments and Access to Care
(Routine, Therapeutic/Diagnostic, and Urgent Care Dental Services)

The Provider Agreement outlines appointment availability standards. These standards are monitored through the Quality Improvement Program:

- Urgent care – defined as the need for immediate medical service for the treatment of acute or chronic illness or injury. Urgent care, including urgent specialty care, must be provided within 24 hours of request a request for services that do not require prior authorization and within 48 hours for a request for services that do require prior authorization.
- Primary Dental Care – within 30 days.
- Follow-up Dental Services – within 30 days after assessment.

6.7. Suspected Child or Adult Abuse or Neglect

Cases of suspected child or adult abuse or neglect might be uncovered during examinations.

Child abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is also an act of omission.

If suspected cases are discovered, a verbal report should immediately be made by telephone or another means to law enforcement and/or a representative of the local Department for Social Services office. Reports of suspected cases of abuse or neglect can also be made by calling the MCNA Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262).

Adult abuse is defined as “the infliction of physical pain, mental injury, or injury of an adult.” An adult is defined as “(a) a person 18 years of age who because of mental or physical dysfunction is unable to manage his [her] own resources or carry out the activity of daily living or protect himself [herself] from neglect or a hazardous or abusive situation without assistance from others and who may be in need of protective services; or (b) a person without regard to age who is the victim of abuse and neglect inflicted by a spouse.”

6.8. Dental Records Standards

State law and Medicaid regulations require that all services provided under the EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program are documented. **Services not adequately documented are considered not to have been delivered.** Providers are required to maintain radiographs and treatment records that should reflect all procedures performed during all appointments. MCNA dentists must ensure that dental records are maintained for each member enrolled. The record shall include the quality, quantity, appropriateness, and timeliness of services performed as described by the remainder of this section of the manual.

All documentation, radiographs, and/or records must be maintained for at least ten (10) years after the last good, service, or supply has been provided to a member or an authorized agent of the state or federal government, or any of its authorized agents, unless those records are subject to review, audit, investigations, or subject to an

administrative or judicial action brought by or on behalf of the state or federal government. Failure to produce these records upon demand for the Medicaid program or MCNA will result in sanctions against the provider.

Records must include a detailed charting of the oral condition that is updated on each visit and a chronological (dated) narrative account of each appointment indicating what services were provided or what conditions were present during those visits. Providers should also include in the member's treatment record copies of all pre-authorization requests (including any attachments), all pre-authorization letters, all radiographs, and any additional supporting documentation. Operative reports, laboratory prescriptions, medical consultations, TMJ summaries, and sedation logs are examples of additional supporting documentation.

A checklist of codes and services billed is insufficient documentation. The claim forms or copies of the claim forms submitted for reimbursement are not considered sufficient to document the delivery of services; however, these items must also be maintained in the member's treatment record.

The following dental record standards must be followed for each member's record as appropriate:

Providers shall ensure dental records are:

- Safeguarded against loss, destruction, or unauthorized use and are maintained, in an organized fashion, for all members evaluated or treated, and are accessible for review and audit.
- Readily available for review and provide dental and other clinical data required for Quality and Utilization Management review.

MCNA shall ensure each member's dental record includes, minimally, the following:

- All pages contain member name and/or member ID.
- Biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
- Documentation of the member's race and language spoken.
- Documentation of vital signs (blood pressure and pulse) if member is 13 years of age or older.
- All necessary forms completed, signed, and present in the record. This includes procedure/treatment consent, incident reports, pre-authorization, member outreach, non-covered services, and criteria for dental therapy under General Anesthesia forms.
- Current medical and dental history (including illness, medical conditions, psychological health, and substance abuse documentation) beginning with, at a minimum, the first member visit to the dental office.
- Documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
- Identification and history of nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
- Documentation of medication list and/or prescribed therapies including medication strength, directions, dose, and the amount and number of refills given.
- Progress notes, lab results, and imaging studies.
- Documentation of written denials for service and the reason for those denials.
- Documentation of imaging reports, initialed by the provider to indicate they have been reviewed.
- Documentation of allergies (e.g., medications or latex) and all known adverse reactions. If no allergies are known, "NKA" or "NKDA" is clearly indicated.
- Documentation of advance directives, as appropriate.

- Indication of the chief complaint or purpose of each visit, objective findings, diagnosis, and proposed treatment.
- **The record is legible, accurate, and maintained in detail. (Staff can read the record)**
- All entries dated and signed by the provider who rendered services, including credentials (DDS, DMD, RDH).
- Documentation of all dental examinations.
- Documentation of emergency and/or after-hours encounters, as well as follow-up for emergency services.
- Documentation of working diagnosis consistent with clinical findings and treatment plan.
- Documentation of schedule for return visit(s) following the AAPD Periodicity Schedule.
- Documentation that unresolved problems from previous visits achieve resolution. This includes diagnostic tests, referral forms, and the outcomes of referrals.
- Evidence of appropriateness and timeliness of care.
- Documentation of outcomes of studies and evidence that they were appropriately ordered.
- Documentation of any known member comments/dissatisfaction.
- Documentation of service site.
- Documentation of each visit, which must include:
    - Date and beginning/ending times of service
    - Chief complaint or purpose of the visit
    - Diagnoses or dental impression
    - Objective findings
    - Member assessment findings
    - Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG)
    - Medications prescribed
    - Health education provided
    - Name and credentials of the provider rendering services (e.g., DDS) and the signature or initials of that provider (initials of providers must be identified with correlating signatures)

6.9. Access to Dental Records

As an MCNA participating provider, you are required to ensure that an accurate and complete member dental record is established and maintained. On-site access to these dental records must be made available to MCNA's authorized personnel, its designated representatives, review organizations, and government agencies during regular business hours. If requested, you must provide MCNA with member dental records according to timelines, definitions, formats, and instructions specified by MCNA.

A request from MCNA may be for any information required under the Provider Agreement including, but not limited to, dental records, reports, and other information related to the performance of your obligations under the agreement. You are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Participating Provider Agreement and any records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- MCNA authorized personnel
- State of Louisiana and/or federal regulatory agencies
- LDH authorized personnel

You must also provide access to the location or facility where such records, books, documents, and papers are maintained, along with the furnishings, equipment, and other conveniences necessary to fulfill any of the following described purposes within reasonable comfort:

- Audits and investigations
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose MCNA deems necessary for contract enforcement or to perform our regulatory functions.

6.10. Transfer of Dental Records

MCNA recommends your office request that all new members authorize the release of their dental records to you from the practitioner(s) who treated them prior to visiting your office.

There will be no charge for the copying of charts and/or radiographs subject to Louisiana State requirements and MCNA policies. All copies must be provided to the MCNA member within five (5) days of their request per MCNA's Dental Provider Agreement.

6.11. The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)

As a healthcare provider, your office is a covered entity as defined under HIPAA. Your office is required to comply with all aspects of the HIPAA regulations and rules that are in effect or that will go into effect as indicated in the final publications of HIPAA rules.

MCNA is a covered entity and has taken the required steps to become compliant with all aspects of the HIPAA rules and regulations. The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form of media, whether electronic, paper, or verbal. The Privacy Rule calls this information protected health information (PHI), and the requirements apply to both electronic medical records and paper medical records.

Individually identifiable health information is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of health care to the individual

This is any information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information (IIHI) includes many common identifiers (e.g., name, address, birth date, Social Security Number).

A central component of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use,

disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances:

- disclosure to or a request by a healthcare provider for treatment
- disclosure to an individual who is the subject of the information, or the individual's personal representative
- use or disclosure made pursuant to an authorization
- disclosure to HHS for complaint investigation, compliance review, or enforcement
- use or disclosure that is required by law
- use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules

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

6.12. Marketing Rules

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

6.13. Provider Information Updates

It is important to keep MCNA informed of all information updates for your office. Providers are required to submit in writing the following information and provider changes to both MCNA and LDH:

- Immediate notification of changes in license status, board actions, practice address or name, DBA name, and tax ID
- Notification 30 days prior to the removal of a treating dentist from practice
- Notification 3 to 4 weeks prior to addition of a new treating dentist
- Notification 90 days prior to termination of participating provider from MCNA network to allow for continuity of care coordination

Please send updated provider information to MCNA at this address:

MCNA Dental
Attn: Credentialing
P.O. Box 740370
Atlanta, GA 30374-0370

Phone: 1-855-702-6262

Email: LA_PR_Dept@mcna.net

6.14. Termination of Dental Contract

MCNA may terminate a provider from the network for any misrepresentation(s) made on his/her credentialing application. Causes for termination with a 90-day notice include, but are not limited to:

- Failure to meet participating criteria
- Failure to provide requested dental records

Causes for immediate termination include, but are not limited to:

- Expulsion from, discipline by, or being barred from participation in any state Medicaid Program
- Loss or suspension of the provider's professional liability coverage
- Failure to satisfy any or all of the credentialing requirements of MCNA
- Failure to cooperate with or abide by MCNA's Quality Improvement Program
- Commission of one or more acts of fraud in connection with the provision of Dental Services
- Conduct injurious to MCNA's business reputation

Providers who wish to terminate participation with MCNA must provide a 90-day notice of termination in writing that includes the final termination date.

When a provider's pending termination is identified, DentalTrac™ will auto-assign all members currently assigned to that provider to a new Primary Care Dentist (general dentist or pediatric specialist) based on the following considerations:

- Member will be assigned to a participating dental provider within the same group practice and at the same facility location, if possible

6.15. Federally Qualified Health Center (FQHC) Billing Requirements

All dental services performed by FQHC providers must be billed on the ADA claim form using the encounter code D0999. In addition to the encounter code, providers must list the specific dental services provided by entering the procedure code for each service rendered on subsequent lines. The provider should also include zero or usual/customary charges for each service provided.

6.15.1. Hygienist Services

The Louisiana Board of Dentistry rules in Title 46 of the Louisiana Administrative Code govern the authorized duties of dental hygienists.

Hygienists can provide limited, preventive services under the supervision of an FQHC dentist that may be participating via telemedicine. The FQHC dentist must be licensed by the Louisiana Board of Dentistry.

These preventive services include: prophylaxis, x-rays, sealants, and fluoride varnish. The dentist must remotely supervise and monitor the work of the hygienist and review the exam results and x-rays via a teledentistry connection to determine if further care is necessary before the patient is dismissed from the clinic on the day of treatment.

Expanded duty dental assistants (EDDA) are not authorized to provide these services. An EDDA may assist a hygienist, but all services must be rendered by a dental hygienist under the supervision of a dentist.

A referral to a licensed dentist selected by the beneficiary shall be made for any additional services that were indicated during the teledentistry visit. All appropriate clinical records shall be provided to the dentist to whom the beneficiary is referred.

The dentist to whom the beneficiary is referred may be either a FQHC dentist or non-FQHC dentist. If a FQHC dentist is selected, a separate reimbursement will not be issued to the FQHC for any services that would have been provided if the dentist had been rendering services in person. For services that could not have been provided under normal circumstances during the initial visit, a separate reimbursement may be requested. If referred to a non-FQHC dentist for further treatment, that dentist will be unable to bill for the preventive services already provided by the FQHC hygienist.

Appropriate documentation of the encounter should be maintained by the provider.

6.15.2. Place of service limitations

The provisions of these services are limited to the locations below:

- A public elementary or middle school in which 50 percent or more of the students are economically disadvantaged and is in a parish with a Health Professional Shortage Area (HPSA) score above 15; or
- A fixed clinic of an FQHC that does not have a dentist and is in a parish with a HPSA score above 15.

Note: HPSA scores are determined by the Health Resources and Services Administration (HRSA) and are available here.

6.15.3. Reimbursement Guidelines

- Claims for these services must include the encounter code D0999 on the first claim line. The detail lines will include the procedure codes for the preventive services rendered by the hygienist and screening/assessment by dentist.
- The billing provider is the FQHC. The FQHC provider number and NPI must be included on the claim.
- The rendering provider is the supervising dentist. The dentist's provider number and NPI must be included on the claim.
- The telemedicine modifier 95 and place of service 02 are required on the claim.
- Place of service 10 used to identify services provided in a beneficiary's home cannot be used for these services.
- Reimbursement will be at the all-inclusive rate on file for the date of services.

7. Verification of Eligibility

Member eligibility varies daily. Therefore, each participating provider is responsible for verifying member eligibility with MCNA **before** providing services.

Eligibility can be verified 24 hours a day, 7 days a week via the following methods (See Section 2: Contact Information):

- Electronically through MCNA's Online Provider Portal
- By calling LDH's Recipient Eligibility Verification System (REVS) at 1-800-776-6323 or 1-225-216-7387
- Electronically through Medicaid Eligibility Verification System (MEVS), an automated eligibility verification system using a swipe card device or PC software through vendors.
- Electronically through e-MEVS, a web application accessed through www.lamedicaid.com

Eligibility can be verified during business hours (7:00 am CST – 7:00 pm CST):

- By calling the MCNA Provider Hotline at 1-855-702-MCNA (1-855-702-6262)
- By calling the MCNA Member Services Department at 1-855-702-MCNA (1-855-702-6262)

You should verify member eligibility **before** providing any services. MCNA strongly recommends using our Provider Portal or the Medicaid Eligibility Systems to easily and quickly verify all member eligibility. Access your Provider Portal account at http://portal.mcna.net.

Please note that due to possible retroactive eligibility status changes, the information provided does not guarantee payment.

8. Referrals

Primary Care Dentists must assess the dental needs of EPSDT Dental members for referrals to specialty providers and provide referrals as needed; however, the member or guardian, as appropriate, must be advised of the referral. Primary Care Dentists must coordinate a member's care with specialty providers after referral.

Referrals are valid for a period of one year.

8.1. Referral to Specialists

Members do not have direct access to in-network specialists. A referral is necessary for EPSDT Dental, Adult Waiver Program and Adult ICF/IID Program members to access in-network specialists. Referrals will be processed by MCNA within two (2) business days of receipt. Urgent request for services that do not require prior authorization are processed within twenty-four (24) hours and within forty-eight (48) hours for a request for services that require prior authorization.

Emergency services do not require a referral. Please indicate any emergency services provided via a detailed narrative and/or documentation of medical necessity with your claim submission. All submissions will be evaluated for medical necessity and compliance with plan rules.

Referrals should be requested through the MCNA Online Portal at http://portal.mcna.net. All referral determinations can be viewed on the MCNA Online Portal.

For Oral Surgery Referrals from General Dentists or Pediatric Dentists, the following information is required:

- Narrative or Office Remarks – Tooth IDs and all symptoms should be provided. Describe any symptoms such as acute pain or infection in narrative form. (The use of "cut and paste" narratives is unacceptable. They must be patient specific.)
- X-rays – Either a pano, periapical or bitewings illustrating the issue.

8.2. Second Opinion – MCNA Generated Referral

The provider should discuss all aspects of a member's treatment plan with the member and parent/guardian prior to beginning treatment. If the member or parent/guardian indicates they would like a second opinion, let them know that MCNA will have to authorize the second opinion visit to a provider in the MCNA network.

If no appropriate provider is available within the network to provide the second opinion, MCNA will cover the cost of seeing a non-network dentist. The provider must provide copies of the chart, radiographs, and any other information to the non-network dentist performing the second opinion upon request.

8.3. Out-of-Network Referrals

8.3.1. General Dental Care

If there are no contracted MCNA network general dentists or pediatric dentists available to treat MCNA members within a geographic area, MCNA will process an out-of-network referral. We will initiate the process with select

dentists in the area and advise them of the guidelines for payment. All out-of-network treatment must be pre-authorized unless for emergency treatment services.

8.3.2. Specialty Care

If a required service is not available within the MCNA provider network, the EPSDT member's Primary Care Dentist may request an out-of-network referral. However, the Primary Care Dentist must obtain a pre-authorization from the MCNA Utilization Management department. They will provide the necessary guidance on a case-by-case basis to ensure that all necessary pre-authorizations and agreements are provided and successfully complete the process.

Reimbursements made for the examination, prophylaxis, bitewing radiographs, and/or fluoride to providers who routinely refer members for restorative, surgical, and other treatment services are subject to recoupment.

Please contact MCNA's Utilization Management department if you have questions (See Section 2: Contact Information).

9. Pre-Authorization of Care

We recommend using our Provider Portal (http://portal.mcna.net) to easily and quickly submit your pre-authorization requests. Pre-authorization requests will be processed by MCNA within fourteen (14) business days of receipt. Urgent/expedited pre-authorization requests will be processed within 72 hours of receipt by MCNA.

MCNA's utilization management criteria incorporate components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed. Pre-authorization requests are reviewed against MCNA-approved criteria.

Failure to submit a request for pre-authorization and supporting documentation will result in non-payment to the provider for services that require pre-authorization. Per the Dental Provider Agreement the provider must hold MCNA, the member, and the state harmless if coverage is denied for failure to obtain pre-authorization, whether before or after service is rendered.

In addition to submitting pre-authorization requests electronically through the MCNA Provider Portal, providers may submit them through *Change Healthcare* (MCNA Payor ID: 65030) or by mail using the completed 2012 or newer ADA Claim Form to this address:

MCNA Dental
P.O. Box 23920
Oakland Park, FL 33307

Approved pre-authorization requests are valid for one year from the date of approval. If orthodontic treatment does not begin within the valid one-year period of the approved pre-authorization the case must be resubmitted.

Once a determination is made, the authorization will be available to view on the Provider Portal. Providers are notified of pre-authorization decisions via the provider portal or mail within two (2) business days of the determination for standard requests and within 72 hours for emergency requests (emergency services do not require pre-authorization.) If all services are approved, there will be no notification by mail~~. If required, the UM department will mail the prior authorization letter to the dentist within two (2) business days of the determination for standard requests and within 72 hours for emergency requests (emergency services do not require pre-authorization.).~~ Members also receive a copy of this notice.

All approvals will be assigned an authorization number for the service. This number must be submitted with the claim after services are rendered. After the provider receives approval of a pre-authorization request, they are required to contact the member to let them know of the approval and schedule the authorized services.

Please note, MCNA does not accept faxed pre-authorization requests at this time.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

9.1. Emergency Treatment Authorization

MCNA ensures that members have access to emergency care without pre-authorization, and to services and treatment as provided through the State agreement and defined in other state and federal regulations. MCNA

ensures that members have the right to access emergency dental care services, consistent with the need for such services.

Should you need to refer a member on an emergency basis please contact MCNA's Provider Hotline at 1-855-701-6262 for assistance with coordination of the member's care.

Authorization prior to emergency treatment may not be possible. In such instances, the provider is required to submit the same documentation with the claim post-treatment as is needed in the submission of a request for pre-authorization. Claims submitted without this documentation will be denied. All submissions will be evaluated for medical necessity and compliance with plan rules.

To submit the required documentation with a claim using MCNA's Provider Portal, please indicate in the "office remarks" section that the service was provided on an emergency basis and pre-authorization does not apply. If submitting the claim on a paper ADA claim form, please indicate this information in Box 35.

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 that are required to prevent pulpal death and the imminent loss of teeth (e.g., excavation of decay and placement of appropriate temporary fillings)
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth

10. Covered Services

10.1. EPSDT Dental Covered Services Overview

- Preventive
- Diagnostic
- Restorative Services (Fillings and Crowns) – age limitation applies
- Oral and Maxillofacial Surgery
- Endodontic Services (Root Canals)
- Periodontal Services (Treatment of Gums)
- Removable Prosthodontics (Dentures) – age limitation applies
- Prosthodontics Fixed Services – age limitation applies
- Orthodontic Services (Braces) – based on necessity
- Adjunctive General Services

10.2. Adult Denture Covered Services Overview

- Office Visits – limited to denture services
- Oral Exams – limited to denture services
- X-rays – limitation of services
- Removable Prosthodontics (Dentures) – limitation of services

10.3. Adult Waiver Program Covered Services Overview

- Preventive
- Diagnostic
- Restorative (Fillings and Crowns)
- Endodontic Services (Root Canals)
- Periodontal (Treatment of Gums)
- Removable Prosthodontics (Dentures)
- Maxillofacial Prosthetics
- Prosthodontic Fixed Services
- Oral and Maxillofacial Surgery
- Orthodontic Services (Braces)
- Adjunctive General Services

10.4. Adult ICF/IID Program Covered Services Overview

- Preventive
- Diagnostic
- Restorative (Fillings and Crowns)
- Endodontic Services (Root Canals)
- Periodontal (Treatment of Gums)
- Removable Prosthodontics (Dentures)
- Maxillofacial Prosthetics

- Prosthodontic Fixed Services
- Oral and Maxillofacial Surgery
- Orthodontic Services (Braces)
- Adjunctive General Services

10.5. Continuity of Care

10.5.1. When a Member Moves Out of Service Area

Members who move out of the service area are responsible for obtaining a copy of their dental records from their current dentist to provide to their new dentist. Participating Primary Care Dentists must furnish members with copies of their records, including x-rays, free of charge.

10.5.2. When a Member has Pre-Existing Conditions

MCNA Dental does not have a pre-existing condition limitation. Regardless of any pre-existing conditions or diagnosis, members are eligible for all covered services on the effective date of their enrollment in the EPSDT Dental Program or the Adult Denture Program unless there is a periodicity limit that applies.

10.5.3. When a Member is in Active Treatment

Medicaid members will be pre-authorized to continue treatment by an out-of-network provider during the course of "active treatment" at the time of enrollment until one of the following conditions occurs, whichever comes first:

- The member's records, clinical information, and care can be transferred to an in-network provider
- The member is disenrolled
- The course of "active treatment" is completed
- A period of 30 days passes

10.6. Non-Capitated Services

The following services will continue to be provided by the member's health plan or the Medicaid fee-for-service program:

- Outpatient facility fees for dental services
- Fluoride Varnish performed by a Primary Care Physician
- Current Procedural Terminology (CPT) codes billed by Oral Surgeons
- Transportation

10.7. Emergency Dental Services

MCNA is responsible for coverage or payment of emergency dental services provided to EPSDT, Adult Waiver Program, and Adult ICF/IID Program members in a hospital or ambulatory surgical center setting by dentists, billed on an ADA Claim Form. These services are part of the medical benefit provided by MCNA.

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

11. Claims Administration

11.1. Claim Submission

MCNA requires all dental providers to identify a place of treatment (service) on the 2012 or newer American Dental Association (ADA) Claim Form.

11.2. Picking and Choosing Services

Providers must bill MCNA for all covered services performed on eligible members whom the provider has accepted as a Medicaid patient. This policy prohibits MCNA providers from "picking and choosing" the services for which they agree to accept reimbursement from MCNA. Providers must accept MCNA reimbursement as payment in full for all services covered by MCNA.

11.3. Submitting Claims to MCNA

Providers may submit a claim to MCNA using any of the following three (3) methods:

- Electronically through MCNA's Provider Portal
- Electronically through a clearinghouse (MCNA Payor ID: 65030)
- Using a paper claim form sent via United States Postal Service (Use 2012 or newer Claim Form). ADA claim forms can be obtained from various vendors.

Please note, MCNA does not accept faxed claims at this time.

11.4. Claims Payment

Claims are paid by MCNA. Please see the Covered Services, Fee Schedules, and Guidelines section of this manual for a list of fees. For any claims questions please contact our Provider Hotline. (See Section 2: Contact Information).

Claims will be denied if the member is not eligible on the date of service.

Providers have 365 days of the date of service (DOS) to submit a claim. If your claim is not received within 365 days from the date of service, it will be denied for late submission. The following are exceptions to the standard 365-day timely filing submission requirement:

- If a provider files a claim erroneously with LDH's Fiscal Intermediary (Gainwell Technologies) within the 365-day submission requirement and produces documentation of that, MCNA must honor the initial filing date as notification of the claim and process it without denying for timely submission. The provider must submit the claim in question to MCNA within 365 days from the date of notification by the wrong plan. If the 365-day timeframe cannot be met, the provider may file an appeal within 30 days of the date of notification by LDH's Fiscal Intermediary. The appeal submission must include the claim, all supporting documentation, and the dated documentation from LDH's Fiscal Intermediary showing the reason for the inability to meet the 365-day timeframe.
- If a claim was unable to be submitted within 365 days of the date of service due to an issue with the provider's clearinghouse, the provider must submit the claim and the supporting documentation from the clearinghouse within 365 days of the date of notification by the clearinghouse. If the 365-day timeframe

cannot be met, the provider may submit an appeal within 30 days of the date of notification from the clearinghouse. The appeal submission must include the claim, all supporting documentation, and the dated documentation from the clearinghouse showing the reason for the inability to meet the 365-day timeframe.

- If a delay in submitting a claim for payment was caused by circumstances beyond the control of the provider, MCNA may receive and process claims upon review of substantiating documentation that justifies the late submittal of a claim.
- Claims for members who have both Medicare and Medicaid coverage fall under Medicare timely filing requirements. These claims must be submitted to MCNA within 365 days from the date on the Medicare Explanation of Medicare Benefits (EOMB).
- Claims for retroactive Medicaid members must be filed within 365 days from the date of eligibility determination.
- Provider requested adjustments and voids of claims must be filed within 365 days from the date of payment.

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

Prompt Pay: MCNA is required to adjudicate a clean claim within 15 business days of receipt.

The State of Louisiana defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

All claims should be submitted to MCNA on a 2012 or newer ADA claim form. The claim form must include all of the following information to be considered a clean claim:

- Member name
- Member identification number
- Member and/or guardian signature (or signature on file)
- Member date of birth
- Description of services rendered
- Provider NPI number (included with all claim submissions regardless of format)
- Provider name, state license number, and signature (included with electronic or online submissions)
- Provider address, phone number, and facility ID number (included with electronic or online submissions)
- Proper CDT coding with tooth numbers, surfaces, quadrants, and arch, when applicable
- Full mouth x-ray series, bitewings, and/or periapical x-rays, documentation of medical necessity, photos, sedation time records, or other documentation, when required

Remittance Advice (RA) documents will be available in the MCNA Provider Portal for all offices that receive Electronic Funds Transfer (EFT) payments. These offices may request a paper RA be sent to their location at the time of payment. For offices receiving payment in the form of a paper check, the RA will be included in the envelope with the check. Please contact MCNA's Credentialing department (See Section 2: Contact Information) with questions.

11.4.1. Example of a Clean Claim

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
MCNA Dental
PO Box 23920
Oakland Park, Florida 33307

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F [ ] U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Jonathan A. Doe, Jr.
5500 North Birmingham Road
Baton Rouge, Louisiana 70806

13. Date of Birth (MM/DD/CCYY): 1/15/2005 | 14. Gender [X] M [ ] F [ ] U | 15. Policyholder/Subscriber ID (Assigned by Plan): 111-22-3333

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [X] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [ ] F [ ] U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	01/01/2018		JP			D0150		1	Comprehensive Oral Evaluation	$30.00
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____

31a. Other Fee(s)
32. Total Fee: $30.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X Signature on File — Patient/Guardian Signature — Date: 05/01/2019

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X Signature on File — Subscriber Signature — Date: 05/01/2019

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
National Pediatric Dental Care Associates
888 SE 10th Avenue, Suite #100
Baton Rouge, Louisiana 70815

49. NPI: 00123456789 | 50. License Number: 12345 | 51. SSN or TIN: 1234567
52. Phone Number: (225) 555 -1234 | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N): N

40. Is Treatment for Orthodontics? [X] No (Skip 41-42) [ ] Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis [X] No [ ] Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Jessica Rivera, DDS — Signed (Treating Dentist) — Date: 05/01/2019

54. NPI: 00987654321 | 55. License Number: 54321
56. Address, City, State, Zip Code: 888 SE 10th Avenue, Suite #100, Baton Rouge, Louisiana 70815 | 56a. Provider Specialty Code: 122300000X
57. Phone Number: (225) 555 -1234 | 58. Additional Provider ID

11.5. Electronic Submission of Claims via MCNA's Provider Portal

MCNA's Provider Portal (http://portal.mcna.net) allows participating providers to easily submit claims to us and track their status. Submitting claims electronically using the Provider Portal is always free.

You have the ability to attach scanned x-rays, periodontal charting, and other documents to your claims. MCNA contracts with NEA FastAttach to allow for the electronic submission of x-rays. For those offices unable to work with digital copies of x-rays, a completed 2012 or newer ADA claim form along with the x-ray(s) must be sent to MCNA at the address listed in the Paper Claim Submission via Mail section.

11.6. Electronic Submission via Clearinghouse and Billing Intermediaries

Providers may submit electronic claims through clearinghouses, which transmit claims to *Change Healthcare*. MCNA's Payor ID code is **65030**. MCNA contracts with NEA FastAttach for the electronic submission of digital attachments.

Providers who use a billing intermediary for claims preparation and submission must notify MCNA of their billing arrangements in writing. If a billing intermediary changes or ceases to exist, you must also notify MCNA in writing. A billing intermediary is not considered to be a provider's salaried employee. A billing intermediary is an individual, partnership, or corporation contracted with the provider to bill on their behalf.

11.7. Paper Claim Submission via Mail

Paper claims must be submitted on the 2012 or newer ADA claim form. Providers can download this form from our Provider Portal (http://portal.mcna.net) and print it. Paper claims may be submitted by mail to:

MCNA Dental
PO Box 23920
Oakland Park, FL 33307

It is important to affix sufficient postage when mailing in bulk as MCNA does not accept postage due mail. Insufficient postage will result in the mail being returned to sender and a delay in processing your claim.

MCNA will not mail back x-rays, periodontal charting, or related documents submitted to us by mail. Please use a duplicate set of these documents for your submission.

