Chapter 14

Medicaid Provider Manual

Dental

October
2019

TABLE OF CONTENTS

14.1 General Services

Dental services for Hawaii Medicaid fee-for-service (FFS) and managed care beneficiaries are covered through the fee-for-service program administered by a third party administrator except for dental services provided to Hawaii Medicaid adult beneficiaries enrolled in the State of Hawaii Organ and Tissue Transplant (SHOTT) program. Dental claims for adult SHOTT enrollees should be submitted to Hawaii Medicaid's third party transplant administrator. The transplant administrator uses Hawaii Medicaid's payment rates in processing dental claims. The available dental benefits may vary depending on the beneficiary's age.

"Dental services" includes (with limitations) diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, orthodontic and select oral surgery services. Oral surgery services associated with trauma and fracture management and the treatment of oral pathology including cysts and tumors are covered through the beneficiary's managed care plan and not the dental program described here.

This fee-for-service program utilizes the CDT Code in effect on the date of service as the claims submission coding standard.

14.2 SERVICES COVERED BY MEDICAL BENEFITS PLAN

The managed care plans are responsible for inpatient and outpatient hospital services, including ambulatory surgical center or same day surgery services, anesthesiology services, and medical services that are required as part of a dental treatment plan. Prior authorization and claims for such medical services must be submitted to patient's managed care plan.

When coordination is needed between the managed care plan and the dental provider, the dental third party administrator and the dental case manager (HDS Medicaid and CCMC) will provide the services described below:

- Assist beneficiaries and dentists to coordinate medical services needed in conjunction with dental services
- Assist beneficiaries and dentists to coordinate follow-up, recall and other dental services related to medical needs to maintain oral health and continuity of care
- Assist beneficiaries with transportation for necessary services as applicable

The responsibilities of the managed care plan include:

- Referring beneficiaries to the dental provider for EPSDT dental services and other dental needs which includes scheduling the initial appointment and documenting follow-up
- Providing referral, follow-up, coordination and provision of appropriate medical services related to medically necessary dental needs including but not limited to emergency room treatment, hospital stays, ancillary inpatient services, operating room, excision of tumors, removal of cysts and neoplasms, excision of bone tissue, surgical incisions, treatment of fractures (simple and compound), oral surgery to repair traumatic injury, surgical supplies, drugs, dressings, anesthesia services and supplies, oxygen, antibiotics, blood transfusion services, ambulatory surgical center services, x- rays, laboratory work, physician examinations, consultations and second opinions.

- Providing sedation services associated with dental treatment, when performed in an acute care setting, by a physician anesthesiologist, shall be the responsibility of the managed care plan. Sedation services administered by an oral and maxillofacial surgeon, or other qualified dental anesthetist, in a private office or hospital-based outpatient clinic for services that are not medically related shall be the responsibility of the Dental Program contractor.

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

- Providing dental services in relation to oral or facial trauma, oral pathology (including but not limited to infections of oral origin, cyst and tumor management) and craniofacial reconstructive surgery, performed on an inpatient basis in an acute care hospital setting.

The managed care plan is not responsible for services that are generally provided by a dentist and covered by the Medicaid fee-for-service dental program. The managed care plan may request assistance from HDS Medicaid or the dental provider to coordinate dental services.

In cases of disputes regarding coverage, the Medicaid dental provider, HDS Medicaid, and/or the managed care plans may consult with the Med-QUEST Medical Director and Dental Consultant to assist in defining and clarifying the respective plan's responsibilities.

14.2.1 Services in a Hospital

Non-emergency treatment performed in a hospital requires an approved authorization. CPT code 41899, Under Other Procedures on the Dentoalveolar Structures serves as a location code to identify treatment performed in a hospital setting. The authorization is not a guarantee of payment by the Medicaid managed care plan.

14.25 DENTAL PHARMACY CLAIMS

Pharmacy prescriptions written by dentists are handled differently from prescriptions written by physicians. Claims for prescriptions written by dentists should be submitted to the State's Medicaid Pharmacy Benefit Manager (PBM) and 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

14.3 PROVIDER OBLIGATIONS

All health care providers must abide by the provisions outlined within the signed Provider Agreement and Condition of Participation with State of Hawai`i Department of Human Services. Through that agreement, providers also agree to abide by the provisions outlined in this manual and the Hawaii Administrative Rules, Title 17, Subtitle 12 Med-QUEST Division and federal provisions set forth in the Code of Federal Regulations (CFR).

- Definitions:

  Covered services. Services that are reimbursed in whole or in part under the conditions of Medicaid, subject to all terms and conditions of the agreement or policy.

