PART 4: SERVICES

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

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

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

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

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

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

DBPM Covered Services

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

Louisiana Medicaid Dental Services include the following programs:

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

The Current Dental Terminology (CDT) codes and nomenclatures in this document have been obtained from *Current Dental Terminology*, including procedure codes, nomenclatures, descriptors, and other data contained therein.

EPSDT Dental Program

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

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

The DBPM shall have written procedures for EPSDT preventive services in compliance with 42 C.F.R. Part 441 Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible enrollees are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and that tracking or follow-up occurs to ensure all necessary services were provided to all of the DBPM's enrollees under the age of 21.

Dental services covered under the EPSDT Dental Program are divided into the following 11 categories:

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

Diagnostic Services

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

Examinations

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

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

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

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

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

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

Radiographic Images

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

D0210 Intraoral - Complete Series of Radiographic Images

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

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

D0220 Intraoral – Periapical First Radiographic Image

D0230 Intraoral – Periapical Each Additional Radiographic Image

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

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

D0240 Intraoral – Occlusal Radiographic Image

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

D0272 Bitewings – Two Radiographic Images

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

D0330 Panoramic Radiographic Images

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

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

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

D0350 Oral/Facial Images

Oral/facial images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations:

- Prior to gingivectomy;
- Prior to frenulectomy; or

- With the presence of a fistula prior to retreatment of previous endodontic therapy, anterior.

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

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

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

Other Diagnostic Services

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

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

D0474 Accession of Tissue, Gross and Microscopic Examination, Including Assessment of Surgical Margins for Presence of Disease, Preparation and Transmission of Written Report

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

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

Preventive Services

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

Prophylaxis

D1110 Adult Prophylaxis

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

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

Procedure code D4355 (Full Mouth Debridement) is not reimbursable if procedure code D1110 (Adult Prophylaxis) has been reimbursed within the prior 12-month period for the same enrollee.

D1120 Child Prophylaxis

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

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

Procedure code D4355 (Full Mouth Debridement) is not reimbursable if procedure code D1120 (Child Prophylaxis) has been reimbursed within the prior 12-month period for the same enrollee.

Fluoride Treatment

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

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

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

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

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

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

D1208 Topical Application of Fluoride – Excluding Varnish

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

Sealants

D1351 Sealants – Per Tooth

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

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

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

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

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

Space Maintenance

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

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

D1551 Recementation of Space Maintainer - Maxillary

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

D1552 Recementation of Space Maintainer - Mandibular

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

D1553 Recement or Rebound Unilateral Space Maintainer – Per Quadrant

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

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

D1556 Removal of Fixed Unilateral Space Maintainer – Per Quadrant

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

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

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

D1557 Removal of Fixed Bilateral Space Maintainer - Maxillary

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

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

D1558 Removal of Fixed Bilateral Space Maintainer - Mandibular

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

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

D1575 Distal Shoe Space Maintainer – Fixed – Unilateral – Per Quadrant

This procedure code is reimbursable for placement of a distal shoe space maintainer which extending subgingivally and distally to guide the eruption of the first permanent molar. The provider is responsible for replacement and recementation within the first 12 months of initial placement. However, this service does not include ongoing

follow-up, adjustments, or replacement appliance once the permanent tooth has erupted. It is limited to fixed appliances. A space maintainer shall not be reimbursed if the space will be maintained for less than six months.

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

Restorative Services

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

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

Laboratory processed crowns are not covered.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four or more surfaces, permanent (D2161); resin-based composite, four or more surfaces, posterior (D2394); resin-based composite, four or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); a prefabricated porcelain/ceramic crown, anterior (D2929) or a prefabricated stainless steel crown (D2930, D2931, D2932, D2933 or D2934).

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

Amalgam Restorations (Including Polishing)

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

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

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

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

Amalgam restorations must be placed in a preparation in which the entire preparation extends through the enamel and into dentin. The restoration must follow established dental protocol in which the preparation and

restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal buccal or occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is a mesial occlusal or distal occlusal restoration, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable, inspectable area.

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

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

Resin-Based Composite Restorations - Direct

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

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

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

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

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

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

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

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

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

Non-Laboratory Crowns

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

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

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

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

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

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

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

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

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

D2929 Prefabricated Porcelain/Ceramic Crown – Anterior Tooth

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

D2930 Prefabricated Stainless Steel Crown – Primary Tooth

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

D2931 Prefabricated Stainless Steel Crown – Permanent Tooth

This procedure is reimbursable for Tooth Numbers 1 through 32.

D2932 Prefabricated Resin Crown (Primary and Permanent Teeth)

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

D2933 Prefabricated Stainless Steel Crown with Resin Window

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

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

D2934 Prefabricated Esthetic Coated Stainless Steel Crown – Primary Tooth

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

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

Other Restorative Services

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

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

D2920 Re-cement Crown

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

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

D2950 Core Buildup, Including Any Pins, in Addition to Crown

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

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

D2951 Pin Retention – Per Tooth, in Addition to Restoration

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

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

D2954 Prefabricated Post and Core in Addition to Crown

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

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

D2999 Unspecified Restorative Procedure, by Report

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

Endodontic Therapy Services

Pulp Capping

D3110 Pulp Cap – Direct (Excluding Final Restoration)

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

D3220 Therapeutic Pulpotomy (Excluding Final Restoration) – Removal of Pulp Coronal to the Dentinocemental Junction and Application of Medicament

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

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

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

D3222 Partial Pulpotomy for Apexogenesis – Permanent Tooth with Incomplete Root Development

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

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

Endodontic Therapy on Primary Teeth

D3240 Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restoration) (Pulpectomy)

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

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

This procedure code is limited to a primary second molar in an arch (maxillary or mandibular), when the first permanent molar has not erupted and when a pulpectomy will eliminate the necessity for extraction and the

placement of a distal shoe space maintainer. A pulpectomy should not be provided in cases where the primary roots are more than half-resorbed or when the six-year molar has erupted.