11.8. Direct Deposit and Electronic Funds Transfer (EFT)

MCNA offers direct deposit to your bank account. To participate in direct deposit, you must complete, sign, and return the Direct Deposit EFT Form, which you can download from our website (www.mcnala.net). Please fax or mail the completed form to MCNA's Credentialing (See Section 2: Contact Information) or email the form directly to MCNAcredentialing@mcna.net.

11.9. MCNA Processing of Deficient Claims

Providers have a total of 365 days from the date of service to submit a claim. If a claim is not received by MCNA within this 365-day timeframe, it will be denied.

MCNA may also deny your claim as deficient if it does not include all supporting documentation, such as x-rays or narrative, when required. When this occurs, the Remittance Advice will state the reason for the denial. For example, a procedure that has been denied is listed with reason code 48, which states "please submit x-ray(s) and narrative with this request."

MCNA sends a notification within five (5) days of claim adjudication to inform providers that a determination for the claim has been made. Active Provider Portal users will be notified via a portal alert. To view why a claim is considered non-clean, providers can log in to the Provider Portal and click on "Non-Clean Claim Notices." Providers who do not use their Provider Portal accounts will receive a letter in the mail with the same information.

Additional information may be required for a non-clean claim to be processed. The provider must send in the required information within 365 days from the date of service with a corrected ADA Claim form. Provider must indicate in the remarks section of the claim form (Item 35) the required or corrected information being submitted. Remarks should be concise and pertinent to the claim submission for review. MCNA considers the official submission date of a corrected claim to be the date that a provider electronically transfers any required additional information and documentation. If a provider mails the information, the official submission date is the date MCNA receives it.

11.10. Reconsiderations

Reconsideration requests must be filed within 365 days from the date of service. Requests for MCNA's reconsideration of a claim may be filed when a claim has been denied for anything other than medical necessity or benefit coverage including, but not limited to, the following examples:

- Timely filing
- Duplicate
- Member and Provider eligibility
- Incorrect fee applied

Any supporting documentation should be included with the reconsideration request. Providers may submit their request in writing by using the Provider Reconsideration and Appeal Request form (See Section 27: Forms) or online using MCNA's Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on support and downloads to access the Online Reconsideration/Appeal link. Please complete the electronic form titled, "*Provider Reconsideration and Appeal Request"* including all information needed to evaluate your request.

11.11. Appeals

Appeal requests must be filed within 90 days of the initial claim determination. Appeals may be filed when a claim has been denied for determinations related to medical necessity and benefit coverage. Any requested or supporting information such as x-rays or documentation of medical necessity should be included with the appeal submission.

Providers may submit an appeal online through MCNA's Provider Portal (http://portal.mcna.net). Once you have logged into the Provider Portal, please click on 'support and downloads' to access the Online Reconsideration/Appeal link. Please include all information needed to evaluate your request. If your original ADA claim form was completed incorrectly, you must submit a corrected ADA claim form with your appeal request.

Providers may also mail an appeal to MCNA's Grievances and Appeals department (See Section 27: Forms).

11.12. Coordination of Benefits

It is the provider's responsibility to determine if members have other dental insurance. When other insurance exists and MCNA is the secondary insurer, a copy of the primary insurance Explanation of Benefits (EOB) must be submitted with all claims for services rendered to the member. These claims may be filed electronically if an electronic copy of the EOB is attached. MCNA will deem a claim paid in full when the primary insurance payment meets or exceeds MCNA's reimbursement rates.

11.13. Third Party Liability

Medicaid is the payor of last resort. Providers must bill third-party insurance carriers prior to requesting reimbursement from Medicaid. A third party insurance carrier is an individual or company who is responsible for the payment of medical or dental services. Examples of third parties are Medicare, private health insurance, automobile, and other liability carriers. When billing MCNA after payment consideration from a third party (except Medicare), an Explanation of Benefits (EOB) from the primary insurance carrier must be attached. The six-digit state assigned carrier code for the primary insurance and the amount paid by the primary insurance carrier (including zero [$0] payment) must be entered in the appropriate places on the claim form. If the third party coverage is found to be erroneous, providers may submit a corrected claim to MCNA. In situations where third party benefits exist, the timeframe for filing a claim with MCNA begins on the date that the third party carrier resolves the claim. MCNA must finalize all claims, including appealed claims, within 24 months of the date of service.

11.14. Non-Covered Services

MCNA will not pay a provider for non-covered services. According to the MCNA's Provider Agreement, the provider will hold harmless members, the plan, MCNA, and the State for payment of non-covered dental services.

No additional charges may be assessed to covered MCNA members. The MCNA Provider Agreement states that the only circumstance in which a provider may bill for non-covered services is when a member has signed a form or letter of understanding agreeing to the fees.

The following services are considered non-covered services:

- Services that are not medically necessary to the member's dental health
- Dental care for cosmetic reasons
- Experimental procedures
- Plaque control
- Certain types of x-rays
- Routine post-operative services - these services are covered as part of the fee for initial treatment provided
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan
- Dental expenses related to any dental services:
    - Started after the member's coverage ended

- Received before the member became eligible for these services
- Prescriptions or drugs
- Administration of in-office pre-medication

11.14.1. ~~Non-Covered Services Private Payment Agreement~~Patient Responsibility Form

MCNA only reimburses for services that are medically necessary or benefits of special preventive and screening programs, such as EPSDT Dental. The provider may bill a member only if a specific service or item is provided at the member's request.

The provider must obtain and keep a written ~~Non-Covered Services~~Patient Responsibility Form that is signed by the member and/or responsible party prior to the services being rendered. It must be filled out completely with the following information:

- A statement that the member is financially responsible for the described services
- A complete description of the dental services to be rendered.
- A statement that ~~the Plan,~~ MCNA ~~,~~ and the State will not be responsible for payment of the described dental services.

11.15. Balance Billing

MCNA network providers may not bill or otherwise attempt to recover from members the difference between the agreed upon contract allowable rate for a service and the provider's billed charge(s). This practice is called balance billing and is not permitted under your MCNA Provider Agreement.

11.16. Fraud Reporting

Providers are expected to bill only for medically necessary covered services delivered to members in accordance with MCNA's policies and procedures. MCNA and the appropriate governmental agencies actively investigate all suspected cases of fraud and abuse. In our commitment to prevent fraud and abuse in the Medicaid Program, MCNA has implemented an integrity component as a part of our Compliance Program. We monitor and maintain integrity through the following activities:

- Prevention of duplicate payments
- Post-payment utilization review to detect fraud and abuse
- Internal controls to ensure payments are not issued to providers that are excluded or sanctioned under Medicare/Medicaid
- Review of alleged illegal, unethical, or unprofessional behavior
- Profiling of providers to identify over or underutilization of services
- Completion of investigations and audits

All program integrity activities are coordinated with MCNA's Compliance department and our Special Investigation Unit (SIU) as needed.

11.16.1. Program Integrity

Providers are not allowed to provide services to an EPSDT Dental member beyond the intent of Medicaid guidelines, limitations, and/or policies for purposes of maximizing payments. If this practice is detected, the

provider may be subject to sanctions. Providers enrolled as a group or individual providers who are not linked to a group but are located in the same office as another provider are responsible for checking office records to assure that Medicaid established guidelines, limitations, and/or policies are not exceeded. Providers not participating in the MCNA network may not use the name and/or provider number of a participating provider in order to bill Medicaid for services rendered.

MCNA is committed to controlling fraud, waste, and abuse in the Louisiana EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program. Our efforts include vigilant monitoring, investigation, enforcement, training, and communication. MCNA monitors the appropriateness and quality of services provided to our members and verifies services billed by dental providers through pre- and post-payment reviews. These reviews help us to prevent or recover overpayments paid to providers. An overpayment includes any amount not authorized to be paid by state and federal programs, whether paid as a result of inaccurate or improper claims submissions, unacceptable practices, fraud, abuse, or a mistake.

In accordance with 42 CFR §438.608(d)(2), any network provider who determines that they have received an overpayment from MCNA must notify us in writing of the reason for the overpayment and return the funds within 60 calendar days of the date on which the overpayment was identified.

The provider's office may return the overpayment by check, or may choose to have the amount deducted from a future Remittance Advice (RA). Overpayment notifications and refund checks should be mailed to the following address:

MCNA Dental
Claims Department - Attn: Recoupment and Overpayments
P.O. Box 740370
Atlanta, GA 30374-0370

If MCNA does not receive the full refund of the overpayment amount within the required time frame, the remaining amount will be satisfied by offset of future reimbursements.

When MCNA identifies an over overpayment, we begin payment recovery efforts. Providers will be given the opportunity to submit a refund or payment plan within the 60-calendar-day time period. If you fail to submit a refund within the specified time period, the overpayment amount will be automatically deducted from future EOBs. Additionally, MCNA will pursue all remedies up to and including the termination of your participation in our network.

11.16.2. Payment Suspensions

If MCNA has credible evidence of fraud, willful misrepresentation, or abuse under the requirements set forth by the Louisiana EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program, MCNA has the right to suspend payment of claims to a provider and/or a facility. Allegations are considered to be credible when they have indicia of reliability. MCNA carefully reviews all allegations, facts, and evidence, and acts judiciously on a case-by-case basis. The suspension of payment action will be temporary and will not continue if MCNA determines that there is insufficient evidence of fraud, willful misrepresentation, or abuse by the provider.

11.16.3. Appeal Rights

MCNA affords to any provider or person against whom it enforces payment holds or recoupment requests a right to appeal this action by requesting an informal review. A request for an informal review must be received in writing within 10 days of the date you receive a notice of the payment hold, and within 45 days of the date you receive a recoupment notice. Appeals should be mailed to MCNA to the attention of "Corporate Investigations" (See Section 2: Contact Information).

Along with your appeal, you may submit any documentary evidence that addresses whether the payment hold is warranted and any related issues. MCNA will consider your appeal and your evidence carefully. You will be contacted after that consideration is completed and a decision about your case is made.

Please contact MCNA's Provider Hotline if you have questions (See Section 2: Contact Information).

11.16.4. Independent Review

If a provider believes MCNA has partially or totally denied claims incorrectly, they may request an independent review. Effective August 1, 2018, there is a $250 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, MCNA will be responsible for paying the fee.

The Louisiana Department of Health (LDH) administers the independent review process. LDH first determines that the disputed claims are eligible for independent review based on statutory requirements (La-RS 46:460.90, et seq.), and if the claims are eligible then forwards them to a reviewer that is not a state employee and is independent of both MCNA and the provider. The decision of the independent reviewer is binding unless either MCNA or the provider appeals the decision to any court having jurisdiction to review the decision.

11.16.5. Laws that Govern Fraud and Abuse

The Federal False Claims Act and the Federal Administrative Remedies for False Claims and Statements Act are specifically incorporated into § 6032 of the Deficit Reduction Act. These acts outline the civil penalties and damages that are allowed to be brought against anyone who knowingly submits, causes the submission, or presents a false claim to any U.S. employee or agency for payment or approval. U. S. agency in this regard means any reimbursement made under Medicare or Medicaid and includes this program. The False Claims Acts prohibits anyone from knowingly making or using a false record or statement to obtain approval of a claim.

"Knowingly" is defined in the statute as meaning not only actual awareness that the claim is false or fraudulent, but situations in which the person acts with his eyes shut, in deliberate ignorance or in reckless disregard of the truth or falsity of the claim.

The following are some examples of billing and coding issues that can constitute false claims and high-risk areas under this act:

- Billing for services not rendered
- Billing for services that are not medically necessary
- Billing for services that are not documented
- Up coding
- Participation in kickbacks

Penalties in addition to amount of damages may range from $5,500 to $11,000 per false claim, plus three (3) times the amount of money the government is defrauded. In addition to monetary penalties, the provider may be excluded from participation in the Medicaid or Medicare program.

11.16.6. Do You Want to Report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other healthcare provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program services that were not necessary or actually provided
- Making false statements about a medical condition in order to get medical treatment
- Letting someone else use Medicaid ID card
- Using another person's Medicaid ID card
- Making false statements about the amount of money or resources in order to get benefits

To report waste, abuse, or fraud, choose one of the following:

- Call the LDH Program Integrity Hotline at 1-800-488-2917
- Visit www.ldh.la.gov and click on "Report Fraud & Abuse" to complete the online form
- Call the MCNA Fraud, Waste, and Abuse Hotline at 1-855-FWA-MCNA (1-855-392-6262)

To report waste, abuse or fraud, gather as much information as possible:

When reporting about a provider (a doctor, dentist, counselor, etc.) include:

- Name, address, and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Date(s) of event(s)
- Summary of what happened

When reporting about someone who gets benefits, include:

- The person's name
- The person's date of birth, Social Security number, or case number, if you have it
- The city where the person lives
- Specific details about the suspected waste, abuse or fraud

12. Provider Complaint Process

MCNA makes every effort to provide the highest quality of service to our members and providers. We understand there are times when issues or concerns need to be discussed, and our Provider Services team is ready to help. Please contact the Provider Hotline at 1-855-701-6262.

Complaints in the Louisiana EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Program are defined as a verbal or written expression by a provider that indicates dissatisfaction or dispute with MCNA policy, procedure, claims processing and/or payment, or any aspect of MCNA functions. Provider complaints may be reported to the Provider Hotline by calling 1-855-701-6262. If the issue cannot be resolved by the Provider Hotline Representative, the call will be escalated to the Provider Relations department. Providers may also submit complaints verbally or in writing directly to their Provider Relations Representative, via mail to the address below, using the Provider Complaint form located in the back of this manual, or via email to contactus@mcna.net. Should a provider (or their representative) wish to present their case in person, please contact the Provider Hotline at 1-855-701-6262 to schedule an appointment.

If you would like to file a complaint in writing with MCNA, please send it to the following address:

MCNA Dental
Attn: Complaints Department- Provider Relations
P.O. Box 740370
Atlanta, GA 30374-0370

Email: LA_PR_Dept@mcna.net

Upon receipt of a complaint, the Provider Relations department will review the issue and forward it to or solicit the assistance of the appropriate MCNA department(s). We will thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties while applying MCNA's written policies and procedures and resolve the complaint within 30 business days from the date we receive it. Providers may consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or claims included in the bundled complaint. When submitting a consolidated complaint, please include all applicable patients and/or claims and denote that the complaint is a consolidated complaint in the submission.

Upon resolution of the complaint, the Provider Relations department will inform the provider in writing of the outcome of the investigation. Should there be extenuating circumstances and the investigation requires longer than 30 days, the Provider Relations department will inform the provider in writing of the need for an extension. Concerns related to medical necessity are not addressed through the complaint system. They can be submitted through the appeal system found in section 11.11 Appeals on behalf of a member, or the provider can utilize MCNA's peer-to-peer process to speak with one of our licensed dentists. You can find more information about our peer-to-peer process in the Utilization Management section of this manual and instructions for filing an appeal on behalf of a member can be found in section 17, Member Grievances and Appeal Process.

After a provider has exhausted MCNA's internal complaint process, if the provider is dissatisfied with the resolution, they have the right to file a complaint directly with Louisiana Department of Health/Medicaid Management Information Systems (LDH/MMIS), including any issues or decisions that are not a unique function

of MCNA. To file a complaint with LDH/MMIS after you have completed MCNA's complaint process, please visit the LDH website at www.healthy.la.gov or call (225) 342-6908.

13. Utilization Management

Utilization Management (UM) is the process of evaluating the necessity and efficiency of healthcare services and affecting member care decisions through assessments of the appropriateness of care. MCNA's UM department helps to assure prompt delivery of medically appropriate dental care services to all members and subsequently monitors the quality of care.

All participating providers are required to obtain pre-authorization from MCNA's UM department. The UM department is available Monday through Friday, 7 am to 7 pm, CST, except on weekends and designated holidays. All requests for the authorization of services may be received during these hours of operation (See Section 2: Contact Information).

MCNA provides an opportunity for the provider to discuss a decision with the Dental Director, to ask questions about a UM issue, or to seek information from a clinical reviewer about the UM process and the authorization of care. If you contact us after business hours or on a holiday, you may leave a message and a representative will return the call the next business day.

MCNA will not enter into any contractual arrangement that rewards clinical reviewers or any other individuals who may conduct utilization review activities for issuing denial of coverage of a service, or any other financial incentives for utilization decision-making. MCNA's UM department ensures that quality of care will not be affected by financial- and reimbursement-related processes and decisions.

MCNA adheres strictly to the following:

- Compensation for utilization management activities is not structured to provide inappropriate incentives for denials, limitations, or discontinuation of authorization of services.
- Compensation programs for MCNA Dental, consultants, dental directors, or staff who make clinical determinations do not include any incentives for denial of medically necessary services.
- Continuous monitoring of the potential effects of any incentive plan on access and/or quality of care is a standard procedure within the UM process.

13.1. Decision Making Criteria

MCNA's Utilization Management Criteria use components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requirements for documentation of these codes are determined by community-accepted dental standards for authorization, such as treatment plans, narratives, radiographs, and periodontal charting.

These criteria are annually reviewed and approved by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

We appreciate your input regarding the criteria used for decision-making. Please contact the Provider Hotline (See Section 2: Contact Information) to comment or make suggestions. MCNA also complies with the Center for

Medicare and Medicaid Services (CMS) national coverage decisions and written decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

13.2. Peer-to-Peer Availability

MCNA offers the availability of peer-to-peer consultations with our Dental Director and specialty clinical reviewers. Louisiana-licensed general dentists, pediatric dentists, and specialty dental providers, such as orthodontists and oral surgeons, make all clinical determinations. The peer-to-peer process enables participating providers to discuss cases and clinical issues, including medical necessity denials, with MCNA clinical reviewers.

To request a peer-to-peer discussion, please contact your Provider Relations Representative or call the Provider Hotline (See Section 2: Contact Information).

13.3. Clinical Practice Guidelines

The Clinical Practice Guidelines are based on the enrolled membership and dictate the provision of dental care services to members with acute, chronic, and complex conditions to assist providers and members in making appropriate dental care decisions to improve quality of care. These guidelines are developed based on the following criteria:

- Reasonable, sound, scientific medical evidence
- Prevalence of dental conditions
- Extent of variation present in current clinical practice patterns
- Magnitude of quality of care issues based on existing patterns of clinical practice
- Ability to impact practice patterns
- Consideration of the needs of the members
- Strength of evidence to support best clinical practice management strategies
- Ability to achieve consensus on optional strategy

To review MCNA's Clinical Practice Guidelines, please visit our website at https://www.mcnala.net/dentists/clinical-practice-guidelines.

13.4. Clinical Decisions

A pre-authorization request for a service may be denied for failure to meet Clinical Practice Guidelines, clinical criteria, protocols, dental policies, or for failure to follow administrative procedures outlined in your Provider Agreement or this Provider Manual. All pre-authorization request approvals and denials are available through MCNA's Provider Portal. Providers who do not have access to the Provider Portal will receive their determinations via mail.

13.5. Medical-Necessity Denials

Utilization management uses dental policies, protocols, and industry standard guidelines to render review decisions. Licensed dentists and specialty dentists serve as clinical reviewers for the plan. All clinical requests are reviewed by an MCNA clinical reviewer who is available to discuss any decision rendered with the attending dental provider through our peer-to-peer process. The peer-to-peer process serves as MCNA's informal reconsideration process for adverse determinations. An adverse determination is any decision by MCNA to deny or partially deny an authorization request.

14. Quality Performance

14.1. Quality Improvement Program

The goal of the MCNA Quality Improvement (QI) Program is to ensure that each member has affordable and convenient access to quality dental care delivered in a timely manner by a network of credentialed providers.

The Board of Directors of MCNA is responsible for establishing the priorities of the QI Program based on the recommendations of the MCNA Dental Management Committee.

The Quality Improvement Committee oversees the QI Program to ensure that the performance of all quality improvement functions is timely, consistent, and effective. This committee reports to the Board of Directors and carries out the following responsibilities:

- Oversees the implementation of the QI Program throughout MCNA's operational departments
- Establishes a method to measure and quantify improvements in dental care delivery to MCNA members resulting from QI initiatives
- Reviews and makes recommendations, which are identified through the QI process, for approval of all new and revised policies, procedures, and MCNA benefit designs
- Ensures that adequate resources are allocated toward the achievement of MCNA's QI Program goals
- Oversees the management of all aspects of MCNA's operations to make sure they are consistent with the goals and objectives of the QI Program
- Monitors the progress of all MCNA-initiated corrective action plans
- Monitors the integration, coordination, and supervision of Risk Management Program activities through the formal reporting of those activities
- Demonstrates compliance with regulatory requirements and delegation standards
- Assesses and confirms that quality care and services are being appropriately delivered to MCNA members
- Reports quarterly to the Board of Directors the status of MCNA QI Program

A copy of the QI Program is available to all participating providers upon request. Please contact the Provider Hotline (See Section 2: Contact Information).

14.2. Your Role in Quality

Every MCNA network provider is a participant in the Quality Improvement (QI) Program through his or her contractual agreement with MCNA. You may be asked to serve on any of the committees that are part of the QI Program or contribute to the development of audits, Clinical Practice Guidelines, member education programs, or other projects. Participation on a committee is voluntary and encouraged.

You can help us identify any issues that may directly or indirectly impact member care by reporting them on an Incident Report Form, which is located in Forms section of this manual. This can be submitted to MCNA via fax, email, or regular mail (See Section 2: Contact Information).

The MCNA Dental Director might contact your office about an incident report. Please keep a copy of any incident report you file with MCNA in the appropriate member's dental record.

14.3. Quality Enhancement Programs (Focus Studies)

MCNA monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through performance improvement projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, MCNA will perform no fewer than three (3) state-approved PIPs per year. The PIPs will focus on both clinical and non-clinical areas.

14.4. Quality Review of Key Clinical and Service Indicators

One of MCNA's Quality Improvement (QI) Program objectives is to perform a quality review of key clinical and service indicators through analysis of member and provider data to assess and improve member and provider satisfaction rates. These clinical and service indicators include reviews of:

- Member and provider complaints about care or service
- Sentinel events (defined as any event involving member care that warrants further investigation for quality of care concerns)
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of Clinical Practice Guidelines
- Application of appropriate dental record documentation, and continuity and coordination of care standards
- Health outcome intervention studies or activities
- Member claims and encounters
- Member pre-authorizations requests and referrals

In order to support the quality review activities of our QI Program, your office is required to make available upon a request from an MCNA representative the dental records of any MCNA member in your care.

14.5. Corrective Action

When the Quality Improvement (QI) Program identifies specific cases of substandard quality of care during its review process, a letter requesting corrective action will be mailed to the treating provider. There are many forms of corrective action that may be recommended. Some examples of corrective action include:

- A Quality Correction Letter indicating the deficiency or deficiencies and requiring changes to be implemented within a maximum of 60 days (the severity of the deficiency or deficiencies noted will dictate the number of days that the provider has to implement the required changes)
- Special pre-authorization/claims review
- Post-treatment reviews of members by an Associate Dental Director
- Requirement for the provider to attend training sessions or participate in continuing education programs
- Restriction on the acceptance of new members until the provider becomes compliant with all standards of care for a specified amount of time
- Recoupment of sums paid where billing discrepancies are found during reviews
- Restriction on a provider's authorized scope of services.
- Referral of a case to the state Board of Dental Examiners and/or the Department of Justice, Attorney General's Office, and/or Office of Inspector General of the State
- Termination of the Provider Agreement

Where corrective action is recommended, our priority is to work with the provider to improve performance and compliance with all MCNA policies and procedures defined in the Provider Agreement and this Manual. MCNA is willing to provide support for a provider who shows sincere intent to correct deficiencies.

14.6. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The CAHPS Survey is a tool that assists MCNA in rating member experience with network providers and with MCNA. The survey addresses key member issues such as level of satisfaction with MCNA, access to care, referral for specialty services, utilization, care received, and interaction with dental office staff. The survey is conducted on an annual basis. MCNA also complies with any state requirements regarding annual CAHPS surveys for its population. This information is used to develop and implement strategies to improve care and service to our members. Providers may be contacted to assist MCNA in developing improvement strategies.

The results and associated improvement strategies will be posted on MCNA's website at www.mcna.net.

14.7. Provider Satisfaction Surveys

MCNA will assess its contracted providers' satisfaction with MCNA. This activity shall include, but not be limited to, analyses of provider satisfaction with the following operational aspects:

- MCNA's response time to provider inquiries and complaints
- MCNA communications
- Claims payment process
- Authorization and referral process
- MCNA availability and effectiveness

We will use the results of our provider satisfaction surveys and any state-approved, contracted independent surveys to develop and implement plan-wide activities designed to improve provider satisfaction.

MCNA will make aggregate survey results available to providers and members upon request.

14.8. Member Records - Chart Reviews

As specified in MCNA's Provider Agreement, we are authorized to conduct reviews of member records. These treatment records are chosen randomly for periodic chart review. The chart review includes assessment of the following member elements:

- Record of medical history, dental history, and existing dental conditions
- Radiograph evaluation and diagnostic material used
- Treatment plan and timeliness of treatment plan
- Actual care delivered in relation to proposed treatment plan
- Recall protocol and utilization analysis of actual care delivered
- A signed Patient Consent Form

A chart review offers an insight into the provider's practice patterns and allows MCNA to identify deficiencies and suggest areas of improvement. The on-site review is a component of our Quality Improvement (QI) Program; all data is collected and entered into a QI database. This data allows MCNA to perform analysis of utilization and

general network and practice patterns, contributing to valuable feedback and information for network dental offices. This information will also be used as part of the re-credentialing process.

15. Member Services

15.1. Discrimination

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

Providers must not differentiate or discriminate in the treatment of any member because of the member's race, color, national origin, ancestry, religion, health status, sex, marital status, age, political beliefs, or source of payment.

15.2. Confidentiality Policy

MCNA follows all HIPAA requirements. We require our contracted providers to also adhere to HIPAA requirements. The Provider Agreement requires that all providers maintain member information in a current, detailed, organized, and comprehensive manner, and in accordance with customary dental practices, and applicable state and federal laws and accreditation standards. Providers must have policies and procedures to implement HIPAA confidentiality requirements. In addition to complying with customary dental practices, applicable state and federal law, and accreditation standards, these policies and procedures should include, but are not limited to, protection of member confidentiality under the following circumstances:

- The release of information, using a release form, at the request of a member and in response to a legal request for information
- The storage of and restricted access to dental records in secured files
- The education of employees regarding the confidentiality of member records and other member information.

15.3. Informed Consent Requirements

Providers must understand and comply with applicable legal requirements regarding informed consent from members, as well as adhere to the policies of the dental community in which they practice. The provider must give MCNA members adequate information and be reasonably sure the member has understood it before proceeding with any proposed treatment. Consent documents should be in writing and be signed by the member and/or responsible party.

The provider must obtain and maintain a specific written informed consent form signed by the member, or the responsible party if the member is a minor or has been adjudicated incompetent, prior to the utilization of a papoose board as part of the member's treatment.

Such consent is required for the utilization of a papoose board and is strongly encouraged for all treatment plans and procedures where a reasonable possibility of complications from the proposed treatment or a procedure exists. Consent should disclose all risks or hazards that could influence a reasonable person in making a decision to give or withhold consent.

Written consent must be given prior to the services being rendered and must not have been revoked. Members or their responsible parties who can give written informed consent must receive information about the dental diagnoses, scope of proposed treatment, including risks and alternatives, anticipated results, and the need for and risks of the administration of sedation or anesthesia. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before treatment is initiated. As a provider, you may consider seeking advice from an attorney to ensure the informed consent meets all applicable legal requirements.

MCNA urges all providers to comply with the AAPD's 2013 "Guideline on Protective Stabilization for Pediatric Dental Patients." You can find the guideline online at the AAPD's website (www.aapd.org).

15.4. Cultural Competence

We facilitate access to dental services for non-English speaking members. MCNA's population is culturally and linguistically diverse, and we recognize that this diversity sometimes serves as a barrier to members, affecting their willingness to access all available services. Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected.

MCNA has adopted the CLAS recommendations (www.minorityhealth.hhs.gov) as a guideline in the development of our Cultural Competency Program. MCNA encourages contracted providers to address the care and service provided to members with diverse values, beliefs, and backgrounds that vary according to their ethnicity, race, language, and abilities.

We want to ensure that we, along with our network providers, are meeting the communication needs of members with limited English proficiency. MCNA's Quality Improvement department monitors and evaluates the level of cultural competency throughout our network through dental services provided by our providers. MCNA encourages employees and network providers to utilize their own diverse cultural backgrounds to enhance our program and the services provided to our members.

Please contact the Provider Hotline to request a copy of our Cultural Competency Program (See Section 2: Contact Information).

15.5. Reading/Grade Level Consideration

All member materials produced by MCNA are written at a 6th-grade reading level to promote enhanced communication between the Medicaid population, providers, and MCNA. Our goal is to create plain and clearly understandable member communications.

15.6. Availability and Coordination of Linguistic Services

MCNA does not require members to provide their own interpreter when utilizing the services available to them through MCNA. We will ensure that dental care services will be presented in a culturally and linguistically appropriate manner utilizing member's primary language:

- Interpreter services are available through MCNA at no charge when assessing dental care. Please have the member contact the MCNA Member Hotline at 1-855-702-6262 or email interpreterservices_dl@mcna.net for interpreter assistance.
- Member refusal of interpreter services must be documented.