  Non-covered services. Services not covered by Medicaid.

All providers must be cognizant of the following:

- Providers may not submit claims to Medicaid for services rendered by another dentist.
- Claims for Medicaid beneficiaries are not eligible for reimbursement if dental services are rendered by a non-participating dentist.
- Non-covered Medicaid dental services may be provided to Medicaid beneficiaries at their own personal expense. The charges for non-covered services are independent of Medicaid but should not exceed a provider's customary fee. Providers shall have the Medicaid beneficiary sign a consent to pay for these services prior to them being performed.

  Examples:

  (1)Medicaid patient requests an implant (not covered under Medicaid)

  (2) An adult Medicaid patient requests an amalgam or composite restoration **(not covered under Medicaid's adult dental benefit)**,

  The provider should obtain informed consent and then may make private arrangements with the patient for payment. Medicaid must not be billed for any portion of the procedure.

- "Code substitution" is the submission of a claim for a covered procedure code when a non-covered service was provided and is prohibited. For example, Medicaid does not reimburse for "screening" or "office visit" encounters, and billing for oral examination in these cases is considered false coding.

- "Up-coding" is prohibited. Providers must bill Medicaid accurately for the specific service rendered. For example, billing for a surgical extraction (D7210) when an extraction of erupted tooth (D7140) was performed is considered "up-coding".

- "Code Parceling" is prohibited. For example, Medicaid reimburses for restorations based upon the number of restored surfaces per tooth. Separate MO and DO restorations on tooth # 13 would be billed as #13 MOD; not #13 MO + #13 DO. Claims submitted with parceled restorations may be denied or reconciled at a later date on claims audit.

- "Balance Billing" is prohibited. Medicaid providers must accept Medicaid payment rates as payment in full. Additional compensation may not be sought or accepted for services for which payment has already been made or will be made by Medicaid. Providers may not collect from Medicaid patients or other sources, the balance between their usual fee and Medicaid reimbursement.

  Example:

  If a Medicaid patient receives a crown which costs the provider $250 and the provider has billed and received a $234 payment from Medicaid, the provider cannot charge the patient the balance of $16. **The reimbursement received from Medicaid constitutes payment in full.**

- "Multiple payments" are prohibited. Providers are responsible for reconciling their claims and payments. If a provider receives multiple payments for the same service, he/she must notify the third party administrator.

- Code substitution, up-coding, parceling, balance billing and accepting multiple payments are all serious breaches of program policy which could have serious ramifications and result in disciplinary action.

- No Shows**:** Providers may not charge patients for missed appointments. Please contact CCMC if a patient frequently misses appointments so that the problem can be addressed.

- Third Party Liability & Coordination of Benefits. Federal regulations specify that all other readily available sources of medical insurance are primary to Medicaid. A third party liability (TPL) refers to another dental coverage or responsible payer whose resources are available to the client in addition to Medicaid. Therefore, providers must bill the other insurance and await payment or rejection notification before filing a claim for Medicaid payment. Once a claim has been processed and paid by the other insurance, amounts remaining that do not exceed the Medicaid fees are eligible for reimbursement by Medicaid. When the TPL payment is the same or exceeds the Medicaid reimbursement fee the service is considered paid in full, no additional payment will be made under Medicaid and the beneficiary cannot be billed.

Procedure	Charge amount	Payment by TPL	Medicaid fee	Patient responsibility	Eligible for HDS Medicaid reimbursement
D2792 crown-full cast metal	$1000	$500	$234.00	$0	$0
D220 intraoral –first film	$20	$8.00	$10.92	$0	$2.92

Examples of third parties which may be liable to pay for services:

1. group health plans 2. self-insured plans 3. managed care organizations 4. court-ordered health coverage	• settlements from a liability insurer • workers' compensation • other State and Federal programs (unless specifically excluded by Federal statute).

Identification of Third Parties: Information is gathered regarding potentially liable third parties, including health coverage, when individuals apply for medical assistance. This information is available on the Medicaid portal.

Coordination of Benefits- Claim Submission: On the ADA form, indicate TPL information in the Other Coverage section. Attach a copy of the TPL statement of payment. Claims for patients with third party coverage that do not indicate a third party payment or denial will be rejected with instructions to bill the third party.

If a third party payer denies a service that is normally covered, a rejection notice must be attached to the Medicaid claim showing the reason for the denial, e.g., pre-existing illness, TPL cancelled, patient ineligible, etc.