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

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

Endodontic Therapy

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

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

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

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

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

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

D3310 Endodontic Therapy, Anterior (Excluding Final Restoration)

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

D3320 Endodontic Therapy, Premolar (Excluding Final Restoration)

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

D3330 Endodontic Therapy, Molar (Excluding Final Restoration)

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

Endodontic Retreatment

D3346 Retreatment of Previous Root Canal Therapy – Anterior

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

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

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

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

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

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

Apexification/Recalcification Procedure

D3352 Apexification / Recalcification – Interim Medication (Excluding Root Canal)

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

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

Apicoectomy/Periradicular Services

D3410 Apicoectomy/ Periradicular Surgery – Anterior

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

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

D3430 Retrograde Filling

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

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

Other Endodontic Procedures

D3999 Unspecified Endodontic Procedure, by Report

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

Periodontal Services

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

Surgical Periodontal Services

D4210 Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant

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

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

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

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

Non-surgical Periodontal Services

D4341 Periodontal Scaling and Root Planing – Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant

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

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

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

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

D4355 Full Mouth Debridement to Enable a Comprehensive Oral Evaluation and Diagnosis

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

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

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

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

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

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

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

Other Periodontal Services

D4999 Unspecified Periodontal Procedure, by Report

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthodontics

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

- The providers are required to obtain enrollee esthetic acceptance prior to processing. This acceptance must be documented by the enrollee'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 enrollee'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 enrollee (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch;
    - The denture must be fitted and adjusted for comfort, function, and aesthetics; and
    - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

Complete Dentures

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

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

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

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

An immediate denture that is not delivered will not be reimbursed, nor will Medicaid reimburse any payment under the interruption of treatment guidelines (see Part 5).

Partial Dentures

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

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider must use the following symbols in Block 34 of the ADA Dental Claim Form to indicate tooth status:

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

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

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

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

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

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

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

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

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

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

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

Denture Repairs

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

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

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

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

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

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

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

Minimal procedural requirements for repair services include the following:

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

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

Denture Relines

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

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

Minimal procedural requirements for reline services include the following:

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

- ❖ Relines must be finished in a skillful manner; they must be clean; they must exhibit a high gloss; and they must be free of voids, scratches, abrasions, and rough spots; and
- ❖ The denture must be fitted and adjusted for comfort and function.

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

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

Other Removable Prosthodontics

D5899 Unspecified removable prosthodontic procedure, by report

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

Maxillofacial Prosthetics

D5986 Fluoride Gel Carrier

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

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

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

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

Fixed Prosthodontics

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

- ❖ The enrollee must have attained the age of 16;
- ❖ The abutment teeth must be caries free and restoration-free and have sound periodontal support;
- ❖ No other maxillary teeth are missing or require extraction;
- ❖ Periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed; and
- ❖ On the tooth number chart on the ADA form, an "X" must be placed over the missing tooth.

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

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

Fixed Partial Denture Pontic

D6241 Pontic – Porcelain Fused to Predominantly Base Metal

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

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

Fixed Partial Denture Retainer

D6545 Retainer – Cast Metal for Resin Bonded Fixed Prosthetics

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

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

Other Fixed Partial Denture Services

D6999 Unspecified, fixed prosthodontic procedure, by report

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

Oral and Maxillofacial Surgery Services

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

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

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

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

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

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

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

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

Non-surgical Extractions

D7111 Extraction, Coronal Remnants – Primary Tooth

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

D7140 Extraction Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)

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

Surgical Extractions

D7210 Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

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

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

D7220 Removal of Impacted Tooth - Soft Tissue

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

D7230 Removal of Impacted Tooth - Partial Bony

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

D7240 Removal of Impacted Tooth - Complete or Full Bony

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

D7241 Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications

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

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

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

D7250 Surgical Removal Of Residual Tooth Roots (Cutting Procedure)

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

Other Surgical Procedures

D7270 Tooth Reimplantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth

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

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

D7280 Surgical Access of an Unerupted Tooth

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

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

D7283 Placement of Device to Facilitate Eruption of Impacted Tooth

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

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

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

D7285 Biopsy of Oral Tissue – Hard (Bone, Tooth)

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

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

D7286 Biopsy of Oral Tissue – Soft

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

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

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

D7291 Transseptal Fiberotomy/Supra Crestal Fiberotomy, by Report

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

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

Alveoloplasty – Surgical Preparation of Ridge for Dentures

D7310 Alveoloplasty in Conjunction with Extractions – Four or More Teeth or Tooth Spaced, per Quadrant

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

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

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

Surgical Incision

D7510 Incision and Drainage of Abscess – Intraoral Soft Tissue

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Temporomandibular Joint (TMJ) Procedure

D7880 Occlusal Orthotic Device, by Report

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

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

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

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

Repair of Traumatic Wounds

D7910 Suture Recent Small Wound up to 5cm

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

Other Repair Procedures

D7961 Buccal/Labial Frenectomy (Frenulectomy)

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

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

D7962 Lingual Frenectomy (Frenulectomy)

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

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

D7997 Appliance Removal (Not by Dentist who Placed Appliance), Includes Removal of Archbar

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

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

D7999 Unspecified Oral Surgical Procedure, by Report

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

Orthodontic Services

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

Limited Orthodontic Treatment

D8010 Limited Orthodontic Treatment of the Primary Dentition

D8020 Limited Orthodontic Treatment of the Transitional Dentition

Orthodontic treatment utilizing any therapeutic modality with a limited objective or scale of treatment. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate. The objective may be limited by:

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

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

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

Comprehensive Orthodontic Treatment

D8070 Comprehensive Orthodontic Treatment of the Transitional Dentition

D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition

D8090 Comprehensive Orthodontic Treatment of the Adult Dentition

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

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

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

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

Reimbursement is payment in full for the procedure code and should an enrollee be unable to complete the treatment (e.g., if the enrollee moves away), the reimbursement is subject to recoupment pro-rata based on the number of months of treatment completed.

