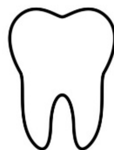
Chapter 14

Medicaid Provider Manual

Dental Benefits



July 2024

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14.0 KEY UPDATES

Updates to Chapter 14 occurred in April 2024 and July 2024. These updates include the following key changes:

- Organized in an easy-to-read format.
- Removed most pre-authorization (PA) requirements. Only General Anesthesia and Orthodontic services require PAs.
- Removed the age limitation for nitrous oxide and intravenous moderate conscious sedation. These are now benefits for all patients that meet the established criteria. See Sections 14.9.9 and 14.9.10.
- The benefit for D9440 has been removed.
- Optional self-pay process clarified. Usual Customary and Reasonable (UCR) fees are billable for services not covered by the plan, if out-of-pocket costs are communicated in advance with a signed acknowledgement of financial cost. See Section 14.7.
- Tracking missed appointments to gain better insight on volume and impact to aid in solution development. This is not a benefit, is not chargeable to the patient, and is for reporting and program improvement purposes only. See "No-Show Fees" in Section 14.2.

<u>Key Changes by Procedure Code</u>

1. D0120 Periodic Oral Evaluation – established patient & D0145 Evaluation for a Patient Under 3 years of age and counseling with primary caregiver. See Section 14.9.1.
    a. Removed the 6 months age requirement.
2. D1354 Interim Caries Arresting Medicament- per tooth. See Section 14.9.2.
    a. Changed denial period from a 30-day to a 60-day timeframe as it relates to performing a restoration on the same tooth.
3. D1516-D1517 Bilateral Space Maintainers. See Section 14.9.2.
    a. Changed from 2 per 2 years to 1 per 2 years.
4. D2952 & D2954 Post and Core. See Section 14.9.3.
    a. Pre-op x-ray now required.
5. D4910 Periodontal Maintenance. See Section 14.9.5.
    a. Removed PA requirement.
    b. Removed the scaling and root planing (SRP) history of Medicaid claim requirement.
    c. No longer limited to 18 months.
    d. Added that the provider is required to maintain SRP history in their records.
6. D7240- Removal of Impacted Tooth – Completely Bony. See Section 14.9.7.
    a. 90% of the crown must be encased in bone.
7. D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications. See Section 14.9.7.
    a. 75% of crown must be encased in bone.
8. D9230- Inhalation of Nitrous Oxide/Analgesia, Anxiolysis & D9239/D9243- Intravenous Moderate (Conscious) Sedation/Analgesia now require the following. See Sections 14.9.9 and 14.9.10
    a. Benefit for all ages when **<u>all three criteria are met</u>**:
        i. The patient displays or expresses an inability to perform the procedures without nitrous oxide, or IV sedation.

ii. Used in conjunction with a completed endodontic procedure D3220-D3425, or a surgical dental procedure D7111-D7971; and
iii. Documented formal medical diagnosis that involves emotional dysregulation due to mental health condition, or neurodivergent condition.

9. D9420 Hospital or Ambulatory Surgical Center Call is only benefited when services are provided by an Oral Surgeon or Orthodontist. See Section 14.9.10
10. D9440 Office visit – after regularly scheduled hours is no longer a benefit.
11. D9986 – Missed Appointment.
    a. Not a benefit, and not chargeable, but we encourage submission for data collection purposes.
12. D9987 - Cancelled Appointment.
    a. Not a benefit, and not chargeable, but we encourage submission for data collection purposes.

Provider questions can be emailed to: HDSMedicaidPR@HawaiiDentalService.com

Member questions can be emailed to: CS@HawaiiDentalService.com

14.1 GENERAL OVERVIEW OF THE DENTAL PROGRAMS

Two main programs define the dental benefits for Hawaii's Medicaid beneficiaries: the Children's Dental Benefits Program is for enrollees younger than age 21 years. The Adult Dental Benefits Program is for enrollees aged 21 and older.

- These programs provide payments to registered dental providers for selected diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, orthodontic, and oral surgery services. Benefits are paid only to registered dental providers at registered office locations, after delivering specific services to Medicaid enrolled patients, using CDT codes in effect on the date of service.

- Benefits are defined by the State of Hawaii Department of Human Services, yet day-to-day operations and claims processing are conducted by a contracted third-party administrator.

- The programs will adjust to changing public need, provider and public behaviors, and budget. Providers can view program updates online through the provider portal, and can confirm that they are referencing the latest version by noting the document version month and year. For example, "Chapter 14, July 2024."

- A third program for special dental benefits for medically related oral surgery services is available through Medicaid medical managed care plans. See section 14.11, "SPECIAL DENTAL SERVICES RELATED TO MEDICAL TREATMENT."

- These Medicaid dental programs are designed to reduce barriers to basic care for qualified Medicaid beneficiaries of our community with particular health, social, or financial circumstances. For children, the intent is to provide basic preventive and therapeutic care. For adults, the intent is to assure access to basic preventive and therapeutic care, and to encourage the ongoing relationship and investment with a dental home.

- Situations with unusual special medical necessity may qualify for exceptions to benefit frequency limits. Pre-authorization is required.

14.1.1 THE CHILDREN'S DENTAL PROGRAM (UNDER AGE 21)

Dental benefits for children are governed by federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. This federal program emphasizes prevention and control of disease through early detection and management. Dental services available through the EPSDT program are broader than what is available to adult (age 21 and older) Medicaid beneficiaries. For more details on the EPSDT program, please see the Medicaid Provider Manual, Chapter 5.

Benefits for comprehensive orthodontic therapy are offered only for children with developmental defects, including orofacial clefts. The extraction of any teeth solely for orthodontic purposes, or third molars without documented signs of pathology, are not program benefits for any individuals.

14.1.2 THE ADULT DENTAL PROGRAM (Age 21 and older)

As of January 2023, adult dental benefits include the following:

- Preventive Services
  - Comprehensive Oral Evaluation – 1 per 5 years
  - Periodic screening examinations - 2 per year
  - Prophylaxis - 2 per year
  - Topical fluoride varnish - 2 per year
- Diagnostic and Radiology Services
  - Bitewing x-rays - 2 per year
  - Full series x-rays – 1 per 5 years
  - Biopsies of oral tissue
- Endodontic Therapy Services
  - Root canal therapy on permanent molars only
- Restorative Services
  - Amalgams on posterior teeth
  - Composites on anterior and posterior teeth
  - Pin and/or post reinforcement
  - Cast cores
  - Recement inlays and crowns
  - Stainless steel crowns
- Oral Surgery
- Periodontal Therapy
  - Scaling and root planning – one every 24 months
- Prosthodontic Services
  - Complete Upper and Lower Dentures – one every 5 years
  - Interim Partial Dentures – one every 1 year
  - Denture relines – one every 2 years
- Emergency and Palliative Treatment
  - Gingivectomy, for gingival hyperplasia
  - Other medically necessary emergency dental services

14.2 PROVIDER OBLIGATIONS

Dental providers must follow their signed ***Provider Agreement and Condition of Participation*** with State of Hawai`i Department of Human Services. Providers agree to follow this manual, and the Hawaii Administrative Rules, Title 17, Subtitle 12 Med-QUEST Division, and federal rules set forth in the Code of Federal Regulations (CFR).

All providers are aware of the following:

- Medicaid welcomes feedback. Constructive suggestions for future revisions can shape future versions of this program. Input should be submitted to the third-party administrator's professional relations team.

- Medicaid audits dental providers to maintain program integrity. Audits may be based on unusual claims activity, reports from patients or other dentists, or by random selection. On a case-by-case basis, additional provider-specific requirements may be imposed, to ensure program integrity and patients' well-being.

- Copays may not be collected from patients for any procedures with Medicaid benefits. Medicaid payments are payment in full. A Medicaid network dentist may bill patients for requested dental services that are not covered by the dental program. The fee to patients shall not exceed a provider's usual and customary rate. Providers must have the patient sign a financial consent for any self-pay services. See section 14.7.

- Providers may not claim reimbursement for services rendered by another dentist, or by an assistant or dental hygienist without legal privilege to perform those services on behalf of the dentist, according to Hawaii's dental practice laws.

- Medicaid shall not be billed for any portion of a non-covered procedure, nor for any other procedure completed solely in conjunction with a non-covered procedure. For example, if an adult patient requests orthodontic aligners for cosmetic reasons, then any exams or x-rays taken solely as part of that treatment are also not covered.

- Providers must bill accurately and ethically. Prohibited actions include, but are not limited to:

    - Claiming services that were not performed

    - Altering dates of service on a claim, to coincide with benefit coverage

    - Misrepresenting a patient's level of uncooperative behavior to justify the use of sedation or nitrous oxide.