14.31 Dental Referrals

A referral should only be made for covered Medicaid dental benefits. Dental providers are able to make referrals for patient care either directly to another Medicaid dentist or through the Third Party Administrator (TPA). Oahu Providers choosing to use the TPA should fax a Specialist Referral Sheet to Community Case Management Corp (CCMC) at (808) 792-1062. For the Neighbor Islands, the fax number is: 1 (888) 792-1062. The referral sheet must be signed (not stamped) by the referring provider. It is important to note that a referral does not constitute authorization for or a guarantee of payment to the treating provider.

CCMC is responsible for coordinating services to address medically necessary dental needs. Referrals are based on a variety of factors ranging from complexity of the case, provider experience and training, workload, geographic factors, etc. As such, referrals are considered a recommendation from one provider to another and actual treatment may vary from what is indicated on the referral form because of the treating provider's diagnosis and judgement. For example, dental services for an individual that cannot be safely performed in one office setting may be able to be safely performed in another. Consequently, adjunctive services that facilitate treatment of medically necessary conditions (e.g.: caries) may be modified by the treating provider.

Whenever possible, beneficiaries are scheduled by CCMC for treatment with Providers nearest their place of residence. As a result, while a referral may initially be made to a specialist, if none are available, then with concurrence of the TPA, a general dentist may be consulted to review the case and either decline or accept the referral. If there are no providers to accept the case locally, then a process may be initiated by CCMC to transport the patient to another island.

14.4 Children's Dental Services Requiring Prior Authorization

The following dental services require prior authorization in order to qualify for reimbursement. The list includes but is not limited to the procedures below. Emergency services do NOT require prior authorization.

- Dental procedures requiring general anesthesia and hospitalization (inpatient and outpatient, excluding hospital-based dental clinics)
- Maxillofacial and other select prosthodontic procedures
- Orthodontics

Dental services requiring prior authorization must be approved before the services are rendered for non-emergency dental services. Provision of services before final approval of the required prior authorization may result in the rejection of the claim and denial of payment.

14.4.1 Requesting Prior Authorization

For dental services requiring prior authorization, providers submit a Prior Authorization Form with supporting documentation, including radiographic image(s) when applicable and an accepted clinical diagnosis.

14.4.2 Expedited Approval of Authorization Requests

Expedited approval may be granted for procedures that require prior authorization but which should not be delayed until a written approval is obtained (approximately five working days). Expedited approval may be obtained by writing "Urgent" on the top of the Dental Authorization form and faxing the form to the third party administrator.

14.4.3 Seven-Day Grace Period

Med-QUEST allows a seven-day grace period for services with a time limitation. For example, if a child's 12-month service year refreshes on June 13st, a service date from June 6th to June 12th will be accepted and paid accordingly.

A service year is based on the patient's prior treatment history and is NOT based on the calendar or fiscal year. Many services are limited to two times per service year and services no less than 4 months apart. In these cases the Dental TPA will evaluate the patient's history, first looking back 4 months from the last service date and then 12 months from the service date to enforce the frequency criteria.

14.5 CLAIM SUBMITTAL

Claims may be submitted electronically via Clearinghouse, the Dental TPA Medicaid portal and by hard copy using the current American Dental Association (ADA) form.

Dental claims for reimbursement must be submitted using the appropriate CDT codes. Coding of dental procedures must be true and accurate as defined by CDT and Chapter 14.

Claims must be submitted within 1 year upon completion of a dental procedure. A claim two-visit endodontic procedure must be submitted upon completion on the second visit. A claim for a crown must be submitted on the seat/cementation date and not the preparation date.

Claims submitted must reflect a provider's customary fee and not the reimbursement rate of the Medicaid program.

The third party administrator may require documentation of findings, diagnosis and treatment plan as needed for review.

14.5.1 Billing Information

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

- Billing entity/dentist
- Mailing address
- NPI (see note below)
- Tax ID Number
- Servicing Provider (Please print name of servicing provider)

Note: Sole providers using their Social Security Number as their Tax ID do not need an Organizational NPI (Type 2) on the claim. Providers not using their Social Security Number as their Tax ID are required to submit an Organization NPI (Type 2) on the claim.

14.5.2 Billing Information for FQHC's

Prospective Payment System (PPS) reimbursement requires that Federal Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) must submit procedure code D9999, which is used to cover Children's preventive/restorative benefits.
In addition, for adult emergency dental services, the FQHCs must submit procedure code D0140 and ICD-10 diagnosis code K08.9

Refer to section 14.10 Tele-dentistry Services for billing procedures.