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

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

Minor Treatment to Control Harmful Habits

D8220 Fixed Appliance Therapy

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

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

- The child must be between the ages of 5 years through 8 years;
- The maxillary incisors (7, 8, 9 and 10) are actively erupting;

- The child still displays the destructive habit; and
- The child has evidenced a desire to stop the destructive habit.

Other Orthodontic Services

D8999 Unspecified Orthodontic Procedure, by Report

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

Adjunctive General Services

Palliative (Emergency) Treatment

D9110 Palliative (Emergency) Treatment of Dental Pain – Minor Procedure

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

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

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

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

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

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

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

Anesthesia

D9230 Nitrous Oxide - Analgesia, Anxiolysis, Inhalation of Nitrous Oxide

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

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

D9239 Intravenous Moderate Conscious Sedation/Analgesia – First 15 Minutes

D9243 Intravenous Moderate Conscious Sedation/Analgesia – Each Additional 15 Minutes

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

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

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

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

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

D9248 Non-Intravenous Conscious Sedation

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

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

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

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

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

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

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

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

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

Professional Visits

D9420 Hospital Call

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

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

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

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

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

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

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

D9440 Office Visit – After Regularly Scheduled Hours

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

Miscellaneous Services

D9920 Behavior Management

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

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

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

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

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

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

D9944 Occlusal Guard – Hard Appliance, Full Arch

D9945 Occlusal Guard – Soft Appliance, Full Arch

D9946 Occlusal Guard – Hard Appliance, Partial Arch

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

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

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

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

D9951 Occlusal Adjustment – Limited

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

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

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

D9999 Unspecified Adjunctive Procedure, by Report

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

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 a participating federally qualified health center (FQHC) dentist 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 directly 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 enrollee shall be made for any additional services that were indicated during the tele-dentistry visit. All appropriate clinical records shall be provided to the dentist to whom the enrollee is referred.

The dentist to whom the enrollee is referred may be either an FQHC dentist or non-FQHC dentist. If an 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 during the initial visit with a dentist present, 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.

Place of Service Limitations

The provisions of these services is 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.

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 an enrollee's home cannot be used for these services.
- Reimbursement will be at the all-inclusive rate on file for the date of service.

Adult Denture Program

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

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

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

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

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

Diagnostic Services

ExaminationD0150 Comprehensive Oral Examination - New or Established Patient

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

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

Examinations in Anticipation of Denture Construction

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

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

Minimum Examination Requirements for the Clinical Examination

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

Examination of Ineligible Enrollees

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

Examination in Conjunction with a Denture Repair

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

Examination in Conjunction with a Denture Reline

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

Radiographs

D0210 Intraoral – Complete Series

A complete series consists of:

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

If radiographs are unobtainable, e.g. the enrollee is physically unable to receive this service or the enrollee 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 enrollee's dental treatment record. In this instance, as radiographs were not taken, the provider shall not be reimbursed for the examination code D0150.

Radiographs must be maintained in the enrollee's record.

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

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthetics

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

- The providers are required to obtain enrollee esthetic acceptance prior to processing. This acceptance must be documented by the enrollee'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 ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the enrollee's treatment record; and
- 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 enrollee (not over or under-closed). The proper centric relation of occlusion must be established for complete dentures or partial dentures opposing full dentures;
    - For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch;
    - The denture must be fitted and adjusted for comfort, function, and aesthetics; and
    - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

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

Complete Dentures

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

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

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

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

Since the 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 enrollee is not able to pay for the extractions of the remaining teeth is not an acceptable reason for not delivering the denture.

Partial Dentures

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

An acrylic partial denture may be provided when the opposing arch has a functioning complete denture, or is having a complete denture fabricated simultaneous to the partial denture and the arch requiring the partial denture is:

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

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

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The design of the prosthesis and materials used should be as simple as possible and consistent with basic principles of prosthodontics.

Denture Repairs

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

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

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

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

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

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

Minimal procedural requirements for repair services include the following:

- The prosthesis should be repaired using appropriate materials and techniques in a commercial or dental office laboratory. If the repair is performed in a commercial dental laboratory, the prosthetic prescription and laboratory bill (or a copy) must be maintained in the enrollee'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; and
- The treatment record must specifically identify the location and extent of the breakage. Failure to provide adequate documentation of services billed as repaired when requested by Medicaid or its authorized representative (AR) will result in recoupment of monies paid by the program for the repair.

Denture Relines

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

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

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

If the same billing provider (or another Medicaid-enrolled provider located in the same office as the requesting provider) requests a complete or partial denture for the same arch within one year after delivery of the reline, the reline fee will be deducted from the new prosthesis fee.

A combination of two complete or partial denture relines or one complete or partial denture and one reline in the same arch are allowed in an eight-year period as prior authorized by Medicaid or its designee.

Reline of existing dentures must be given priority over the construction of new dentures if the reline will result in a serviceable denture for at least eight years.

NOTE: Chair-side relines (cold cure acrylics) are not reimbursable. Minimal procedural requirements for reline services include the following:

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

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

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

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

Other Removable Prosthodontics

D5899 Unspecified Removable Prosthodontic Procedure, by Report

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

Adult Waiver Dental Program

Dental services are provided to adults 21 years of age and older with developmental or intellectual disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver.

Dental services covered under the Adults Waiver Dental Program are divided into the following 11 categories:

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

Diagnostic Services

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

Examinations

D0120 Periodic oral examination – established patient

D0150 Comprehensive oral examination – new or established patient

The DBPM shall cover one periodic oral examination in a six-month period. The periodic oral examination shall be at least six months after the comprehensive oral examination, when applicable.