    - Code substitution: the submission of a claim using a covered procedure code when a non-covered service was provided.
        - Example: submitting a claim for an exam, when only an office visit occurred

    - Up-Coding: the submission of a claim for an extensive, often higher priced procedure, when a less extensive or lower cost procedure was provided.
        - Example: billing for a surgical extraction (D7210) when an extraction of erupted tooth (D7140) was performed.
        - Example: billing for palliative treatment (D9110), when only a limited exam (D0140) was completed
        - Example: billing for an occlusal filling, when only a sealant was completed

    - Code Parceling: the submission of multiple, separate codes, when a single code exists that captures the entire service provided. For example, separate MO and DO restorations placed on the same day on a tooth must be billed as MOD; not MO and DO. Claims submitted with parceled services may be denied or reconciled later.

    - Balance Billing: the collection of additional money from patients for any service that are covered benefits in the Medicaid Dental Program.
        - Medicaid dental providers must accept Medicaid payment rates as payment in full. Additional compensation may not be sought or accepted for any service paid by Medicaid.

    - Multiple payments: the acceptance of multiple reimbursements from the same or multiple payors, that bring the total amount collected by the provider to above the Medicaid Dental Program rate for each service. Providers are responsible for reconciling claims and payments. If a provider receives multiple payments for a service, resulting in collection

above the rate listed in the Dental Program fee schedule, he/she is obligated to notify the payors of the overpayment.

  - No-Show Fees: Providers may not charge patients a fee for missed appointments that were scheduled to perform procedures within the Medicaid dental program. The Medicaid office is aware that broken appointments pose significant challenges to a dental office, and we are developing solutions to reduce this problem. Dental providers are **highly encouraged to submit tracking claims for any broken appointment** using one of the following codes:
    - D9986 (patient missed appointment, no notice given)
    - D9987 (patient canceled appointment with less than 24h notice)

Tracking these behaviors will allow Medicaid to better reduce this problem

- Third Party Liability & Coordination of Benefits. When a patient has dental benefit or dental insurance coverage in addition to Medicaid, federal regulations specify that all other dental benefit plans are primary to Medicaid. A third party liability (TPL) is the term used for any agency offering additional coverage.

  Before submitting a claim to Medicaid, dental providers must first process a claim with the TPL. If the TPL payment meets or exceeds the Medicaid reimbursement fee for that code, then the provider has been paid in full, and no additional payment will be made by Medicaid. Medicaid will only make payment for the difference between the TPL payment, and the Medicaid fee for that code. This process is known as "coordination of benefits."

  Providers can verify if a patient has a known TPL by accessing and viewing the patient's eligibility on the Medicaid online portal. Claims to Medicaid that lack any necessary coordination of benefits information will be denied. The method to submit the coordination of benefits information is:

  - For online claims submissions, the online process will indicate when a TPL statement of payment must be uploaded as an attachment.
  - For mailed or faxed claims on the ADA form, indicate TPL information in the Other Coverage section. Attach a copy of the TPL statement of payment.
  - If a TPL denies payment for any service, a rejection notice must be attached to the Medicaid claim detailing the specific reason for the denial. A simple TPL statement of "denied" is insufficient to process a Medicaid claim.

14.3 REFERRALS

When a patient is referred to another dentist for care of a specific problem, the final treatment may differ from what was included on a referral form. Each provider is solely responsible for the diagnosis and treatment delivered by him/her to any patient, and for obtaining informed consent, and for discussing available benefits or alternatives for any care delivered.

Dental providers are encouraged to make referrals directly to another dentist using their own referral forms. If a dentist needs assistance with finding a specialist, he/she should contact Community Case Management Corp (CCMC). For questions regarding the referral process, please contact CCMC:

Oahu
Phone : (808) 792-1070
Fax : (808) 792-1062

Neighbor Islands
Phone : Toll Free 1 (888) 792-1070
Fax : Toll Free 1 (888) 792-1062

E-mail: ofcmgr@ccmcorp.net
Hours: Monday through Friday 7:45 am – 4:30 pm (closed on State Holidays)

CCMC has a specific referral sheet that must be signed (not stamped) by the referring provider. CCMC will refer patients to participating Medicaid dental providers. Patients must be seen on the island of residence if an appropriate provider is available. While a referral may initially be requested for a specialist, if none are available, then a general dentist may be consulted.

14.4 PRE-AUTHORIZATION

Some dental benefits are only available after pre-authorization. Delivering these services before approval will result in denial of payment to the dentist. Emergency services do not require prior authorization. Pre-authorization is required for payments for:

- Any dental treatment performed under general anesthesia
- Orthodontics
- Special benefit exceptions related to patients with severe developmental disability, or special medical need, or severe medical fragility
- Laboratory relines less than one (1) year after insertion.

Requesting Prior Authorization

Providers must submit a Prior Authorization Form with supporting documentation, including radiographic image(s) when applicable and an accepted clinical diagnosis. Submission may be done by fax, mail, or through the Medicaid online portal.

Expedited Approval of Authorization Requests

Expedited approval may be requested for urgent procedures that require prior authorization but which should be performed within a week. Expedited approval may be obtained by writing “Urgent” on the top of the authorization form when submitting the request.

Denied Requests

If a request for benefit pre-authorization has been properly submitted with all appropriate information, yet the request is denied because the situation does not meet benefit criteria, then the office may choose to collect payment from a patient with a signed pre-agreement to specific charges. See section 14.7.

If a patient’s situation meets benefit criteria, but the office did not submit a necessary pre-authorization request, or a pre-authorization request is denied because the office did not properly submit needed information, then the office may not collect payment from a patient.

Severe Medical Fragility and Special Medical Need

Patients with severe developmental disability, or special medical need, or severe medical fragility may qualify for special allowances to standard benefit criteria or limitations. Considerations are made on a case-by-case basis. Pre-authorization is required.

14.5 SUBMITTING CLAIMS

Claims for completed services may be submitted electronically, via clearinghouse, the Medicaid online portal, or by fax or mail using the current American Dental Association (ADA) form.

Dental claims must be submitted using CDT codes, within one year of completion of the dental procedure. A claim for a multiple-visit procedure must be submitted only with the service date set to the date of completion of the entire procedure. For example, a claim for a crown or space maintainer must be submitted on the seat/cementation date, and no claim would be created for either procedure on the preparation or impression date. Claims should be submitted with a provider's usual and customary fee, rather than the reimbursement rate of the Medicaid program. Any claim submission must be limited to procedures with the same service date. Services provided on other service dates must have separate claims submissions.

Additional information (e.g., x-ray images, clinical photographs, clinical notes, periodontal charts, narratives, itemized dental laboratory invoices, pathology reports, study models, materials, chair time, diagrams, etc.) may be required to support a specific service.

Billing Dentist Information

When submitting claims, the following information must be complete and accurate to prevent delays in payment and ensure timely reimbursement:

- Billing entity/dentist
- Mailing address
- NPI: sole providers that registered their social security number as their tax ID do not need an organizational NPI (Type 2)
- Tax ID Number
- Servicing Provider (Please print name of servicing provider)

Billing Information for FQHC's

Prospective Payment System (PPS) reimbursement requires that Federal Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) submit the D-codes of all eligible dental services completed at the encounter. PPS payments will be limited to the clinical, submission, and frequency limitation requirements described in Chapter 14.

Multiple-visit procedures may be submitted for a claim, only upon completion of the entire procedure. For example, a claim for a crown or space maintainer must be submitted on the seat/cementation date and not the preparation or impression date. An appointment does not qualify for encounter-rate payment if that appointment did not result in the completion of a benefitted procedure.

When health centers submit a PPS pediatric encounter claim for a patient younger than age 21, the first line of the claim should be code D9999, with the fee set to the center's encounter rate. All program-eligible services provided shall be listed on subsequent lines, with fees set to zero.

When health centers submit a PPS encounter claim for an adult patient 21 years or older, the first line of the claim should be code D0140, with the fee set to the center's encounter rate. All program-eligible services provided shall be listed on subsequent lines, with fees set to zero. If the appointment includes a limited, problem-focused exam, then a second entry for D0140 should be included in the claim, with fee set to zero.

Claims for dentures are paid to health centers according to fee-for-service rates, not PPS rates. Therefore, denture claims should not use the D9999/D0140 codes described above. Claims should simply list the completed procedures, with the appropriate office fees for each code.

If other dental services not related to dentures are also rendered on the same day as a denture procedure, FQHCs can submit two separate claims to receive both denture FFS reimbursement, and PPS reimbursement.