- Friends and family are only used as an interpreter when specifically requested by the member. A Minor may not ~~to~~ be used as an interpreter.
- Member may request face-to-face or telephone interpreter services to discuss complex dental information and treatment options.
- Informative documents must be translated into and available in threshold languages.
- Member has the right to file a complaint or grievance if linguistic needs are not met.
- Dental provider offices are informed of the availability of the TTY contact number (1-800-846-5277) for members with hearing impairment.

15.7. Role of Provider's Bilingual Staff

The role of the bilingual staff in the office is to assist members to access and receive dental services and to understand the instructions they receive from the person speaking to them. If the member speaks a language not spoken by an office staff person, the telephone interpreter service should be utilized.

It is the responsibility of the provider's office to notify MCNA in writing within 30 days of a change in the linguistic capacity of the office that may affect the provider's ability to provide dental services.

To get a free copy of MCNA Cultural Competency Program, contact MCNA's Member Hotline (See Section 2: Contact Information).

15.8. Appointment Attendance Concerns

We track the appointment attendance history of members who are consistent "no shows" to their scheduled dental appointments. Providers cannot charge members for missed or failed appointments. For assistance with members who routinely break appointments, please use the Member Outreach Form located in the Forms section of this manual. In addition to the Member Outreach Form, providers have the option to report the code D9986 (missed appointment) via claim submission. MCNA will use the reported D9986 data to provide outreach and education to members on the importance of keeping appointments and/or canceling with notice when appropriate.

15.9. Case Management

MCNA has dedicated Case Managers to assist members with special health care needs in coordinating dental care with their Primar~~e~~y Care Dentist and specialty providers.

Members or providers may contact Case Management to initiate the assessment process for members with conditions that are medically compromising or are otherwise physically or mentally disabled. Our Case Mangers will act as a liaison between the member and provider in all aspects of arranging care, including coordinating travel arrangements, communication services, facilitating treatment pre-authorization, and assisting with scheduling follow-up while the member is in active care. Please call 855-702-6262 to refer a member to Case Management.

16. Member Eligibility, Enrollment, and Disenrollment

16.1. EPSDT Dental, the Adult Denture program, the Adult Waiver Program and the Adult ICF/IID Programs

MCNA does not perform enrollment functions for EPSDT, Adult Denture Program, Adult Waiver Program, or Adult ICF/IID Program members. All eligibility information provided by MCNA is the information that we have received from the Louisiana Department of Health (LDH) or its designee. The effective date of enrollment will be the first day of the month after eligibility is determined.

For instructions on how to verify member eligibility before providing services, please refer to Section IV: Verification of Eligibility in this manual.

To qualify for Louisiana Medicaid dental services, a child must be:

- Age 20 or younger
- A Louisiana resident
- A U.S. citizen or legal permanent resident

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

To qualify for Louisiana CHIP dental services, a child must be:

- Age 20 or younger
- A Louisiana resident
- A U.S. citizen or legal permanent resident

Louisiana Medicaid refers to both Medicaid and CHIP enrollees as members of the EPSDT Program. Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

To qualify for Louisiana Medicaid Adult Denture dental services, an adult must be:

- Age 21 or older
- A Louisiana resident
- A U.S. citizen or legal permanent resident
- Missing all teeth in the maxillary and/or mandibular arches
- Not a Qualified Medicare Beneficiary Only (QMB Only)

To qualify for Adult Waiver Program dental services, an adult must be:

- 21 years of age or older
- A Louisiana resident
- A U.S. citizen or legal permanent resident
- Enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver

To qualify for Adult ICF/IID Program dental services, an adult must be:

- 21 years of age or older
- A Louisiana resident
- A resident of an Intermediate Care Facility for persons with Intellectual and Developmental Disabilities

Please note that due to possible eligibility status changes, the information provided does not guarantee payment.

16.2. Medicaid ID Cards

MCNA strongly recommends all provider offices require each member to present their MCNA identification card and confirm eligibility at each appointment. You may quickly and easily complete eligibility verification through our Provider Portal (http://portal.mcna.net) or ~~through~~ the Medicaid Eligibility Systems. You may also call our Provider Hotline to complete verification (See Section II: MCNA Contact Information).

MCNA advises that you keep a copy of each member's Medicaid ID card on file in the member's record.

16.3. Value-Added Services (VAS)

Value-added services are extra services MCNA offers to members. Our value-added benefits are focused on promoting proper oral hygiene, ensuring access to care, and improving health outcomes. In addition to the standard Medicaid services, MCNA members can also receive:

Amazon Gift Card

$10 Amazon.com gift card for children under age 21 when the parent/guardian provides their email address and phone number through the Member Portal or Member Hotline.

Caries Risk Assessment

When a dentist sees an Adult Denture Program member aged 21 or older for their comprehensive oral exam (D0150) who is in need of a denture or partial denture, MCNA will reimburse the provider for the completion of a caries risk assessment. The provider must include the appropriate CDT code indicating the risk level on their claim with the examination:

- D0601 (low risk)
- D0602 (moderate risk)
- D0603 (high risk)

The reimbursement rate for these codes will be $3.00 for each service rendered during the member's examination, not to exceed one per member per year.

Extractions

Adult Denture Program members 21 and older may receive up to three dental extractions (D7140) per year when~~for~~ receiving dentures. Prior authorization required.

Silver Diamine Fluoride Treatment

Covers the use of silver diamine fluoride (D1354) for children ages 6 months to 6 years of age who are members of the EPSDT Program when prescribed by the child's primary care dentist to arrest dental disease and prevent further decay. The reimbursement rate for D1354 will be $10.00 per tooth every 180 days.

Teledentistry

Teledentistry (D9996 Teledentistry – asynchronous) will be covered for adult members 21 and older with intellectual or developmental disabilities at a reimbursement rate of $10. Must be billed with an approved D0150 for reimbursement.

If you are a Federally Qualified Health Center, Indian Health Services or you are reimbursed using an encounter rate or PPS methodology, you will receive only the amount listed for the VAS. A VAS alone does not qualify for an encounter rate or PPS rate. If you bill a VAS along with a payable service, you will receive the encounter rate plus the VAS payment.

17. Member Rights and Responsibilities

17.1. EPSDT Dental, Adult Denture Program, Adult Waiver Program, and Adult ICF/IID Program

Members are informed of their rights and responsibilities in the MCNA Member Handbook. MCNA providers are also expected to respect and honor members' rights.

17.1.1. Member Rights as written in the MCNA Member Handbook

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and the right to express preferences about future treatment decisions.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations.
- You have the right to be able to request a copy of your medical records (one copy free of charge) and request that they be amended or corrected.
- You have the right to receive healthcare services that are easy to access. These services should be comparable in amount, duration, and scope to those provided under Medicaid Fee-for-Service. They should be sufficient in amount, duration, and scope to ~~reasonable~~reasonably be expected to achieve their purpose.
- You have the right to receive services that are appropriate and are not denied or reduced because of diagnosis, type of illness, or dental condition.
- You have the right to receive all information, like enrollment notices, informational materials, instructional materials, and available treatment options and alternatives in a way that is easy to understand.
- You have the right to receive assistance from the Louisiana Department of Health in understanding the requirements and benefits of MCNA.
- You have the right to receive interpretation services for free and in all non-English languages, not just those that are the most common.
- You have the right to be notified that interpretation services are available and how to access those services.
- You have the right to receive information on MCNA's services, to include, but not be limited to:
    - Benefits covered (before treatment begins)
    - Benefits **not** covered and any associated costs related to receiving them
    - The way to use benefits, including any authorization requirements
    - Service area
    - Names, locations, telephone numbers of, and non-English language spoken by current network providers, like Primary Care Dentists, specialists, Federally Qualified Health Clinics, Rural Health Clinics, and hospitals.
    - Any restrictions on your freedom of choice among network providers
    - Providers who are not accepting new patients
    - Benefits not ~~offered~~ covered by MCNA that are available to you and how to obtain them, including transportation
- You have the right to receive a complete description of disenrollment rights at least once a year.

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- You have the right to receive notice of any major changes in core benefits and services at least 30 days before the intended effective date of the change.
- You have the right to receive information on grievance, appeal, and State Fair Hearing procedures.
- You have the right to receive detailed information on emergency and after-hours coverage, to include, but not be limited to:
    - What constitutes an emergency medical condition and emergency services, and post-stabilization services
    - That emergency services do not require prior authorization
    - The process and procedures for getting emergency services
    - The locations of any emergency rooms and other places where MCNA has contracted to furnish emergency dental services and post-stabilization services
    - The right to use any hospital or other setting for emergency care
    - The rules about post-stabilization services after emergency care
- You have the right to receive MCNA's policy on referrals for specialty care and other benefits not provided by your Primary Care Dentist.
- You have the right to have your privacy protected according to legal privacy requirements.
- You have the right to exercise your rights without being treated differently by MCNA, our network providers, or the Louisiana Department of Health.

17.1.2. Member Responsibilities as written in the MCNA Member Handbook

- Present your Louisiana Department of Health issued Medicaid ID card when getting services from your dentist.
- Be familiar with MCNA's procedures to the best of your ability.
- Call or contact MCNA to obtain information and have questions answered.
- Let the dentist know any reasons your treatment cannot be followed as soon as possible.
- Live a healthy lifestyle and avoid behavior that can hurt your health.
- Follow the grievance process that MCNA provides for you if you have a disagreement with a dentist.
- Use the preventive dental services that are a part of your benefits.
- Be respectful of the dentist and their staff.
- Be respectful of the rights of other patients.
- Follow the dentist's rules and regulations about patient care and conduct while at the dental office.
- Provide the dentist and their office staff with true and complete information so they can give you proper care.
- Obtain services from only in-network Primary Care Dentists or specialists, except if you have a dental emergency.
- Ask the dentist questions about his or her instructions.
- Ask the dentist about the care you receive.
- Understand your dental problems and work with your dentist to decide treatment goals.
- Make good decisions about your dental health and avoid things that can damage it.
- Follow the plan of treatment for dental care agreed upon by you and your dentist ~~agree~~ and/or their staff.
- Make sure that payments for non-covered dental services are fulfilled as soon as possible.
- Report unexpected changes in your dental condition to your dentist.
- Keep all appointments and arrive on time. If you are unable to do so for any reason, call your dentist's office as soon as you can.

If you think the member has been treated unfairly or discriminated against, please call MCNA toll-free at 1-855-701-6262. You also can file a complaint on behalf of the member by email at contactus@mcna.net.

17.2. Non-Compliant Members

If your assigned member is non-compliant and would like to request that the member be reassigned, please follow these steps:

- Document all instances of non-compliance in the member record.
- Complete the Member Outreach Form (located in the Forms section of this manual) and select the following item, “Provider requests transfer of member from panel.”
- Upon receipt of a provider’s request to re-assign a member, the Provider Relations department will review with the Dental Director the situation and any documentation for appropriateness, and then inform the provider of the resolution.

18. Member Grievances and Appeal Process

Member grievances and appeals can be filed verbally or in writing. At no time will a member be discriminated against because he or she has filed an appeal. All information contained within a grievance or appeal and anything that comes to light throughout the grievance and appeal process is kept strictly confidential. A provider acting on behalf of a member or a member's representative may submit grievances and appeals on behalf of members with their written consent. All appeals submitted by a provider on behalf of a member or by a member's representative must be submitted in writing with a signed copy of the member consent form.

If you would like to file a grievance or appeal on behalf of a member, please call or send it to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II: MCNA Contact Information in this manual.

The member must first exhaust MCNA's appeal process before requesting a State Fair Hearing. The member may request a State Fair Hearing within 120 calendar days from the date of the last decision notification by MCNA. MCNA will cooperate with any decision the State makes.

18.1. What is a Grievance?

A member grievance is any dissatisfaction expressed by a member, or a person acting on behalf of the member, either verbally or in writing, to MCNA concerning any aspect of MCNA's operation. A member grievance may be filed at any time. This includes, but is not limited to, dissatisfaction with MCNA's administration or the way a service is provided. A grievance does not include a request for review of an action or a decision by MCNA related to covered services or services provided, misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to the satisfaction of the member.

18.2. Member Grievance Process

Members have the right to file a grievance at any time. Grievances can be filed verbally, in writing, or in person. A provider may file a grievance on a member's behalf. Grievances filed by a provider on a member's behalf require the member's written consent.

MCNA will acknowledge receipt of a grievance in writing. MCNA will resolve and provide written resolution of all member grievances within 90 days from the date the complaint is received.

To file a grievance on behalf of a member, contact MCNA's Member Services department or send the request via mail to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II (MCNA Contact Information) in this manual.

At no time will a member be discriminated against because he or she has filed a grievance. We always respect our members' privacy. Anything said or written is kept confidential.

18.3. What is a Member Appeal?

A member has the right to file an appeal. An appeal is a request for review of an action or a decision by MCNA related to covered services or services provided. An action is defined as the denial or limited authorization of a requested service, including:

- The type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within specified timeframes
- Denial of a request to obtain services outside the network for specific reasons

18.4. Member Appeal Process

MCNA will notify the member and requesting provider of a decision about the request for a covered service through a Notice of Action Letter. If the member, member's representative, or provider disagrees with our decision, he or she can file an appeal. Appeals filed by a provider on behalf of a member or a member's representative require the member's written consent.

An appeal may be filed verbally or in writing within 60 calendar days of the date when the member receives the Notice of Action Letter. If there is an oral request, a written notice must be received from the member or the member's representative unless they request an expedited resolution. We will acknowledge receipt of a member appeal in writing.

MCNA or the member can request a 14 calendar-day extension if there is a need for additional information and the delay is in the member's best interest. If an extension is needed by MCNA, we will notify the member in writing of the reason.

The member's benefits will not end while we review the appeal unless the member is taken out of the EPSDT or the Adult Denture program. A member will continue to receive current authorized services until one of the following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days pass after MCNA mails the Notice of Action providing the resolution of the appeal unless the member requests a State Fair hearing with continuation of benefits until a State Fair Hearing decision is reached;
- A State Fair Hearing Officer issues a hearing decision against the member; or
- The time period or service limits of a previously authorized service has been met.

The member may have to pay for the continued services if the final decision is that MCNA does not have to cover them.

The written appeal must clearly state that the member wishes to continue getting the services. Services may be continued until the appeal decision is made. If, however, the appeal decision agrees with MCNA's denial, the member may have to pay for the services.

To file an appeal on behalf of a member, contact MCNA's Member Services department or send the request via mail to MCNA's Grievance and Appeals department. Phone numbers and address are located in Section II (MCNA Contact Information) of this manual.

The member has the right to request a State Fair Hearing if they are not satisfied with the resolution provided by MCNA's appeals process. To request a State Fair Hearing please contact the MCNA Member Services department by phone or in writing.

18.5. Member Expedited Appeals

If the member's appeal is about care that is medically necessary and needed soon, a dental professional who has the relevant clinical experience and who did not render the original denial decision will review the appeal on an expedited basis. You may file an expedited review request verbally (must be followed up in writing) or in writing and you must include the member's written consent.

An expedited review process is available for a member appeal that is for pre-service medical necessity. This expedited review process may take place when MCNA determines or the provider/practitioner indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function.

MCNA will make a decision about an expedited review request no later than 72 hours after we receive it. If MCNA denies a request for expedited resolution of an appeal, the appeal will be transferred to the standard appeals process and be resolved in 30 calendar days.

MCNA will contact the member by telephone to inform them of the decision to deny the expedited request. We will send a written notice indicating our denial of the request within two (2) calendar days.

18.6. Informal Reconsiderations

An informal reconsideration is the review of MCNA's decision about a service authorization request made at the request of a member or the member's representative. If a member is dissatisfied with MCNA's adverse determination of a service authorization request, they have the right to ask for an informal reconsideration. A service authorization request is any one of the following:

- Pre-Authorization
- Referral
- Second Opinion

This process will take no more than one (1) business day from the date we receive your request. Call MCNA's Member Services Hotline (See Section 2: Contact Information) for assistance ~~in~~ submitting an informal reconsideration request.

You, with the member's consent, may ask for an informal reconsideration. An informal reconsideration may be requested verbally or in writing within 30 calendar days of when the member receives the Notice of Action from MCNA.

MCNA will set up a meeting between the member, you and/or their representative and the clinical reviewer who made the adverse determination within one (1) business day of receipt of the request. If the clinical reviewer who made the determination will not be available within the specified timeframe, the Dental Director will select another clinical reviewer to meet with you. MCNA will provide its response to the informal reconsideration request at the conclusion of the meeting. This meeting can be an in-person meeting.

18.7. Member Request for a State Fair Hearing

If a member is not happy with MCNA's decision about an appeal, they have the right to ask for a State Fair Hearing within 120 days of the date of MCNA's Notice of Appeal Resolution. A provider may also request a State Fair Hearing on behalf of the member.

To request a State Fair Hearing on behalf of a member, you must first have the member complete and sign a one-page form, which you can request by calling the Provider Hotline (See Section 2: Contact Information) or download from our website (www.mcnala.net). This form is located in section 18.8 of this manual and will serve as the member's authorization for you to request a State Fair Hearing for the member.

During the hearing, a member may represent himself or herself, or be represented by any authorized individual, such as a friend, relative, dentist, legal counsel, or anyone the member names to speak on their behalf.

To request a State Fair Hearing, call or write to MCNA Member Services department. Phone numbers and address are located in Section II (MCNA Contact Information) of this manual.

Alternatively, you can also request a hearing by sending a letter to:

Division of Administrative Law
HH Section
PO Box 4189
Baton Rouge, LA 70821

A member's benefits will not end during the State Fair Hearing unless they are taken out of the EPSDT Dental or the Adult Denture program. If the member wants to continue to receive the services that were denied, the member must inform MCNA within 10 days from the date on the Notice of Action and before the intended effective date of MCNA's action. The member may have to pay for the services if the final decision is that MCNA does not have to cover them.

Once a decision is made, all administrative remedies with the Louisiana Department of Health have been exhausted. If the member is dissatisfied with this ruling, he/she has the right to seek judicial review in accordance with Louisiana Revised Statute 46:107(C). The request for judicial review may be filed either in the 19th Judicial District Court, Parish of East Baton Rouge, or the district court of the parish of their domicile, within 30 days from the date of this certification.

18.8. Member Request for a State Fair Hearing Form

LOUISIANA DEPARTMENT OF HEALTH REQUEST FOR STATE FAIR HEARING FORM

[Recipient Name]

[Street Address]

[City, State & Zip Code]

I want to appeal the decision MCNA made on my case because: _____

_____

_____

Date: _____ Signature: _____

Recipient/Representative: _____

Your address if different from the address shown above: _____

_____

Telephone No: _____

Social Security Number: _____

Email address: _____

Name, Address and Phone number of your Authorized Representative at the Hearing, if any:

_____

Mail this complete form to:

DIVISION OF ADMINISTRATIVE LAW—HEALTH AND HOSPITALS SECTION
P.O. BOX 4189
BATON ROUGE, LA 70821-4189

The postmark showing the date you mailed your appeal will be the date of your appeal request. You may fax the completed form to **(225) 219-9823** or email to LDHprocessing@adminlaw.state.la.us or complete the form online at: **http://www.adminlaw.state.la.us/HH.htm**

After you ask for a State Fair Hearing, the Division of Administrative Law will send you a Notice by mail of the date, time and location of your State Fair Hearing. If you are unable to mail or fax the attached form, you may phone **(225) 342-5800** to give the information for your appeal.

***** DON'T FORGET TO INCLUDE THE NOTICE OF ADVERSE ACTION LETTER WITH THIS FORM****

19. EPSDT Covered Services and Fee Schedules

19.1. Benefit Limits Key

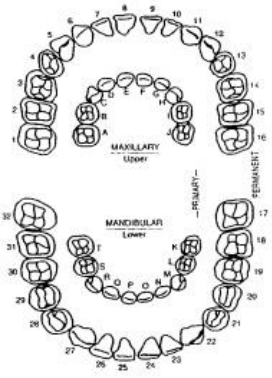
A = Age range limitations
TID = Tooth ID

19.2. Initial Dental Screening and Annual Recall Visits

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

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

This visit should also include preparation and/or updating the member's records, development of a current treatment plan, and the completion of reporting forms. The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1206 or D1208) are limited to once per six (6) months.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

19.3. Diagnostic Services

Diagnostic services should be performed for all members, starting within the first six (6) months of the eruption of the first primary tooth, but no later than one (1) year of age.

19.4. Examinations

Clinical Oral Evaluations			
Code	**Description**	**Benefit Limits**	**Fee**
D0120	Periodic oral evaluation (established patient)	A 3-20. Limited to one (1) every six (6) months as is age appropriate. NOT reimbursable if procedure code D0145 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member unless filed by a specialist.	$36.88
D0140	Limited oral evaluation- problem focused	A 0-20.	$15.00
D0145	Oral evaluation, patient less than 3 years old	A 0-35 months. **This procedure may be reimbursed once in a six (6) month period by the same provider.** ~~Procedure code D0145 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member. P~~In addition, ~~p~~rocedure codes D0120 and D0150 are NOT reimbursable if procedure code D0145 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member unless filed by a specialist.	$65.65

D0150	Comprehensive oral evaluation – new or established patient	A 3-20. Limited to one (1) every three (3) years by the same provider. However, procedure code D0150 is NOT reimbursable if procedure code D0120, D0145 or D0150 has been reimbursed to any general dentist, facility, or group within a six (6) month period for the same Member unless filed by a specialist. Denied when submitted for the same DOS as D0145 by any provider. MCNA recognizes this code for a new member only. A new member is described as a member that has not been seen by this provider for at least three (3) years. This procedure code is to be used by a general dentist and/or specialist when evaluating a member comprehensively for the first time (specialists must include a detailed narrative as to why a comprehensive exam was needed and performed since most specialty care visits are for a specific, targeted reason). This would include the examination and recording of the member's dental and medical history and a general health assessment. This procedure should not be billed unless it has been at least three (3) years since the member was seen by the specified provider, facility, or group. An initial comprehensive oral examination (D0150) is limited to once per three (3) years when performed by the same billing provider. A recognized dental specialist within the same office (group) may perform a D0150 prior to the expiration of the three-year period.	$64.13

19.5. Radiographic Images

In order for the MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and oral/facial images that are not of good diagnostic quality will be denied.

There must be a diagnostic purpose for the taking of each radiograph. This must be documented in the member's record and be in accordance with the accepted standard of care.

Table: ***RECOMMENDATIONS FOR PRESCRIBING DENTAL RADIOGRAPHS***

Patient Age and Dental Developmental Stage				
Type of Encounter	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous
New Patient* being evaluated for oral diseases.	Individualized radiographic exam consisting of selected periapical/occlusal views and/ or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radio-graphic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.	
Recall Patient* with clinical caries or at increased risk for caries.**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.			Posterior bitewing exam at 6-18 month intervals.
Recall Patient* with no clinical caries and not at increased risk for caries.**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.		Posterior bitewing exam at 18-36 month intervals.	Posterior bitewing exam at 24-36 month intervals.
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/ skeletal relationships.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships.		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radio- graphic image for evaluation of dental and skeletal relationships.
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/ endodontic needs, treated periodontal disease and caries remineralization.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these conditions.			

*Clinical situation for which radiographs may be indicated include, but are not limited to:

A. Positive Historical Findings
1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive Clinical Signs/Symptoms
1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathosis
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleedings
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical tooth erosion
23. Peri-implantitis

**Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0-6 years of age and over 6 years of age).

Radiographs/Diagnostic Imaging (Including Interpretation)			
Code	**Description**	**Benefit Limits**	**Fee**
The fee for a comprehensive series of radiographic images (D0210) will be applied when a provider, facility or group submits any combination of periapical, occlusal or bitewing radiographic imaging within a 15 day period exceeding the reimbursable value of the comprehensive series of radiographic images. One comprehensive series of radiographic images is available per member every year by provider, facility, or group. Requirements when submitting x-rays: • Must be of diagnostic quality • All X-rays must be marked right & left • Must include the member's name • Must include the date x-rays were taken MCNA encourages the use of digital images. Please be aware that MCNA will not return hardcopy x-rays. We encourage you to make two (2) sets of x-rays and send us the duplicate set.			
D0210	Intraoral-comprehensive series	MCNA will pay for a comprehensive series of radiographic images (D0210) once every year by the same provider, facility, or group. The fee for a comprehensive series of radiographic images (D0210) will be applied when an office submits any combination of periapical and bitewing x-rays exceeding the reimbursable value of the comprehensive series of radiographic images. Not allowed as an emergency service.	$81.46
D0220	Intraoral-periapical-first film	Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated.	$19.89
D0230	Intraoral-periapical-each additional film	The total cost of periapicals and other radiographs cannot exceed the payment for the comprehensive series. When the fee submitted for any combination of intraoral x-rays in a series meets or exceeds the fee for a comprehensive series, it is considered that the films are the equivalent of a comprehensive series, procedure D0210. When submitting a claim, the tooth number must be indicated.	$16.81

D0240	Intraoral - occlusal film	A Birth-20. Requires documentation of medical necessity with pre-authorization submission. Limited to two (2) services per day by the same provider, facility, or group. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0220 or D0230, if more than one code of D0240 is reported. Reimbursable for oral cavity 01 and 02. Claim must include arch designator. May be submitted as an emergency service. If an occlusal film is used in the course of a routine dental exam to aid in caries detection, it will be deemed to be the same as a periapical radiograph (D0220 and D0230) and will be bundled with the other films taken for routine examination and not paid separately.	$27.63
D0272	Bitewings – two (2) films	A 1-20. Limited to one service in a 12-month period per member by the same provider, facility, or group. Not reimbursable when submitted within a 12-month period of a D0210 by the same Provider, facility or group except when submitted by a Medicaid-recognized specialist.	$29.01
D0330	Panoramic film	A 3-20. Limited to one (1) service a day by any provider, facility, or group, and to one service every year by the same provider, facility, or group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Documentation of medical necessity required if member is less than age 3. Documentation of medical necessity required for emergency claims.	$77.23

Procedure code **D0350** must be used to submit claims for photographs and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's dental record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210 and D4355.			
D0350	Oral/facial photographic images	A 1-20. Requires pre-authorization. Limited to two (2) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Oral/facial photographic images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations: prior to gingivectomy; prior to frenulectomy; in conjunction with D7286; or with the presence of a fistula prior to retreatment of previous endodontic therapy, anterior. The provider should bill Medicaid for oral/facial photographic images **ONLY** when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment. Reimbursable for oral cavity designators 01, 02, 10, 20, 30, and 40. Claim must include oral cavity designator.	$37.12

Any periapical radiographic images, occlusal radiographic images, comprehensive 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.

If a comprehensive series of radiographic images (D0210) is billed within 12 months of bitewing radiographic images (D0272), the fee for the comprehensive 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 comprehensive series of radiographic images (D0210), the bitewing radiographic images (D0272) may be subject to recoupment.

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 enrollee'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.

19.6. Other Diagnostic Services

Tests and Examinations			
Code	**Description**	**Benefit Limits**	**Fee**
D0470	Diagnostic casts	A 1-20. Diagnostic casts will be covered only when MCNA requests them. Requires pre-authorization and documentation of medical necessity.	$64.22

Oral Pathology Laboratory			
Code	**Description**	**Benefit Limits**	**Fee**
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	A birth-20. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and documentation of medical necessity.	$74.49
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	A birth-20. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and documentation of medical necessity.	$77.03

19.7. Preventive Services

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

Dental Prophylaxis			
Code	**Description**	**Benefit Limits**	**Fee**

D1110	Prophylaxis adult	A 12-20. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis). If submitted on an emergency claim, procedure code will be denied.	$65.00
D1120	Prophylaxis child	A 6months - 11 years. Limited to one (1) prophylaxis per member per six (6) month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If D1120 (Child Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1120 (Child Prophylaxis).	$47.41

Topical Fluoride Treatment (Office Procedure)

Code	Description	Benefit Limits	Fee
D1206	Topical application of fluoride varnish	A 0-20. Includes oral health instructions. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. **Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.** ~~In addition, MCNA reimbursement of fluoride for Members is limited to 2 (two) fluoride services (D1206 and/or D1208) per 12-month period.~~	$32.88
D1208	Topical application of fluoride – excluding fluoride varnish	A 0-20. Includes oral health instructions. Per the AAPD periodicity table, application of fluoride is allowed once every six (6) months. **Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.** ~~**This procedure is limited to once in a six (6) month period.** In addition, MCNA reimbursement of fluoride for Members is limited to 2 fluoride services (D1206 and/or D1208) per twelve (12) month period.~~	$26.40

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Other Preventive Services			
Code	**Description**	**Benefit Limits**	**Fee**
D1351	Dental sealant per tooth	Reimbursable once per tooth in a 36-month period. 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. Sealants are available for the occlusal surface only. In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana. (TIDs #2, 3, 14, 15, 18, 19, 30 and 31 only).	$34.54
D1354	Interim caries arresting medicament application – per tooth	A 6 months to 6 years. Limited to Silver Diamine Fluoride. Reimbursed per tooth every 180 days when prescribed by member's primary care dentist.	$10.00

Space Maintenance (Passive Appliances)			
Code	**Description**	**Benefit Limits**	**Fee**
The billing Provider is responsible for replacement and recementation within the first twelve (12) months after placement of the space maintainer.			
D1510	Space maintainer - fixed unilateral – per quadrant (Excludes a distal shoe space maintainer)	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to passive appliances. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$205.13
D1516	Space maintainer – fixed – bilateral, maxillary	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to passive appliances. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided.	$279.71
D1517	Space maintainer – fixed – bilateral, mandibular	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to passive appliances. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided.	$279.71

D1551	Re-cement or re-bond bilateral 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 does not require authorization and is limited to one (1) recementation per appliance, in a five (5) year period. Requires pre-placement x-rays.	$52.49
D1552	Re-cement or re-bond bilateral 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 does not require authorization and is limited to one (1) recementation per appliance, in a five (5) year period. Requires pre-placement x-rays.	$52.49
D1553	Re-cement or re-bond 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 does not require authorization and is limited to one (1) recementation per appliance, in a five (5) year period. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~ Requires pre-placement x-rays.	$52.49
D1556	Removal of fixed unilateral space maintainer – per quadrant	This procedure is NOT reimbursable to the same billing provider, facility, or group that billed the original D1510 or D1575. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$51.80
D1557	Removal of fixed bilateral space maintainer – maxillary	This procedure is NOT reimbursable to the same billing provider, facility, or group that billed the original D1515 (01) or D1516. .	$51.80
D1558	Removal of fixed bilateral space maintainer - mandibular	This procedure is NOT reimbursable to the same billing provider, facility, or group that billed the original D1515 (02) or D1517. .	$51.80

D1575	Distal shoe space maintainer – fixed - unilateral – per quadrant	The billing provider is responsible for replacement and recementation within the first 12 months after placement of the space maintainer. Limited to passive appliances. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Fixed-space maintainers require pre-authorization and are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth (teeth). Removable, maxillary anterior or active space maintainers are not provided. Quadrant designator 10, 20, 30, 40 required. ~~Reimbursable by quadrant..~~	$205.13

19.8. Restorative Services

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

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, group, or facility is responsible for the replacement of the original restoration within the first 12 months after initial placement. Duplicate surfaces are not payable on the same tooth in amalgam or composite restorations in a 12-month period by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and the provider will receive full fee for service. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be cut back to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 12-month period by same provider, facility, or group. Additional restorative services(s) on the same tooth within a 12-month period by the same provider or facility do not require PA.