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

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

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

Radiographic Images

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

D0210 Intraoral - complete series of radiographic images

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

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

D0220 Intraoral – periapical first radiographic image

D0230 Intraoral – periapical each additional radiographic image

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

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

D0240 Intraoral – Occlusal radiographic image

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

D0272 Bitewings – two radiographic images

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

D0330 Panoramic radiographic images

This procedure code is reimbursable only once per day by any provider, facility or group and is limited to one service every 12-months by the same provider.

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

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

D0350 Oral/Facial Images

Oral/facial images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations:

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

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

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

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

Other Diagnostic Services

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

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

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

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

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

Preventive Services

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

Prophylaxis

D1110 Adult Prophylaxis

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

This procedure is limited to once per six-month period. More frequent prophylaxis may be approved if deemed medically necessary.

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

Fluoride Treatment

D1208 Topical Application of Fluoride – excluding varnish

Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.

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

Other Preventive Services

D1354 Interim caries arresting medicament application – per tooth

Reimbursed per tooth every 6 months. Total of four times per lifetime of the tooth. Limited to Silver Diamine Fluoride. Covered with topical application of fluoride (D1208) when performed on the same date of service if D1354 is being used to treat caries and D1208 is being used to prevent caries.

Restorative Services

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

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

Laboratory processed crowns are not covered.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four or more surfaces, permanent (D2161); resin-based composite, four or more surfaces, posterior (D2394); resin-based composite, four or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); a prefabricated porcelain/ceramic crown, anterior (D2929) or a prefabricated stainless steel crown (D2930, D2931, D2932, D2933 or D2934).

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

Amalgam Restorations (including polishing)

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.

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

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

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

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

~~Procedure codes D2140, D2150, and D2160 are reimbursable for Tooth Numbers 1 through 32.~~

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

Resin-Based Composite Restorations - Direct

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

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

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

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

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

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

~~Procedure codes D2330, D2331, D2332, D2335, and D2390 are reimbursable for Tooth Numbers 6 through 11 and 22 through 27.~~

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

~~Procedure codes D2391, D2392, D2393, and D2394 are reimbursable for Tooth Numbers 1 through 5, 12 through 16, 17 through 21, and 28 through 32.~~

Non-Laboratory Crowns

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

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

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

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

Stainless steel crowns (D2930) are not medically indicated and reimbursement should not be made for incipient carious lesions.

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

~~This procedure is reimbursable for Tooth Numbers 1 through 32.~~

~~**D2932 Prefabricated Resin Crown (permanent teeth)**~~

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

Other Restorative Services

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

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

D2920 Re-cement Crown

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

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

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

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

D2951 Pin Retention – per tooth, in addition to restoration

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

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

D2954 Prefabricated Post and core in addition to crown

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

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

D2999 Unspecified Restorative Procedure, by report

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

Endodontic Therapy Services

Pulp Capping

D3110 Pulp Cap – direct (excluding final restoration)

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

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

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

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

Endodontic Therapy

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

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

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

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

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

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

D3310 Endodontic Therapy, anterior (excluding final restoration)

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

D3320 Endodontic Therapy, premolar (excluding final restoration)

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

D3330 Endodontic Therapy, molar (excluding final restoration)

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

Endodontic Retreatment

D3346 Retreatment of previous root canal therapy – anterior

This procedure is reimbursable only to a different provider or provider group than whom originally performed the initial root canal therapy.

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

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

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

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

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

Apexification/Recalcification Procedure

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

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

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

Apicoectomy/Periradicular Services

D3410 Apicoectomy/ periradicular surgery – anterior

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

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

D3430 Retrograde filling

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

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

Other Endodontic Procedures

D3999 Unspecified Endodontic Procedure, by report

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

Periodontal Services

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

Surgical Periodontal Services

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

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

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

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

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

Non-surgical Periodontal Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Periodontal Services

D4999 Unspecified Periodontal Procedure, by report

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthodontics

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

- The providers are required to obtain enrollee esthetic acceptance prior to processing. This acceptance must be documented by the enrollee'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 enrollee's treatment record; and
    - 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 enrollee (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch;
    - The denture must be fitted and adjusted for comfort, function, and aesthetics; and
    - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

Complete Dentures

Only one prosthesis per enrollee per arch is allowed in an eight-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 prior authorization. If an immediate denture is requested, the provider must state the reasons for the request in the "Remarks" section of the claim form.

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

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

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

Partial Dentures

Only one prosthesis (excluding interim partial dentures) per enrollee per arch is allowed in an eight-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid under the Louisiana Medicaid program.

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider must use the following symbols in Block 33 of the ADA Dental Claim Form to indicate tooth status:

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

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

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

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

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

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

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

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

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

- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- Missing at least three adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement);

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

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

Denture Repairs

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

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

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

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

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

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

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

Minimal procedural requirements for repair services include the following:

- The prosthesis should be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the enrollee's treatment record;
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion;

- ❖ The prosthesis must be finished in a skillful manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots; and
- ❖ The treatment record must specifically identify the location and extent of the breakage, including the side of the prosthesis involved (right or left).

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

Denture Relines

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

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

Minimal procedural requirements for reline services include the following:

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

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

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

Other Removable Prosthodontics

D5899 Unspecified removable prosthodontic procedure, by report

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

Fixed Prosthodontics

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

- ❖ The abutment teeth must be caries free and restoration-free and have sound periodontal support;

- ❖ No other maxillary teeth are missing or require extraction;
- ❖ Periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed; and
- ❖ On the tooth number chart on the ADA form, "X" out the missing tooth.

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

Only one Maryland-type bridge can be authorized in an eight-year period.