14.6 CRITERIA FOR PAYMENT

Benefits require that patients are enrolled in Medicaid on the date of service, and the provider approved for participation in Medicaid on the date of service.

Clinical Need
To qualify for payment, procedures must be of reasonable clinical benefit to the patient. For more information, see the Medicaid Provider Manual, Chapter 2, section 2.6 (b)(c). The following are examples of situations where benefits may not be paid, or payments could be recouped from providers, due to lack of clinical need:

- A long-term restoration is placed on a tooth that is near exfoliation or is planned for extraction.
- Radiographs are taken or retaken at short interval, including when no signs or symptoms of pathology are present.
- A space maintainer is placed when the related permanent tooth is near eruption, or when it brings no benefit to the patient.

Procedure Frequency Limitations
Procedures, apart from D4910 (calendar year) have frequency limitations based on elapsed time, rather than calendar year. Elapsed time is measured in years, which is a 12-month period starting with the last date of that service.

A procedure with a 2-year frequency interval has a benefit renewal 24 months after an initial procedure. A procedure allowed “twice a year” will pay a benefit a maximum of twice within any consecutive 12-month period.

Some procedures also have a minimum period between any two service dates, during which no benefit will be paid.

Provider-Based Limitations
Some procedures have benefits with provider-specific limitations that limit the total amount paid to a dentist for a particular patient for a specific service code or range of codes. These limitations follow the provider across all service locations.

Teledentistry
For billing related to teledentistry, see section 14.10.

14.7 OPTIONAL SERVICES, AND OPTIONS FOR SELF-PAY

The dental benefit programs are intended to provide financial coverage for the most essential services related to health. Providers must first inform patients of any covered procedures that reasonably address or satisfy their situations. Additional dental services may be requested and delivered to patients on a self-pay basis. A provider may collect payment from a patient for a requested procedure without an available program benefit. This includes any service code not within the Medicaid dental program, and any code that has already been used by that patient, or has met frequency limits.

Some beneficiaries mistakenly expect that any dental service is “covered” or “free.” Medicaid dental providers must clearly communicate any out-of-pocket costs in advance, with a signed acknowledgement of financial cost. Failure to create a signed agreement will disqualify a dentist from collecting payment.

- Providers may not bill or collect from patients any amount related to any service code with an available/unused benefit. Providers may charge patients for services that are covered by the Dental Program, only when the patient has exceeded the usage/frequency limits of those procedures.
- Providers must inform patients of any covered Medicaid procedures that may reasonably address or satisfy their situation before suggesting a non-covered procedure.
- Providers may not collect General Excise Tax from a patient for services reimbursed through Medicaid benefits. Dentists may collect GET for all self-pay services.
- Providers may not impose a fee for missed appointments by Medicaid patients for appointments that were scheduled to include procedures covered under the dental program - yet dentists are highly encouraged to submit Medicaid claims for D9986 or D9987 for tracking purposes.
- The dentist must inform and have the patient sign an understanding of the costs, in advance of any self-payments. The collected fee may not exceed the dentist’s UCR.

Four examples of these self-pay situations are given below:

1) Teeth whitening may be requested by a patient. Because this is not a benefit in the Medicaid program, the dentist may collect payment from the patient for this service, up to his/her UCR. The dentist must first have the patient sign a financial understanding of the out-of-pocket cost. The dentist may not submit a claim to Medicaid for any exam, x-rays, or other service related solely to this procedure. FQHCs may not submit encounter claims for these appointments.

2) Following a root canal on a molar, an adult Medicaid patient requests a gold crown (not a benefit for adults) as opposed to a stainless-steel crown (benefit). Gold crowns are benefits in the Children's Dental Program, but not the Adult Dental Program, therefore the patient may opt to pay for the gold crown, up to the dentist's UCR. The dentist must have the patient sign a financial understanding of the out-of-pocket cost, and must inform the patient that a stainless-steel crown is available as a benefitted alternative. The dentist may not submit a claim for a stainless-steel crown to offset some of the cost. If a stainless-steel crown was used as a provisional crown, the dentist may not submit a claim for a stainless-steel crown, because any provisional crowns are considered part of the gold crown procedure. FQHCs may not submit encounter claims for these appointments.

3) A mother and father request their child receive prophylactic cleaning and fluoride varnish every 3 months, exceeding the benefit frequency of these services. After any available benefits are used, the office must have the parent sign a pre-agreement to fees, and may charge the family up to the office's UCR fees. FQHCs may not submit an encounter claim for this self-pay appointment.

4) A dentist may recommend x-rays beyond the benefit limits for radiographs. The dentist may charge the patient for additional x-rays, up to the office UCR, if a signed agreement is created in advance.

14.8 DENTAL SERVICES UNDER GENERAL ANESTHEISA

General anesthesia (GA) for dental services is an option of last resort. This is most often reserved for exceptional circumstances when prevention, early intervention, and behavior guidance efforts have failed to prevent or address severe pathology. Payments to dentists are limited to situations where necessary dental services cannot be safely performed in a normal office setting. Payments will not be approved when other options for treatment are available or unexplored.

Criteria for benefits involves meeting one of the following three conditions:

1. patients with intellectual or developmental disabilities that prevent cooperation necessary to safely complete a needed and specific procedure, or
2. a medical condition where necessary local anesthesia is ineffective or contraindicated for a needed procedure, or
3. an individual with sustained extensive orofacial or dental trauma for which treatment under local anesthesia would be ineffective or compromised

Or when ALL the following four conditions are met:

1. the patient is extremely physically resistant/uncooperative, AND
2. when extensive oral treatment is necessary, AND
3. postponement of treatment is likely to result in significant adverse effects upon patient's medical or dental condition, AND
4. alternative dental treatment cannot be completed both safely and effectively in an office using adjunctive techniques or modalities such as:
    - behavioral management
    - protective stabilization
    - sedative medications
    - caries arrest (Silver Diamine Fluoride) applications
    - nitrous oxide or conscious sedation

Medicaid payments for dental procedures performed under general anesthesia do not extend to situations where GA is requested to:

- avoid dentist, patient, or parental apprehension about treatment
- avoid situations with nervousness, anxiety, or crying in a patient
- reduce scheduling inconveniences to the patient, parents, or dentist related to multiple in-office appointments
- perform a clinical examination to determine if pathology is present
- or when alternate therapies/modalities can/could successfully address the clinical problems

Requesting Pre-authorization for GA:

First, providers submit pre-authorization documents to the dental third party administrator for review and approval. Med-QUEST or Dental TPA may confirm submitted documents, or require a clinical evaluation by another dentist before approving pre-authorization. DHS Forms 1190, 1191, and 1192 can be downloaded from the provider portal, or from the Med-QUEST website: https://medquest.hawaii.gov/en/resources/forms.html. Required documentation must include the following five components:

1. Form DHS 1190 "Criteria for Dental Therapy Under General Anesthesia"

2. Form DHS 1191 "Case Details and Checklist"

3. Form DHS 1192 "General Anesthesia Acknowledgement"

4. A dental authorization request that includes CPT code 41899. This request may be completed by one of three methods:
   a. Submission of a pre-authorization request via the provider portal
   b. Submission of a pre-authorization request via ADA claim form
   c. Submission of HDS's "Request for Dental Authorization Form", available on the provider portal

5. Submission of chart notes or other supporting documentation that includes:
   - Dental diagnosis including specific teeth or structures with pathology, and a tooth specific treatment plan with an itemized list of expected clinical procedures
   - Report substantiating that general anesthesia is necessary, and alternative treatment options or methods have been attempted, and do not address or satisfy the disease or condition. This narrative should include (but is not limited to) the use of SDF or interim caries management, efforts with pharmacologic, physical, or psychological behavior management, and the option of delaying non-urgent treatment.
   - Description of why/how treatment in a normal office setting is dangerous for the patient or provider.

Second, after pre-authorization of dental benefits is approved, the dentist may then submit the dental authorization forms to the appropriate Medicaid medical health plan for approval of medical benefits for hospital and anesthesia-related services.

Pre-approval of GA does not guarantee that all individual services performed will be covered by available benefits. Code-specific benefit/frequency limits still apply.