Restorations of any type are not payable for deciduous central or lateral incisor teeth (Tooth letters D, E, F, G, N, O, P, and Q) for members who have reached the age of 5 (five).

Laboratory processed crowns are not covered. Provider payments received for restorative work performed within 12 months of a crown procedure on the same tooth will be deducted from the crown procedure reimbursement except in cases of pulpal necrosis or traumatic injury.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161); resin-based composite, four (4) or more surfaces, posterior (D2394); resin-based composite, four (4) or more anterior surfaces (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932 or D2933).

Unless contraindicated, for encounter-based reimbursement situations 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 is a circumstance that requires restorative treatment outside of this parameter, the documentation of medical necessity and circumstance must be clearly documented on the claim submission and will be subject to clinical review.

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

19.8.1. Permanent Tooth Restorations

MCNA will reduce payment for a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same Member, same permanent tooth when billed within 12 months from the date of the original restoration by the same, provider, facility, or group. In these situations, the maximum combined fee for the two or more restorations within a 12 month period on the same permanent tooth will not exceed the maximum fee of the larger restoration. For the same provider, facility, or group, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same member, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury, including codes D2140 and D2330, require x-rays and documentation of medical necessity to be included with claims submission in order to be considered for payment. MCNA must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The provider is required to submit x-rays and documentation of medical necessity showing the presence of pulpal necrosis (root canal) or traumatic injury with subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee in order to have the claim reconsidered for payment. The pre-authorization number must be entered in the appropriate block on the claim for payment.

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

19.8.2. Primary Tooth Restorations

For the same provider, facility, or group, MCNA will reduce the payment of a second or subsequent amalgam restoration (Procedure Codes D2140, D2150 and D2160); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same patient, same primary tooth when the date of service of the second restoration is within twelve (12) months from the date of the original restoration. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee allowed 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 (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration.

MCNA policy allows reimbursement for certain second or subsequent restorations on primary teeth at the full Medicaid reimbursement fee for the same member, 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) or traumatic injury to the tooth.

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

19.8.3. General Information

Providers must utilize MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within 12 months from the date of original restoration. MCNA will reduce the payment of other second or subsequent restorations that are rendered within a 12-month period for the same member, same primary tooth. In these situations, the maximum combined fee for two (2) or more restorations within a 12-month period on the same tooth, same member will not exceed the maximum fee of the higher reimbursed restoration.

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

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

Amalgam Restorations (Including Polishing)

Code	Description	Benefit Limits	Fee
Procedure codes D2140, D2150, D2160, and D2161 represent final restorations. Procedure code D2161 is not payable for primary teeth. Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.			
D2140	Amalgam-one surface posterior - primary	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$87.71
D2140	Amalgam-one surface posterior – permanent	A 0-20 This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	$101.25
D2150	Amalgam-two surfaces posterior - primary	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$111.20

D2150	Amalgam-two surfaces posterior – permanent	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	$124.74
D2150	Amalgam-two surfaces posterior – permanent	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	$158.58
D2160	Amalgam-three surfaces posterior - primary	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$134.68
D2160	Amalgam-three surfaces posterior-permanent	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	$178.00
D2160	Amalgam-three surfaces posterior-permanent	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$148.21
D2161	Amalgam-four or more surfaces posterior - permanent	A 0-20. This procedure is reimbursable for Tooth Number 1 through 32.	$178.00

19.9. Resin-Based Composite Restorations - Direct

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two (2) restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period, by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same member, same tooth when billed within 12 months from the date by same provider, facility, or group 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.

Providers must utilize the MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within the 12 months from the date of original restoration. All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto

the claimed surface. A Class V resin-based composite restoration is a one surface restoration. If the tooth is decayed extensively a crown should be considered.

The resin-based composite – four (4) or more anterior surfaces (D2335 & D2394) – is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four (4) surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two (2) D2332 restorations would not adequately restore the tooth or in cases where two (2) D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

The resin-based composite – four (4) or more surfaces (D2394) – is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

If the same tooth requires a second or subsequent restoration on the same surface(s) by a different provider, pre-authorization is required.

Resin-Based Composite Restorations - Direct			
Code	**Description**	**Benefit Limits**	**Fee**
Resin restoration includes composites or glass ionomer. Duplicate surfaces are not payable on the same tooth in restorations in resin-based restorations in a 12-month period by the same provider, facility, or group. **If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.**			
D2330	Resin-one surface, anterior	A 0-20. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age.	$102.90
D2330	Resin-one surface, anterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$129.98
D2331	Resin-two surfaces, anterior	A 0-20. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age.	$127.77

D2331	Resin-two surfaces, anterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo except MI or DI.	$168.39
D2331	Resin-two surfaces, anterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo of MI or DI.	$171.09
D2332	Resin-three surfaces, anterior	A 0-20. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age.	$155.40
D2332	Resin-three surfaces, anterior	A 0-20. This procedure is reimbursable for permanent teeth. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$205.49
D2335	Resin-four or more surfaces (anterior) - primary	A 0-20. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age.	$194.77
D2335	Resin-four or more surfaces (anterior) - permanent	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with surface I.	$269.23
D2390	Resin-based composite crown, anterior	A 0-20. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M and R for members under 21 years of age; and Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. Pre-authorization for Tooth Letters C, H, M and R is required only for members nine (9) years of age and older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$285.25
D2390	Resin-based composite crown, anterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27. Requires pre-authorization.	$413.86
D2391	Resin-based composite - one surface, posterior	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$87.71
D2391	Resin-based composite – one surface, posterior	A 0-20. This procedure is reimbursable for permanent teeth. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$101.25

D2392	Resin-based composite - two surfaces, posterior	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$111.20
D2392	Resin-based composite - two surfaces, posterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	$124.74
D2392	Resin-based composite - two surfaces, posterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	$158.58
D2393	Resin-based composite - three surfaces, posterior	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$134.68
D2393	Resin-based composite - three surfaces, posterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	$178.00
D2393	Resin-based composite - three surfaces, posterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$148.21
D2394	Resin-based composite - four or more surfaces, posterior	A 0-20. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$158.85
D2394	Resin-based composite - four or more surfaces, posterior	A 0-20. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$178.00

19.10. Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation that depicts the pretreatment condition. The documentation supporting the need for crown services must be available for review by the LDH or MCNA upon request.

Other Restorative Services			
Code	**Description**	**Benefit Limits**	**Fee**
D2920	Recement crown	A 1-20. The billing provider, facility, or group is responsible for recementation within the first 12 months after placement of the crown. This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter A through T.	$84.61

Procedure codes D2930, D2931, D2932, D2933 and D2934 represent final restorations. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable. 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 member's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by the LDH or MCNA upon request. **Pre-authorization is not required except as noted by code below.**			
D2929	Prefabricated porcelain/ceramic crown, primary teeth only anterior teeth only	This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age and for tooth letters D, E, F, G, N, O, P, and Q only if the recipient is under 5 years of age. **Exceptions require prior authorization with documentation of medical necessity.**	$370.37
D2930	Prefabricated stainless steel crown - primary tooth	A birth-20. This procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. **Exceptions require prior authorization with documentation of medical necessity.** Pre-authorization for procedure code D2930 is required only for Tooth Letters B, I, L, and S for members nine (9) years of age and older; and for Tooth Letters A, C, H, J, K, M, R and T for members 10 years of age and older.	$215.83
D2931	Prefabricated stainless steel crown - permanent tooth	A 1-20. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 1 through 32.	$341.88
D2932	Prefabricated resin crown	A 1-20. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 with pre-authorization; and Tooth Letters C, H, M and R for members under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. **Exceptions require prior authorization with documentation of medical necessity.** Pre-authorization is required for Tooth Letters C, H, M and R only for members nine (9) years of age or older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$280.57

D2933	Prefabricated stainless steel crown with resin window	A 0-20. This procedure is reimbursable for Tooth Letters C, H, M and R for members under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. **Exceptions require prior authorization with documentation of medical necessity.** Pre-authorization is required for Tooth Letters C, H, M and R only for members nine (9) years of age or older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$285.75
D2934	Prefabricated esthetic coated stainless steel crown primary	A 0-20. This procedure is reimbursable for Tooth Letters C, H, M and R for members under 21 years of age; and for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. **Exceptions require prior authorization with documentation of medical necessity.** Pre-authorization is required for Tooth Letters C, H, M and R only for members nine (9) years of age or older. Pre-authorization is not required for Tooth Letters D, E, F, G, N, O, P and Q.	$370.37

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.			
D2950	Core build-up, including any pins	A 0-20. Not allowed on primary teeth. Requires post-operative endodontic x-ray with claim submission. Only available for permanent teeth that have undergone endodontic treatment. A core build-up cannot be authorized in conjunction with a post and core. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$174.04
D2951	Pin retention-per tooth, in addition to restoration	A 0-20. Not allowed on primary teeth. Requires x-rays with claim submission. Reimbursement for pins is limited to one (1) per tooth, within a 12-month period and may only be billed in conjunction with the complex restoration codes D2160 or D2161. This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	$47.65

D2954	Prefabricated post and core in addition to crown	A 0-20. Not allowed on primary teeth. 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. Pre-authorization is required and will not be authorized in combination with a core build-up. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$271.94
D2999	Unspecified restorative procedure	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

19.11. Endodontic Therapy Services

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed intra and postoperatively are included in the root canal reimbursement.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Only endodontic treatment completed to an acceptable standard of care will be approved for reimbursement. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Pulp Capping

Code	Description	Benefit Limits	Fee
Procedure code D3110 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330. **Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth.**			
D3110	Pulp cap-direct (excluding final restoration)	A 1-20. Permanent teeth require x-rays with claim submission. Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp.Pre-operative radiographic images must substantiate the need for this service. This procedure is reimbursable for Tooth Numbers 1 through 32.	$51.80

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	Procedure code D3220 is reimbursable for Tooth Letters A through T. However, this procedure code D3220 is reimbursable for Tooth Letters D, E, F, G, N, O, P and Q only if the member is under five (5) years of age. This is not to be billed as the first stage of root canal therapy. This procedure is limited to once per tooth every 24 months.	$127.77
D3222	Partial Pulpotomy for Apexogenisis – permanent tooth with incomplete root development	This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. This procedure is not considered as the first stage of endodontic therapy and requires pre-authorization. This service is reimbursable only once a 12-month period, per tooth.	$127.77

Endodontic Therapy on Primary Teeth			
Code	**Description**	**Benefit Limits**	**Fee**
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	Coverage is provided 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. If the endodontic pathology on these teeth cannot be treated with a pulpotomy, then extraction and space maintenance may be indicated. Authorization will be limited to a primary second molar in an arch (maxillary or mandibular), when the first permanent molar has not erupted and when a pulpectomy will eliminate the necessity for extraction and the placement of a distal shoe space maintainer. A pulpectomy will not be approved in cases where the primary roots are more than half resorbed or when the six (6) year molar has erupted. Intra-operative radiograph(s), which must include a post-operative radiograph, are included in the reimbursement for the pulpal therapy. This procedure is reimbursable for Tooth Letters A, J, K, and T. Requires pre-authorization. Post-operative radiograph must be submitted with claim.	$205.82

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**
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. **Diagnostic evaluation and necessary radiographs/diagnostic images can be billed separately.** Pre-authorization is required unless performed by an endodontist. Requests for pre-authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the member. Specific treatment plans for final restoration of the tooth must be submitted. In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable. Final approvals for root canals require post authorization. Request for post authorization must be accompanied by the approved pre-authorization request and post-operative radiographs prior to reimbursement. The date of service on the payment request must reflect the final treatment date. Written documentation must also include the type of filling material used as well as the notation of any complications encountered which may compromise the success of the endodontic treatment.			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	A 6-20. This procedure is reimbursable for Tooth Numbers 6-11 and 22-27. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$455.84
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	A 6-20. This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$535.25
D3330	Endodontic therapy, molar tooth (excluding final restoration)	A 6-20. Permanent teeth only. This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$642.31

Endodontic Retreatment			
Code	**Description**	**Benefit Limits**	**Fee**

D3346	Retreatment of root canal - anterior	A 6-20. Requires pre-authorization, x-rays, and documentation of medical necessity. When submitting claims, please include pre-operative and post-operative films. 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 pre- and post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the member's treatment records. Not reimbursable when submitted by the same provider, facility or group that performed the original root canal therapy.	$529.73

Apexification/Recalcification Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following code requires pre-authorization, x-rays, and documentation of medical necessity.			
D3352	Apexification/recalcification-interim medication replacement	A 6-20. Requires pre-authorization. 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 (3) treatments per tooth with the root canal being billed separately. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. A time period of 90 days must elapse between D3352 treatments. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. When submitting claims, please include post-operative films.	$164.38

Apicoectomy/Periradicular Services			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization and x-rays.			
D3410	Apicoectomy/periradicular surgery-anterior	A 6-20. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$437.87
D3430	Retrograde filling-per root	A 6-20. Requires pre-authorization. This procedure will be approved only in conjunction with code D3410. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$174.04

Other Endodontic Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D3999	Unspecified Endodontic procedure	A 1-20. Requires pre-authorization. When submitting claims, please include pre-operative and post-operative films.	Manually Priced

19.12. Periodontal Services

Procedure codes D4210, D4341, and D4999 require pre-authorization, x-rays, and documentation of medical necessity. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210 and possibly D4999.

Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210 and D4355.

Claims for any D4000 series periodontal procedure codes will be denied when submitted for the same DOS as any preventive dental procedure codes D1110, D1120, D1208, and D1206.

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

Surgical Services			
Code	**Description**	**Benefit Limits**	**Fee**

D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	A 0-20. Requires quadrant. This procedure requires pre-authorization, documentation of medical necessity, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. Quadrant designator 10, 20, 30, 40 required. ~~Reimbursable by quadrant.~~	$399.88

Nonsurgical Periodontal Services			
Code	**Description**	**Benefit Limits**	**Fee**
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	A 13-20. Requires pre-authorization, x-rays, periodontal charting, and documentation of medical necessity. D4341 is denied if provided within 21 days of D4355. 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 enrollee's treatment for review with bitewings and/or posterior/anterior periapicals. This service is not allowable for enrollees who have not progressed beyond the mixed dentition stage of development. Only two (2) units of periodontal scaling and root planing may be reimbursed per day. For members requiring hospitalization for dental treatment, a maximum of four (4) units of procedure code D4341 may be paid on the same date of service if pre-authorized and must be billed in conjunction with D9420. When using the 2006 or 2012 or newer ADA claim form used to request pre-authorization or reimbursement, you 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 service is reimbursable by quadrant (10, 20, 30, 40) only once per quadrant in a 12 month period.	$158.85

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit.	A 0-20. Requires x-rays and documentation of medical necessity. D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as any code except D0150, D0210, D0330 or D0350. ~~No other dental services except radiographic images or oral/facial photographic images are reimbursable on the same date of service as full mouth debridement. The exam must be performed after completion of the full mouth debridement.~~ Only one (1) full mouth debridement is allowed in a 12-month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) or Child Prophylaxis (D1120) to the same billing provider, facility, or group within a 12-month period. If the post-authorization request for D4355 is denied and it has been determined that a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis) has not been provided within the preceding 12 months for this member, the provider may render and bill MCNA for a D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis), whichever is applicable based on the member's age.	$117.41

Other Periodontal Services

Code	Description	Benefit Limits	Fee
D4999	Unspecified periodontal procedure	A 0-20. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

19.13. Removable Prosthodontics

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

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

19.13.1. Minimum Standards for Complete and Partial Denture Prosthodontics

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

- The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member'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 member'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 member (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 esthetics.
  - 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 delivery date of the denture and/or partial dentures is the billing date of service (DOS).
- The chart record indicating denture and/or partial delivery date must be submitted with the claim. The claim will also need documentation of the member's signature of acceptance from the aesthetic try-on.
~~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 member (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 esthetics.~~
  - ~~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 delivery date of the denture and/or partial dentures is the billing date of service (DOS).~~

~~The chart record with date of delivery of the dentures, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.~~

The dentist is responsible for all necessary adjustments for a period of six (6) months.

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

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

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

19.13.2. Denture Identification Information

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

- The first four (4) letters of the member's last name and first initial
- The month and year (00/00) the denture was processed

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5110	Complete denture, maxillary	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) 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 member reaches 21 years of age, the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken.	$837.66

		An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5110 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5110 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5120	Complete denture, mandibular	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) 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 member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5120 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5120 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	$837.66
D5130	Immediate denture, maxillary	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) year period.	$837.66

		The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. Once the member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than five (5) years from any prior D5130 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5130 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5140	Immediate denture, mandibular	A 3-20. Only one (1) prosthesis per member, per arch is allowed in a five (5) 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 member reaches 21 years of age the rules of the Adult Denture Program apply. All missing teeth must be marked on the claim form. Radiographic images documenting the necessity for complete denture(s) must be submitted with the request for pre-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	$837.66

		member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than 5 years from any prior D5140 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5140 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.

Partial Dentures (Including Routing Post Delivery Care)

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and documentation of medical necessity. Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition states in the following cases: • Missing one (1) or two (2) maxillary permanent anterior teeth or, • Missing two (2) mandibular permanent anterior teeth or, • Missing three (3) or more permanent teeth in the same arch (of which at least one must be anterior) Medicaid may provide a partial denture (D5211, D5212, D5213, D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (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 (2) or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. Only one (1) complete or partial denture per arch is allowed in a five (5) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. 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. For those members requiring extensive restorations, periodontal services, extractions, etc. clinical/operational notes may be requested with the claim for coverage consideration.			

D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5211 with a D5760 in history with in the past 12 months the fee for D5211 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5211 is reported more than five (5) years from any prior D5211 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5211 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	$795.36
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 3-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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.	$795.36

		If submitted more than 5 years from any prior D5212 with a D5760 in history with in the past 12 months the fee for D5212 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5212 is reported more than five (5) years from any prior D5212 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5212 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 18-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. 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. If submitted more than 5 years from any prior D5213 with a D5760 in history with in the past 12 months the fee for D5213 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5213 is reported more than five (5) years from any prior D5213 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5213 will be reduced by the fee for the D5511, D5512,	$1164.27

		D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 18-20. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in a five (5) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5214 with a D5760 in history with in the past 12 months the fee for D5214 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5214 is reported more than five (5) years from any prior D5214 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5214 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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.	$1164.27

		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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	

Repairs to Complete Dentures

Code	Description	Benefit Limits	Fee
D5511	Repair broken complete denture base, mandibular	A 3-20. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the “Remarks” section of the claim form.	$211.53

D5512	Repair broken complete denture base, maxillary	A 3-20. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5520	Replace missing or broken teeth-complete denture -per tooth~~(each tooth)~~	A 3-20. Cost of repairs cannot exceed replacement costs. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
Cost of repairs cannot exceed replacement costs.			

D5611	Repair resin partial denture base, mandibular	A 3-20. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5612	Repair resin partial denture base, maxillary	A 3-20. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5630	Repair or replace broken retentive/clasping materials - per tooth	A 3-20. Requires documentation of medical necessity. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$201.38

D5640	Replace missing or broken teeth- partial denture - per tooth	A 3-20. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00
D5650	Add tooth to existing partial denture – per tooth	A 3-20. Requires documentation of medical necessity. Requires tooth ID. 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. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00
D5660	Add clasp to existing partial denture - per tooth	A 3-20. Requires documentation of medical necessity. Requires tooth ID. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the “Remarks” section of the claim form.	$119.00

Denture Reline Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
Allowed if the reline makes the denture serviceable. The following codes require pre-authorization and documentation of medical necessity. Not covered within one (1) year of initial placement of dentures.			

D5750	Reline complete maxillary denture (indirect)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75
D5751	Reline complete mandibular denture (indirect)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75

D5760	Reline maxillary partial denture (indirect)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99
D5761	Reline mandibular partial denture (indirect)	A 3-20. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in a five-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least five (5) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99

Interim Prosthesis			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.			
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth) maxillary	A 3-20. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59

D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth) mandibular	A 3-20. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59

Other Removable Prosthetic Services

Code	Description	Benefit Limits	Fee
D5899	Unspecified removable prosthodontic procedure, by report	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity. This procedure code is used for a procedure that is not adequately described by another code. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.	Manually Priced

Maxillofacial Prosthetics

Code	Description	Benefit Limits	Fee
D5986	Fluoride applicator	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity. Reimbursable for arch Designators 01 and 02. Only available for member who are undergoing or who have undergone head and neck radiation therapy.	$98.76

19.14. Fixed Prosthodontics

Prosthodontic procedure codes require pre-authorization. Periapical radiographs are required for each tooth involved in the authorization request.

When a member is missing a single maxillary anterior incisor a resin-bonded fixed prosthesis (Maryland-type bridge consisting of two (2) retainers and a pontic) can be approved. The following requirements apply:

- The member must be at least 16 years of age
- The abutment teeth must be caries-free, restoration-free, and have sound periodontal support
- No other maxillary teeth are missing or require extraction
- Providers must submit with the request for pre-authorization periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed
- Providers must "X" out the missing tooth in the tooth number chart on the ADA form

The overall condition of the mouth is an important consideration in whether a fixed partial denture is authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch. Only one (1) Maryland-type bridge can be authorized in a five (5) year period.

Fixed Partial Dental Pontics

Code	Description	Benefit Limits	Fee
D6241	Pontic - porcelain fused to predominantly base metal	A 16-20. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6545. Limited to one (1) per member in a five (5) year period. This procedure is reimbursable for Tooth Numbers 7, 8, 9, or 10.	$828.68

Fixed Partial Dental Retainers - Inlays/Onlays

Code	Description	Benefit Limits	Fee
D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 16-20. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two (2) per member, in a five (5) year period. This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.	$667.34

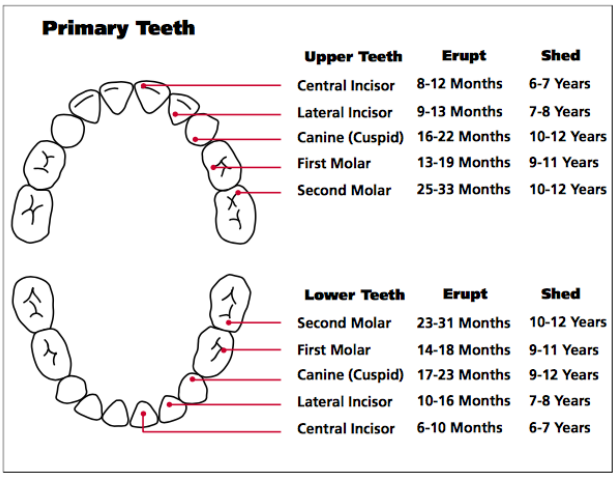
Other Fixed Partial Dental			
Code	**Description**	**Benefit Limits**	**Fee**
D6999	Unspecified fixed prosthodontic procedure	A 16-20. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

19.15. Oral and Maxillofacial Surgery Services

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

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7111	Extraction, coronal remnants - primary tooth	A birth-20. TIDs #A-T and AS-TS.	$87.71
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A birth-20. TIDs 1-32 and A-T, as well as 51-82, and AS-TS as needed. All primary teeth within six (6) months of the ADA's shed age chart will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and documentation of medical necessity. All permanent teeth require an x-ray with claim submission.	$107.04

https://www.mouthhealthy.org/all-topics-a-z/eruption-charts



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Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity for all teeth: 1-32, A-T, 51-82, and AS-TS.			
D7210	Extraction, erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	A 1-20. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment 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. **Oral surgeons are not required to submit documentation for clinical review of this service for symptomatic teeth with the exception of treatment limited to TID 1,16, 17, and 32.**	$176.12
D7220	Removal of impacted tooth-soft tissue	A 1-20. This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for supernumerary teeth 51 through 82 and AS through TS.	$203.75
D7230	Removal of impacted tooth-partially bony	A 1-20. This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for supernumerary teeth 51 through 82 and AS through TS.	$271.11
D7240	Removal of impacted tooth-completely bony	A 1-20. This procedure is reimbursable for Tooth Numbers 1 through 32 and A through T; and for supernumerary teeth 51 through 82 and AS through TS.	$332.52

D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	A 1-20. Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis. Please submit pre-operative x-rays and clinical/operative notes outlining the unusual surgical complications with the claim.	$376.41
D7250	Removal of residual tooth roots (cutting procedure)	A 1-20. Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred.	$195.46

Other Surgical Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 1-20. Requires pre- and post-operative x-rays and documentation of medical necessity. Pre-authorization is required. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form. This information must also be recorded in the member's treatment record. This procedure is not reimbursable for periodontal splinting. Requires Arch Designator 01 or 02. .	Manually Priced, Maximum Fee $345.29
D7280	Exposure of an unerupted tooth	A 1-20. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure no longer includes the placement of orthodontic attachment.	$310.79
D7283	Placement of device to facilitate eruption of impacted tooth	A 1-20. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. Placement of an attachment on an unerupted tooth, after exposure, to aid in its eruption. Report the surgical exposure separately using D7280. This procedure is only reimbursable in conjunction with an MCNA-approved comprehensive orthodontic treatment plan.	$332.90
D7285	Biopsy of oral tissue hard	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity. 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. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	Manually Priced, Maximum Fee $263.83
D7286	Biopsy of oral tissue soft	A 1-20. Requires pre-authorization, x-rays and documentation of medical necessity. 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 submitted with the claim. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$206.51

D7291	Transseptal fiberotomy - by report	A 1-20. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure is only reimbursable in conjunction with a MCNA-approved comprehensive orthodontic treatment plan. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$152.03

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
D7310	Alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity. A minimum of four (4) adjacent teeth must be extracted. Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the “Remarks” section of the claim form. Quadrant designator 10, 20, 30, 40 required.	$189.92

Surgical Incision

Code	Description	Benefit Limits	Fee
D7510	Incision and drainage of abscess - intraoral soft tissue	A 1-20. TID 1-32. Requires x-rays and documentation of medical necessity. This service is not reimbursable for primary teeth. Not payable for same tooth on the same date of service as the extraction.	$148.48

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions

Code	Description	Benefit Limits	Fee

D7880	Occlusal orthotic appliance	A 1-20. Requires pre-authorization, pre-operative x-ray and documentation of medical necessity. Pre-authorization must include a completed TMJ Summary Form, located in the Forms section of this manual, which must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Requires arch 01 or 02.	$461.69

Repair of Traumatic Wounds			
Code	**Description**	**Benefit Limits**	**Fee**
D7910	Suture recent small wound up to 5cm	A 1-20. Requires post-operative color photos and documentation of medical necessity.	$190.61

Other Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
D7961	Buccal/labial frenectomy (frenulectomy)	A ~~01~~20. Oral Cavity Designators 01, 02, 10, 20, 30 or 40. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21
D7962	Lingual frenectomy (frenulectomy)	A ~~01~~20. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21
D7997	Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	This procedure requires pre-authorization and can only be considered for the removal of appliances due to interrupted or discontinued treatment cases. This procedure is not reimbursable to the same billing provider, facility, or group that placed the appliance. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $324.91
D7999	Unspecified oral surgery procedure, by report	A 1-20. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization.	Manually Priced

19.16. Orthodontic Services

Orthodontic treatment is available to members meeting specified criteria. All orthodontic procedures must be pre-authorized. Providers are reminded that the MCNA reimbursement is payment in full for that procedure code.

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

Members who have only crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions, and/or 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 member's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

Comprehensive orthodontic treatment is approved by MCNA 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: other severe craniofacial deformities that result in age appropriate surgical cases as determined by an MCNA Clinical Reviewer.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, MCNA will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for one year.

Providers are reminded that MCNA reimbursement is payment in full for the procedure code.

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. MCNA reimbursement includes the brackets/appliance and all visits and adjustments.