Fixed Partial Denture Pontic

D6241 Pontic – porcelain fused to predominantly base metal

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

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

Fixed Partial Denture Retainer

D6545 Retainer – cast metal for resin bonded fixed prosthetics

This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two per enrollee, in an eight-year period.

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

Other Fixed Partial Denture Services

D6999 Unspecified, fixed prosthodontic procedure, by report

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

Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the Adult Waiver Dental program.

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

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

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 enrollee's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

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

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

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

Non-surgical Extractions

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

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

Surgical Extractions

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

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

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

D7220 Removal of impacted tooth - soft tissue

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

D7230 Removal of impacted tooth - partial bony

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

D7240 Removal of impacted tooth - complete or full bony

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

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

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

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

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

D7250 Surgical removal of residual tooth roots (cutting procedure)

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

Other Surgical Procedures

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

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

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

D7280 Surgical access of an unerupted tooth

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

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

D7283 Placement of Device to Facilitate Eruption of Impacted Tooth

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

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

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

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

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

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

D7286 Biopsy of Oral Tissue – Soft

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

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

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

D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report

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

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

Alveoloplasty – Surgical Preparation of Ridge for Dentures

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

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

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

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

Surgical Incision

D7510 Incision and Drainage of abscess – intraoral soft tissue

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Temporomandibular Joint (TMJ) Procedure

D7880 Occlusal orthotic device, by report

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

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

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

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

Repair of Traumatic Wounds

D7910 Suture recent small wound up to 5cm

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

record.

Other Repair Procedures

D7961 Buccal/labial frenectomy (frenulectomy)

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

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

D7962 Lingual frenectomy (frenulectomy)

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

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

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

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

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

D7999 Unspecified oral surgical procedure, by report

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

Orthodontic Services

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

Comprehensive Orthodontic Treatment

D8090 Comprehensive orthodontic treatment of the adult dentition

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

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

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

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

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

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

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

Adjunctive General Service

Palliative (Emergency) Treatment

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

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

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

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

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

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

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

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

Anesthesia

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

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

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

D9239 Intravenous moderate conscious sedation/analgesia – first 15 minutes

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

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

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

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

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

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

D9248 Non-intravenous conscious sedation

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

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

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

Non-intravenous conscious sedation is not reimbursable on the same day, by any provider as procedure codes D9230 (Nitrous Oxide) and D9997 (Dental case management).

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

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

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

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

Professional Visits

D9420 Hospital call

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

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

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

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

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

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

D9440 Office Visit – after regularly scheduled hours

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

Miscellaneous Services

D9944 Occlusal Guard – hard appliance, full arch

D9945 Occlusal Guard – soft appliance, full arch

D9946 Occlusal Guard – hard appliance, partial arch

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

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

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

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

D9951 Occlusal Adjustment – limited

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

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

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

D9997 Dental Case management – patients with special health care needs

Special treatment considerations for enrollees with developmental or intellectual disabilities, which require that the provider use special techniques requiring extra time, skill and staff when communicating and treating patients with physical, medical, developmental or cognitive conditions.

- A maximum of four dental case management services, per enrollee, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider. Consideration for additional occurrences may be approved if deemed medically necessary.
- 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.
- This is not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia.

Documentation of the circumstances requiring special treatment consideration, as well as the specific efforts or techniques utilized must be recorded in the enrollee's treatment record for each treatment visit.

D9999 Unspecified adjunctive procedure, by report

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

Adult ICF/IID Dental Services

Formatted: Heading 3

Dental services are provided to adults 21 years of age and older ~~with developmental or intellectual disabilities~~ who reside in an Intermediate Care Facilities for Individuals with Intellectual Disabilities.

Dental services covered under the Adult~~s~~ ICF/IID Dental Program are divided into the following 11 categories:

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

Diagnostic Services

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

Examinations

D0120 Periodic oral examination – established patient

D0150 Comprehensive oral examination – new or established patient

Diagnostic codes D0120, Periodic oral examination and D0150 Comprehensive oral examination are excluded from coverage by the DBPM for members of the Adult ICF/IID Dental Program. Federal regulations require Intermedi~~c~~ate Care Facilities to provide these services to their residents.

Radiographic Images

Radiographic imaging codes D0210, D0272 and D0330 shall also be excluded from payment by the DBPMs for the adult ICF/IID population. D0210 will be covered once annually by the ICF/IID. Federal regulations require Intermediate Care Facilities to provide radiographs for their beneficiaries when indicated.

Any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination appointment for screening purposes are

not covered. If a routine practice of taking such radiographic images, without adequate diagnostic justification, is discovered during post payment review, all treatment records may be reviewed and recoupment of payments for all radiographic images will be initiated.

D0220 Intraoral – periapical first radiographic image

D0230 Intraoral – periapical each additional radiographic image

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

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

D0240 Intraoral – Occlusal radiographic image

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

D0350 Oral/Facial Images

Oral/facial images are required when dental radiographic images do not adequately indicate the necessity for the requested treatment in the following situations:

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

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

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

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

Other Diagnostic Services

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

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

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

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

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

Preventive Services

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

Prophylaxis

D1110 Adult Prophylaxis

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

This procedure is limited to once per six-month period. More frequent prophylaxis may be approved if deemed medically necessary.

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

Fluoride Treatment

D1208 Topical Application of Fluoride – excluding varnish

Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.

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

Other Preventive Services

D1354 Interim caries arresting medicament application – per tooth

Reimbursed per tooth every 6 months. Total of four times per lifetime of the tooth. Limited to Silver Diamine Fluoride. Covered with topical application of fluoride (D1208) when performed on the same date of service if D1354 is being used to treat caries and D1208 is being used to prevent caries.

Restorative Services

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

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

Laboratory processed crowns are not covered.