14.6 EMERGENCY TREATMENT CLAIM SUBMISSION

Prior authorization is not required for emergency exams and palliative treatment to relieve dental pain. However, claims must be submitted as follows to avoid payment delays or denials:

When submitting a claim for an eligible Medicaid adult patient 21 years or greater, the ICD-10 diagnosis code K08.9 must be entered in the Block 35 Remarks section of the 2012 ADA Claim form. Diagnosis code K08.9 certifies that the completed dental procedure was of an emergent nature and was needed for relief of pain, control of infection or management of trauma. With the exception of extractions, a valid clinical diagnosis and a brief description of the treatment performed is required. Benefits are denied when emergency treatment criteria are not met.

Payment is based on meeting the medical necessity benefit criteria as determined by the third-party administrator.

14.7 Payment Requirements

The patient must be eligible under Medicaid and the provider must be approved for participation under Medicaid at the time services are rendered or an approved expense incurred. Payment cannot be made to a non-approved provider even if the patient was eligible and the services approved.

Dental services requiring prior authorization must be approved before the services are rendered. Provision of services before final approval of the required prior authorization may result in the rejection of the claim and denial of payment. Payment is based on meeting the medical necessity benefit criteria as determined by the third-party administrator.

Approval of a treatment plan is not a prior authorization for payment or an approval of the charges.

14.8 CHILDREN'S DENTAL SERVICES (INDIVIDUALS UNDER THE AGE OF 21)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federally mandated program for children up to age 21(that is, through age 20) that emphasizes prevention and control of disease through early detection of medical, dental and behavioral health conditions and timely management of disorders.

The scope of dental services available through the EPSDT program is broader than that available to adult Medicaid beneficiaries. Federal requirements imposed by the EPSDT statutory provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA'89) mandate that the State covers all Title XIX services included in Section 1905 (a) of the Act when medically needed, to correct or ameliorate defects and physical and mental illness and conditions discovered as a result of EPSDT screening services. For more details on this program, please refer to Chapter 5 EPSDT Program. With regard to dental services, Medicaid provides coverage for comprehensive preventive and treatment services, the most notable exception being the limitation of orthodontic therapy to cases involving development orofacial clefts. In addition, Medicaid does not cover elective surgery, including the extraction of teeth for orthodontic purposes and third molars without documented signs of pathology.

14.8.1 EPSDT Diagnostic Services

Procedure Frequency Limitations

The procedure frequency limitations are based on a12-month time between service periods. For example: If a procedure is allowed twice a year, the procedure must be performed no sooner than four months apart and not more than twice within the specific12-month period. If medical necessity dictates that frequency limits be amended for a particular patient, proper documentation and preauthorization is required prior to the date the service (where appropriate) is performed. It is also an expectation that periodic and comprehensive EPSDT oral examination of infants and children should be documented in the clinical records to include age appropriate anticipatory guidance such as counseling; oral hygiene, dietary, speech, injury prevention, substance abuse, etc. with the primary caregiver and child.

Clinical Oral Evaluation

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0120 Periodic oral evaluation- established patient 1. Oral evaluations (D0120, D0145, D0150) are covered two times per service year no sooner than four months apart starting as early as age 6 months and are cumulatively applied to the oral evaluation frequency limit.		
D0140 Limited oral evaluation-problem focused	A-T,1-32, UL, UR, LL, LR, UA, LA	
1. Limited to one per day. 2. This code should be submitted for a dental emergency visit and should not be submitted when the patient is undergoing comprehensive care.		
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver 1. Oral evaluations (D0120, D0145, D0150) are covered two times per service year no sooner than four months apart starting as early as age 6 months and are cumulatively applied to the oral evaluation frequency limit.		
D0150 Comprehensive oral evaluation-new or established patient 1. Oral evaluations (D0120, D0145, D0150) are covered two times per service year no sooner than four months apart starting as early as age 6 months and are cumulatively applied to the oral evaluation frequency limit.		