The member must be a good candidate for orthodontic treatment as assessed by the potential provider. The member must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, addressing any noted pathology, including receiving a cleaning within the last six months) must be completed prior to submission of an orthodontic prior authorization request. If approved for this service, the orthodontist is responsible for referring member annually for prophylaxis. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for orthodontic treatment.

Orthodontic Fee Schedule			
Code	**Description**	**Benefit Limits**	**Fee**
D8010	Limited treatment of primary dentition	Requires pre-authorization. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $438.00
D8020	Limited treatment of transitional dentition	Requires pre-authorization. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $438.00
D8070	Comprehensive orthodontic treatment of the transitional dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,182.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,281.00
D8090	Comprehensive orthodontic treatment of the adult dentition.	Requires pre-authorization.	Manually Priced, Maximum Fee $4,515.00
D8220	Fixed appliance therapy	The request for pre-authorization must include sufficient documentation to substantiate the need for and the utility of the appliance. For approval of procedure code D8220, the following must apply: • The child must be between the ages of five (5) years through eight (8) years • The maxillary incisors (7, 8, 9 and 10) are actively erupting • The child still displays the destructive habit • The child has evidenced a desire to stop the destructive habit	$534.71
D8999	Unspecified Orthodontic Procedure	Requires pre-authorization.	Manually Priced

19.17. Adjunctive General Services

Unclassified Treatment			
Code	**Description**	**Benefit Limits**	**Fee**
D9110	Palliative treatment of dental pain – per visit	Emergency service only, limited to trauma case. Requires documentation of medical necessity. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) if authorized, in addition to this procedure code. All codes other than those listed above for radiographs will be denied if billed for the same date of service as D9110. A maximum of two palliative treatments per member are available in a 12-month period.	$79.43

Anesthesia			
Code	**Description**	**Benefit Limits**	**Fee**
Providers rendering sedation services for codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate Provider and Office Permit Level for the level of sedation provided. Providers are responsible for submitting their correct Permit Level for the level of sedation to MCNA. D9222, D9223, D9239, and D9243 can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 or D9243 are available per member per visit. If requested, each must be listed on a separate claim line for both pre-authorization and payment. Oral Surgeons must submit an anesthesia time record with a claim submission of four (4) or more units of IV or deep sedation. All anesthesia time records must be maintained in the clinical record per state requirements.		

D9222	Deep Sedation, general anesthesia – first 15 minutes	A 1-20. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting.	$147.79
D9223	Deep Sedation, general anesthesia – each additional 15 minutes	A 1-20. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9222 and D9223.	$100.15

D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	A 1-20. May not be submitted more than once per member per day. If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied. D9230 (Nitrous Oxide) is not reimbursable on the same day by any provider as procedure codes D9248 (Non-intravenous conscious sedation) and/or D9920 (Behavior Management).	$49.72
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	A 1-20. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting.	$147.79

D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	A 1-20. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9243 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9239 and D9243.	$100.15

D9248	Non-intravenous conscious sedation	A 1-5 for children with behavioral problems, and A 6-20 for individuals with physical or mental disabilities. Sedation form must be submitted with the claim. Must comply with all state rules and AAPD guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. Pre-authorizations are required only for members six (6) years of age and older. A maximum of four (4) non-intravenous conscious sedation/analgesia administrations, per member, are available within a 12-month period by the same billing provider, facility, or group. The request for pre-authorization must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the member. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration. A request for pre-authorization for conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the provider or staff from administration through the time of discharge. The Conscious Sedation Form, located in the Forms section of this manual, must be completed by the provider and sent with the claim submission. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation the provider must document the circumstances in the member's treatment record. Administration of oral pre-medication is not a covered service.	$169.83

Professional Visits			
Code	**Description**	**Benefit Limits**	**Fee**
D9420	Hospital call	A 1-20. One (1) charge per hospital or ASC case. Procedure code D9420 is reimbursable once per six (6) month period, per member. Requires documentation of medical necessity. 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. Reimbursable when providing treatment in a hospital, an outpatient clinic, or an outpatient ambulatory surgical center. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). Hospitalization solely for the convenience of the member or the provider is not allowed. Reimbursement for hospital call is limited to members under the age of six (6) years, unless the child is an individual with a physical or mental disability. Pre-authorization is required only for members six (6) years of age and older. The request for pre-authorization must adequately justify the need for hospitalization in the “Remarks” section of the claim form. If the child is physically or mentally disabled, the particular disability and its impact on the delivery of dental treatment in the office setting must be stated in the “Remarks” section. The request for pre-authorization must outline the entire treatment plan with the hospital code listed first. Additionally, the dental office treatment record for the member must also document the justification for hospitalization including accurate dental charting. A copy of the operative report must be maintained in the member’s dental office treatment record. Denial of a hospital call request member does not prevent payment to the dental provider for any covered, pre-authorized (if required) treatment performed in the hospital. The denial is only for the code D9420 and its accompanying fee for additional reimbursement to the provider as compensation for time out of the office.	$106.18

D9440	Office visit after hours	A 1-20. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. Requires documentation of medical necessity. Procedure code D9440 is to be used for an office visit after regularly scheduled hours for the treatment of a dental emergency. The dental office must be reopened specifically to treat this emergency. The service(s) provided must be reimbursable under the Medicaid EPSDT Dental Program and must be listed on the claim form.	$79.59

Miscellaneous Services

Code	Description	Benefit Limits	Fee
D9920	Behavior management - by report	Requires submission of the MCNA Behavior Management Report Form (located in the Forms section of this manual) with the claim. All services rendered must comply with the AAPD guidelines for the use of passive restraint if passive restraint is utilized. Additional compensation paid for behavior management is intended to help offset the additional cost of providing care to members 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 members receiving similar treatment who do not demonstrate negative or disruptive behavior • Use of an additional dental personnel/assistant(s) • Use of restraint devices such as a papoose board Behavior management is reimbursable for members below the age of eight (8), unless documentation indicates that the individual has a physical or mental disability. The particular disability and its impact on the delivery of dental treatment in the office setting must be stated in the request for pre-authorization. Administration of nitrous (D9230) is not reimbursable when billed conjunction with behavior management on the same day, by any provider. Behavior Management is not reimbursable on the	$68.87

		same day by any provider as procedure code D9248 (Non-intravenous conscious sedation). Pre-authorizations are required only for members eight (8) years of age and older. Providers must indicate on the request for pre-authorization which dental treatment services are scheduled to be delivered at each treatment visit for which a management fee is requested. Behavior management is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7111 - D7999) are performed. Behavior management, if provided, must be billed on the same claim form as the restorative and/or surgical service(s). A maximum of four (4) behavior management services, per member, are available annually by the same billing provider, facility, or group.	
D9944	Occlusal guard – hard appliance, full arch	A 13-20. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96

D9945	Occlusal guard – soft appliance, full arch	A 13-20. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9946	Occlusal guard – hard appliance, partial arch	A 13-20. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9951	Occlusal adjustment - limited	A 13-20. Full mouth procedure. Limited to once per year, per member, any provider, facility, or group. Requires pre-authorization and documentation of medical necessity. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ Summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided.	$145.04
D9999	Unspecified adjunctive procedure, by report	A 1-20. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

20. EPSDT Non-Covered Services

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

- Plaque control
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- Administration of in-office pre-medication

21. EPSDT Pre- and Post-Authorizations

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA's Utilization Management department.

For ease of billing, it is preferable to group services requiring authorization on a single form so that only one pre-authorization request needs to be issued per member.

EPSDT Dental Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided above. **The need for pre-authorization is noted above in the column labeled "Benefit Limits" for all covered procedure codes.**

A provider may choose to submit a post-authorization request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims submitted without a pre-authorization noted in Box 2 of the claim form or without the narrative and documentation required for post-authorization review will be denied. Pre-authorizations are valid for one year. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.

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

Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

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

A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

21.1. Pre-Authorization Reminders

Within 72 hours of the completion of MCNA's review of a pre-authorization request, MCNA will send a pre-authorization letter to the provider detailing those services that have been pre-authorized. The letter will also list any denied services along with an explanation of those denials. A pre-authorization number will be furnished to allow the provider to bill for services as they are completed. If a pre-authorization is required for a procedure code, your claim will be denied if you do not supply an approved pre-authorization number for the service.

The member will also receive a copy of the pre-authorization letter and in the case of a denial, the explanation of denied benefits. The letter will advise members of their appeal rights.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

22. Adult Denture Program Covered Services

The dental services that are covered under the Adult Denture Program are divided into two (2) 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
- Acrylic partial dentures (only in conjunction with an opposing full denture)

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

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

22.1. Examinations

Procedure code D0150 is to be used for the comprehensive examination of the adult Medicaid member who is in need of a complete or partial denture.

Reimbursement for this procedure code requires that radiographs be taken and submitted with the request for denture pre-authorization. The comprehensive oral examination and/or radiographs can only be paid in conjunction with a pre-authorized denture or partial denture.

Procedure code D0150 should be entered on the first line of the claim form followed on the second line by the procedure code for radiographs (D0210, D0240, or D0330).

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

The request for denture pre-authorization must also include all of the other procedures scheduled for the member.

Procedure code D0150 is reimbursable once every eight (8) years when performed by the same billing provider, facility, or group.

22.1.1. Examinations in Anticipation of Denture Construction

If, after verifying the member's eligibility for Medicaid, the provider perceives that the member is eligible for the services available in the Adult Denture Program (e.g. the member is edentulous in one arch or the member 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 member treatment record that the member is in need of a dental prosthesis and that she/he has determined that the member has a qualifying medical need for dentures. The provider must also assess for and record that the member 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).

22.1.2. Minimum Examination Requirements for the Clinical Examination

The member'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 in the member treatment record and appropriate treatment recommendations made.

22.1.3. Examination of Ineligible Members

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

22.1.4. Examination in Conjunction with a Denture Repair

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

22.1.5. 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.

22.2. Radiographs

If radiographs are unobtainable (e.g. the member is physically unable to receive this service or the member 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 member treatment record and on all pre-authorization requests submitted. In this instance, because radiographs were not taken, the provider will not be reimbursed for the examination code D0150.

In order for MCNA to be able to make the necessary authorization determination, radiographs and/or oral/facial images must be of good diagnostic quality. Those requests for pre-authorization that contain radiographs and oral/facial images that are not of good diagnostic quality will be denied.

As the comprehensive oral examination will only be paid in conjunction with the appropriate radiographs, the comprehensive oral examination will be denied if the radiographs are denied.

Procedure code D0210 is reimbursable once every eight (8) years when performed by the same billing provider, facility, or group.

22.3. Removable Prosthodontics

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

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

~~The delivery date of the denture and/or partial dentures is the billing date of service (DOS).~~ **The delivery date of the denture and/or partial denture is the billing date of service (DOS). The chart record indicating denture and/or partial delivery date must be submitted with the claim. The claim will also need documentation of the member's signature of acceptance from the aesthetic try-on.** ~~**The chart record with** date of delivery of the dentures~~**, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.**

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The fee for a comprehensive series of radiographic images (D0210) will be applied when a provider, facility or group submits any combination of D0240 and D0330 within a ~~15 day~~15-day period exceeding the reimbursable value of the comprehensive series of radiographic images.

Exams and x-rays for Adult Denture members are only reimbursed if the denture or partial denture pre-authorization request is approved. Providers should check the member's claims history in the MCNA Provider Portal to determine eligibility for dentures or partial dentures.

Code	Description	Benefit Limits	Fee
D0150	Comprehensive oral evaluation – new or established patient	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) every eight (8) years by the same provider, facility, or group. Must include D0210, D0240, or D0330 as well as a treatment plan for the Adult Denture Program procedures scheduled for the member by any provider. Also denied in conjunction with denture repair or reline.	$64.13

D0210	Intraoral-comprehensive series	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) series every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. • Minimum of five (5) mounted periapical radiographs of each edentulous or partially edentulous arch for which a prosthesis is requested (three (3) periapical radiographs if the arch does not require a prosthesis); or, • Any combination of occlusal films (only for an edentulous arch), periapicals or, panoramic radiographs equal to or greater than the reimbursement allowed for the D0210. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$81.46
D0240	Intraoral-occlusal film	A 21 and older. **This procedure may be reimbursed once per arch in a six (6) month period by any provider, facility or group.** Limited to one (1) film per arch every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$20.41
D0330	Panoramic film	A 21 and older. **This procedure may be reimbursed once in a six (6) month period by any provider, facility or group.** Limited to one (1) service every eight (8) years by the same provider, facility, or group. Denied when radiographs and/or oral/facial images are not of good diagnostic quality. A lead apron and thyroid shield must be used when taking any radiographs. This is generally accepted standard of care practice, and is part of normal, routine, radiographic hygiene.	$57.05

22.4. Caries Risk Assessment

Caries Risk Assessment			
Code	**Description**	**Benefit Limits**	**Fee**
D0601	Caries risk assessment and documentation, with a finding of low risk	A 21 and older. Once in a 12-month period when billed with a valid exam code (D0150) on the same date of service.	$3.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk	A 21 and older. Once in a 12-month period when billed with a valid exam code (D0150) on the same date of service.	$3.00
D0603	Caries risk assessment and documentation, with a finding of high risk	A 21 and older. Once in a 12-month period when billed with a valid exam code (D0150) on the same date of service.	$3.00

~~22.5. Silver Diamine Fluoride~~

~~Silver Diamine Fluoride~~			
~~Code~~	~~Description~~	~~Benefit Limits~~	~~Fee~~

~~22.6.~~22.5. Complete Dentures

Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by Medicaid/MCNA.

All missing teeth or teeth to be extracted must be marked in Block 34 of the ADA Dental Claim Form in the following manner: “X” out missing teeth and “/” out teeth to be extracted.

Immediate dentures are not considered temporary. The provider must inform the member that no reline will be reimbursed by MCNA within one (1) 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 pre-authorized. Radiographs must confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the “Remarks” section that six (6) or fewer teeth will remain when the final impression is taken.

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

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

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing, delivery and adjustment. Although no minimum number of appointments is set the following minimum standards must be adhered to: • The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member’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 member’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 member (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 esthetics. ○ 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 provider is responsible for all necessary adjustments for a period of six (6) months. Records must include a chronological (dated) narrative account of each member's visit indicating what treatment was provided and what conditions were present on those visits. A check 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 member refuses delivery of the complete or partial denture, it cannot be considered delivered. Failure to deliver a minimally acceptable full or partial denture, failure to provide adequate follow-up care, or failure to document the services provided will be considered grounds for recouping the fee paid for the denture. All full and partial dentures reimbursed under the Medicaid Adult Denture Program must have the following unique identification information processed into the acrylic base: • The first four (4) letters of the member's last name and first initial • The month and year (mm/yy) the denture was processed The following codes require pre-authorization, x-rays, and documentation of medical necessity. The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member's signature in the treatment record and submitted to MCNA along with the claim for payment. Additionally, the provider must complete the Adult Denture Program Clinical Condition Certification Form located in the back of the manual under Section 27 and submit with the request for pre-authorization.		
D5110	Complete denture, maxillary	A 21 and older.	$837.00
D5120	Complete denture, mandibular	A 21 and older.	$837.00
D5130	Immediate denture, maxillary	A 21 and older.	$837.00
D5140	Immediate denture, mandibular	A 21 and older.	$837.00

~~22.7.~~22.6. Partial Dentures

The Adult Denture Program only provides for acrylic partials to oppose a full denture and does not provide for two (2) partial dentures in the same oral cavity.

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

- Missing two (2) or more maxillary anterior teeth
- Missing three (3) or more mandibular anterior teeth
- Missing at least four (4) posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion.

Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. A combination of two (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by MCNA.

For relines, at least one (1) 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. Occlusal rest are expected if remaining dentition allows. For those members requiring extensive restorations, periodontal services, extractions, etc. clinical/operational notes may be requested with the claim for coverage consideration.

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

Partial Dentures (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The Adult Denture Program only provides for acrylic partials to oppose a full denture and does not provide for two (2) partial dentures in the same oral cavity. Medicaid may provide an acrylic partial denture when the opposing arch has a functioning complete denture, or is having a complete denture fabricated simultaneous to the partial denture and the arch requiring the partial denture is: • Missing two (2) or more maxillary anterior teeth • Missing three (3) or more mandibular anterior teeth • Missing at least four (4) posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function and balance the occlusion 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. For those members requiring extensive restorations, periodontal services, extractions, etc. clinical/operational notes may be requested with the claim for coverage consideration. The following codes require pre-authorization, x-rays, and documentation of medical necessity. The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member’s signature in the treatment record and submitted to MCNA along with the claim for payment. Additionally, the provider must complete the Adult Denture Program Clinical Condition Certification Form located in the back of the manual under Section 27.7 and submit with the request for pre-authorization.		
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older.	$795.36

D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older.	$795.36

~~22.8.~~22.7. Denture Repairs

Repairs to partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Members 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 (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable, eliminating the need for a new denture unit.

If the same billing provider, facility, or group 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 member as long as the repair makes the denture fully serviceable.

A $296.14 limit in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same member is allowed within a single one (1) year period for the same billing provider, facility, or group.

The fee assigned for the first tooth billed using the codes D5520, 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.

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 member'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 member's 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 the fee paid by the program for the repair.

Repairs to Complete Dentures			
A $296.14 limit in base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same member is allowed within a single one (1) year period for the same billing provider, facility, or group.			
Code	**Description**	**Benefit Limits**	**Fee**

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D5511	Repair broken complete denture base, mandibular	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5512	Repair broken complete denture base, maxillary	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5520	Replace missing or broken teeth-complete denture - per tooth ~~(each tooth)~~	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed 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.	$110.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
D5611	Repair resin partial denture base, mandibular	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5612	Repair resin partial denture base, maxillary	A 21 and older. A repair is allowed in conjunction with a reline on the same member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5630	Repair or replace broken clasp, partial denture - per tooth	A 21 and older. The appropriate tooth ID must be included when requesting reimbursement for these procedures.	$201.38
D5640	Replace missing or broken teeth – partial denture -per tooth	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed 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.	$110.00 $33.00
D5650	Add tooth to existing partial denture – per tooth	A 21 and older. TIDs 2-15 and 18-31. The first tooth billed 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.	$110.00 $33.00
D5660	Add clasp to existing partial denture, per tooth	A 21 and older. The appropriate tooth ID must be included when requesting reimbursement for these procedures.	$119.00

~~22.9.~~22.8. Denture Relines

Relines for partial dentures are covered in the Adult Denture Program only if the partial denture opposes a complete denture. Members 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 (2) complete or partial denture relines per arch or one (1) complete or partial denture and one (1) reline per arch is allowed in an eight (8) year period as pre-authorized by MCNA. The time 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 (1) year has elapsed since the previous complete or partial denture was constructed or last relined.

If the same billing provider, facility, or group requests a complete or partial denture for the same arch within one (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight (8) year period as pre-authorized by MCNA.

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 (8) 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 provider is responsible for all necessary adjustments for a period of six (6) 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

MCNA will result in recoupment of the fee paid for the reline.

Denture Reline Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization and documentation of medical necessity.			
D5750	Reline complete maxillary denture (indirect)	A 21 and older. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$402.75
D5751	Reline complete mandibular denture (indirect)	A 21 and older. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$402.75
D5760	Reline maxillary partial denture (indirect)	A 21 and older. Reimbursable only if the partial denture opposes a complete denture. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$351.99
D5761	Reline mandibular partial denture (indirect)	A 21 and older. Reimbursable only if the partial denture opposes a complete denture. **The provider is responsible for all necessary adjustments for a period of six (6) months.**	$351.99

~~22.10.~~22.9. Other Removable Prosthodontics

Complete Dentures (Including Routine Post-Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5899	Unspecified removable prosthodontic procedure, by report	A 21 and older. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization. Please describe the situation requiring treatment and the treatment proposed in the “Remarks” section of the claim form.	Manually Priced

~~22.11.~~22.10. Oral and Maxillofacial Surgery Services

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A 21 and older. Up to three dental extractions per year (excluding impacted third molars). Requires prior authorization. This procedure will only be paid in conjunction with a pre-authorized denture or partial denture.	$79.07

~~22.12.~~22.11. Teledentistry

Teledentistry			
Code	**Description**	**Benefit Limits**	**Fee**
D9996	Teledentistry (asynchronous)	A 21 and older. Once per year for members with intellectual or developmental disabilities. Must be billed with an approved D0150 for reimbursement. No other services including radiographs are reimbursable with D9996. 'Telehealth' must be indicated as the 'Place of Service' on the claim.	$10.00

23. Adult Denture Non-Covered Services

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

24. Adult Denture Program Pre- and Post- Authorizations

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Providers must include with their pre-authorization requests the appropriate mounted bitewing or periapical radiographs that support the clinical findings and justify the treatment requested.

Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member's record and provide that information to MCNA.

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

All Adult Denture Program services (except for exam, x-rays, and repairs) require pre-authorization. Exams and x-rays are only reimbursed if the denture is approved. Check the member's claims history to ensure the member is eligible for services based on frequency guidelines. The procedure codes for services requiring pre-authorization must be authorized by MCNA before payment will be made. **A provider may choose to submit a post-authorization request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims submitted without a pre-authorization noted on the claim in Box 2 of the claim form, or without the required narrative and documentation required with the claim for post-authorization review, will be denied. Pre-authorizations are valid for one year. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.**

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

When requesting a pre-authorization, the provider should list all services that are anticipated, even those not requiring authorization, in order for MCNA to fully understand the general dental health and condition of the member for whom the request is being made. Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

If a cover sheet is used, please be certain it includes the date of the request, the member's name and Medicaid ID #, the provider's name, and the provider's Medicaid ID or NPI #. A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

If the provider proceeds with treatment before receiving authorization from MCNA, the provider should consider that the request might not be authorized for services rendered. However, providers may render and bill for services that do not require pre-authorization while waiting for MCNA's decision about the authorization of those services that do.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

All pre-authorization requests should be sent to MCNA using the Provider Portal or by mail.

25. Interruption of Treatment

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

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

If a failure to deliver the denture was due to circumstances beyond the provider's control, such as if the member discontinues treatment or loses eligibility during the course of the construction of a denture, then under the

interruption of treatment guidelines, the provider should not bill MCNA using the procedure code as originally pre-authorized.

Because the original procedure could not be completed, the case must be resubmitted to the Utilization Management department so the pre-authorization number can be reissued with the proper procedure code relating to the service attempted. The provider will then be able to bill MCNA for that portion of the treatment that has been completed using the reissued procedure code and pre-authorization number. If the 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. It is the responsibility of the provider to verify member eligibility with MCNA before the delivery of dentures. Please refer to Section 11.14.1 Non-Covered Services Private Payment Agreement Form.

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

For the purpose of determining the amount the provider will be paid for interrupted services, the denture fabrication process is divided into four (4) stages:

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

If treatment is interrupted after completion of Stage 1 (Impressions), 25% of the fee may be paid upon submission of the custom dental impression tray to MCNA. If treatment is interrupted after initial impression but prior to construction of custom impression tray, no reimbursement will be made.

If treatment is interrupted after Stage 2 (Bite Registration), 50% of the fee may be paid upon submission of the wax try-in with denture teeth to MCNA Dental

If treatment is interrupted after completion of Stage 3 (Processing), 75% of the reimbursement fee will be paid upon submission of a color photo with the claim request.

26. Adult Waiver Program Covered Services and Fee Schedules

Reminder: To qualify for the Adult Waiver Program dental services, an adult must be enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver.

26.1. Benefit Limits Key

A = Age

TID = Tooth ID

26.2. Initial Dental Screening and Annual Recall Visits

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

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

This visit should also include preparation and/or updating the member's records, development of a current treatment plan, and the completion of reporting forms. The initial comprehensive oral examination (D0150) or the periodic oral examination (D0120), prophylaxis (D1110 or D1120), and topical application of fluoride (D1206 and D1208) are limited to once per six (6) months.

26.3. Diagnostic Services

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

26.4. Examinations

Clinical Oral Evaluations			
Code	**Description**	**Benefit Limits**	**Fee**
D0120	Periodic oral evaluation (established patient)	A 21 and older. Limited to one (1) every six (6) months as is age appropriate. NOT reimbursable if procedure code D0150 has been reimbursed to the same billing provider, facility, or group within the prior six (6) month period for the same member unless filed by a specialist.	$36.88
D0140	Limited oral evaluation- problem focused	A 21 and older.	$15.00

D0150	Comprehensive oral evaluation – new or established patient	A 21 and older. Limited to one (1) every three (3) years by the same provider. However, procedure code D0150 is NOT reimbursable if procedure code D0120 or D0150 has been reimbursed to any general dentist, facility, or group within a six (6) month period for the same Member unless filed by a specialist. MCNA recognizes this code for a new member only. A new member is described as a member that has not been seen by this provider for at least three (3) years. This procedure code is to be used by a general dentist and/or specialist when evaluating a member comprehensively for the first time (specialists must include a detailed narrative as to why a comprehensive exam was needed and performed since most specialty care visits are for a specific, targeted reason). This would include the examination and recording of the member's dental and medical history and a general health assessment. This procedure should not be billed unless it has been at least three (3) years since the member was seen by the specified provider, facility, or group. An initial comprehensive oral examination (D0150) is limited to once per three (3) years when performed by the same billing provider. A recognized dental specialist within the same office (group) may perform a D0150 prior to the expiration of the three-year period.	$64.13

26.5. Radiographic Images

In order for the MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and oral/facial images that are not of good diagnostic quality will be denied.

There must be a diagnostic purpose for the taking of each radiograph. This must be documented in the member's record and be in accordance with the accepted standard of care. MCNA supports the ADA's principle that patients' radiation exposure be kept as low as reasonably achievable (ALARA) and in compliance with as low as diagnostically acceptable principles.

Table: ***RECOMMENDATIONS FOR PRESCRIBING DENTAL RADIOGRAPHS***

Patient Age and Dental Developmental Stage				
Type of Encounter	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous
New Patient* being evaluated for oral diseases.	Individualized radiographic exam consisting of selected periapical/occlusal views and/ or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radio-graphic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.	
Recall Patient* with clinical caries or at increased risk for caries.**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.			Posterior bitewing exam at 6-18 month intervals.
Recall Patient* with no clinical caries and not at increased risk for caries.**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.		Posterior bitewing exam at 18-36 month intervals.	Posterior bitewing exam at 24-36 month intervals.
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/ skeletal relationships.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships.		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radio- graphic image for evaluation of dental and skeletal relationships.
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/ endodontic needs, treated periodontal disease and caries remineralization.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these conditions.			

*Clinical situation for which radiographs may be indicated include, but are not limited to:

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathosis
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleedings
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical tooth erosion
23. Peri-implantitis

**Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0-6 years of age and over 6 years of age).

Radiographs/Diagnostic Imaging (Including Interpretation)			
Code	**Description**	**Benefit Limits**	**Fee**
The fee for a comprehensive series of radiographic images (D0210) will be applied when a provider, facility or group submits any combination of periapical, occlusal or bitewing radiographic imaging within a 15 day period exceeding the reimbursable value of the comprehensive series of radiographic images. One comprehensive series of radiographic images is available per member every year by provider, facility, or group. Requirements when submitting x-rays: • Must be of diagnostic quality • All x-rays must be marked right & left • Must include the member's name • Must include the date x-rays were taken MCNA encourages the use of digital images. Please be aware that MCNA will not return hardcopy x-rays. We encourage you to make two (2) sets of x-rays and send us the duplicate set.			
D0210	Intraoral-comprehensive series	A 21 and older. MCNA will pay for a comprehensive series of radiographic images (D0210) once every 12-month period by the same provider, facility, or group. The fee for a comprehensive series (D0210) will be applied when an office submits any combination of periapical and bitewing x-rays exceeding the reimbursable value of the comprehensive series. Not allowed as an emergency service.	$81.46
D0220	Intraoral-periapical-first film	A 21 and older. Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated.	$19.89
D0230	Intraoral-periapical-each additional film	A 21 and older. The total cost of periapicals and other radiographs cannot exceed the payment for a comprehensive series. When the fee submitted for any combination of intraoral x-rays in a series meets or exceeds the fee for a comprehensive series, it is considered that the films are the equivalent of a comprehensive series, procedure D0210. When submitting a claim, the tooth number must be indicated.	$16.81

D0240	Intraoral - occlusal film	A 21 and older. Requires documentation of medical necessity with pre-authorization submission. Limited to two (2) services per day by the same provider, facility, or group. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0220 or D0230, if more than one code of D0240 is reported. Claim must include arch designator. May be submitted as an emergency service. If an occlusal film is used in the course of a routine dental exam to aid in caries detection, it will be deemed to be the same as a periapical radiograph (D0220 and D0230) and will be bundled with the other films taken for routine examination and not paid separately.	$27.63
D0272	Bitewings – two (2) films	A 21 and older. Limited to one service in a 12-month period per member by the same provider, facility, or group. Not reimbursable when submitted within a 12-month period of a D0210 by the same provider, facility or group except when submitted by a Medicaid-recognized specialist.	$29.01
D0330	Panoramic film	A 21 and older. Limited to one (1) service a day by any provider, facility, or group, and to one service every year by the same provider, facility, or group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Documentation of medical necessity required for emergency claims.	$77.23

Procedure code **D0350** must be used to submit claims for photographs and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's dental record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210 and D4355.			
D0350	Oral/facial photographic images	A 21 and older. Limited to two (2) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Requires pre-authorization. Oral/facial photographic images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations: prior to gingivectomy; prior to frenulectomy; in conjunction with D7286; or with the presence of a fistula prior to retreatment of previous endodontic therapy, anterior. The provider should bill Medicaid for oral/facial photographic images **ONLY** when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment. Reimbursable for oral cavity designators 01, 02, 10, 20, 30, and 40. Claim must include oral cavity designator.	$37.12

Any periapical radiographic images, occlusal radiographic images, comprehensive 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.