If the tooth is decayed extensively, consideration should be given for the provision of an amalgam, four or more surfaces, permanent (D2161); resin-based composite, four or more surfaces, posterior (D2394); resin-based composite, four or more surfaces or involving incisal angle, anterior (D2335); a resin-based composite crown, anterior (D2390); a prefabricated porcelain/ceramic crown, anterior (D2929) or a prefabricated stainless steel crown (D2930, D2931, D2932, D2933 or D2934).

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

Amalgam Restorations (including polishing)

Procedure codes D2140, D2150, D2160, and D2161 represent final restorations.

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

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

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

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

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

Resin-Based Composite Restorations - Direct

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

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

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

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

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

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

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

Non-Laboratory Crowns

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

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

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

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

Stainless steel crowns (D2930) are not medically indicated and reimbursement should not be made for incipient carious lesions.

Other Restorative Services

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

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

D2920 Re-cement Crown

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

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

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

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

D2951 Pin Retention – per tooth, in addition to restoration

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

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

D2954 Prefabricated Post and core in addition to crown

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

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

D2999 Unspecified Restorative Procedure, by report

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

Endodontic Therapy Services

Pulp Capping

D3110 Pulp Cap – direct (excluding final restoration)

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Pulpotomy

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

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

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

Endodontic Therapy

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

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

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

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

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

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

D3310 Endodontic Therapy, anterior (excluding final restoration)

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

D3320 Endodontic Therapy, premolar (excluding final restoration)

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

D3330 Endodontic Therapy, molar (excluding final restoration)

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

Endodontic Retreatment

D3346 Retreatment of previous root canal therapy – anterior

This procedure is reimbursable only to a different provider or provider group than whom originally performed the initial root canal therapy.

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

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

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

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

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

Apexification/Recalcification Procedure

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

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

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

Apicoectomy/Periradicular Services

D3410 Apicoectomy/ periradicular surgery – anterior

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

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

D3430 Retrograde filling

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

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

Other Endodontic Procedures

D3999 Unspecified Endodontic Procedure, by report

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

Periodontal Services

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

Surgical Periodontal Services

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

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

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

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

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

Non-surgical Periodontal Services

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

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

Radiographic evidence of bone loss indicating a true periodontal disease state must be maintained in the enrollee's treatment record 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 units of periodontal scaling and root planing may be reimbursed per day. For enrollees requiring hospitalization for dental treatment, a maximum of four units of procedure code D4341 may be paid on the same date of service. The claim form used to request reimbursement must identify the "Place of Treatment" (Block 38) and "Treatment Location" (Block 56) if the service was performed at a location other than the primary office.

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

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

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

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

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

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

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

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

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

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

Other Periodontal Services

D4999 Unspecified Periodontal Procedure, by report

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

Removable Prosthodontics

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

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

Minimum Standards for Complete and Partial Denture Prosthodontics

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

- The providers are required to obtain enrollee esthetic acceptance prior to processing. This acceptance must be documented by the enrollee'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 enrollee's treatment record; and
    - 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 enrollee (not over-closed or under-closed). The proper centric relation of occlusion should be established for complete dentures or partial dentures opposing full dentures. For partial dentures opposing natural dentition or another partial denture, the occlusion must be harmonious with the opposing arch;
    - The denture must be fitted and adjusted for comfort, function, and aesthetics; and
    - The denture must be finished in a professional manner; it must be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots.

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

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

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

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

Complete Dentures

Only one prosthesis per enrollee per arch is allowed in an eight-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 PA. 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 enrollee that no reline will be reimbursed within one year of the denture delivery.

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

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

Partial Dentures

Only one prosthesis (excluding interim partial dentures) per enrollee per arch is allowed in an eight-year period. The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. An interim partial denture cannot be authorized to replace a partial denture that was previously paid under the Louisiana Medicaid program.

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

A description of the arch receiving the prosthesis must be provided by indicating which teeth are to be replaced and which are to be retained. The provider must use the following symbols in Block 33 of the ADA Dental Claim Form to indicate tooth status:

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

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

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

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

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

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

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

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

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

- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- Missing at least three adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement);

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

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

Denture Repairs

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

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

There is a limit to how much a provider can bill within a single year for base repair, clasp addition or replacement, or tooth addition or replacement services per arch for the same enrollee. This limit applies to the billing provider or another Medicaid-enrolled provider located in the same office as the requesting provider. See the Adult ICF/IID Dental fee schedule on the Louisiana Medicaid website for limits.

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

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

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

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

Minimal procedural requirements for repair services include the following:

- The prosthesis shall~~should~~ be processed under heat and pressure in a commercial or dental office laboratory using ADA certified materials. The prosthetic prescription and laboratory bill (or a copy) must be maintained in the enrollee's treatment record;
- Repairs must make the prosthesis fully serviceable, retaining proper vertical dimension and centric relation of occlusion;

- The prosthesis must be finished in a skillful manner; be clean, exhibit a high gloss, and be free of voids, scratches, abrasions, and rough spots; and
- The treatment record must specifically identify the location and extent of the breakage, including the side of the prosthesis involved (right or left).

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

Denture Relines

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

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

Minimal procedural requirements for reline services include the following:

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

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

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

Other Removable Prosthodontics

D5899 Unspecified removable prosthodontic procedure, by report

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

Fixed Prosthodontics

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

- The abutment teeth must be caries free and restoration-free and have sound periodontal support;

- ❖ No other maxillary teeth are missing or require extraction;
- ❖ Periapical radiographic images of the abutment teeth and bitewings showing that all other treatment needs in the maxillary arch have been completed; and
- ❖ On the tooth number chart on the ADA form, "X" out the missing tooth.

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

Only one Maryland-type bridge can be authorized in an eight-year period.

Fixed Partial Denture Pontic

D6241 Pontic – porcelain fused to predominantly base metal

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

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

Fixed Partial Denture Retainer

D6545 Retainer – cast metal for resin bonded fixed prosthetics

This code is only reimbursable when submitted in conjunction with code D6241. Procedure code D6545 is limited to two per enrollee, in an eight-year period.