14.9 BENEFITS: CODES AND CRITERIA

14.9.1 Diagnostic Benefits

Oral Evaluations

All oral examinations of infants and children must include age-appropriate anticipatory guidance such as dietary counseling, oral hygiene instruction, counseling for oral habits, injury prevention, substance abuse, etc. with either the child or the primary caregiver, as appropriate. This prevention-focused guidance must be documented in the patient record maintained by the dental office.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D0120	Periodic Oral Evaluation – Established Patient 1. No sooner than 4 months apart 2. Applied to the oral evaluation annual limit (D0120, D0145, D0150)		2 per year				
x	x	D0140	Limited Oral Evaluation - Problem Focused 1. Applies to evaluation for a specific oral health problem, complaint, dental emergency, trauma, acute infection, etc 2. Does not apply to: a. Post op evaluations for services performed by the treating dentist or practice b. Procedures being performed as part of a comprehensive treatment plan within 6. months of D0120 or D0150 c. Consultations for non-emergency related dental care d Subsequent treatment visit related to the initial D140 3. Chart documentation must support the claim request and is subject to review by Third Party Administrator for findings, diagnosis, and treatment plan	A-T, 1-32, UL, UR, LL, LR, UA, LA	1 per day				
x		D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver 1. No sooner than 4 months apart 2. Applied to the oral evaluation annual limit (D0120, D0145, D0150)		2 per year				
x	x	D0150	Comprehensive Oral Evaluation – New or Established Patient 1. When performed by the same dentist/dental office less than 5 years, limited to allowance and limitation of a D0120 2. Applied to the oral evaluation annual limit (D0120, D0145, D0150)		1 per 5 years per dentist or dental office				

Radiographs

Radiographic images must be clinically necessary and should be prescribed in accordance with American Dental Association and Food and Drug Administration guidelines, only to be rendered when providing additional diagnostic information to the dentist. Radiographs must be individually prescribed rather than taken on an administrative timetable. Images must be of diagnostic quality to qualify for payment. Med-QUEST or Dental TPA may request submission of any x-rays claimed. Mid-procedure "working", and post-operative radiographs are considered part of a procedure, and are not billable to Med-QUEST or the patient.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D0210	Intraoral - Complete Series of Radiographic Images 1. Consists of 12-22 periapical and posterior bitewing images		1 per 5 years				
x	x	D0220	Intraoral - Periapical First Radiographic Image						
x	x	D0230	Intraoral - Periapical Each Additional Radiographic Image		4 per day				
x	x	D0240	Intraoral - Occlusal Radiographic Image		1 per day				
x	x	D0270	Bitewing - Single Radiographic Image		2 per year				
x	x	D0272	Bitewings - Two Radiographic Images						
x	x	D0274	Bitewings - Four Radiographic Images 1. No sooner than 4 months apart 2. Applied to the bitewing annual limit (D0270, D0272, and D0274)						
x		D0310	Sialography 1. Justification for this procedure is required		1 per day				Narrative
x	x	D0330	Panoramic Radiographic Image		1 per 2 years				
			Child: 1. Not to be used with D0210 2. Covered for Oral Surgeons when extracting tooth/teeth (regardless of frequency limit) for the diagnosis of specific conditions, pathology or injury						
			Adult: 1. D0210 has not been taken within the last 5 years. 2. When a periapical radiographic image is not practical for the following reasons: a. Patient has limited ability to open mouth b. Periapical image cannot sufficiently record the necessary anatomy to diagnose the dental condition for treatment c. Teeth planned for extractions are in four quadrants and pano is a substitute to multiple images d. Other circumstances deemed necessary by the Dental Review						
x		D0340	2D cephalometric radiographic image-acquisition, measurement and analysis 1. Limited to repair of cleft lip and/or cleft palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing must be restored		1 per day				

x	x	D0364	Cone Beam CT and interpretation with limited field of view- less than one whole jaw						
x	x	D0365	Cone beam CT capture and interpretation with field of view of one full dental arch-mandible						
x	x	D0366	Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch - maxilla, with or without cranium						
x	x	D0367	Cone Beam CT Capture and Interpretation with Field of View of Both Jaws; with or without cranium 1. Covered benefit for Oral Surgeons only and when other radiographic/diagnostic imaging is not sufficient for proper diagnosis and/or treatment						

14.9.2 Preventive Benefits

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D1110	Prophylaxis - Adult 1. No sooner than 4 months apart 2. Limited to ages 15 and over 3. D1110/D4355 is denied when performed on the same day as D4341 or D4342		2 per year				
x		D1120	Prophylaxis - Child 1. No sooner than 4 months apart 2. Limited to ages 14 and under		2 per year				
x	x	D1206	Topical Application of Fluoride Varnish		2 per year				
x		D1208	Topical Application of Fluoride – Excluding Varnish 1. No sooner than 4 months apart 2. Applied to the fluoride annual limit (D1206 and D1208)						
x		D1351	Sealant - Per Tooth 1. Limited to ages 5 through 20	2-3, 14-15, 18-19, 30-31	1 per 5 years per tooth				
x	x	D1354	Application of Caries Arresting Medicament - per tooth 1. Limited to silver diamine fluoride (SDF) only 2. Denied when a restoration on the same tooth is placed on the same date of service 3. Denied when performed within 60 days of a restoration (D2140 – D2954) placed by the same dentist/dental office Reimbursement for D1354 will be recouped when a restoration (D2140 – D2954) is placed on the same tooth within 60 days of the date of service	A-T, 1-32	1 per day per tooth 2 per 12 months per tooth				

Space Maintenance

When performed by the office that originally placed the appliance, the ongoing maintenance, re-cementation, and final removal of a space maintainer are considered part of the original procedure, and may not be billed or claimed as an encounter.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x		D1510	Space Maintainer - Fixed – Unilateral – per quadrant	Missing Tooth # A-T, 2-15, 18-31	4 per 2 years				
x		D1516	Space maintainer - fixed - bilateral, maxillary	Missing Tooth # A-J, 2-15	1 per 2 years				
x		D1517	Space maintainer-fixed-bilateral, mandibular	Missing Tooth # K-T, 18-31	1 per 2 years				
x		D1551	Re-cement/Re-bond of bilateral space maintainer - maxillary 1. After 6. months from the initial placement	Missing Teeth # A-J, 2-15	1 per year				
x		D1552	Re-cement/Re-bond of bilateral space maintainer - mandibular 1. No sooner than 6. months after the initial placement	Missing Teeth # K-T, 18-31	1 per year				
x		D1553	Re-cement/Re-bond of unilateral space maintainer- per quadrant 1. No sooner than 6. months after the initial placement	UR, UL, LR, LL	1 per year				
x		D1556	Removal of fixed unilateral space maintainer - per quadrant	UR, UL, LR, LL					
x		D1557	Removal of fixed bilateral space maintainer - maxillary						
x		D1558	Removal of fixed bilateral space maintainer - mandibular						
x		D1575	Distal shoe space maintainer - unilateral – per quadrant 1. Limited to ages 8 and under	Missing Tooth # A-T, 2-15, 18-31					

14.9.3 Restorative Benefits

Fillings
Fillings are reimbursable based upon total number of restored surfaces. Noncontiguous restorations on the same tooth should be billed as a single restoration. For example, DO and MO on a single tooth on the same day shall be submitted as MOD.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D2140	Amalgam - One Surface, Primary or Permanent	A-T, 1-32	1 per 2 years per tooth per surface				
x	x	D2150	Amalgam - Two Surfaces, Primary or Permanent						
x	x	D2160	Amalgam - Three Surfaces, Primary or Permanent						
x	x	D2161	Amalgam - Four or More Surfaces, Primary or Permanent						
x	x	D2330	Resin-based Composite - One Surface, Anterior	C-H, M-R, 6-11, 22-27					
x	x	D2331	Resin-based Composite Two Surfaces, Anterior						
x	x	D2332	Resin-based Composite - Three Surfaces, Anterior						
x	x	D2335	Resin-based Composite - Four or More Surfaces (Anterior)						
x	x	D2391	Resin-based Composite - One Surface, Posterior	A-B, I-J, K-L, S-T, 1-5, 12-21, 28-32					
x	x	D2392	Resin-based Composite - Two Surfaces, Posterior						
x	x	D2393	Resin-based Composite - Three Surfaces, Posterior						
x	x	D2394	Resin-based Composite - Four or More Surfaces, Posterior						