Diagnostic Imaging

Radiographic images must be clinically necessary and should be prescribed in accordance with American Dental Association and Food and Drug Administration guidelines. These services should only be rendered in cases where they will provide additional diagnostic information to the dentist/dental office and must be prescriptive rather than taken on an administrative time table.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0210 Intraoral-complete series of radiographic images 1. Limited to one complete series per 5 service years. 2. Usually consisting of 14-22 periapical and posterior bitewing images. 3. Images must be of diagnostic quality and clinically necessary.		
D0220 Intraoral-periapical first radiographic image 1. Limited to one per day. 2. Images must be of diagnostic quality and clinically necessary.		
D0230 Intraoral-periapical each additional radiographic image 1. Images must be of diagnostic quality and clinically necessary. 2. Not to exceed 4 per day.		
D0240 Intraoral-occlusal radiographic image 1. Images must be of diagnostic quality and clinically necessary. 2. Not to exceed 1 per day.		
D0270 Bitewing-single radiographic image 1. Images must be of diagnostic quality and clinically necessary. 2. Limited to 2 times per service year and service dates no less than 4 months apart.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0272 Bitewing-two radiographic images 1. Images must be of diagnostic quality and clinically necessary. 2. Limited to 2 times per service year and service dates no less than 4 months apart. 3. D0274 performed on a patient under age 10 is processed as a D0272.		
D0274 Bitewing-four radiographic images 1. Images must be of diagnostic quality and clinically necessary. 2. Limited to 2 times per service year and service dates no less than 4 months apart. 3. D0274 performed on a patient under age 10 is processed as a D0272.		
D0310 Sialography 1. Limited to one per day. 2. Dental reviewed, justification for this procedure is required.		Narrative
D0330 Panoramic radiographic image 1. Images must be clinically necessary and of diagnostic quality. 2. Limited to one every 2 service years. Cannot be used with D0210. 3. Covered for Oral Surgeons when extracting tooth/teeth (regardless of frequency limit) for the diagnosis of specific conditions, pathology or injury.		

Dental Code Exceptions: D0210, D0272, D0274, D0330. If the frequency limit is exceeded, services may be reimbursed only when the radiographic image(s) are required for proper diagnosis and/or treatment. A narrative is required.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0340 Cephalometric radiographic image 1. Limited to one per day. 2. 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.		
D0364 Cone beam CT capture and interpretation with limited field of view – less than one whole jaw 1. Covered benefit for Oral Surgeons only and when other radiographic/diagnostic imaging is not sufficient for proper diagnosis and/or treatment.		
D0365 Cone beam CT capture and interpretation with field of view of one full dental arch – mandible 1. Covered benefit for Oral Surgeons only and when other radiographic/diagnostic imaging is not sufficient for proper diagnosis and/or treatment.		
D0366 Cone beam CT capture and interpretation with field of view of one full dental arch-maxilla, 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.		
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.		

14.8.2 EPSDT Preventive

Dental Prophylaxis/Topical Fluoride Treatment/other Preventive Service

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1110 Prophylaxis – adult 1. Limited to 2 times per service year and service dates no less than 4 months apart. 2. Limited to ages 15 through 20.		
D1120 Prophylaxis - child 1. Limited to 2 times per service year and service dates no less than 4 months apart. 2. Limited through age 14 and under.		

Dental Code Exceptions: D1110, D1120. Clinical circumstances: Exceeds the frequency coverage limit; and necessary for proper maintenance of oral cavity to prevent periodontal disease (due to high plaque index, calculus build-up, and/or medical condition). A narrative is required.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1206 Topical application of fluoride varnish 1. Limited to 2 times per service year and service dates no less than 4 months apart.		
D1208 Topical application of fluoride-excluding varnish 1. Limited to 2 times per service year and service dates no less than 4 months apart.		
Dental Code Exceptions: D1206, D1208. Exceeds the frequency coverage limit; and fluoride treatment is necessary to prevent caries (due to high caries index and/or medical condition). A narrative should be included to justify services that exceed the frequency limit.		
D1351 Sealant – per tooth 1. A tooth may be resealed every 5 service years if necessary. 2. Limited to ages 5 through 20.	2-3,14-15, 18-19, 30-31	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1354 Interim caries arresting medicament application – per tooth 1. Benefit is limited to silver diamine fluoride (SDF) only. 2. Benefit is limited to one application per tooth per day and allowed twice per tooth within a 12 month period. 3. Benefit is denied when a restoration on the same tooth is placed on the same date of service. 4. Benefit is denied when performed within 30 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 30 days of the date of service.	A-T 2-15, 18-31	

Dental Code Exceptions: D1354. Benefits may be allowed on functional third molars when clinically necessary. A narrative is required.

Space Maintenance (Passive Appliances)