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

Other Fixed Partial Denture Services

D6999 Unspecified, fixed prosthodontic procedure, by report

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

Oral and Maxillofacial Surgery Services

The services listed below are the oral and maxillofacial surgery services covered under the Adult ICF/IID Dental program.

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

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

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 enrollee's record, and must be furnished to post-payment review if requested. Written documentation of the reason for the extraction must be noted in the dental treatment record.

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

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

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

Non-surgical Extractions

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

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

Surgical Extractions

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

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

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

D7220 Removal of impacted tooth - soft tissue

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

D7230 Removal of impacted tooth - partial bony

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

D7240 Removal of impacted tooth - complete or full bony

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

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

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

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

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

D7250 Surgical removal of residual tooth roots (cutting procedure)

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

Other Surgical Procedures

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

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

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

D7280 Surgical access of an unerupted tooth

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

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

D7283 Placement of Device to Facilitate Eruption of Impacted Tooth

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

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

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

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

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

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

D7286 Biopsy of Oral Tissue – Soft

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

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

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

D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report

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

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

Alveoloplasty – Surgical Preparation of Ridge for Dentures

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

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

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

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

Surgical Incision

D7510 Incision and Drainage of abscess – intraoral soft tissue

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

This procedure is reimbursable for Tooth Numbers 1 through 32.

Temporomandibular Joint (TMJ) Procedure

D7880 Occlusal orthotic device, by report

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

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

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

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

Repair of Traumatic Wounds

D7910 Suture recent small wound up to 5cm

Post-operative color photos and rationale ~~is to~~must be documented and maintained within the enrollee's

treatment record.

Other Repair Procedures

D7961 Buccal/labial frenectomy (frenulectomy)

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

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

D7962 Lingual frenectomy (frenulectomy)

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

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

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

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

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

D7999 Unspecified oral surgical procedure, by report

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

Orthodontic Services

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

Comprehensive Orthodontic Treatment

D8090 Comprehensive orthodontic treatment of the adult dentition

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

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

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

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

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

The enrollee's treatment records must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case.

Reimbursement includes the brackets/appliance and all visits and adjustments.

Adjunctive General Service

Palliative (Emergency) Treatment

D9110 Palliative (emergency) treatment of dental pain – minor procedure

Palliative treatment is the treatment of a specific dental complaint and is limited to trauma cases. It is to be used when a specific procedure code is not indicated and a service is rendered to the enrollee. Records must indicate the tooth or area of the mouth that was treated.

On the date of service that a palliative treatment is rendered, a provider shall only be reimbursed for periapical radiographic images (D0220 and D0230), occlusal radiographic images (D0240) if authorized, bitewing radiographic images (D0272), or panoramic radiographic images (D0330) in addition to this procedure code. Panoramic images (D0330) are not allowed on emergency claims unless third molars or a traumatic complaint is involved.

If definitive therapeutic treatment is performed on the same date of service as the palliative treatment, the provider may choose to bill for the definitive therapeutic treatment instead of the palliative treatment.

A maximum of two palliative treatments per enrollee are available annually. Emergency or palliative dental care services include the following:

- Procedures used to control bleeding;
- Procedures used to relieve pain;
- Procedures used to eliminate acute infection, opening the pulp chamber to establish drainage, and the appropriate pharmaceutical regimen;
- Operative procedures which are required to prevent pulpal death and the imminent loss of teeth, e.g., excavation of decay and placement of appropriate temporary fillings;
- Complaint where assessment is provided, or diagnosis is determined, or referral is made; or
- Palliative therapy for pericoronitis associated with partially erupted/impacted teeth.

The enrollee's treatment record must contain a narrative of the specific treatment rendered (tooth number, temporization, opened tooth for drainage, etc.). The treatment provided must **not** be one that the program lists as non-covered nor can it be a treatment that would be covered under a specific dental service code.

If endodontic therapy is anticipated and the provider has not already obtained bitewing radiographic images, bitewing radiographic images must be taken for inclusion with the request for PA of the root canal, in addition to any periapical radiographic images taken for diagnosis of the affected tooth.

Anesthesia

D9230 Nitrous Oxide - analgesia, anxiolysis, inhalation of nitrous oxide

Nitrous oxide inhalation analgesia is only payable to providers who possess a personal permit for its administration from the Louisiana State Board of Dentistry and administer it in a State Board approved facility. Nitrous oxide is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. Nitrous oxide, if provided, must be billed on the same claim form as the restorative and/or surgical service(s) and may not be submitted more than once per member per day.

NOTE: This code is not reimbursable when billed in conjunction with D9248 (Non-intravenous conscious sedation) by any provider.

D9239 Intravenous moderate conscious sedation/analgesia – first 15 minutes

D9243 Intravenous moderate conscious sedation/analgesia – each additional 15 minutes

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the enrollee. Anesthesia services are considered completed when the enrollee can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients.

Intravenous conscious sedation/analgesia can only be performed by doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

These procedures are only allowable in conjunction with difficult impactions or other extensive surgical procedures done in the office setting.

A maximum of three units of D9243 are available per enrollee per visit.

Anesthesia time record is required when billing D9239 and the three-unit maximum for D9243.

D9248 Non-intravenous conscious sedation

Non-intravenous conscious sedation is a medically controlled state of depressed consciousness while maintaining the enrollee's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

Non-intravenous conscious sedation/analgesia can only be performed by doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

A maximum of four non-intravenous conscious sedation/analgesia administrations, per enrollee, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider.

Non-intravenous conscious sedation is not reimbursable on the same day, by any provider as procedure codes D9230 (Nitrous Oxide) and D9997 (Dental case management).