Crowns

- Additional supporting documentation or photos may be requested if radiographs do not clearly justify a crown, especially for any patient under age 12.
- Special exceptions may be made for third molar crowns when necessary for primary function, or for a primary tooth when there is a congenitally missing corresponding permanent tooth. Pre-authorization required.
- Posts, cores, and pins are not benefitted procedures for primary teeth, unless there is a congenitally missing corresponding permanent tooth. Pre-authorization is required.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x		D2740	Crown – Porcelain/Ceramic	2-15, 18-31	1 per 5 years per tooth	Pre-Op			
x		D2750	Crown - Porcelain Fused to High Noble Metal						
x		D2751	Crown - Porcelain Fused to Predominantly Base Metal						
x		D2752	Crown - Porcelain Fused to Noble Metal						
x		D2790	Crown - Full Cast High Noble Metal						
x		D2791	Crown - Full Cast Predominantly Base Metal						
x		D2792	Crown - Full Cast Noble Metal 1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior) or when there is less than 50% of sound tooth structure remaining 2. Temporary crowns are considered part of the crown procedure 3. Supporting documents may be requested for a patient under age 12						
x	x	D2910	Re-cement or Re-bond Inlay, Onlay, Veneer or Partial Coverage Restoration	A-T, 1-32					
x	x	D2920	Re-cement or re-bond crown 1. Denied if within 6 months of initial placement when performed by the same dentist or dental office 2. Benefited once if within 6 months of initial placement when performed by a different dentist or dental office. 3. Subsequent recementations are allowed every 12 months thereafter.						
x		D2930	Prefabricated stainless-steel crown – primary tooth 1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior) or when there is less than 50% of sound tooth structure remaining	A-T	1 per 2 years per tooth				
x	x	D2931	Prefabricated stainless steel crown – permanent tooth 1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior) or when there is less than 50% of sound tooth structure remaining	2-15, 18-31	1 per2 years per tooth				
x		D2932	Prefabricated Resin Crown	C-H, M-R	1 per 2 years per tooth				
x		D2933	Prefabricated stainless steel crown with resin window						
x		D2934	Prefabricated esthetic coated stainless steel crown-primary tooth 1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior) or when there is less than 50% of sound tooth structure remaining						
x	x	D2950	Core Buildup, including any pins when required 1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior) or when there is less than 50% of sound tooth structure remaining	2-15, 18-31	1 per 5 years per tooth	Pre-Op			
x	x	D2951	Pin Retention - Per Tooth, In Addition to Restoration		1 per 24 mo per tooth				
x	x	D2952	Post and Core In Addition to Crown, Indirectly Fabricated		1 per 5 yrs per tooth	Pre-Op			
x	x	D2954	Prefabricated Post and Core In Addition to Crown		1 per 5 yrs per tooth	Pre-Op			

14.9.4 Endodontic Benefits

Root Canal Therapy (RCT) codes D3220-D3425:

- Prior authorization is not required, unless otherwise stated.
- Tooth must be restorable, with favorable periodontal prognosis.
- Claim must be submitted only after final obturation is completed. If the patient fails to complete final obturation within 4 months of initiation, then the office may submit a single claim for one D9110 appointment, dated on the initial treatment date, with the pre-operative radiographic image and narrative.

Covered						Submission Requirement(s)			
Child	Adult	Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	X-Ray	Perio Chart	Report	Other
x		D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	A-T	1 per tooth per lifetime				
x		D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	2-15, 18-31	1 per tooth per lifetime	Pre-Op			
x		D3230	Pulpal therapy (resorbable filling)-anterior primary tooth (excluding final restoration)	C-H, M-R					
x		D3240	Pulpal therapy (resorbable filling-posterior primary tooth (excluding final restoration)	A, B, I-L, S, T					
x		D3310	Endodontic therapy, anterior tooth (excluding final restoration)	6-11, 22-27		Post-Op			
x		D3320	Endodontic therapy, premolar tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29					
x	x	D3330	Endodontic therapy, molar tooth (excluding final restoration) 1. Final post-operative radiographic image must demonstrate final and complete obturation of the root canal system 2. 1. diagnostic radiographic image is allowed per tooth Additional radiographic images/working films are considered as part of the root canal treatment and cannot be billed separately 3. An angled film may be required to view all endodontically treated canals	2-3,14-15, 18-19, 30-31					
x		D3346	Retreatment of Previous Root Canal Therapy – anterior	6-11, 22-27	1 per tooth per lifetime	Pre-Op Post-Op			Narrative
x		D3347	Retreatment of Previous Root Canal Therapy - premolar	4-5, 12-13, 20-21, 28-29					

x		D3348	Retreatment of Previous Root Canal Therapy - molar 1. Retreatment of previous root canal therapy is covered only for specific clinical circumstances based on dental consultant review 2. Retreatment of RCT by the same dentist/dental office within 24 months of initial treatment is considered part of the original procedure 3. 1 diagnostic radiographic image is allowed per tooth Additional radiographic images/working films are considered as part of the root canal treatment and cannot be billed separately 4. The narrative should include an endodontic diagnosis and reason for retreatment to support the claim request	2-3, 14-15, 18-19, 30-31					
x		D3351	Apexification/recalcification/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	2-15, 18-31	1 per tooth per lifetime	Pre-Op			
x		D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)		1 per tooth per lifetime				
x		D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		1 per tooth per lifetime	Post-Op			
x		D3355	Pulpal Regeneration - Initial Visit		1 per tooth per lifetime	Pre-Op			
x		D3356	Pulpal Regeneration - Interim Medication Replacement		1 per tooth per lifetime				
x		D3357	Pulpal Regeneration - Completion of Treatment 1. Benefit is limited to treatment performed by an Endodontist or Pedodontist		1 per tooth per lifetime	Post-Op			
x		D3410	Apicoectomy/periradicular surgery – anterior	6-11, 22-27	1 per tooth per lifetime	Pre-Op			
x		D3421	Apicoectomy/periradicular surgery – premolar (first root)	4-5, 12-13, 20-21, 28-29					
x		D3425	Apicoectomy/periradicular surgery – molar (first root)	2-3, 14-15, 18-19, 30-31					
x		D3921	Decoronation or submergence of an erupted tooth 1. Sealing of the remaining root with glass ionomer, amalgam, composite is considered a component of the primary D3921 procedure	1-32	1 per tooth per lifetime			Op	

14.9.5 Periodontic Benefits

Periodontal charting is expected to indicate patient's name, date of periodontal probing examination, 6-point pocket depth measurements on all teeth, areas of clinical attachment loss, and probing sites that exhibit bleeding. As of 2024, periodontal scaling and root planning (SCRP) procedures will no longer require pre-authorization. Offices may choose to pre-authorize benefits/payment for SCRP. Periodontal Maintenance (D4910) no longer requires history of a previous Medicaid claim for periodontal therapy.

Covered						Submission Requirement(s)			
Child	Adult	Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	X-Ray	Perio Chart	Report	Other
x	x	D4341	Periodontal Scaling and Root Planing – four or more teeth per quadrant	UL, UR, LL, LR	1 per 24 months	x	x		Prior Auth optional
x	x	D4342	Periodontal Scaling/ and Root Planing – one to three teeth per quadrant 1. Periodontal pocket depth measurements must be within 6 months prior to the date of service 2. Clinical attachment loss must be 4 mm or greater 3. Denied when documentation does not support alveolar bone loss or attachment loss 4. D1110/D4355 is denied when performed on the same day as D4341 or D4342	1-32					
x	x	D4355	Full Mouth Debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit 1. Limited to ages 14 and over and has not had a prophylaxis or debridement (D4355) for at least 24 months 2. Denied when performed by the same dentist/dental office on the same day with the following evaluation codes: D0120 and D0150 3Denied when performed on the same day as D1110, D1120, D4341 or D4342						
x	x	D4910	Periodontal Maintenance 1. Record of prior history of D4341 or D4342 must be maintained in the patient's record		2 per calendar year		x		

14.9.6 Removable Prosthodontics

The insertion date is the billable date of service for denture(s). Office visits related to denture services are considered part of the same procedure. This includes preparation and all adjustment visits for six (6) months after the delivery date. During this period, neither dental office nor FQHC may claim for procedures or appointments solely related to adjustments or other follow-up.

Laboratory relines for dentures are allowed one (1) year after the insertion of a new denture. A reline less than one (1) year after the insertion requires prior authorization. Subsequent relines are limited to once every two (2) years.

Medicaid benefits for fabrication of bilateral partial dentures require:

- Missing at least one permanent anterior tooth, or
- Missing both first permanent molars in the same arch, or
- Missing three posterior permanent teeth in the same arch, or
- Missing two adjacent posterior permanent teeth
- Unilateral partial dentures (“Nesbit”) are not included in this benefit program

Medicaid benefits for fabrication of complete dentures require:

- Missing all natural teeth in the arch, other than non-erupted 3rd molars
- Fabrication of a new denture is not covered if a beneficiary has acceptable dentures that may be adjusted and/or relined.

As of 2024, denture procedures no longer require pre-authorization. Offices may choose to pre-authorize dentures, to ensure that documentation meets the criteria for program benefit.