If a comprehensive series of radiographic images (D0210) is billed within 12 months of bitewing radiographic images (D0272), the fee for the comprehensive 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 comprehensive series of radiographic images (D0210), the bitewing radiographic images (D0272) may be subject to recoupment.

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 enrollee'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.

26.6. Other Diagnostic Services

Tests and Examinations			
Code	**Description**	**Benefit Limits**	**Fee**
D0470	Diagnostic casts	A 21 and older. Requires pre-authorization and documentation of medical necessity.	$64.22
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	A 21 and older.	$74.49
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	A 21 and older. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and documentation of medical necessity.	$77.03

26.7. Preventive Services

Preventive services include prophylaxis and topical fluoride treatment.

Dental Prophylaxis			
Code	**Description**	**Benefit Limits**	**Fee**

D1110	Prophylaxis adult	A 21 and older. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis). If submitted on an emergency claim, procedure code will be denied.	$65.00

Topical Fluoride Treatment (Office Procedure)

Code	Description	Benefit Limits	Fee
D1206	Topical application of fluoride varnish	A 21 and older. Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure. Application of fluoride is allowed once every six (6) months. Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.	$32.88
D1208	Topical application of fluoride – excluding varnish	A 21 and older. Includes oral health instructions. Application of fluoride is allowed once every six (6) months. Procedure code D1206 or D1208 is reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.	$26.40

Other Preventive Services

Code	Description	Benefit Limits	Fee

D1351	Dental sealant per tooth	Reimbursable once per tooth in a 36-month period. 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. Sealants are available for the occlusal surface only. In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana. (TIDs #2, 3, 14, 15, 18, 19, 30 and 31 only).	$34.54
D1354	Interim caries arresting medicament application – per tooth	A 21 and older. Limited to Silver Diamine Fluoride. Limited to one application per tooth per 6 months, with a total of 4 applications per lifetime of the tooth. Covered when submitted as the same DOS for D1208 if D1354 is being used to treat caries and D1208 is being used to prevent caries.	$14.63

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26.8. Restorative Services

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

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, group, or facility is responsible for the replacement of the original restoration within the first 12 months after initial placement. Duplicate surfaces are not payable on the same tooth in amalgam or composite restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 12-month period by same provider, facility, or group. Additional restorative services(s) on the same tooth within a 12-month period by the same provider or facility do not require PA.

Laboratory processed crowns are not covered. Provider payments received for restorative work performed within twelve (12) months of a crown procedure on the same tooth will be deducted from the crown procedure reimbursement except in cases of pulpal necrosis or traumatic injury.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161); resin-based composite, four (4) or more surfaces, posterior (D2394); resin-based composite, four (4) or more anterior surfaces (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932 or D2933).

Unless contraindicated, for encounter-based reimbursement situations 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 is a circumstance that requires restorative treatment outside of this parameter, the documentation of medical necessity and circumstance must be clearly documented on the claim submission and will be subject to clinical review.

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

26.8.1. Permanent Tooth Restorations

MCNA will reduce payment for a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same Member, same permanent tooth when billed within 12 months from the date of the original restoration by the same, provider, facility, or group. In these situations, the maximum combined fee for the two or more restorations within a 12 month period on the same permanent tooth will not exceed the maximum fee of the larger restoration. For the same provider, facility, or group, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same member, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury, including codes D2140 and D2330, require x-rays and documentation of medical necessity to be included with claims submission in order to consider for payment. MCNA must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The provider is required to submit x-rays and documentation of medical necessity showing the presence of pulpal necrosis (root canal) or traumatic injury with subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee in order to have the claim reconsidered for payment. The pre-authorization number must be entered in the appropriate block on the claim for payment.

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

26.8.2. General Information

Providers must utilize MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within 12 months from the date of original restoration. MCNA will reduce the payment of other second or subsequent restorations that are rendered within a 12-month period for the same member, same primary tooth. In these situations, the maximum combined fee for two (2) or more restorations within a 12-month period on the same tooth, same member will not exceed the maximum fee of the higher reimbursed restoration.

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

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

Amalgam Restorations (Including Polishing)

Code	Description	Benefit Limits	Fee
Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.			
D2140	Amalgam-one surface - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$87.71
D2140	Amalgam-one surface posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	$101.25
D2150	Amalgam-two surfaces - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$111.20
D2150	Amalgam-two surfaces posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	$124.74
		A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	$158.58
D2160	Amalgam-three surfaces - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$134.68
D2160	Amalgam-three surfaces posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	$178.00
		A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$148.21
D2161	Amalgam-four surfaces posterior - permanent teeth only	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	$178.00

26.9. Resin-Based Composite Restorations - Direct

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two (2) restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period, by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same member, same tooth when billed within 12 months from the date by same provider, facility, or group 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.

Providers must utilize the MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within the 12 months from the date of original restoration. All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration. If the tooth is decayed extensively a crown should be considered.

The resin-based composite – four (4) or more anterior surfaces (D2335 & D2394) – is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four (4) surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two (2) D2332 restorations would not adequately restore the tooth or in cases where two (2) D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

The resin-based composite – four (4) or more surfaces (D2394) – is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

If the same tooth requires a second or subsequent restoration on the same surface(s) by a different provider, pre-authorization is required.

Resin-Based Composite Restorations - Direct

Code	Description	Benefit Limits	Fee
Resin restoration includes composites or glass ionomer. Duplicate surfaces are not payable on the same tooth in restorations in resin-based restorations in a 12-month period by the same provider, facility, or group. **If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.**			
D2330	Resin-one surface, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$102.90
D2330	Resin-one surface, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$129.98
D2331	Resin-two surfaces, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$127.77
D2331	Resin-two surfaces, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo except MI or DI.	$168.39
		A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo of MI or DI.	$171.09
D2332	Resin-three surfaces, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$155.40
D2332	Resin-three surfaces, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$205.49
D2335	Resin-four or more surfaces (anterior) - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$194.77
D2335	Resin-four or more surfaces (anterior) - permanent	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with surface I.	$269.23
D2390	Resin-based composite crown, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$285.25
D2390	Resin-based composite crown, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27. Requires pre-authorization.	$413.86
D2391	Resin-based composite - one surface, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$87.71

D2391	Resin-based composite – one surface, posterior	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$101.25
D2392	Resin-based composite - two surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$111.20
D2392	Resin-based composite - two surfaces, posterior	A 21 and older. Tooth numbers 1, 2, 3. 4. 5, 12. 13. 14. 15, 16. 17. 18. 19. 20. 21. 28, 29, 30. 31. 32 with three surfaces combo except MO or DO. A 21 and older. Tooth numbers 1, 2, 3, 4, 5. 12. 13, 14. 15. 16, 17, 18, 19, 20, 21, 28 29, 30, 31, 32 with two surfaces combo of MO and DO.	$124.74 $158.58
D2393	Resin-based composite - three surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$134.68
D2393	Resin-based composite - three surfaces, posterior	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL. A 21 and older. Tooth Numbers 1, 2 3, 4, 5, 12 ,13, 14 15.16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$178.00 $148.21
D2394	Resin-based composite - four or more surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$158.85
D2394	Resin-based composite - four or more surfaces, posterior	A 21 and older. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$178.00

26.10. Non-Laboratory Crowns

Crown services require radiographic images, photographs, other imaging media or other documentation that depicts the pretreatment condition. The documentation supporting the need for crown services must be available for review by the LDH or MCNA upon request.

Other Restorative Services			
Code	**Description**	**Benefit Limits**	**Fee**

D2920	Recement crown	A 21 and older. The billing provider, facility, or group is responsible for recementation within the first 12 months after placement of the crown. This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter A through T.	$84.61
Procedure codes D2931 and D2932 represent final restorations. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable. 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 member's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by the LDH or MCNA upon request. Pre-authorization is required for all except as noted by code below.		
D2929	Prefabricated porcelain/ceramic crown, primary anterior teeth only	A 21 and older. This procedure is reimbursable for tooth letters C, H, M, and R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$370.37
D2930	Prefabricated stainless steel crown - primary tooth	A 21 and older. This procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q, A, C, H, J, K, M, R and T. Requires prior authorization.	$215.83
D2931	Prefabricated stainless steel crown - permanent tooth	A 21 and older. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 1 through 32.	$341.88
D2932	Prefabricated resin crown	A 21 and older. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$280.57
D2933	Prefabricated stainless steel crown with resin window	A 21 and older. This procedure is reimbursable for Tooth Letters C, H, M, R, D, E, F, G, N, O, P, and Q. Requires prior authorization.	$285.75
D2934	Prefabricated esthetic coated stainless steel crown primary	A 21 and older. This procedure is reimbursable for Tooth Letters C, H, M and R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$370.37

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.			
D2950	Core build-up, including any pins	A 21 and older. Requires post-operative endodontic x-ray with claim submission. A core build-up cannot be authorized in conjunction with a post and core. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$174.04
D2951	Pin retention-per tooth, in addition to restoration	A 21 and older. Requires x-rays with claim submission. Reimbursement for pins is per tooth regardless of number of pins used within a 12-month period and may only be billed in conjunction with the complex restoration codes D2160 or D2161. This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	$47.65
D2954	Prefabricated post and core in addition to crown	A 21 and older. 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 half the length of the root and must closely approximate the canal walls. Pre-authorization is required and will not be authorized in combination with a core build-up. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$271.94
D2999	Unspecified restorative procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

26.11. Endodontic Therapy Services

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed intra and postoperatively are included in the root canal reimbursement.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Only endodontic treatment completed to an acceptable standard of care will be approved for

reimbursement. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Pulp Capping			
Code	**Description**	**Benefit Limits**	**Fee**
Procedure code D3110 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330. **Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth.**			
D3110	Pulp cap-direct (excluding final restoration)	A 21 and older. Requires x-rays with claim submission. Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp. 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.	$51.80

Pulpotomy			
Code	**Description**	**Benefit Limits**	**Fee**
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	A 21 and older. Procedure code D3220 is reimbursable for This procedure is reimbursable for Tooth Numbers 1 through 32. This procedure is limited to once per tooth every 24 months.	$127.77
D3222	Partial Pulpotomy for Apexogenisis – permanent tooth with incomplete root development	A 21 and older. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. This procedure is not considered as the first stage of endodontic therapy and requires pre-authorization. This service is reimbursable only once a 12-month period, per tooth.	$127.77

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**

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. **Diagnostic evaluation and necessary radiographs/diagnostic images can be billed separately.** Pre-authorization is required unless performed by an endodontist. Requests for pre-authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the member. Specific treatment plans for final restoration of the tooth must be submitted. In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable.

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

The date of service on the payment request must reflect the final treatment date. Written documentation must also include the type of filling material used as well as the notation of any complications encountered which may compromise the success of the endodontic treatment.

D3310	Endodontic therapy, anterior tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 6-11 and 22-27. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$455.84
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$535.25
D3330	Endodontic therapy, molar tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$642.31

Endodontic Retreatment

Code	Description	Benefit Limits	Fee

D3346	Retreatment of root canal - anterior	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. When submitting claims, please include pre-operative and post-operative films. 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 pre- and post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the member's treatment records. Not reimbursable when submitted by the same provider, facility or group that performed the original root canal therapy.	$529.73

Apexification/Recalcification Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following code requires pre-authorization, x-Rays, and documentation of medical necessity.			

D3352	Apexification/recalcification-interim medication replacement	A 21 and older. Requires pre-authorization. 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 (3) treatments per tooth with the root canal being billed separately. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. A time period of 90 days must elapse between D3352 treatments. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal. ~~Requires pre-authorization. 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 (3) treatments per tooth with the root canal being the end service of D3350. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. A time period of 90 days must elapse betweenD3351, D3352 and D3353 treatments. A time period of 90 days must elapse between the final D3352 and D3353, which is the completion of the root canal process.~~ This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. When submitting claims, please include post-operative films.	$164.38

Apicoectomy/Periradicular Services			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization and x-rays.			
D3410	Apicoectomy/periradicular surgery-anterior	A 21 and older. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$437.87

D3430	Retrograde filling-per root	A 21 and older. Requires pre-authorization. This procedure will be approved only in conjunction with code D3410. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$174.04

Other Endodontic Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D3999	Unspecified Endodontic procedure	A 21 and older. Requires pre-authorization. When submitting claims, please include pre-operative and post-operative films.	Manually Priced

26.12. Periodontal Services

Procedure codes D4210, D4341, and D4999 require pre-authorization, x-rays, and documentation of medical necessity. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210 and possibly D4999.

Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210 and D4355.

Claims for any D4000 series periodontal procedure codes will be denied when submitted for the same DOS as any preventive dental procedure codes D1110, D1208,and D1354.

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

Surgical Services			
Code	**Description**	**Benefit Limits**	**Fee**

D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	A 21 and older. This procedure requires pre-authorization, documentation of medical necessity, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$399.88

Nonsurgical Periodontal Services

Code	Description	Benefit Limits	Fee
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	A 21 and older. Requires pre-authorization, x-rays, periodontal charting, and documentation of medical necessity. D4341 is denied if provided within 21 days of D4355. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. 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 enrollee's treatment for review with bitewings and/or posterior/anterior periapicals. This service is not allowable for enrollees who have not progressed beyond the mixed dentition stage of development. This service is reimbursable by quadrant (10, 20, 30, 40) only once per quadrant in a 12 month period.~~This service is reimbursable by quadrant only once per quadrant in a 12 month period.~~	$158.85

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	A 21 and older. Requires x-rays and documentation of medical necessity ~~with documentation of medical necessity~~. D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as any code except D0150, D0210, D0330 or D0350. ~~No other dental services except radiographic images or oral/facial photographic images are reimbursable on the same date of service as full mouth debridement. The exam must be performed after completion of the full mouth debridement.~~ Only one (1) full mouth debridement is allowed in a 12-month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) to the same billing provider, facility, or group within a 12-month period. If the post-authorization request for D4355 is denied and it has been determined that a D1110 (Adult Prophylaxis) has not been provided within the preceding 12 months for this member, the provider may render and bill MCNA for a D1110 (Adult Prophylaxis.) ~~whichever is applicable based on the member's age.~~	$117.41

Other Periodontal Services			
Code	**Description**	**Benefit Limits**	**Fee**
D4999	Unspecified periodontal procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

26.13. Removable Prosthodontics

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

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

26.13.1. Minimum Standards for Complete and Partial Denture Prosthodontics

Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing,

delivery, and adjustment. Although no minimum number of appointments is set, the following minimum standards must be adhered to:

The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member'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 member'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 member (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 esthetics.
  - ~~o~~ 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 delivery date of the denture and/or partial dentures is the billing date of service (DOS).

The chart record indicating denture and/or partial delivery date must be submitted with the claim. The claim will also need documentation of the member's signature of acceptance from the aesthetic try-on. ~~The chart record with date of delivery of the dentures, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.~~

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The dentist is responsible for all necessary adjustments for a period of six (6) months.

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

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

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

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5110	Complete denture, maxillary	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period.	$837.66

		The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5110 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5110 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5120	Complete denture, mandibular	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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	$837.66

		member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5120 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5120 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5130	Immediate denture, maxillary	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken.	$837.66

		An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5130 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5130 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5140	Immediate denture, mandibular	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5140 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5140 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	$837.66

Partial Dentures (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity. Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition states in the following cases: • Missing one (1) or two (2) maxillary permanent anterior teeth or, • Missing two (2) mandibular permanent anterior teeth or, • Missing three (3) or more permanent teeth in the same arch (of which at least one must be anterior) • Medicaid may provide a partial denture (D5211, D5212, D5213, D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (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 (2) or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. 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. Occlusal rests are expected if remaining dentition allows. For those members requiring extensive restorations, periodontal services, extractions, etc. clinical/operational notes may be requested with the claim for coverage consideration.			
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5211 with a D5760 in history with in the past 12 months the fee for D5211 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5211 is reported more than eight (8) years from any prior D5211 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5211 will be reduced by the fee for the D5511,	$795.36

		D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5212 with a D5760 in history with in the past 12 months the fee for D5212 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5212 is reported more than eight (8) years from any prior D5212 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5212 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment	$795.36

		radiographic images may be requested prior to approval of a partial denture.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. 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. If submitted more than 8 years from any prior D5213 with a D5760 in history with in the past 12 months the fee for D5213 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5213 is reported more than eight (8) years from any prior D5213 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5213 will be reduced by the fee for D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	$1164.27

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 8 years from any prior D5214 with a D5760 in history with in the past 12 months the fee for D5214 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5214 is reported more than eight (8) years from any prior D5214 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5214 will be reduced by the fee for D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	$1164.27

Repairs to Complete Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
D5511	Repair broken complete denture base, mandibular	A 21 and older. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5512	Repair broken complete denture base, maxillary	A 21 and older. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53

D5520	Replace missing or broken teeth-complete denture – per tooth~~(each tooth)~~	A 21 and older. Cost of repairs cannot exceed replacement costs. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
Cost of repairs cannot exceed replacement costs.			
D5611	Repair resin partial denture base, mandibular	A 21 and older. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the “Remarks” section of the claim form.	$211.53

D5612	Repair resin partial denture base, maxillary	A 21 and older. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5630	Repair or replace broken retentive/clasping materials - per tooth	A 21 and older. Requires Documentation of medical necessity. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$201.38
D5640	Replace missing or broken teeth- partial denture - per tooth	A 21 and older. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00
D5650	Add tooth to existing partial denture – per tooth	A 21 and older. Requires documentation of medical necessity. Requires tooth ID. 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. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00

D5660	Add clasp to existing partial denture - per tooth	A 21 and older. Requires documentation of medical necessity. Requires tooth ID. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$119.00

Denture Reline Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
Allowed if the reline makes the denture serviceable. The following codes require pre-authorization and documentation of medical necessity. Not covered within one (1) year of initial placement of dentures.			
D5750	Reline complete maxillary denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75

D5751	Reline complete mandibular denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75
D5760	Reline maxillary partial denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99

D5761	Reline mandibular partial denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99

Interim Prosthesis			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, diagnostic quality x-rays, and documentation of medical necessity for an interim prosthesis. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.			

D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth) maxillary	A 21 and older. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59

D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth) mandibular	A 21 and older. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59

Other Removable Prosthetic Services			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5899	Unspecified removable prosthodontic procedure, by report	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This procedure code is used for a procedure that is not adequately described by another code. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.	Manually Priced

26.14. Fixed Prosthodontics

Prosthodontic procedure codes require pre-authorization. Periapical radiographs showing at least 2mm of apical bone are required for each tooth involved in the authorization request.

When a member is missing a single maxillary anterior incisor a resin-bonded fixed prosthesis (Maryland-type bridge consisting of two (2) retainers and a pontic) can be approved. The following requirements apply:

- The abutment teeth must be caries-free, restoration-free, and have sound periodontal support
- No other maxillary teeth are missing or require extraction
- Providers must submit with the request for pre-authorization periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed
- Providers must "X" out the missing tooth in the tooth number chart on the ADA form

The overall condition of the mouth is an important consideration in whether a fixed partial denture is authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch. Only one (1) Maryland-type bridge can be authorized in an eight (8) year period.

Fixed Partial Dental Pontics			
Code	**Description**	**Benefit Limits**	**Fee**
D6241	Pontic - porcelain fused to predominantly base metal	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6545. Limited to one (1) per member in an eight (8) year period. This procedure is reimbursable for Tooth Numbers 7, 8, 9, or 10.	$828.68

Fixed Partial Dental Retainers - Inlays/Onlays			
Code	**Description**	**Benefit Limits**	**Fee**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two (2) per member, in an eight (8) year period. This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.	$667.34

Other Fixed Partial Dental			
Code	**Description**	**Benefit Limits**	**Fee**
D6999	Unspecified fixed prosthodontic procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

26.15. Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the Adult Waiver Program.

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7111	Extraction, coronal remnants - primary tooth	A 21 and older. TIDs #A-T and AS-TS.	$87.71
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A 21 and older. TIDs 1-32 and A-T as well as 51-82 and AS-TS as needed. Requires an x-ray with claim submission.	$107.04

Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity for all teeth: 1-32 and 51-82.			
D7210	Extraction, erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	A 21 and older. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment 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. **Oral surgeons are not required to submit documentation for clinical review of this service for symptomatic teeth with the exception of treatment limited to TID 1,16, 17, and 32.**	$176.12
D7220	Removal of impacted tooth-soft tissue	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$203.75
D7230	Removal of impacted tooth-partially bony	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$271.11
D7240	Removal of impacted tooth-completely bony	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$332.52

D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	A 21 and older. Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis. Please submit pre-operative x-rays and clinical/operative notes outlining the unusual surgical complications with the claim.	$376.41
D7250	Removal of residual tooth roots (cutting procedure)	A 21 and older. Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred.	$195.46

Other Surgical Procedures

Code	Description	Benefit Limits	Fee
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 21 and older. Requires pre- and post-operative x-rays and documentation of medical necessity. Pre-authorization is required. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form. This information must also be recorded in the member's treatment record. This procedure is not reimbursable for periodontal splinting. Requires Arch Designator 01 or 02.	Manually Priced, Maximum Fee $345.29
D7280	Exposure of an unerupted tooth	A 21 and older. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure no longer includes the placement of orthodontic attachment.	$310.79
D7283	Placement of device to facilitate eruption of impacted tooth	A 21 and older. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. Placement of an attachment on an unerupted tooth, after exposure, to aid in its eruption. Report the surgical exposure separately using D7280. This procedure is only reimbursable in conjunction with an MCNA-approved comprehensive orthodontic treatment plan.	$332.90

D7285	Biopsy of oral tissue hard	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. 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. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	Manually Priced, Maximum Fee $263.83
D7286	Biopsy of oral tissue soft	A 21 and older. Requires pre-authorization, x-rays and documentation of medical necessity. 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 submitted with the claim. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$206.51
D7291	Transseptal fiberotomy - by report	A 21 and older. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure is only reimbursable in conjunction with a MCNA-approved comprehensive orthodontic treatment plan. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$152.03

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
D7310	Alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. A minimum of four (4) adjacent teeth must be extracted. Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the “Remarks” section of the claim form. Quadrant designator 10, 20, 30, 40 required.~~.~~	$189.92

Surgical Incision			
Code	**Description**	**Benefit Limits**	**Fee**
D7510	Incision and drainage of abscess - intraoral soft tissue	A 21 and older. TID 1-32. Requires x-rays and documentation of medical necessity. This service is not reimbursable for primary teeth. Not payable for same tooth on the same date of service as the extraction.	$148.48

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions			
Code	**Description**	**Benefit Limits**	**Fee**
D7880	Occlusal orthotic appliance	A 21 and older. Requires pre-authorization, pre-operative x-ray and documentation of medical necessity. Pre-authorization must include a completed TMJ Summary Form, located in the Forms section of this manual, which must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Requires arch 01 or 02.	$461.69

Repair of Traumatic Wounds			
Code	**Description**	**Benefit Limits**	**Fee**
D7910	Suture recent small wound up to 5cm	A 21 and older. Requires post-operative color photos and documentation of medical necessity.	$190.61

Other Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
D7961	Buccal/labial frenectomy (frenulectomy)	A 21 and older. Oral Cavity Designators 01, 02, 10, 20, 30 or 40. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21

D7962	Lingual frenectomy (frenulectomy)	A 21 and older. Oral Cavity Designators 02, 30, or 40. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21
D7997	Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	A 21 and older. This procedure requires pre-authorization and can only be considered for the removal of appliances due to interrupted or discontinued treatment cases. This procedure is not reimbursable to the same billing provider, facility, or group that placed the appliance. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $324.91
D7999	Unspecified oral surgery procedure, by report	A 21 and older. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization.	Manually Priced

26.16. Orthodontic Services

Orthodontic treatment is available to members meeting specified criteria. All orthodontic procedures must be pre-authorized. Providers are reminded that the MCNA reimbursement is payment in full for that procedure code.

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

Members who have only crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions, and/or 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 member's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

Comprehensive orthodontic treatment is approved by MCNA 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: other severe craniofacial deformities that result in age appropriate surgical cases as determined by an MCNA Clinical Reviewer.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, MCNA will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for

each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for one year.

Providers are reminded that MCNA reimbursement is payment in full for the procedure code.

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. MCNA reimbursement includes the brackets/appliance and all visits and adjustments.

The member must be a good candidate for orthodontic treatment as assessed by the potential provider. The member must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, addressing any noted pathology, including receiving a cleaning within the last six months) must be completed prior to submission of an orthodontic prior authorization request. Orthodontist must refer member to ensure at least one prophylaxis per year. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for the orthodontic treatment.

Orthodontic Fee Schedule			
Code	**Description**	**Benefit Limits**	**Fee**
D8090	Comprehensive orthodontic treatment of the adult dentition.	A 21 and older. Requires pre-authorization.	Manually Priced, Maximum Fee $4,515.00

26.17. Adjunctive General Services

Unclassified Treatment			
Code	**Description**	**Benefit Limits**	**Fee**

D9110	Palliative treatment of dental pain – per visit	A 21 and older. Emergency service only, limited to trauma case. Requires documentation of medical necessity. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. A 21 and older. On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) if authorized, in addition to this procedure code. All codes other than those listed above for radiographs will be denied if billed for the same date of service as D9110. A maximum of two palliative treatments per member are available in a 12-month period.	$79.43

Anesthesia			
Code	**Description**	**Benefit Limits**	**Fee**
Providers rendering sedation services for codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate Provider and Office Permit Level for the level of sedation provided. Providers are responsible for submitting their correct Permit Level for the level of sedation to MCNA. D9222, D9223, D9239 and D9243 can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 and D9243 are available per member per visit. If requested, each must be listed on a separate claim line for both pre-authorization and payment. Oral Surgeons must submit an anesthesia time record with a claim submission of four (4) or more units of IV or deep sedation. All anesthesia time records must be maintained in the clinical record per state requirements.			

D9222	Deep Sedation, general anesthesia – first 15 minutes	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9222 and D9223.	$147.79
D9223	Deep Sedation, general anesthesia – each additional 15 minutes	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9222 and D9223.	$100.15

D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	A 21 and older. May not be submitted more than once per member per day. If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied. D9230 (Nitrous Oxide) is not reimbursable on the same day by any provider as procedure codes D9248 (Non-intravenous conscious sedation.)	$49.72
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9239 and D9243.	$147.79

D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9243 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9239 andD9243.	$100.15

D9248	Non-intravenous conscious sedation	A 21 and older. Sedation form must be submitted with the claim. Must comply with all state rules and guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. Pre-authorizations are required. A maximum of four (4) non-intravenous conscious sedation/analgesia administrations, per member, are available within a 12-month period by the same billing provider, facility, or group. The request for pre-authorization must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the member. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration. A request for pre-authorization for conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the provider or staff from administration through the time of discharge. The Conscious Sedation Form, located in the Forms section of this manual, must be completed by the provider and sent with the claim submission. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation the provider must document the circumstances in the member's treatment record. Administration of oral pre-medication is not a covered service.	$169.83

Professional Visits			
Code	**Description**	**Benefit Limits**	**Fee**
D9420	Hospital call	A 21 and older. One (1) charge per hospital or ASC case. Procedure code D9420 is reimbursable once per six (6) month period, per member. Requires documentation of medical necessity. 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. Reimbursable when providing treatment in a hospital, an outpatient clinic, or an outpatient ambulatory surgical center. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). Hospitalization solely for the convenience of the member or the provider is not allowed. Pre-authorization is required and must include documentation outlining the necessity for hospitalization. A copy of the operative report must be maintained in the member's dental record. Denial of a hospital call request member does not prevent payment to the dental provider for any covered, pre-authorized (if required) treatment performed in the hospital. The denial is only for the code D9420 and its accompanying fee for additional reimbursement to the provider as compensation for time out of the office.	$106.18
D9440	Office visit after hours	A 21 and older. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. Requires documentation of medical necessity. 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 Adult Waiver Program and must be listed on the claim form.	$79.59

Miscellaneous Services			
Code	**Description**	**Benefit Limits**	**Fee**
D9944	Occlusal guard – hard appliance, full arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9945	Occlusal guard – soft appliance, full arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96

D9946	Occlusal guard – hard appliance, partial arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9951	Occlusal adjustment - limited	A 21 and older. Full mouth procedure. Limited to once per year, per member, any provider, facility, or group. Requires pre-authorization and documentation of medical necessity. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ Summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided.	$145.04
D9997	Dental Case Management – patients with special health care needs	A 21 and older. A maximum of four dental case 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. This is a per visit reimbursement to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population; This fee will be paid in addition to the normal fees for specific dental procedures. **Documentation of the circumstances requiring special treatment considerations as well as the specific efforts or techniques utilized must be recorded in the enrollee's treatment record for each treatment visit.**	$29.00
D9999	Unspecified adjunctive procedure, by report	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

27. Adult Waiver Program Non-Covered Services

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

- Plaque control
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- Administration of in-office pre-medication

28. Adult Waiver Program Pre- and Post-Authorizations

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA's Utilization Management department.

For ease of billing it is preferable to group services requiring authorization on a single form so that only one pre-authorization request need be issued per member.