The enrollee's treatment records must adequately document the need for extensive dental restorative or surgical treatment performed in the office setting and must document the need for this service based on prior experience attempting to treat the patient. The provider must indicate the drug(s) anticipated to be used and route(s) of administration in the treatment records.

The use of conscious sedation indicates that the provider intends to administer drugs of a suitable type, strength, and mode of administration that necessitates constant monitoring by the dentist or staff from administration through the time of discharge.

A conscious sedation form must be completed and maintained in the enrollee's treatment record. If the restorative/surgical phase of the treatment is aborted after the initiation of conscious sedation, the provider must document the circumstances in the enrollee's treatment record.

Administration of oral pre-medication is not a covered service.

Professional Visits

D9420 Hospital call

This code may be reimbursed when providing treatment in hospital outpatient clinic or outpatient ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Those services must be covered under the Adult ICF/IID Dental program.

A hospital call is only reimbursable for dates of service on which restorative and/or surgical services (codes D2140 - D4999 and D7140 - D7999) are performed. A hospital call, if provided, must be billed on the same claim form as the restorative and/or surgical service(s). If a claim or payment is received for a hospital call and there are no restorative and/or surgical service(s) listed on the claim form or no claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the hospital call, the payment for the hospital call will be denied.

Hospitalization solely for the convenience of the enrollee or the dentist is not allowed.

The dental office treatment record for the enrollee must also document the justification for hospitalization including accurate dental charting. A copy of the operative report must be maintained in the enrollee's dental office treatment record.

Procedure code D9420 is reimbursable once per six-month period, per enrollee.

For more information on billing for hospital claims payment for dental services by an oral surgeon please refer to Informational Bulletin 12-25.

D9440 Office Visit – after regularly scheduled hours

Procedure code D9440 is to be used for an office visit after regularly scheduled hours for the treatment of a dental emergency. The dental office must be reopened specifically to treat this emergency. The service(s) provided must be reimbursable under the Louisiana Medicaid Dental Program. A statement describing the situation must be recorded in the enrollee's treatment records.

Miscellaneous Services

D9944 Occlusal Guard – hard appliance, full arch

D9945 Occlusal Guard – soft appliance, full arch

D9946 Occlusal Guard – hard appliance, partial arch

An Occlusal Guard is a removable dental appliance that is designed to minimize the effects of bruxism (grinding) and other occlusal factors.

The enrollee must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The enrollee's treatment record must include a completed TMJ summary form. Indicate whether the condition is acute or chronic and if any other services are to be provided in addition to the requested splint.

This procedure is reimbursable for Oral Cavity Designation areas 01 and 02.

D9951 Occlusal Adjustment – limited

May also be referred to as equilibration; a reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth and is reported on a "per visit" basis.

The enrollee must have an occlusion that has progressed beyond the mixed dentition stage of tooth eruption.

The enrollee's treatment record must include a completed TMJ summary form.

D9997 Dental Case management – patients with special health care needs

Special treatment considerations for enrollees with developmental or intellectual disabilities, which require that the provider use special techniques requiring extra time, skill and staff when communicating and treating patients with physical, medical, developmental or cognitive conditions.

- A maximum of four dental case management services, per enrollee, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider. Consideration for additional occurrences may be approved if deemed medically necessary.
- 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.
- This is not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia.

Documentation of the circumstances requiring special treatment consideration, as well as the specific efforts or techniques utilized must be recorded in the enrollee's treatment record for each treatment visit.

D9999 Unspecified adjunctive procedure, by report

This procedure code is used for a procedure that is not adequately described by another code. It requires PA. Providers must describe the situation requiring treatment and the treatment proposed in the "Remarks" section of the claim form when submitting for PA.

Out-of-State Dental Care

The DBPM shall cover medically necessary services to enrollees provided outside of the state when dental services are needed due to an emergency.

Prohibited and Non-Covered Services

The DBPM shall ensure that dentists and all other professionals abide by the professional guidelines set forth by their certifying and licensing agencies in addition to complying with Louisiana Medicaid regulations.

In general, services that are not approved by the Food and Drug Administration or the Louisiana State Board of Dentistry or services that are experimental, investigational, or cosmetic are excluded from Medicaid coverage and will be deemed not medically necessary.

The following non-exhaustive list of services excluded from DBPM covered services and/or otherwise limited by Louisiana Medicaid shall be reflected in the DBPM's coverage policy:

- Any service (device, procedure, or equipment) that is not medically necessary;
- Experimental/investigational, devices, procedures, or equipment, unless approved by the Secretary of LDH;
- Cosmetic devices, procedures, or equipment;
- Surgical procedures discontinued before completion; and
- Provider preventable conditions.

Coordination of Care

The DBPM shall maintain written care coordination and continuity of care procedures that include the following minimum functions:

- Appropriate referral and scheduling assistance for enrollees needing specialty dental care;
- A mechanism for access to specialists, without the need for a referral, for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs;
- Coordination with the enrollee's MCO for oral health issues exceeding the coverage of the Contract;
- Coordination with the enrollee's MCO for transportation to and from covered dental services; and
- Coordination with the enrollee's MCO regarding value-added dental benefits offered by the enrollee's MCO.

Ambulatory Surgical Services

The enrollee's health plan shall cover ambulatory surgical services, defined as surgical services where enrollees do not require hospitalization and in which the expected duration of services would not exceed 24 hours. Ambulatory surgical services can be provided in non-hospital ambulatory surgical centers and outpatient hospitals.

The DBPM is responsible for coordination of care with the enrollee's MCO or FFS Medicaid for oral health issues exceeding the coverage of the Contract. This includes dental services requiring anesthesia performed in an outpatient facility. The DBPM will be responsible for payment for all covered dental services rendered in non-hospital ambulatory surgical centers and outpatient hospitals.

Medical Transportation

The DBPM is responsible for coordination with the enrollee's MCO for transportation to and from covered dental services.