Covered						Submission Requirement(s)			
Child	Adult	Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	X-Ray	Perio Chart	Report	Other
x	x	D5110	Complete Denture - Maxillary		1 per 5 years per prosthesis				Doc of missing teeth
x	x	D5120	Complete Denture - Mandibular						
x	x	D5130	Immediate Denture - Maxillary						
x	x	D5140	Immediate Denture - Mandibular						
x		D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)						
x		D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)						
x		D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)						
x		D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)						
x		D5227	Immediate Maxillary Partial Denture- Flexible base (including any clasps, rests and teeth)						

x		D5228	Immediate Mandibular Partial Denture- Flexible base (including any clasps, rests and teeth) 1. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth						
x	x	D5410	Adjust Complete Denture - Maxillary		1 per day				
x	x	D5411	Adjust Complete Denture - Mandibular						
x	x	D5421	Adjust Partial Denture - Maxillary						
x	x	D5422	Adjust Partial Denture - Mandibular						
x	x	D5511	Repair Broken Complete Denture Base, Mandibular						
x	x	D5512	Repair Broken Complete Denture Base, Maxillary						
x	x	D5520	Replace missing or broken teeth – complete denture (each tooth)		1 per 6 months per tooth				
x	x	D5611	Repair broken partial denture base, Mandibular		1 per year				
x	x	D5612	Repair broken partial denture base, Maxillary						
x		D5621	Repair Cast Framework , Mandibular						
x		D5622	Repair Cast Framework , Maxillary						
x		D5630	Repair or Replace Broken Retentive Clasping Materials - Per Tooth	1-32	1 per year per tooth				
x	x	D5640	Replace Broken Teeth - Per Tooth		1 per 6 months per tooth				
x	x	D5650	Add Tooth to Existing Partial Denture						
x	x	D5660	Add Clasp to Existing Partial Denture - Per Tooth 1. No sooner than 6 months after delivery date						
x	x	D5710	Rebase Complete Maxillary Denture		1 per 2 years				Prior Auth optional
x	x	D5711	Rebase Complete Mandibular Denture						
x	x	D5720	Rebase Maxillary Partial Denture						
x	x	D5721	Rebase Mandibular Partial Denture						
x	x	D5730	Reline Complete Maxillary Denture (Chairside)						
x	x	D5731	Reline Complete Mandibular Denture (Chairside)						
x	x	D5740	Reline Maxillary Partial Denture (Chairside)						
x	x	D5741	Reline Mandibular Partial Denture (Chairside)						
x	x	D5750	Reline Complete Maxillary Denture (Laboratory)						
x	x	D5751	Reline Complete Mandibular Denture (Laboratory)						
x	x	D5760	Reline Maxillary Partial Denture (Laboratory)						
x	x	D5761	Reline Mandibular Partial Denture (Laboratory)						
x		D5765	Soft liner for complete or partial removable denture- indirect 1. No sooner than 1 year after final insertion of a new denture 2. Reline limitations apply to any type (laboratory or chairside)						
	x	D5820	Interim partial denture – (maxillary) 1. Benefit of D5820 is available for anterior and 1st premolar teeth	5-12	1 per year per arch				Prior Auth optional
	x	D5821	Interim partial denture – (mandibular) 1. Benefit of D5821 is available only for anterior teeth	22-27					

14.9.7 Oral & Maxillofacial Surgery

All tooth extraction benefits are limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection, or radiographic evidence of pathology. Elective extractions of asymptomatic teeth are not covered by Medicaid. This applies to the removal of primary or permanent teeth for orthodontic purposes, or the extraction of asymptomatic third molars in teens and adults. Extraction of any supernumerary teeth that are not detrimentally affecting surrounding teeth will not earn Medicaid payment. Payment for any non-covered elective services may be collected from the patient, following section 14.7.

The paid benefit for all extractions/oral surgery includes any postoperative care for 30 days following surgery (e.g., bleeding, dry socket) by the same dentist/dental office. Within this period, neither private office nor FQHC may submit a D0140 or D9110 claim for post-op office visits related to the original procedure.

Some oral surgery procedures do not have benefits in the Medicaid dental programs, yet may have benefits in a Medicaid managed care medical plan (eq: Aloha Care, HMSA, etc.). This includes benefits for some medically necessary dental needs, such as: oral surgery to repair traumatic injury, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple and compound). Refer to section 14.11.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D7111	Extraction, coronal remnants – primary tooth	A-T					
x	x	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A-T, 1-32					
x	x	D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated 1. Requires removal of bone and/or sectioning of teeth			Pre-Op			
x	x	D7220	Removal of Impacted Tooth – Soft Tissue 1. Occlusal surface of tooth covered by soft tissue 2. Requires mucoperiosteal flap elevation		1 per tooth per lifetime	Pre-Op			
x	x	D7230	Removal of Impacted Tooth – Partially Bony 1. Part of crown covered by bone 2. Requires mucoperiosteal flap elevation and bone removal		1 per tooth per lifetime	Pre-Op			
x	x	D7240	Removal of Impacted Tooth – Completely Bony 1. 90% of the crown must be encased in bone 2. Requires mucoperiosteal flap elevation and bone removal		1 per tooth per lifetime	Pre-Op			
x	x	D7241	Removal of impacted tooth – completely bony, with unusual surgical complications 1. 75% of crown must be encased in bone 2. Unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position 3. Operative report must indicate the specific complications incurred during the surgical procedure		1 per tooth per lifetime	Pre-Op		Op	
x	x	D7250	Removal of residual tooth roots (cutting procedure) 1. Includes cutting of soft tissue and bone 2. Removal of tooth structure and closure 3. Tooth root(s) must be fully encased in bone (subosseous)		1 per tooth per lifetime	Pre-Op			
x	x	D7260	Oroantral Fistula Closure 1. Dental reviewed for description of the procedure completed 2. Not applicable to an iatrogenic sinus exposure by the treating dentist	A-J, 1-16, UL, UR		x			Narrative
x	x	D7261	Primary closure of a sinus perforation 1. Dental reviewed for description of the procedure completed			Pre-Op		Op	
x	x	D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth 1. Dental reviewed for description of the procedure completed	1-32	1 per tooth per lifetime	Pre-Op		Op	
x	x	D7280	Exposure of an unerupted tooth	2-15, 18-31		Pre-Op			
x	x	D7282	Mobilization of Erupted/Malpositioned Tooth to Aid Eruption						
x		D7283	Placement of Device to Facilitate Eruption of Impacted Tooth 1. Must be necessary to move tooth into normal function through surgical access, and/or facilitation of eruption with or without device; and under the conditions that the tooth will be extracted if procedure(s) is not completed						

x	x	D7285	Incisional biopsy of oral tissue – hard (bone, tooth) 1. Requires submission of pathology report and is denied if one is not submitted 2. Subject to dental review when performed in conjunction with extractions in the same surgical area or same date of service	1 – 32, UR, UL, LR, LL, UA, LA		x		Path	
x	x	D7286	Incisional biopsy of oral tissue – soft 1. Requires submission of pathology report and is denied if one is not submitted 2. Not applicable to the routine removal of the periradicular inflammatory tissues 3. Subject to dental review when performed in conjunction with extractions in the same surgical area or same date of service					Path	
x	x	D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	UR, UL, LR, LL					
x	x	D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant 1. The alveoloplasty is distinct (separate procedure) from extractions, usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. 2. Alveoloplasty is included in the fee for surgical extractions (D7210-D7250) and is denied if performed by the same dentist/dental office in the same surgical area on the same day of service as surgical extractions.	1-32					
x	x	D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	UR, UL, LR, LL					Tooth Chart
x	x	D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	1-32					Tooth Chart
x	x	D7410	Excision of Benign Lesion up to 1.25 cm	A-T, 1-32				Path	
x	x	D7411	Excision of Benign Lesion greater than 1.25 cm 1. Requires submission of pathology report and is denied if one is not submitted 2. Subject to dental review when performed in conjunction with extractions in the same surgical area or same date of service						
x	x	D7510	Incision and drainage of abscess – intraoral soft tissue 1. Requires separate surgical procedure involving tissue incision. 2. Narrative must include clinical diagnosis and description of the procedure completed	A-T, 1-32					Narrative
x		D7961	Buccal/labial frenectomy (frenulectomy) 1. Narrative must include a diagnosis and medical/clinical necessity	A-T 1 – 32, UA, LA					Narrative
x		D7962	Lingual frenectomy (frenulectomy) 1. Narrative must include a diagnosis, KOTLOW class, and medical/clinical necessity						Narrative
x	x	D7970	Excision of Hvperplastic Tissue – Per Arch 1. Limited to edentulous areas	UA, LA				Op	
x	x	D7971	Excision of Pericoronal Gingiva 1. Limited to surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth	1-2, 15-16, 17-18, 31-32				Op	

14.9.8 Orthodontics

Medicaid orthodontic benefits are only available when provided by a trained orthodontist, when treating a patient with a history of cleft lip and/or cleft palate, other severe facial birth defects, or a severe injury which requires restoration or the facial structures to allow speech, swallowing, or chewing.