D1510 Space maintainer – fixed unilateral-per quadrant 1. Limited to 4 per 2 service years.	Missing Tooth # A-T, 2-15, 18-31	
D1516 Space maintainer – fixed – bilateral, maxillary 1. Limited to 2 per 2 service years.	Missing Tooth # A-J, 2-15	
D1517 Space maintainer – fixed – bilateral, mandibular 2. Limited to 2 per 2 service years.	Missing Tooth # K-T, 18-31	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1550 Re-cement or rebond space maintainer	Missing Tooth # A-T, 2-15, 18-31	
1. Once per year after 6 months from the initial placement. 2. Removal is not a separate benefit and is included in the fee for the same dentist/same dental office originally placing the space maintainer. 3. Procedure is benefited for the dentist/dental office not originally placing the space maintainer.		
D1555 Removal of fixed space maintainer	Missing Tooth # A-T, 2-15, 18-31	
1. Once per year after 6 months from the initial placement. 2. Removal is not a separate benefit and is included in the fee for the same dentist/same dental office originally placing the space maintainer. 3. Procedure is benefited for the dentist/dental office not originally placing the space maintainer.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1575 Distal shoe space maintainer – fixed – unilateral – per quadrant	Missing Tooth # A-T, 2-15, 18-31	
1. Removal of distal shoe space maintainer by the same dentist/dental office who placed the appliance is included in the fee for D1575. 2. Limited to children aged 8 and younger. 3. A subsequent space maintainer may be considered upon individual review.		

Dental Code Exceptions: D1510, D1516, D1517, D1555, D1575. Exceeds the frequency coverage limit; and necessary to replace space maintainer if dislodged from tooth (cannot be recemented), lost or broken. A narrative is required.

14.8.3 EPSDT Restorative

Restorative

Composite and amalgam restorations are reimbursable based upon total number of restored surfaces. For example, noncontiguous restorations, such as a separate distal occlusal (DO) and mesial occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2140 Amalgam – one surface, primary or permanent	A-T, 1-32	
1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.		
D2150 Amalgam – two surfaces, primary or permanent	A-T, 1-32	
1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2160 Amalgam – three surfaces, primary or permanent 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	A-T, 1-32	
D2161 Amalgam – four or more surfaces, primary or permanent 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	A-T, 1-32	
D2330 Resin-based composite – one surface, anterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	C-H, M-R, 6-11, 22-27	
D2331 Resin-based composite – two surfaces, anterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	C-H, M-R, 6-11, 22-27	
D2332 Resin-based composite – three surfaces, anterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	C-H, M-R, 6-11, 22-27	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2335 Resin-based composite – four or more surfaces or involving incisal angle (anterior) 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	C-H, M-R, 6-11, 22-27	
D2391 Resin-based composite – one surface, posterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	A-B, I-J, K-L, S-T 1-5, 12-21, 28-32	
D2392 Resin-based composite – two surfaces, posterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	A-B, I-J, K-L, S-T 1-5, 12-21, 28-32	
D2393 Resin-based composite – three surfaces, posterior 1. Separate multiple restorations per tooth are not covered. 2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.	A-B, I-J, K-L, S-T 1-5, 12-21, 28-32	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2394 Resin-based composite – four or more surfaces, posterior	A-B, I-J, K-L, S-T 1-5, 12-21, 28-32	

1. Separate multiple restorations per tooth are not covered.
2. The replacement of restorations on the same tooth and surface(s) is a benefit once every 24 months.

Dental Code Exceptions: Composite and amalgam restorations. Clinical Circumstances: exceeds the frequency coverage limit; and necessary to replace/redo/extend restoration due to new or recurrent caries, or restoration that is compromised; and provider's judgment that restoration needs to be replaced immediately and not be deferred to a later date. A narrative and radiographic image(s) are required.

Crowns

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2740 Crown – porcelain/ceramic	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		
D2750 Crown – porcelain fused to high noble metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		
D2751 Crown – porcelain fused to predominantly base metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		
D2752 Crown – porcelain fused to noble metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2790 Crown – full cast high noble metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		
D2791 Crown – full cast predominantly base metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		
D2792 Crown – full cast noble metal	2-15, 18-31	Pre-op radiographic image
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. Once per tooth every five years. 3. Temporary crowns are considered part of the crown procedure.		