Adult Waiver Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided above. **The need for pre-authorization is noted above in the column labeled "Benefit Limits" for all covered procedure codes.**

A provider may choose to submit a post-authorization request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims submitted without a pre-authorization noted in Box 2 of the claim form or without the narrative and documentation required for post-authorization review will be denied. Pre-authorizations are valid for one year. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.

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

Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

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

A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

28.1. Pre-Authorization Reminders

Within 72 hours of the completion of MCNA's review of a pre-authorization request, MCNA will send a pre-authorization letter to the provider detailing those services that have been pre-authorized. The letter will also list any denied services along with an explanation of those denials. A pre-authorization number will be furnished to allow the provider to bill for services as they are completed. If a pre-authorization is required for a procedure code, your claim will be denied if you do not supply an approved pre-authorization number for the service.

The member will also receive a copy of the pre-authorization letter and in the case of a denial, the explanation of denied benefits. The letter will advise members of their appeal rights.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

29. Adult ICF/IID Program Covered Services and Fee Schedules

Reminder: To qualify for the Adult ICF/IID Program dental services, a member must reside in an Intermediate Care Facilities for Individuals with Intellectual Disabilities and be 21 years of age and older.

29.1. Benefit Limits Key

A = Age
TID = Tooth ID

29.2. Diagnostic Services

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

29.3. Examinations

Diagnostic codes D0120, D0140 and D0150 are excluded from payment for members of the ICF/IID Program as these are covered annually by the ICF/IID. Federal regulations require Intermediate Care Facilities to provide these services to their residents.

29.4. Radiographic Images

In order for the MCNA to be able to make the necessary authorization determinations, radiographic images and/or oral/facial images must be of good diagnostic quality. Requests for pre-authorization that contain radiographic images and oral/facial images that are not of good diagnostic quality will be denied.

There must be a diagnostic purpose for the taking of each radiograph. This must be documented in the member's record and be in accordance with the accepted standard of care.

Radiographic imaging codes D0210, D0240, D0272 and D0330 are excluded from payment for members of the ICF/IID Program as these are covered annually by the ICF/IID.

Any periapical radiographic images, occlusal radiographic images, comprehensive 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.

Radiographs/Diagnostic Imaging (Including Interpretation)			
Code	**Description**	**Benefit Limits**	**Fee**

Requirements when submitting x-rays: • Must be of diagnostic quality • All x-rays must be marked right & left • Must include the member's name • Must include the date x-rays were taken MCNA encourages the use of digital images. Please be aware that MCNA will not return hardcopy x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.			
D0220	Intraoral-periapical-first film	A 21 and older. Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated.	$19.89
D0230	Intraoral-periapical-each additional film	A 21 and older.	$16.81
Procedure code **D0350** must be used to submit claims for photographs and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's dental record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210 and D4355.			
D0350	Oral/facial photographic images	A 21 and older. Limited to two (2) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. Oral/facial photographic images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations: prior to gingivectomy; prior to frenectomy; in conjunction with D7286; or with the presence of a fistula prior to retreatment of previous endodontic therapy, anterior. The provider should bill Medicaid for oral/facial photographic images **ONLY** when the photographs are taken under these circumstances. If post payment review discovers the billing of oral/facial images not in conjunction with these specific services, recoupment will be initiated. Oral/facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment. Reimbursable for oral cavity designators 01, 02, 10, 20, 30, and 40. Claim must include oral cavity designator.	$37.12

Any periapical radiographic images, occlusal radiographic images, comprehensive 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.

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 enrollee'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.

29.5. Other Diagnostic Services

Tests and Examinations			
Code	**Description**	**Benefit Limits**	**Fee**
D0470	Diagnostic casts	A 21 and older. Requires pre-authorization and documentation of medical necessity.	$64.22
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	A 21 and older.	$74.49
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	A 21 and older. Oral pathologists and medical pathologists may be reimbursed for histopathologic study and interpretation of oral specimens. The attending dental provider may not request pre-authorization or bill this code on the pathologist's behalf. For pre-authorization of the surgical procedure to obtain the specimen for biopsy please refer to the section on Oral Surgery Services, codes D7285 and D7286. Requires pre-authorization and documentation of medical necessity.	$77.03

29.6. Preventive Services

Preventive services include prophylaxis and topical fluoride treatment.

Dental Prophylaxis			
Code	**Description**	**Benefit Limits**	**Fee**

D1110	Prophylaxis adult	A 21 and older. Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. If, at the initial visit, it is determined that the Adult Prophylaxis is the appropriate treatment and code D1110 (Adult Prophylaxis) is billed to and reimbursed by Medicaid or MCNA, then procedure code D4355 (Full Mouth Debridement) will not be reimbursed if it is billed within 12 months subsequent to the date of service of the D1110 (Adult Prophylaxis.)If submitted on an emergency claim, procedure code will be denied.	$65.00

Topical Fluoride Treatment (Office Procedure)

Code	Description	Benefit Limits	Fee
D1206	Topical application of fluoride varnish	A 21 and older. Includes oral health instructions. Application of fluoride is allowed once every six (6) months. Procedure code D1206 and D1208 are reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.	$32.88
D1208	Topical application of fluoride – excluding varnish	A 21 and older. Includes oral health instructions. Application of fluoride is allowed once every six (6) months. Procedure code D1206 and D1208 are reimbursable by MCNA to any billing provider, facility, or group once per six (6) month period, per member.	$26.40

Other Preventive Services

Code	Description	Benefit Limits	Fee

D1351	Dental sealant per tooth	Reimbursable once per tooth in a 36-month period. 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. Sealants are available for the occlusal surface only. In order for a tooth to be reimbursable for sealant services, it must be caries-free on the date of service. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana. (TIDs #2, 3, 14, 15, 18, 19, 30 and 31 only).	$34.54
D1354	Interim caries arresting medicament application – per tooth	A 21 and older. Limited to Silver Diamine Fluoride. Limited to one application per tooth per 6 months, with a total of 4 applications per lifetime of the tooth. Covered when submitted as the same DOS for D1208 if D1354 is being used to treat caries and D1208 is being used to prevent caries.	$14.63

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29.7. Restorative Services

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

The surfaces that may be billed as restored can be any one or combination of five (5) of the seven (7) recognized tooth surfaces: mesial, distal, occlusal (or incisal), lingual, or facial (or buccal).

The original billing provider, group, or facility is responsible for the replacement of the original restoration within the first 12 months after initial placement. Duplicate surfaces are not payable on the same tooth in amalgam or composite restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service. All restored surfaces on a single tooth shall be considered connected. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum restorative fee for the combined number of non-duplicated surfaces when performed within a 12-month period by same provider, facility, or group. Additional restorative services(s) on the same tooth within a 12-month period by the same provider or facility do not require PA.

Laboratory processed crowns are not covered. Provider payments received for restorative work performed within twelve (12) months of a crown procedure on the same tooth will be deducted from the crown procedure reimbursement except in cases of pulpal necrosis or traumatic injury.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four (4) or more surfaces, permanent (D2161); resin-based composite, four (4) or more surfaces, posterior (D2394); resin-based composite, four (4) or more anterior surfaces (D2335); a resin-based composite crown, anterior (D2390); or a prefabricated stainless steel crown (D2930, D2931, D2932 or D2933).

Unless contraindicated, for encounter-based reimbursement situations 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 is a circumstance that requires restorative treatment outside of this parameter, the documentation of medical necessity and circumstance must be clearly documented on the claim submission and will be subject to clinical review.

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

29.7.1. Permanent Tooth Restorations

MCNA will reduce payment for a second or subsequent amalgam restoration (Procedure Codes D2140, D2150, D2160 and D2161); and/or a second or subsequent resin-based composite restoration (Procedure Codes D2330, D2331, D2332 and D2335) for the same Member, same permanent tooth when billed within 12 months from the date of the original restoration by the same, provider, facility, or group. In these situations, the maximum combined fee for the two or more restorations within a 12 month period on the same permanent tooth will not exceed the maximum fee of the larger restoration. For the same provider, facility, or group, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full Medicaid reimbursement fee for the same member, same permanent tooth when billed within 12 months from the date of the original restoration when the need for the restoration is due to pulpal necrosis (root canal) or traumatic injury to the tooth. All second and subsequent restorations that are requested as a result of pulpal necrosis (root canal) or traumatic injury, including codes D2140 and D2330, require x-rays and documentation of medical necessity to be included with claims submission in order to consider for payment. MCNA must be able to determine that the services are required as a result of pulpal necrosis (root canal) or traumatic injury; therefore, thorough documentation is required. The provider is required to submit x-rays and documentation of medical necessity showing the presence of pulpal necrosis (root canal) or traumatic injury with subsequent claims for permanent teeth that are eligible for reimbursement at the full reimbursement fee in order to have the claim reconsidered for payment. The pre-authorization number must be entered in the appropriate block on the claim for payment.

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

29.7.2. General Information

Providers must utilize MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within 12 months from the date of original restoration. MCNA will reduce the payment of other second or subsequent restorations that are rendered within a 12-month period for the same member, same primary tooth. In these situations, the maximum combined fee for two (2) or more restorations within a 12-month period on the same tooth, same member will not exceed the maximum fee of the higher reimbursed restoration.

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

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

Amalgam Restorations (Including Polishing)

Code	Description	Benefit Limits	Fee
Duplicate surfaces are not payable on the same tooth in amalgam restorations in a 12-month period by same provider, facility, or group. If the same tooth requires a second or subsequent restoration and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.			
D2140	Amalgam-one surface - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$87.71
D2140	Amalgam-one surface posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	$101.25
D2150	Amalgam-two surfaces - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$111.20
D2150	Amalgam-two surfaces posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	$124.74
		A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	$158.58
D2160	Amalgam-three surfaces - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, C, H, I, J, K, L, M, R, S, and T.	$134.68
D2160	Amalgam-three surfaces posterior – permanent	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	$178.00
		A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$148.21
D2161	Amalgam-four surfaces posterior - permanent teeth only	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	$178.00

29.8. Resin-Based Composite Restorations - Direct

Procedure codes D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394 represent final restorations. If two (2) restorations are placed on the same tooth, a maximum fee for resin-based composites that can be reimbursed per tooth has been established. The fee for any additional restorative service(s) on the same tooth will be reduced to the maximum fee for the combined number of surfaces when performed within a 12-month period, by the same provider, facility, or group. If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.

Procedure D2335 or D2394 is reimbursable only once per day, same tooth, any billing provider.

In these situations, the maximum combined fee for the two (2) or more restorations within a 12-month period on the same tooth will not exceed the maximum fee of the larger restoration. In addition, MCNA policy allows reimbursement for certain second or subsequent restorations on permanent teeth at the full reimbursement fee for the same member, same tooth when billed within 12 months from the date by same provider, facility, or group 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.

Providers must utilize the MCNA's Provider Portal or call the Provider Hotline in order to determine whether the member has received a restoration within the 12 months from the date of original restoration. All composite restorations must be placed in a preparation that extends through the enamel and into the dentin. To bill for a particular surface in a complex restoration, the margins of the preparation must extend past the line angles onto the claimed surface. A Class V resin-based composite restoration is a one surface restoration. If the tooth is decayed extensively a crown should be considered.

The resin-based composite – four (4) or more anterior surfaces (D2335 & D2394) – is a restoration in which both the lingual and facial margins extend beyond the proximal line angle and the incisal angle is involved. This restoration might also involve all four (4) surfaces of a tooth and not involve the incisal angle. To receive reimbursement for a restoration involving the incisal angle, the restoration must involve at least 1/3 of the clinical crown of the tooth.

The resin-based composite crown, anterior (D2390) is a single anterior restoration that involves full resin-based composite coverage of a tooth. Providers may request this procedure in cases where two (2) D2332 restorations would not adequately restore the tooth or in cases where two (2) D2335 would be required. Providers may also request this procedure on a tooth that has suffered a horizontal fracture resulting in the loss of the entire incisal segment.

The resin-based composite – four (4) or more surfaces (D2394) – is a single posterior restoration that involves full resin-based composite coverage of a tooth. Providers may bill this procedure in cases where two D2393 restorations would not adequately restore the tooth.

If the same tooth requires a second or subsequent restoration on the same surface(s) by a different provider, pre-authorization is required.

Resin-Based Composite Restorations - Direct

Code	Description	Benefit Limits	Fee
Resin restoration includes composites or glass ionomer. Duplicate surfaces are not payable on the same tooth in restorations in resin-based restorations in a 12-month period by the same provider, facility, or group. **If the same tooth requires a second or subsequent restoration, and the provider did not perform the initial surface(s) restoration, pre-authorization is required and provider will receive full fee for service.**			
D2330	Resin-one surface, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$102.90
D2330	Resin-one surface, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$129.98
D2331	Resin-two surfaces, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$127.77
D2331	Resin-two surfaces, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo except MI or DI.	$168.39
		A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces combo of MI or DI.	$171.09
D2332	Resin-three surfaces, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$155.40
D2332	Resin-three surfaces, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	$205.49
D2335	Resin-four or more surfaces (anterior) - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$194.77
D2335	Resin-four or more surfaces (anterior) - permanent	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with surface I.	$269.23
D2390	Resin-based composite crown, anterior - primary	A 21 and older. This procedure is reimbursable for primary teeth. Tooth Letters C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$285.25
D2390	Resin-based composite crown, anterior	A 21 and older. Tooth Numbers 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27. Requires pre-authorization.	$413.86
D2391	Resin-based composite - one surface, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$87.71

D2391	Resin-based composite – one surface, posterior	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$101.25
D2392	Resin-based composite - two surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$111.20
D2392	Resin-based composite - two surfaces, posterior	A 21 and older. Tooth numbers 1, 2, 3. 4. 5, 12. 13. 14. 15, 16. 17. 18. 19. 20. 21. 28, 29, 30. 31. 32 with three surfaces combo except MO or DO. A 21 and older. Tooth numbers 1, 2, 3, 4, 5. 12. 13, 14. 15. 16, 17, 18, 19, 20, 21, 28 29, 30, 31, 32 with two surfaces combo of MO and DO.	$124.74 $158.58
D2393	Resin-based composite - three surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$134.68
D2393	Resin-based composite - three surfaces, posterior	A 21 and older. Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL. A 21 and older. Tooth Numbers 1, 2 3, 4, 5, 12 ,13, 14 15.16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	$178.00 $148.21
D2394	Resin-based composite - four or more surfaces, posterior - primary	A 21 and older. This procedure is reimbursable for primary teeth, Tooth Letters A, B, I, J, K, L, S and T.	$158.85
D2394	Resin-based composite - four or more surfaces, posterior	A 21 and older. This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	$178.00

Other Restorative Services

Code	Description	Benefit Limits	Fee
D2920	Recement crown	A 21 and older. The billing provider, facility, or group is responsible for recementation within the first 12 months after placement of the crown. This procedure is reimbursable for Tooth Numbers 1 through 32 and Tooth Letter A through T.	$84.61

Procedure codes D2931 and D2932 represent final restorations. Non-laboratory or chair-side full coverage restorations such as stainless steel and polycarbonate crowns are available but should only be considered when other conventional chair-side types of restorations such as complex amalgams and composite resins are unsuitable. 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 member's treatment records if radiographic images are medically contraindicated. The documentation that supports the need for crown services must be available for review by the LDH or MCNA upon request. Pre-authorization is required for all except as noted by code below.			
D2929	Prefabricated porcelain/ceramic crown, primary teeth only anterior teeth only	A 21 and older. This procedure is reimbursable for tooth letters C, H, M, and R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$370.37
D2930	Prefabricated stainless steel crown - primary tooth	A 21 and older. This procedure code is payable for Tooth Letters D, E, F, G, N, O, P and Q, A, C, H, J, K, M, R and T. Requires prior authorization.	$215.83
D2931	Prefabricated stainless steel crown - permanent tooth	A 21 and older. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 1 through 32.	$341.88
D2932	Prefabricated resin crown	A 21 and older. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27 and C, H, M, R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$280.57
D2933	Prefabricated stainless steel crown with resin window	A 21 and older. This procedure is reimbursable for Tooth Letters C, H, M, R, D, E, F, G, N, O, P, and Q. Requires prior authorization.	$285.75
D2934	Prefabricated esthetic coated stainless steel crown primary	A 21 and older. This procedure is reimbursable for Tooth Letters C, H, M and R, D, E, F, G, N, O, P and Q. Requires prior authorization.	$370.37

The codes D2950 and D2954 are intermediate restorative codes for endodontically treated permanent teeth.			
D2950	Core build-up, including any pins	A 21 and older. Requires post-operative endodontic x-ray with claim submission. A core build-up cannot be authorized in conjunction with a post and core. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$174.04

D2951	Pin retention-per tooth, in addition to restoration	A 21 and older. Requires x-rays with claim submission. Reimbursement for pins is limited to one (1) per tooth, within a 12-month period and may only be billed in conjunction with the complex restoration codes D2160 or D2161. This procedure is reimbursable for Tooth Numbers 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	$47.65
D2954	Prefabricated post and core in addition to crown	A 21 and older. 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. Pre-authorization is required and will not be authorized in combination with a core build-up. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$271.94
D2999	Unspecified restorative procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

29.9. Endodontic Therapy Services

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed intra and postoperatively are included in the root canal reimbursement.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Only endodontic treatment completed to an acceptable standard of care will be approved for reimbursement. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

Pulp Capping			
Code	**Description**	**Benefit Limits**	**Fee**
Procedure code D3110 will not be reimbursed when submitted with the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330. **Indirect pulp caps are not covered. The program does not cover pulp caps in primary teeth.**			

D3110	Pulp cap-direct (excluding final restoration)	A 21 and older. Requires x-rays with claim submission. Pulp capping is approved when calcium hydroxide or other ADA accepted pulp-capping material is placed directly on an exposed pulp. 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.	$51.80

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	A 21 and older. Procedure code D3220 is reimbursable for This procedure is reimbursable for Tooth Numbers 1 through 32. This procedure is limited to once per tooth every 24 months.	$127.77
D3222	Partial pulpotomy for Apexogenisis – permanent tooth with incomplete root development	A 21 and older. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. This procedure is not considered as the first stage of endodontic therapy and requires pre-authorization. This service is reimbursable only once a 12-month period, per tooth.	$127.77

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)

Code	Description	Benefit Limits	Fee
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. **Diagnostic evaluation and necessary radiographs/diagnostic images can be billed separately.** Pre-authorization is required unless performed by an endodontist. Requests for pre-authorization must be accompanied by a treatment plan supported by sufficient, readable, most-current bitewings and current periapical radiographic images, as applicable, to judge the general oral health status of the member. Specific treatment plans for final restoration of the tooth must be submitted. In cases where multiple root canals are requested or when teeth are missing or in need of endodontic therapy in the same arch, a partial denture may be indicated. Third molar root canals are not reimbursable. Final approvals for root canals require post authorization. Request for post authorization must be accompanied by the approved pre-authorization request and post-operative radiographs prior to reimbursement. The date of service on the payment request must reflect the final treatment date. Written documentation must also include the type of filling material used as well as the notation of any complications encountered which may compromise the success of the endodontic treatment.		

D3310	Endodontic therapy, anterior tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 6-11 and 22-27. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$455.84
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 4, 5, 12, 13, 20, 21, 28 and 29. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$535.25
D3330	Endodontic therapy, molar tooth (excluding final restoration)	A 21 and older. This procedure is reimbursable for Tooth Numbers 2, 3, 14, 15, 18, 19, 30 and 31. Requires pre-authorization and x-rays. When submitting claims, please include post-operative films.	$642.31

Endodontic Retreatment

Code	Description	Benefit Limits	Fee
D3346	Retreatment of root canal - anterior	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. When submitting claims, please include pre-operative and post-operative films. 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 pre- and post-operative radiograph, are included in the reimbursement for the retreatment of the root canal and must be maintained in the member's treatment records. Not reimbursable when submitted by the same provider, facility or group that performed the original root canal therapy.	$529.73

Apexification/Recalcification Procedures

Code	Description	Benefit Limits	Fee
The following code requires pre-authorization, x-rays, and documentation of medical necessity.			

D3352	Apexification/recalcification-interim medication replacement	A 21 and older. Requires pre-authorization. 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 (3) treatments per tooth with the root canal being billed separately. This service is available to both anterior and posterior permanent teeth and will be considered when the tooth fulfills all of the requirements for root canal authorization as well as an open apex, which cannot be sealed using conventional endodontic technique. A time period of 90 days must elapse between D3352 treatments. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31. When submitting claims, please include post-operative films.	$164.38

Apicoectomy/Periradicular Services

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization and x-rays.			
D3410	Apicoectomy/periradicular surgery-anterior	A 21 and older. Requires pre-authorization. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$437.87
D3430	Retrograde filling-per root	A 21 and older. Requires pre-authorization. This procedure will be approved only in conjunction with code D3410. This procedure is reimbursable for Tooth Numbers 6 through 11 and 22 through 27. When submitting claims, please include post-operative films.	$174.04

Other Endodontic Procedures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D3999	Unspecified Endodontic procedure	A 21 and older. Requires pre-authorization. When submitting claims, please include pre-operative and post-operative films.	Manually Priced

29.10. Periodontal Services

Procedure codes D4210, D4341, and D4999 require pre-authorization, x-rays, and documentation of medical necessity with documentation of medical necessity. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210 and possibly D4999.

Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210 and D4355.

Claims for any D4000 series periodontal procedure codes will be denied when submitted for the same DOS as any preventive dental procedure codes D1110, D1208,and D1354.

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

Surgical Services

Code	Description	Benefit Limits	Fee
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	A 21 and older. This procedure requires pre-authorization, documentation of medical necessity, and pre-operative color photographs. A gingivectomy may be approved by MCNA only when the tissue growth interferes with mastication. Quadrant designator 10, 20, 30, 40 required. ~~Reimbursable by quadrant.~~	$399.88

Nonsurgical Periodontal Services

Code	Description	Benefit Limits	Fee

D4341	Periodontal scaling and root planing - four or more teeth per quadrant	A 21 and older. Requires pre-authorization, x-rays, periodontal charting, and documentation of medical necessity. D4341 is denied if provided within 21 days of D4355. Radiographic evidence of bone loss indicating a true periodontal disease state must be supplied with bitewings and/or posterior/anterior periapicals. 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 enrollee's treatment for review with bitewings and/or posterior/anterior periapicals. This service is not allowable for enrollees who have not progressed beyond the mixed dentition stage of development. This service is reimbursable by quadrant (10, 20, 30, 40) only once per quadrant in a 12 month period.	$158.85

D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	A 21 and older. Requires x-rays and documentation of medical necessity with documentation of medical necessity. D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as any code except D0150, D0210, D0330 or D0350. ~~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. The exam must be performed after completion of the full mouth debridement.~~ Only one (1) full mouth debridement is allowed in a 12-month period. This procedure will not be reimbursed if payment has previously been made for an Adult Prophylaxis (D1110) to the same billing provider, facility, or group within a 12-month period. If the post-authorization request for D4355 is denied and it has been determined that a D1110 (Adult Prophylaxis) has not been provided within the preceding 12 months for this member, the provider may render and bill MCNA for a D1110 (Adult Prophylaxis.) ~~whichever is applicable based on the member's age.~~	$117.41

Other Periodontal Services			
Code	**Description**	**Benefit Limits**	**Fee**
D4999	Unspecified periodontal procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

29.11. Removable Prosthodontics

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

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

29.11.1. Minimum Standards for Complete and Partial Denture Prosthodontics

Denture services provided to members under the Medicaid Program must follow acceptable techniques in all stages of construction, such as preliminary and final impressions, wax rim and esthetic try-in, processing,

delivery, and adjustment. Although no minimum number of appointments is set, the following minimum standards must be adhered to:

The provider is required to obtain acceptance of esthetic appearance from member prior to processing. This acceptance must be documented by the member'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 member'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 member (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 esthetics.
  - 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 delivery date of the denture and/or partial dentures is the billing date of service (DOS).
- The chart record indicating denture and/or partial delivery date must be submitted with the claim. The claim will also need documentation of the member's signature of acceptance from the aesthetic try-on.
~~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 member (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 esthetics.~~
  - ~~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 delivery date of the denture and/or partial dentures is the billing date of service (DOS).~~

~~The chart record with date of delivery of the dentures, including the member's signature for acceptance of the aesthetic try in, must be submitted with the claim for payment.~~

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The dentist is responsible for all necessary adjustments for a period of six (6) months.

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

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

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

Complete Dentures (Including Routine Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5110	Complete denture, maxillary	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8)e years from any prior D5110 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5110 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	$837.66
D5120	Complete denture, mandibular	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis.	$837.66

		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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5120 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5120 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5130	Immediate denture, maxillary	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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	$837.66

		pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5130 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5130 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	
D5140	Immediate denture, mandibular	A 21 and older. Only one (1) prosthesis per member, per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. 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 pre-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 member that no reline is covered within one (1) 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 pre-authorized. Radiographic images should confirm that no more than six (6) teeth remain. If more than six (6) teeth remain, the attending provider must certify by statement in the "Remarks" section that six (6) or fewer teeth will remain when the final impression is taken. An immediate denture that is not delivered will be denied under the interruption of treatment guidelines. If submitted more than eight (8) years from any prior D5140 with a code of D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5140 will be	$837.66

		reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same provider, facility or group.	

Partial Dentures (Including Routing Post Delivery Care)

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and documentation of medical necessity. Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition states in the following cases: • Missing one (1) or two (2) maxillary permanent anterior teeth or, • Missing two (2) mandibular permanent anterior teeth or, • Missing three (3) or more permanent teeth in the same arch (of which at least one must be anterior) • Medicaid may provide a partial denture (D5211, D5212, D5213, D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (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 (2) or more anterior and at least one posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Cast partials (D5213 and D5214) will be considered only for those recipients who are 18 years of age or older. Only one (1) complete or partial denture per arch is allowed in an eight (8) year period. The time period begins from the date the previous complete or partial denture for the same arch was delivered. 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. For those members requiring extensive restorations, periodontal services, extractions, etc. clinical/operational notes may be requested with the claim for coverage consideration.			
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5211 with a D5760 in history with in the past 12 months the fee for D5211 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group.	$795.36

		If code D5211 is reported more than eight (8) years from any prior D5211 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5211 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 5 years from any prior D5212 with a D5760 in history with in the past 12 months the fee for D5212 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5212 is reported more than eight (8) years from any prior D5212 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5212 will be reduced by the fee for the D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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	$795.36

		must serve to increase masticatory function and stability of the entire mouth. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. 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. If submitted more than 8 years from any prior D5213 with a D5760 in history with in the past 12 months the fee for D5213 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5213 is reported more than eight (8) years from any prior D5213 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5213 will be reduced by the fee for D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	$1164.27

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasp materials, rests and teeth)	A 21 and older. Only one (1) prosthesis (excluding interim partial dentures) per member per arch is allowed in an eight (8) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. 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. If submitted more than 8 years from any prior D5214 with a D5760 in history with in the past 12 months the fee for D5214 will be reduced by the amount of the fee for the D5760 by the same Provider, facility or group. If code D5214 is reported more than eight (8) years from any prior D5214 with a D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 in history within the past 12 months the fee for D5214 will be reduced by the fee for D5511, D5512, D5520, D5611, D5612, D5630, D5640, D5650, D5660 by the same Provider, facility or group. 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. Radiographic images should verify that all pre-prosthetic services have been successfully completed. For members requiring extensive restorations, periodontal services, extractions, etc., post treatment radiographic images may be requested prior to approval of a cast partial denture.	$1164.27

Repairs to Complete Dentures			
Code	**Description**	**Benefit Limits**	**Fee**

D5511	Repair broken complete denture base, mandibular	A 21 and older. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5512	Repair broken complete denture base, maxillary	A 21 and older. Requires documentation of medical necessity. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53

D5520	Replace missing or broken teeth-complete denture – per tooth~~(each tooth)~~	A 21 and older. Cost of repairs cannot exceed replacement costs. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00

Repairs to Partial Dentures			
Code	**Description**	**Benefit Limits**	**Fee**
Cost of repairs cannot exceed replacement costs.			
D5611	Repair resin partial denture base, mandibular	A 21 and older. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the “Remarks” section of the claim form.	$211.53

D5612	Repair resin partial denture base, maxillary	A 21 and older. Reimbursement for repairs of complete and partial dentures (excluding interim partial dentures) are allowed only if more than one (1) year has elapsed since denture insertion by the same billing provider, facility, or group and the repair makes the denture fully serviceable and eliminates the need for a new denture. If the same provider, facility, or group 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 member as long as the repair makes the denture fully serviceable. Must include the location and description of the fracture in the "Remarks" section of the claim form.	$211.53
D5630	Repair or replace broken retentive/clasping materials - per tooth	A 21 and older. Requires Documentation of medical necessity. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$201.38
D5640	Replace missing or broken teeth- - partial denture - per tooth	A 21 and older. Requires documentation of medical necessity. 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. Requires tooth ID. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00
D5650	Add tooth to existing partial denture – per tooth	A 21 and older. Requires documentation of medical necessity. Requires tooth ID. 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. This procedure is reimbursable for Tooth Numbers 2 through 15 and 18 through 31.	$110.00 $33.00

D5660	Add clasp to existing partial denture - per tooth	A 21 and older. Requires documentation of medical necessity. Requires tooth ID. When requesting payment for these procedures, the side of the prosthesis involved (right or left) must be indicated in the "Remarks" section of the claim form.	$119.00

Denture Reline Procedures			
Code	**Description**	**Benefit Limits**	**Fee**
Allowed if the reline makes the denture serviceable. The following codes require pre-authorization and documentation of medical necessity. Not covered within one (1) year of initial placement of dentures.			
D5750	Reline complete maxillary denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75

D5751	Reline complete mandibular denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$402.75
D5760	Reline maxillary partial denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99

D5761	Reline mandibular partial denture (indirect)	A 21 and older. Reimbursement for complete and partial denture relines are allowed only if one (1) 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 (1) year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee. A combination of two (2) complete or partial denture relines or one (1) complete or partial denture and one (1) reline in the same arch are allowed in an eight-year period as pre-authorized by LDH or its designee. Reline of existing dentures must be given priority over the construction of new dentures if it is judged that the existing dentures are serviceable for at least eight (8) years. Chair-side relines (cold cure acrylics) are not reimbursable. The dentist is responsible for all necessary adjustments for a period of six (6) months.	$351.99

Interim Prosthesis			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity. For members requiring extensive restorations, periodontal services, extractions, etc., post-treatment radiographic images may be requested prior to approval of a partial denture.			