All Medicaid orthodontic benefits require a prior authorization that includes medical and or dental diagnoses, treatment plan, anticipated treatment time and other relative information for treatment with the prior authorization request.

For all limited (D8010 and D8020) and comprehensive (D8070, D8080, and D8090) orthodontic treatment, the reimbursement fee includes the following, which are not billable to patients as separate procedures:

- diagnostic casts (D0470)
- photographic images (D0350)
- pre-orthodontic treatment visit (D8660)
- detailed and extensive oral evaluation – problem focused (D0160)

Cephalometric (D0340) and panoramic (D0330) radiographic image(s) are eligible for separate reimbursement.

During orthodontic treatment, the provider will submit to the TPA periodic progress/treatment notes for each child, upon request, which may include clinical records from the treating orthodontists and/or oral surgeons. Providers are also required to submit clinical records documenting the completion of orthodontic treatment.

If an orthodontic patient transitions to a new provider (a different provider than the one which initiated treatment for thepatient) to continue or complete treatment, reimbursement is determined on a case-by-case basis.

An Orthodontist will receive payment in full at the beginning of the approved treatment, for the entirety of that treatment. Clinical records documenting completion must be maintained by the treating provider. Audits may be performed to verify that treatments are completed. Cases in which treatment is not completed (i.e., treatment ended due to a non-compliant patient) will result in partial or complete recoupment of funds.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x		D8010	Limited orthodontic treatment of the primary dentition						Prior Auth
x		D8020	Limited orthodontic treatment of the transitional dentition						
x		D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition 1. Any of these three may be used for Phase I limited treatment 2. Includes pre-orthodontic treatment visit (D8660)						
x		D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition						Prior Auth
x		D8090	Comprehensive Orthodontic Treatment of the Adult Dentition 1. Used for Phase II comprehensive orthodontic treatment 2. Includes pre-orthodontic treatment visit (D8660)						
x		D8660	pre-orthodontic treatment examination to monitor growth and development 1. The narrative must indicate that treatment was not started 2. The provider has not been previously reimbursed for limited (D8010, 8020) interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment 3. Includes consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (D9310)		1 per lifetime				Prior Auth, Narrative

14.9.9 Moderate/IV Sedation (D9239 and D9243)

D9239 intravenous moderate (conscious) sedation – first 15 minutes
D9243 Intravenous moderate (conscious) sedation – each subsequent 15 minutes

- Intramuscular (IM) techniques may be used.
- If nitrous oxide is used in conjunction with the sedation procedure, it is considered part of the D9239 or D9243 service. D9230 (Nitrous oxide) is not billable as a separate procedure to Medicaid or the patient.
- The office shall maintain the following clinical information:
    - Medical history
    - Sedation record
    - Diagnosis
    - Pre-surgical radiographic image(s)
- IV sedation is a program benefit available to all ages, only when all three of the following criteria are met:
    1. The patient displays or expresses an inability to perform the procedures without IV sedation.
    2. IV sedation is used in conjunction with a completed endodontic procedure D3220-D3425 with a program benefit, or a surgical dental procedure D7111-D7971 with a program benefit. This completed procedure must be included on the same claim.
    3. The patient has a formal medical diagnosis that involves emotional or behavioral dysregulation due to mental health condition, or neurodivergent condition. This may include, but is not limited to: autism spectrum disorder, anxiety disorder, ADHD, PTSD, dementia, or traumatic brain injury.
- Pre-authorization is optional. Claims or pre-authorization must include supporting documents including:
    - A narrative that describes the patient's displayed or expressed inability to cooperate safely without sedation, for a specific qualifying procedure.
    - A statement or chart note from a Hawaii licensed medical provider of a formal diagnosis involving emotional or behavioral dysregulation.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 minutes						Supporting Doc, Sedation record for >45 minutes
x	x	D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute increment						

14.9.10 Other Miscellaneous Codes:

D9110 Palliative treatment of dental pain: This code is available to compensate dentists for procedures in situations where a patient seeks an urgent dental procedure to relieve immediate pain, and when that procedure does not have a distinct procedure code. If a performed procedure is included in the list of Medicaid program benefit codes, then that code must be used rather than D9110. This benefit requires the following:

- A clinical procedure was performed by the dentist that resulted in the reduction of pain reported by a patient. A narrative describing the details of the procedure must accompany the claim submission. Unusual therapy or situations may be rejected, or may require additional information for review before payment.

D9230 Nitrous Oxide: This is a program benefit available to all ages, only when all three of the following criteria are met:

1. The patient displays or expresses an inability to perform the procedures without nitrous oxide.
2. Nitrous oxide is used in conjunction with a completed endodontic procedure D3220-D3425 with a program benefit, or a surgical dental procedure D7111-D7971 with a program benefit. This completed procedure must be included on the same claim.
3. The patient has a formal medical diagnosis that involves emotional dysregulation due to mental health condition, or neurodivergent condition. This may include, but is not limited to: autism spectrum disorder, anxiety disorder, ADHD, PTSD, dementia, or traumatic brain injury.

- Pre-authorization is optional. Claims or pre-authorization submissions must include:
  - A narrative that describes the patient's displayed or expressed inability to cooperate safely without nitrous oxide, for a specific qualifying procedure.
  - A statement or chart note from a Hawaii licensed medical provider of a formal diagnosis involving emotional dysregulation.

D9420 Hospital or Ambulatory Center Call: This benefit is only available to oral surgeons or orthodontists, when performing another procedure with a benefit within the dental program. This code is intended to compensate oral surgeons and orthodontists for travel to and from their private clinic settings to a hospital for on-call service of a particular patient.

Covered		Proc Code	Description & Criteria	Valid Tooth, Quad, or Arch	Frequency Limitation	Submission Requirement(s)			
Child	Adult					X-Ray	Perio Chart	Report	Other
x	x	D9110	Palliative treatment of dental pain – per visit 1. Billable only once per visit regardless of the number of teeth treated 2. Not covered if performed within14 days prior to completion date of D33XX by the same dentist/dental office 3. When submitting a claim, the provider must document the nature of the emergency, a clinical diagnosis, the area of the oral cavity and/or teeth involved, and the specific treatment performed to relieve pain 4. Limited to 1 treatment per tooth per year 5. Requires the performance of a treatment intervention to alleviate pain. May not be applied for consultation, referral or issuance of prescription medication alone 6. When a specific procedure has been performed and it is a covered procedure, it will be processed as that specific procedure.	A-T, 1-32, UR, UL, LR, LL UA, LA	1 per day 1 per tooth per year				Narrative
x	x	D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis 1. Use in conjunction with a completed endodontic procedure D3220-D3425, or a surgical dental procedure D7111-D7971. 2. Documented medical diagnosis that involves emotional dysregulation due to mental health condition, or neurodivergent condition.		1 per day				Supporting Doc
x	x	D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician 1. Limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist (for specialties as recognized by the American Dental Association) for a specific problem. Not applicable for patients seen at long term care facilities. A written report of the consultation results must be returned to the referring dentist and documented for record purposes 2. Must include referring provider and purpose of consultation 3. Dental specialist billing the consultation code may provide treatment for which the consultation is obtained						Narrative
x	x	D9420	Hospital or Ambulatory Surgical Center Call 1. Dental reviewed for reason for the hospital call 2. Benefit only available when services are provided by an Oral Surgeon, or Orthodontist						Narrative
x	x	D9999	Unspecified Adjunctive Procedure, By Report 1. Used as a data marker for FQHC claims encounters for children						

14.10 TELEDENTISTRY SERVICES

"Telehealth" is the use of telecommunication services to transmit patient health information for interpretation and diagnosis while a patient is at an originating site and the health care provider is at a distant site. It is intended to facilitate access for patients who would otherwise not receive services due to geographic barriers. "Teledentistry" is a form of telehealth.

14.10.1 Claims for Teledentistry Services

1. Eligible Dental Sites: Medicaid payments for teledentistry-related services will be consistent with the State's rules on where teledentistry may be used.