Dental Code Exceptions: D2740, D2750, D2751, D2752, D2790, D2791, D2792. Clinical Circumstances: exceeds the frequency coverage limit; and necessary to replace crown if lost or dislodged from tooth (cannot be recemented), or the integrity of crown is compromised. Third molar crowns may be allowed when necessary for primary function; and the tooth meets the conditions for crown coverage. For a primary tooth, when there is a congenitally missing corresponding permanent tooth; and meets the conditions of crown coverage. A prior authorization, narrative and pre-operative radiographic image(s) are required.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2910 Recement or rebond inlay, onlay, veneer or partial coverage restoration	A-T,1-32	
1. Benefit is denied within 6 months of initial placement when performed by the same dentist or dental office. 2. Recementation by a different dentist or dental office is a benefit within 6 months of initial placement.		
D2920 Recement or rebond crown	A-T,1-32	
1. Benefit is denied within 6 months of initial placement when performed by the same dentist or dental office. 2. Recementation by a different dentist or dental office is a benefit within 6 months of initial placement.		
D2930 Prefabricated stainless steel crown-primary tooth	A-T	
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. Benefited once per tooth per 24 months. A replacement on the same day or within 24 months is denied.		
D2931 Prefabricated stainless steel crown-permanent tooth	2-15, 18-31	
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. Benefited once per tooth per 24 months. A replacement on the same day or within 24 months is denied.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2932 Prefabricated resin crown 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. Benefited once per tooth per 24 months. A replacement on the same day or within 24 months is denied.	C-H, M-R	
D2933 Prefabricated stainless steel crown with resin window 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. Benefited once per tooth per 24 months. A replacement on the same day or within 24 months is denied.	C-H, M-R	
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. 2. Benefited once per tooth per 24 months. A replacement on the same day or within 24 months is denied.	C-H, M-R	
Dental Code Exceptions: D2930, D2931, D2932, D2933, D2934. Clinical Circumstances: exceeds the frequency coverage limit; and necessary to replace crown if lost or dislodged from tooth (cannot be recemented), or the integrity of crown is compromised. A narrative and radiographic image(s) are required.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
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. Once per tooth every five years.	2-15, 18-31	Pre-op radiographic image
D2951 Pin retention-per tooth, in addition to restoration	2-15, 18-31	
D2952 Post and core in addition to crown, indirectly fabricated 1. Once per tooth every five years.	2-15, 18-31	
D2954 Prefabricated post and core in addition to crown 1. Once per tooth every five years.	2-15, 18-31	

14.8.4 EPSDT Endodontics

Root Canal Therapy (RCT)

Prior authorization is not required. If the patient fails to complete the RCT, submit as palliative (D9110), emergency examination (D0140) and appropriate radiographic images.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament 1. Once per tooth per lifetime.	A-T	
D3222 Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development 1. Once per tooth per lifetime.	2-15, 18-31	
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) 1. Once per tooth per lifetime.	C-H, M-R	Pre-op radiographic image
D3240 Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration) 1. Once per tooth per lifetime.	A, B, I-L, S,T	Pre-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3310 Endodontic therapy – anterior tooth (excluding final restoration)	6-11, 22-27	Post-op radiographic image
1. Final post-operative radiographic image must demonstrate final and complete obturation of the root canal system. 2. One 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.		
D3320 Endodontic therapy – premolar tooth (excluding final restoration)	4, 5,12,13, 20, 21, 28, 29	Post-op radiographic image
1. Final post-operative radiographic image must demonstrate final and complete obturation of the root canal system. 2. One 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.		
D3330 Endodontic therapy – molar tooth (excluding final restoration)	2-3,14-15, 18-19, 30-31	Post-op radiographic image
1. Final post-operative radiographic image must demonstrate final and complete obturation of the root canal system. 2. One 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.		
Dental Code Exceptions: D3330. Clinical circumstances: Endodontic therapy on third molars may be allowed when necessary for primary function; and if the tooth meets the clinical condition for endodontic therapy.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3346 retreatment of previous root canal therapy-anterior	6-11, 22-27	Narrative, Pre-op and Post-op radiographic image
1. Once per tooth per lifetime. 2. Retreatment of previous root canal therapy is covered only for specific clinical circumstances based on dental consultant review. 3. Retreatment of RCT by the same dentist/dental office within 24 months of initial treatment is considered part of the original procedure. 4. One 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. 5. The narrative should include an endodontic diagnosis and a reason for retreatment that is beneficial to support the claim request.		
D3347 retreatment of previous root canal therapy-bicuspid	4-5,12-13, 20-21, 28-29	Narrative, Pre-op and Post-op radiographic image
1. Once per tooth per lifetime. 2. Retreatment of previous root canal therapy is covered only for specific clinical circumstances based on dental consultant review. 3. Retreatment of RCT by the same dentist/dental office within 24 months of initial treatment is considered part of the original procedure. 4. One 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. 5. A narrative including an endodontic diagnosis and reason for retreatment should be beneficial to support the claim request.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3348 retreatment of previous root canal therapy-molar	2-3,14-15, 18-19, 30-31	Narrative, Pre-op and Post-op radiographic image
1. Once per tooth per lifetime. 2. Retreatment of previous root canal therapy is covered only for specific clinical circumstances based on dental consultant review. 3. Retreatment of RCT by the same dentist/dental office within 24 months of initial treatment is considered part of the original procedure. 4. One 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. 5. The narrative including an endodontic diagnosis and reason for retreatment should be beneficial to support the claim request.		
D3351 Apexification/ recalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc.) 1. Once per tooth per lifetime.	2-15, 18-31	Pre-op radiographic image
D3352 Apexification/ recalcification-interim medication replacement 1. Once per tooth per lifetime.	2-15, 18-31	
D3353 Apexification/ recalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.) 1. Once per tooth per lifetime.	2-15, 18-31	Post-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3355 pulpal regeneration – initial visit 1. Once per tooth per lifetime. 2. Benefit is limited to treatment performed by an Endodontist or Pedodontist.	2-15, 18-31	Pre-op radiographic image
D3356 pulpal regeneration – interim medication replacement 1. Once per tooth per lifetime. 2. Benefit is limited to treatment performed by an Endodontist or Pedodontist.	2-15, 18-31	
D3357 pulpal regeneration – completion of treatment 1. Once per tooth per lifetime. 2. Benefit is limited to treatment performed by an Endodontist or Pedodontist.	2-15, 18-31	Post-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3410 Apicoectomy - anterior 1. Once per tooth per lifetime.	6-11, 22-27	Pre-op radiographic image
D3421 Apicoectomy - bicuspid (first root) 1. Once per tooth per lifetime.	4-5,12-13, 20-21, 28-29	Pre-op radiographic image
D3425 Apicoectomy - molar (first root) 1. Once per tooth per lifetime.	2-3,14-15, 18-19, 30-31	Pre-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)