D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth) maxillary	A 21 and older. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Louisiana Medicaid or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth) mandibular	A 21 and older. Only one (1) prosthesis per member per arch is allowed in a one (1) year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid by Medicaid of Louisiana or MCNA. A description of the arch receiving the prosthesis must be provided by indicating in the "Remarks" section which teeth are to be replaced and which are to be retained. 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.	$634.59

Other Removable Prosthetic Services			
Code	**Description**	**Benefit Limits**	**Fee**

The following codes require pre-authorization, x-rays, and documentation of medical necessity.			
D5899	Unspecified removable prosthodontic procedure, by report	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This procedure code is used for a procedure that is not adequately described by another code. Please describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form.	Manually Priced

29.12. Fixed Prosthodontics

Prosthodontic procedure codes require pre-authorization. Periapical radiographs are required for each tooth involved in the authorization request.

When a member is missing a single maxillary anterior incisor a resin-bonded fixed prosthesis (Maryland-type bridge consisting of two (2) retainers and a pontic) can be approved. The following requirements apply:

- The abutment teeth must be caries-free, restoration-free, and have sound periodontal support
- No other maxillary teeth are missing or require extraction
- Providers must submit with the request for pre-authorization periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed
- Providers must "X" out the missing tooth in the tooth number chart on the ADA form

The overall condition of the mouth is an important consideration in whether a fixed partial denture is authorized. A removable partial denture can be requested if multiple anterior teeth or if any posterior teeth are missing in the maxillary arch. Only one (1) Maryland-type bridge can be authorized in an eight (8) year period.

Fixed Partial Dental Pontics			
Code	**Description**	**Benefit Limits**	**Fee**
D6241	Pontic - porcelain fused to predominantly base metal	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6545. Limited to one (1) per member in an eight (8) year period. This procedure is reimbursable for Tooth Numbers 7, 8, 9, or 10.	$828.68

Fixed Partial Dental Retainers - Inlays/Onlays			
Code	**Description**	**Benefit Limits**	**Fee**

D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two (2) per member, in an eight (8) year period. This procedure is reimbursable for Tooth Numbers 6, 7, 8, 9, 10 and 11.	$667.34

Other Fixed Partial Dental			
Code	**Description**	**Benefit Limits**	**Fee**
D6999	Unspecified fixed prosthodontic procedure	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

29.13. Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the Adult ICF/IID Program.

Oral and Maxillofacial Surgery Services			
Code	**Description**	**Benefit Limits**	**Fee**
D7111	Extraction, coronal remnants - primary tooth	A 21 and older. TIDs #A-T and AS-TS.	$87.71
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A 21 and older. TIDs 1-32 and A-T as well as 51-82 and AS-TS as needed. Requires an x-ray with claim submission.	$107.04

Surgical Extractions			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and documentation of medical necessity for all teeth: 1-32 and 51-82.			

D7210	Extraction, erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	A 21 and older. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment 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. **Oral surgeons are not required to submit documentation for clinical review of this service for symptomatic teeth with the exception of treatment limited to TID 1,16, 17, and 32.**	$176.12
D7220	Removal of impacted tooth-soft tissue	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$203.75
D7230	Removal of impacted tooth-partially bony	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$271.11
D7240	Removal of impacted tooth-completely bony	A 21 and older. This procedure is reimbursable for Tooth Numbers 1 through 32 and for supernumerary teeth 51 through 82.	$332.52
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	A 21 and older. Document unusual circumstance. This procedure code will only be authorized on a post-surgical basis. Please submit pre-operative x-rays and clinical/operative notes outlining the unusual surgical complications with the claim.	$376.41
D7250	Removal of residual tooth roots (cutting procedure)	A 21 and older. Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred.	$195.46

Other Surgical Procedures			
Code	**Description**	**Benefit Limits**	**Fee**

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 21 and older. Requires pre- and post-operative x-rays and documentation of medical necessity. Pre-authorization is required. This code is reimbursable for accidental trauma involving permanent anterior teeth only. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved, must be provided in the "Remarks" section of the claim form. This information must also be recorded in the member's treatment record. This procedure is not reimbursable for periodontal splinting. Requires Arch Designators 01 or 02.	Manually Priced, Maximum Fee $345.29
D7280	Exposure of an unerupted tooth	A 21 and older. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure no longer includes the placement of orthodontic attachment.	$310.79
D7283	Placement of device to facilitate eruption of impacted tooth	A 21 and older. TIDs 2-15 and 18-31. Requires pre-authorization, x-rays and documentation of medical necessity. Placement of an attachment on an unerupted tooth, after exposure, to aid in its eruption. Report the surgical exposure separately using D7280. This procedure is only reimbursable in conjunction with an MCNA-approved comprehensive orthodontic treatment plan.	$332.90
D7285	Biopsy of oral tissue hard	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. 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. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	Manually Priced, Maximum Fee $263.83
D7286	Biopsy of oral tissue soft	A 21 and older. Requires pre-authorization, x-rays and documentation of medical necessity. 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 submitted with the claim. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant~~.	$206.51

D7291	Transseptal fiberotomy - by report	A 21 and older. Requires pre-authorization, x-rays and documentation of medical necessity. This procedure is only reimbursable in conjunction with a MCNA-approved comprehensive orthodontic treatment plan. Quadrant designator 10, 20, 30, 40 required.~~Reimbursable by quadrant.~~	$152.03

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
D7310	Alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity. A minimum of four (4) adjacent teeth must be extracted. Alveoloplasty during a surgical removal is considered integral to the procedure and will not be reimbursed. The date of service and an explanation of the circumstances and procedures performed, including the teeth involved must be provided in the "Remarks" section of the claim form. Quadrant designator 10, 20, 30, 40 required.~~.~~	$189.92

Surgical Incision

Code	Description	Benefit Limits	Fee
D7510	Incision and drainage of abscess - intraoral soft tissue	A 21 and older. TID 1-32. Requires x-rays and documentation of medical necessity. This service is not reimbursable for primary teeth. Not payable for same tooth on the same date of service as the extraction.	$148.48

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions

Code	Description	Benefit Limits	Fee

D7880	Occlusal orthotic appliance	A 21 and older. Requires pre-authorization, pre-operative x-ray and documentation of medical necessity. Pre-authorization must include a completed TMJ Summary Form, located in the Forms section of this manual, which must indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Requires arch 01 or 02.	$461.69

Repair of Traumatic Wounds

Code	Description	Benefit Limits	Fee
D7910	Suture recent small wound up to 5cm	A 21 and older. Requires post-operative color photos and documentation of medical necessity.	$190.61

Other Procedures

Code	Description	Benefit Limits	Fee
D7961	Buccal/labial frenectomy (frenulectomy)	A 21 and older. Oral Cavity Designators 01, 02, 10, 20, 30 or 40. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21
D7962	Lingual frenectomy (frenulectomy)	A 21 and older. Oral Cavity Designators 02, 30, or 40. Diagnostic quality photographs and documentation of medical necessity must be maintained in the clinical record.	$211.21
D7997	Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	A 21 and older. This procedure requires pre-authorization and can only be considered for the removal of appliances due to interrupted or discontinued treatment cases. This procedure is not reimbursable to the same billing provider, facility, or group that placed the appliance. This procedure is reimbursable for Oral Cavity Designators 01, 02, 10, 20, 30, and 40.	Manually Priced, Maximum Fee $324.91

D7999	Unspecified oral surgery procedure, by report	A 21 and older. This procedure code is used for a procedure that is not adequately described by another code. It requires pre-authorization.	Manually Priced

29.14. Orthodontic Services

Orthodontic treatment is available to members meeting specified criteria. All orthodontic procedures must be pre-authorized. Providers are reminded that the MCNA reimbursement is payment in full for that procedure code.

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

Members who have only crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions, and/or 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 member's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances.

Comprehensive orthodontic treatment is approved by MCNA 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: other severe craniofacial deformities that result in age appropriate surgical cases as determined by an MCNA Clinical Reviewer.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, MCNA will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for one year.

Providers are reminded that MCNA reimbursement is payment in full for the procedure code.

To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. MCNA reimbursement includes the brackets/appliance and all visits and adjustments.

The member must be a good candidate for orthodontic treatment as assessed by the potential provider. The member must exhibit a history of good oral hygiene, be under the care of a dentist for routine care and all necessary dental care (i.e., prophylaxis, restorations, addressing any noted pathology, including receiving a cleaning within the last six months) must be completed prior to submission of an orthodontic prior authorization

request. This approach is designed to lessen the occurrence of tooth decay and promote the best possible outcome for the orthodontic treatment.

Orthodontic Fee Schedule			
Code	**Description**	**Benefit Limits**	**Fee**
D8090	Comprehensive orthodontic treatment of the adult dentition.	A 21 and older. Requires pre-authorization.	Manually Priced, Maximum Fee $4,515.00

29.15. Adjunctive General Services

Unclassified Treatment			
Code	**Description**	**Benefit Limits**	**Fee**
D9110	Palliative treatment of dental pain – per visit	A 21 and older. Emergency service only, limited to trauma case. Requires documentation of medical necessity. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. A 21 and older. On the date of service that a palliative treatment is rendered, a provider will only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) if authorized, in addition to this procedure code. All codes other than those listed above for radiographs will be denied if billed for the same date of service as D9110. A maximum of two palliative treatments per member are available in a 12-month period.	$79.43

Anesthesia			
Code	**Description**	**Benefit Limits**	**Fee**

Providers rendering sedation services for codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate Provider and Office Permit Level for the level of sedation provided. Providers are responsible for submitting their correct Permit Level for the level of sedation to MCNA. D9222, D9223, D9239, and D9243 can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 and D9243 are available per member per visit. If requested, each must be listed on a separate claim line for both pre-authorization and payment. Oral Surgeons must submit an anesthesia time record with a claim submission of four (4) or more units of IV or deep sedation. All anesthesia time records must be maintained in the clinical record per state requirements.			
D9222	Deep Sedation, general anesthesia – first 15 minutes	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9222 and D9223.	$147.79

D9223	Deep sedation, general anesthesia – each additional 15 minute increment	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Deep sedation/general anesthesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9223 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9222 and D9223.	$100.15
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	A 21 and older. May not be submitted more than once per member per day. If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service(s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied. D9230 (Nitrous Oxide) is not reimbursable on the same day by any provider as procedure codes D9248 (Non-intravenous conscious sedation.)	$49.72

D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9239 and D9243.	$147.79
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	A 21 and older. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the recipient. Anesthesia services are considered completed when the recipient can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be approved for those doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation. This procedure can only be authorized in conjunction with difficult impactions or other extensive surgical procedures done in the office setting. A maximum of three (3) units of D9243 are available per recipient per visit. Must submit anesthesia time record, including start and stop times, with claim for clinical review. Oral surgeons excluded from clinical review unless the claim exceeds the combined 3-unit maximum of D9239 and D9243.	$100.15

D9248	Non-intravenous conscious sedation	A 21 and older. Sedation form must be submitted with the claim. Must comply with all state rules and guidelines, including maintaining a current permit to provide non-intravenous (IV) conscious sedation. Pre-authorizations are required. A maximum of four (4) non-intravenous conscious sedation/analgesia administrations, per member, are available within a 12-month period by the same billing provider, facility, or group. The request for pre-authorization must document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the member. The provider must indicate in the "Remarks" section of the claim form the drug(s) anticipated to be used and route(s) of administration. A request for pre-authorization for conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the provider or staff from administration through the time of discharge. The Conscious Sedation Form, located in the Forms section of this manual, must be completed by the provider and sent with the claim submission. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation the provider must document the circumstances in the member's treatment record. Administration of oral pre-medication is not a covered service.	$169.83

Professional Visits			
Code	**Description**	**Benefit Limits**	**Fee**
D9420	Hospital call	A 21 and older. One (1) charge per hospital or ASC case. Procedure code D9420 is reimbursable once per six (6) month period, per member. Requires documentation of medical necessity. 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. Reimbursable when providing treatment in a hospital, an outpatient clinic, or an outpatient ambulatory surgical center. The provider must document the need for this service based on his experience with prior attempts to treat the patient and the severity of the procedure(s). Hospitalization solely for the convenience of the member or the provider is not allowed. Pre-authorization is required and must include documentation outlining the necessity for hospitalization. A copy of the operative report must be maintained in the member's dental record. Denial of a hospital call request member does not prevent payment to the dental provider for any covered, pre-authorized (if required) treatment performed in the hospital. The denial is only for the code D9420 and its accompanying fee for additional reimbursement to the provider as compensation for time out of the office.	$106.18
D9440	Office visit after hours	A 21 and older. Visits for routine postoperative care are included in all therapeutic and oral surgery fees. Requires documentation of medical necessity. 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 Adult ICF/IID Program and must be listed on the claim form.	$79.59

Miscellaneous Services			
Code	**Description**	**Benefit Limits**	**Fee**
D9944	Occlusal guard – hard appliance, full arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9945	Occlusal guard – soft appliance, full arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96

D9946	Occlusal guard – hard appliance, partial arch	A 21 and older. Requires pre-authorization x-rays or color photographs, and documentation of medical necessity. Limited to once per year, per member, any provider, facility, or group. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint. Reimbursable for Arch Designator 01 or 02.	$473.96
D9951	Occlusal adjustment - limited	A 21 and older. Full mouth procedure. Limited to once per year, per member, any provider, facility, or group. Requires pre-authorization and documentation of medical necessity. The member must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption. The request for pre-authorization must include a completed TMJ Summary form (located in the Forms section of this manual). A copy of this form must be retained in the member's treatment record. Indicate whether the condition is acute or chronic and if any other services are to be provided.	$145.04
D9997	Dental Case Management – patients with special health care needs	A 21 and older. A maximum of four dental case 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. This is a per visit reimbursement to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population; This fee will be paid in addition to the normal fees for specific dental procedures. **Documentation of the circumstances requiring special treatment considerations as well as the specific efforts or techniques utilized must be recorded in the enrollee's treatment record for each treatment visit.**	$29.00
D9999	Unspecified adjunctive procedure, by report	A 21 and older. Requires pre-authorization, x-rays, and documentation of medical necessity.	Manually Priced

30. Adult ICF/IID Program Non-Covered Services

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

- Plaque control
- Treatment of incipient or non-carious lesions (other than covered sealants and fluoride)
- Routine panoramic radiographs
- Occlusal radiographs or upper and lower anterior or posterior periapical radiographs (when utilized as part of an initial examination or screening without a specific diagnostic reason why the radiograph is necessary)
- Administration of in-office pre-medication

31. Adult ICF/IID Program Pre- and Post-Authorizations

Requests for pre-authorization can be submitted electronically using MCNA's Provider Portal or by using an ADA Claim Form, the same paper claim form used for billing. Radiographs should be included with each request for authorization. MCNA will deny pre-authorizations that do not have the adequate information or radiographs necessary to make the authorization determination. Radiographs must be of diagnostic quality. If radiographs are contraindicated or unobtainable, the reason must be stated in the "Remarks" section of the electronic Provider Portal form or the paper ADA claim form submitted for the pre-authorization request. You must also document this reason in the member's record.

It is the responsibility of the provider to document the need for treatment and the actual treatments performed in the member record and provide that information to MCNA's Utilization Management department.

For ease of ~~billing~~billing, it is preferable to group services requiring authorization on a single form so that only one pre-authorization request need be issued per member.

Adult ICF/IID Program procedure codes, which conform to the ADA Code on Dental Procedures and Nomenclature, are provided above. **The need for pre-authorization is noted above in the column labeled "Benefit Limits" for all covered procedure codes.**

A provider may choose to submit a post-authorization request by submitting the narrative and attachments required for pre-authorization at the time of claims submission. Claims submitted without a pre-authorization noted in Box 2 of the claim form or without the narrative and documentation required for post-authorization review will be denied. Pre-authorizations are valid for one year. The provider is financially liable for services provided that are deemed not medically necessary upon post-authorization review.

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

Explanations or reasons for treatment, if not obvious from the radiographs, should also be noted on the pre-authorization request. If submitting a pre-authorization request using the paper ADA Claim Form and the information required for a full explanation exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services.

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

A copy of this cover sheet, along with a copy of the pre-authorization request, must be kept in the member's treatment record.

31.1. Pre-Authorization Reminders

Within 72 hours of the completion of MCNA's review of a pre-authorization request, MCNA will send a pre-authorization letter to the provider detailing those services that have been pre-authorized. The letter will also list any denied services along with an explanation of those denials. A pre-authorization number will be furnished to allow the provider to bill for services as they are completed. If a pre-authorization is required for a procedure code, your claim will be denied if you do not supply an approved pre-authorization number for the service.

The member will also receive a copy of the pre-authorization letter and in the case of a denial, the explanation of denied benefits. The letter will advise members of their appeal rights.

Pre-authorization is not a guarantee of member Medicaid eligibility. When a member loses Medicaid eligibility, any authorization of services becomes void.

32. Dental Guidelines

MCNA's Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs and periodontal charting.

These criteria are approved and annually reviewed by MCNA's Utilization Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute. Please refer to the Section of this manual titled, "Covered Services and Fee Schedules," for a list of all codes covered under the program and additional limitations and requirements for coverage.

32.1. Guidelines for Oral Surgery

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and may be performed by a Primary Care Dentist (PCD). The Member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the PCD.

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

If the extraction is warranted due to therapeutically indicated circumstances such as prolonged retention, blocking out of erupting permanent teeth, severe decay, abscess with bone loss, or other specifically identifiable indications, a preoperative periapical radiograph must be taken as a diagnostic aid and as means of documentation.

This radiograph must be maintained in the member's record and must be furnished for 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 is reimbursable only if symptomatic, and the symptoms must be noted in the member's record.

32.1.1. Criteria

- A tooth broken below the bone level
- Supernumerary tooth
- Dentigerous cyst
- Untreatable Periodontal disease
- Pathology not treatable by other means
- Recurrent pericoronitis
- Non-restorable carious lesion
- Pain and/or swelling due to impeded eruption

- Exfoliation of a deciduous tooth not anticipated within six months
- No extractions of third molars if roots are not substantially formed
- Alveolplasty (7310) in conjunction with four or more extractions in the same quadrant.
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent
- Extractions performed within a six-month period of a prior placement of restorations on the same tooth are subject to clinical review and may be recouped if restoration was found not to be performed to the standard of care

32.1.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex
- Narrative demonstrating medical necessity

32.1.3. Procedure Codes

- D7210, D7220, surgical removal of erupted tooth, radiographs and narrative.
- D7230, D7240, D7241, surgical removal of impacted teeth, radiographs and narrative.
- D7250, removal of residual roots, radiographs and narrative.
- D7280, exposure of unerupted tooth, radiographs and narrative.
- D7310, alveoloplasty in conjunction with extraction, radiographs and narrative.
- D7510, incision and drainage of abscess, radiographs and narrative. Will not be considered on same date with extraction of tooth related to incision and drainage.

32.1.4. Code Descriptions

- **D7140 - extraction, erupted tooth or exposed root (Elevation and/or forceps removal)**
  Includes routine removal of tooth structure, minor smoothing of socket of socket bone, and closure, as necessary.
- **D7210 – extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated**
  Includes related cutting of gingival and bone, removal of tooth structures, minor smoothing of socket bone and closure.
- **D7220 - removal of impacted - soft tissue**
  Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.
- **D7230 - removal of impacted tooth - partially bony**
  Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7240 - removal of impacted tooth - completely bony**
  Most or all crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7241 - removal of impacted tooth-complete bony, with unusual surgical complications**
  Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.
- **D7250 - removal of residual tooth roots (cutting procedure)**
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

32.2. Guidelines for Endodontics

32.2.1. Criteria

- The tooth is infected and/or abscessed.
- Trauma or fracture that damages the pulp.
- The pulp of the primary tooth is infected and the exfoliation of the deciduous tooth is not anticipated within six months. (This is for pulpotomy or pulpectomy only.)
- Tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3.
- Root canal therapy not in anticipation of placement of an overdenture.

32.2.2. Criteria for Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, which is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal therefore this will cause a denial for a retreatment
- Fractured root tip is not reachable therefore this will cause a denial for a retreatment

32.2.3. Criteria for Apexification

- The apex of the root is not closed and needs to be treated so closure can be achieved. (Usually after trauma)
- Apexification requires three phases that end with obturation
- Additional root canal therapy is not allowed with apexification

32.2.4. Criteria for Apicoectomy and Retrograde Filling

- The apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; it requires a filling to be placed in the apical part of the tooth to seal that part of the root canal.
- Perforation of the root in the apical one-third of the canal.

32.2.5. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex.
- Emergency treatment will require a dated pre- and post-operative radiograph for claims review.
- In situations where pathology is not apparent, a written narrative justifying treatment is required.

32.2.6. Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a final root canal fill radiograph.
- In cases where the root canal filling does not meet MCNA's treatment standards, MCNA can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after MCNA reviews the circumstances.

32.2.7. Procedure Codes

- D3310, endodontic therapy, anterior tooth (excluding final restoration)
- D3320, endodontic therapy, premolar tooth (excluding final restoration)
- D3330, endodontic therapy, molar tooth (excluding final restoration)
- D3220, therapeutic pulpotomy
- D3240, pupal therapy on primary teeth (resorbable filling)
- D3352 apexification / recalcification interim visit
- D3410 apicoectomy
- D3430 retrograde filling

32.3. Guidelines for Non-Intravenous and IV Sedation

32.3.1. Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the Louisiana State Board of Dentistry for the level of sedation or anesthesia provided.
- MCNA must have on file a copy of the certification prior to rendering sedation services.

32.3.2. Criteria

Acceptable conditions include, but are not limited to, one or more of the following:

- Documented local anesthesia toxicity.
- Severe cognitive impairment or developmental disability.
- Severe physical disability.
- Uncontrolled management problem.
- Extensive or complicated surgical procedures.
- Failure of local anesthesia.
- Documented medical complications.
- Acute infections.

32.3.3. Documentation Required for Claims Processing

Certain procedures require submission of narrative stating medical necessity. All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes

5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

32.3.4. Procedure Codes

- D9230, Analgesia, anxiolysis, inhalation of nitrous oxide
- D9239, Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
- D9222, Deep Sedation, general anesthesia – first 15 minutes
- D9223, Deep Sedation, general anesthesia – each additional 15 minutes
- D9243, Intravenous moderate (conscious) sedation/ analgesia- each additional 15 minute ~~units~~
- D9248, Non intravenous conscious sedation

32.3.5. Criteria for Medical Immobilization Including Papoose Boards

The Provider must obtain a written informed consent from the legal guardian and documented in the Member's record prior to medical immobilization. The Provider must complete MCNA's Medicaid Behavior Management Report Form (located in the Forms section of this manual).

The Patient's record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

32.4. Guidelines for Core Build Up

32.4.1. Criteria

- The foundation of the tooth is insufficient to place a crown.
- Performed on a previously endodontic treated tooth to provide a foundation to place a crown.
- Not covered on primary teeth.

32.4.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Requires post-operative endodontic x-ray in order to approve prefabricated post & core

32.4.3. Procedure Codes

- D2950, Core build up
- D2951, Pin retention per tooth
- D2954, Prefab post and core in addition to a crown

32.5. Guidelines for Crowns

32.5.1. Criteria

- Criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar, bicuspid or anterior teeth must have pathologic destruction to the tooth by caries or trauma.
-

Note: To meet criteria, a crown must be opposed to a tooth or denture in the opposite arch or be an abutment for a partial denture.

Crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- Crowns are being planned to alter vertical dimension

32.6. Guidelines for Crowns following Root Canal Therapy

32.6.1. Criteria

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

- The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3.

32.6.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex.
- Require submission of radiographs showing clearly the adjacent and opposing teeth submitted with the claim for review of payment.
- Claims request should include a dated radiograph of RCT if RCT was done by submitting Dentist.

32.6.3. Procedure Codes

- D2930, Prefabricated stainless steel crown primary tooth
- D2931, Prefabricated stainless steel crown permanent tooth
- D2932, Prefabricated resin crown
- D2933, Prefabricated stainless steel crown with resin window
- D2934, Prefabricated esthetic coated stainless steel crown primary

32.7. Guidelines for Periodontal Treatment

32.7.1. Criteria

- Periodontal charting indicates abnormal pocket depths in multiple sites. Probing depths must be 4mm or greater.
- Radiographic evidence of root surface calculus.
- Radiographic evidence of noticeable loss of bone support. Attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession.

32.7.2. Criteria for Gingivectomy

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia.

32.7.3. Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

32.7.4. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings or periapical preferred
- Complete periodontal charting
- Narrative
- Photograph is required for CDT code (4210)

32.7.5. Procedure Codes

- D4341, periodontal scaling and root planing requiring radiographs and perio chart.
- D4355, gross debridement requiring radiographs, narrative, and photos.

- D4210, gingivectomy and/or gingivoplasty.

32.8. Guidelines for Orthodontics

Please see the "Orthodontic Services" section.

32.9. Guidelines for X-rays

Criteria

- Must be of diagnostic quality
- All x-rays must be marked as right or left, as appropriate
- Must have the member's name
- Must have the date x-rays were taken

32.10. Guidelines for Removable Prosthodontics (Full and Partial Dentures)

32.10.1. Criteria

- If favorable prognosis is present.
- If abutment teeth are more than 50% supported in bone.
- Adjustments, repairs and relines are allowed when there are extenuating circumstances, and/or medical necessity.
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment.
- If more than one posterior tooth will be replaced not including third molars.
- A denture is determined to be an initial placement if the Patient has never worn a prosthesis. This does not refer to just the time a Patient has been receiving treatment from a certain Provider.

Authorizations for removable prosthesis will not meet criteria if extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or clasp to a partial denture is a covered benefit if the addition makes the dentures functional.

Please see the "Removable Prosthodontics" section.

32.10.2. Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex

Procedure Codes

Complete Dentures

- D5110, complete denture maxillary (upper)
- D5120, complete denture mandibular (lower)
- D5130, dentures immediate maxillary
- D5140, dentures immediate mandible

Partial Dentures

- D5211, Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
- D5212, Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)

- D5213, Maxillary partial denture - cast metal framework with resin denture base
- D5214, Mandibular partial denture - cast metal framework with resin denture base

Repairs to Complete Dentures

- D5511, Repair broken complete denture base, mandibular
- D5511, Repair broken complete denture base, maxillary
- D5520, Replace missing or broken teeth - complete denture – per tooth~~(each tooth)~~

Repairs to Partial Dentures

- D5611, Repair resin partial denture base, mandibular
- D5612, Repair resin partial denture base, maxillary
- D5630, Repair or replace broken clasp, Partial Denture- per tooth
- D5640, Replace missing or broken teeth ~~–~~ partial denture - per tooth
- D5650, Add tooth to existing partial denture – per tooth
- D5660, Add clasp to existing partial denture, per tooth

Denture Reline Procedures

- D5750, Reline complete maxillary denture (indirect)
- D5751, Reline complete mandibular (indirect)
- D5760, Reline maxillary partial denture (indirect)
- D5761, Reline mandibular partial denture (indirect)

Interim Prosthesis

- D5820, Interim partial denture (including retentive/clasping materials, rests, and teeth) maxillary
- D5821, Interim partial denture (including retentive/clasping materials, rests, and teeth) mandibular

33. Forms

The following forms can be downloaded using the links provided.

- **Member Outreach Form for Louisiana Providers**
  - http://forms.mcna.net/la-member-outreach
- **Behavior Management Form**
  - http://forms.mcna.net/behavior-management
- ~~**Non-Covered Services Form**~~
- **Patient Responsibility Form**
  - **https://docs.mcna.net/forms/patient-responsibility**
- **Pediatric Dentistry Conscious Sedation Form**
  - http://forms.mcna.net/conscious-sedation
- **TMJ Summary Form**
  - http://forms.mcna.net/tmj-summary
- **Incident Report Form**
  - http://forms.mcna.net/incident-report
- **Adult Denture Program Clinical Condition Certification Form**
  - http://forms.mcna.net/la-dent-clin-cond
- **Referral Form**
  - http://forms.mcna.net/referral
- **Louisiana Medicaid EPSDT and Adult Denture Provider Complaint Form**
  - http://forms.mcna.net/la-provider-complaint
- **Provider Reconsideration and Appeal Request Form**
  - http://forms.mcna.net/la-provider-appeal
- **Overpayment and Recoupment Form**
  - https://docs.mcna.net/forms/overpayment-recoup

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