2. Eligible Codes: Claim submission must involve encounters with specific exam and radiograph codes. See 14.10.2 for codes approved for teledentistry. Code D0145 is added to this list. All eligible codes are subject to the same processing policies defined in this manual.

3. Service Date
While the reimbursement for radiographic services is traditionally based on the date that the radiograph is read by the dentist providing the diagnosis, to minimize confusion that may potentially arise with asynchronous technology, the following protocol will be used when filing claims:

- Only one claim submission is allowed for each patient visit. All services to be claimed must be included in that single submission.
- The service date on the claim is the date that the patient was treated at the originating site regardless of whether asynchronous or synchronous technology was used.
- When asynchronous technology is used and the service date on the claim does not match the clinical notes (interpretation of the x-rays was done on a different day from when the patient was seen), a notation in clinical records should explain the discrepancy for auditing purposes.

4. Billing Procedure

- The FFS reimbursement fee is based on the location of the eligible Medicaid provider at the time of service, Oahu or Neighboring Island.

- All claims for eligible telehealth services must include either code D9995 (teledentistry-synchronous) or D9996 (teledentistry-asynchronous). These codes should have a fee set to zero.

- Clinics that qualify for FQHC Prospective Payment System (PPS) reimbursement may submit telehealth claims using PPS reimbursement, as long as both the patient and dentist were each physically located at separate eligible FQHC/RHC sites during the encounter and the diagnosis. (Form 5b service sites registered with Med-QUEST as a Medicaid location and issued a HRSA Notice of Award identifying the specific service location address). Refer to Provider Memo QI-2338/ FFS 23-22. The first lines of these claims should be D9999 or D0140.

- Claims for patients that were located at "public health settings" not federally registered as a FQHC or RHC service site are not eligible for PPS reimbursement.

- All claims must indicate the treatment location in the "Remarks" section of the claim form. This is the location of the patient, including the name and address of "public health setting." For example: Roosevelt High School, 1120 Nehoa Street, Honolulu, 96822. Claims that do not include the specific location of the patient will be denied.

14.10.2 CDT Codes approved for Teledentistry

CDT	Description
D0120	Periodic oral evaluation - established patient
D0140	Limited oral evaluation - problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0240	Intraoral - occlusal radiographic image
D0270	Bitewing - single radiographic image
D0272	Bitewing - two radiographic images
D0274	Bitewing - Four radiographic images
D0330	Panoramic radiographic image

14.11 SPECIAL DENTAL SERVICES RELATED TO MEDICAL TREATMENT

Separate from the adult and child benefit programs described above, two additional options exist to provide some benefits for other dental services related to medical treatment.

- Beneficiaries enrolled in the State of Hawaii Organ and Tissue Transplant (SHOTT)
- Beneficiaries requiring some medically necessary oral surgery procedures, required as part of medical inpatient and outpatient services

These benefits are not processed through the child or adult dental programs described above. Prior authorization and claims for these medical services are processed through the patient's managed care medical plan.

Referrals made for such services should only be made to oral surgeons who are participating providers within the beneficiary's medical plan. When coordination is needed between the medical plan and a surgeon's office or dental home, a dental case manager (Community Case Management Corp) will assist in coordinating medical and dental services. This assistance includes:

- Coordinating follow-up, recall, and other dental services needed as part of a medical treatment plan
- Transportation for necessary services, as applicable

Other responsibilities of the managed care medical plan include:

- Providing sedation benefits for services associated with medically related dental treatment, when performed in an acute care setting by a physician anesthesiologist. Sedation services administered by an oral and maxillofacial surgeon for dental services that are not medically related fall under the Dental Program, not the managed care plan.

- Providing benefits for dental services by a dentist or physician that are needed due to a medical emergency (i.e., car accident) where most of the services required are medical services.

- The managed care plan is not responsible for "routine dental services" that are generally provided by a dentist and covered by the child or adult Medicaid dental programs.

ORAL SURGERY PROCEDURES WITH BENEFITS IN MEDICAID MEDICAL PLANS (not dental plans)

CDT Procedure Code*	Description
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Intra-Osseous Lesions
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
	Removal of Cysts and Neoplasms
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor lesion diameter greater than 1.25 cm
D7460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7461	Removal of benign non-odontogenic cyst or tumor lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
	Excision of Bone Tissue
D7471	Removal of lateral exostosis – maxilla or mandible
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7490	Radical resection of maxilla or mandible
	Surgical Incision
D7511	Incision and drainage of abscess-intraoral soft tissue-complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess-extraoral soft tissue
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	Treatment of Fractures - Simple
D7610	Maxilla – open reduction (teeth immobilized if present)
D7620	Maxilla – closed reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)

CDT Procedure Code*	Description
D7640	Mandible closed reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch-open reduction
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus – Closed reduction, may include stabilization of teeth, splinting
D7671	Alveolus – Open reduction, may include stabilization of teeth, splinting
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Treatment of fractures - Compound
D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7760	Malar and/or zygomatic arch-closed reduction
D7770	Alveolus – open reduction stabilization of teeth
D7771	Alveolus – closed reduction stabilization of teeth
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/ without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7870	Arthrocentesis
D7872	Arthroscopy – diagnosis, with or without biopsy
D7873	Arthroscopy: lavage and lysis of adhesions
D7874	Arthroscopy: disc repositioning and stabilization
D7875	Arthroscopy: synovectomy
D7876	Arthroscopy: discectomy
D7877	Arthroscopy: debridement

CDT Procedure Code*	Description
D7880	Occlusal – orthotic devise, by report
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture up to 5 cm
D7912	Complicated suture over 5 cm
D7920	Skin grafts (identify defect covered, location and type graft)
	Other Repair Procedures
D7940	Osteoplasty for orthognathic deformities
D7941	Osteotomy – mandibular rami
D7943	Osteotomy mandibular rami with bone graft; including obtaining the graft
D7944	Osteotomy, segmented or subapical, per sextant or quadrant
D7945	Osteotomy, body of mandible
D7946	Le Fort I (maxilla – total)
D7947	Le Fort I (maxilla – segmented)
D7948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)
D7949	Le Fort II or Le Fort III – with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous
D7955	Repair of maxillofacial soft and hard tissue defects
D7980	Sialolithotomy
D7981	Excision of salivary glands, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7990	Coronoidectomy
D7995	Synthetic graft – mandible or facial bones, by report
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance removal (not by dentist who replaced appliance), includes removal or arch bar
D7999	Unspecified oral surgery procedure, by report
D9222	Deep sedation/general anesthesia-first 15 minutes
D9223	Deep sedation/general anesthesia-each subsequent 15 minute increment

14.12 DENTAL RELATED PHARMACY CLAIMS

For pharmacists, claims processing is different depending on if the prescription was written by a dentist or a physician. Claims for prescriptions written by dentists should be submitted to the State's Medicaid Pharmacy Benefit Manager (PBM), not the beneficiary's QUEST Integration (QI) health plan. Please see Chapter 19 for procedures and policies on Pharmacy Services. Specific information on drug coverage and claims submittal can be found at https://medquest.hawaii.gov/en/plans-providers/pharmacy.html

14.13 QUESTIONS AND COMMENTS

1) Thank you for being part of this program. This program relies upon the participation and skills of community-minded dental professionals. We appreciate you bringing your professional dental services to our statewide community.

2) Why does this program have benefits that are different than private insurance plans?
Every health benefit program, whether private insurance or public assistance, must balance expenditures with funding. Medicaid dental programs are taxpayer funded safety-net programs designed to reduce financial barriers to basic care for at-need members of our community within particular health, social, or financial circumstances. The dental program is designed to offer no-cost coverage to the approximately one third of Hawaii's residents enrolled in Medicaid in 2024.

3) How are the importance/priority of the covered procedures determined?
For children, the federal government mandates much of the range of covered procedures. The result is a benefits package that extends far beyond basic or critical services, including a wide array of non-critical procedures like esthetic restorations and space maintenance. For adults, the program prioritizes prevention of disease, and the procedures that lead to an adult's long-term relationship with a dental home. Therapeutic services are prioritized to treat active disease, and promote long-term function and maintenance of the oral structures. Esthetic services, and non-critical procedures are not priority.

4) What if a patient requests a service that is not included in the benefits list?
These programs offer benefits intended to help individuals maintain basic health, and to create a relationship with a dental home. Individuals may choose to build upon this foundation, taking an active role in decisions, options, and elected services. Like private insurance plans, the Medicaid dental programs are intended to promote a culture of patient engagement and participation with their healthcare. If a patient requests services that are not included as program benefits, then the dentist office may choose to collect payment from the patient, following Section 14.7.