14.8.5 EPSDT Periodontics

D4341 Periodontal scaling and root planing – four or more teeth per quadrant	UL, UR, LL, LR	Prior authorization, Periodontal chart, Radiographic image
1. Limited to once every 24 months. 2. Periodontal pocket depth measurements must be documented within 6 months prior to the date of service and show 4mm or greater. 3. Benefits are denied when documentation does not support alveolar bone loss or attachment loss. 4. Services are benefited on an individual basis.		
D4342 Periodontal scaling and root planing – one to three teeth per quadrant	1-32	Prior authorization, Periodontal chart, Radiographic image
1. Limited to once every 24 months. 2. Periodontal pocket depth measurements must be documented within 6 months prior to the date of service and show 4mm or greater. 3. Benefits are denied when documentation does not support alveolar bone loss or attachment loss. 4. Services are benefited on an individual basis.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit 1. The patient must be 14 years or older and has not had a prophylaxis or debridement (D4355) for at least 24 months. 2. D4355 is denied when performed by the same dentist/dental office on the same day with the following evaluation codes: D0120 and D0150. 3. D4355 is denied when performed on the same day as the following procedures: D1110, D1120, D4341 and D4342.		
D4910 Periodontal maintenance 1. Limited to twice per calendar year. 2. The patient must have prior history of D4341 or D4342 to benefit.		Periodontal chart

14.8.6 Prosthodontics (Removable)

Dentures

Partial Denture - Eligibility	Complete Denture – Eligibility
Any missing anterior permanent teeth (incisors or canines) • Two (2) missing permanent first molars in an arch • Three (3) missing posterior permanent teeth in an arch • Two (2) adjacent missing posterior permanent teeth in an arch	• Replacement of all natural teeth

Note: Only permanent teeth (excluding missing third molars) are applicable when determining coverage for partial and full denture coverage.

Unilateral partial dentures ("Nesbit") are not covered. Fabrication of a new denture is not covered if a beneficiary has acceptable dentures that may be adjusted and/or relined.

All office visits related to denture services, including preparation and all adjustment visits for six (6) months after the delivery date are considered a part of the complete procedure. The final insertion date is considered the date of service for payment of denture(s).

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 must be medically necessary and requires a prior authorization. Subsequent relines are limited to once every two (2) years.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5110 Complete denture - maxillary 1. Limited to one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		Documentation of missing teeth

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5120 Complete denture – mandibular		Documentation of missing teeth
1. Limited to one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		
D5130 Immediate denture – maxillary		Documentation of missing teeth
1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		
D5140 Immediate denture – mandibular		Documentation of missing teeth
1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5211 maxillary partial denture – resin base (including rests and teeth) 1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		Documentation of missing teeth
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) 1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		Documentation of missing teeth
D5213 Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) 1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		Documentation of missing teeth
D5214 Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) 1. Limited one per five years. 2. A tooth chart labeled with the date or current dated radiographic image(s) is acceptable to document missing teeth.		Documentation of missing teeth

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5410 Adjust complete denture-maxillary 1. Limited to one per day.		
D5411 Adjust complete denture-mandibular 1. Limited to one per day.		
D5421 Adjust partial denture-maxillary 1. Limited to one per day.		
D5422 Adjust partial denture-mandibular 1. Limited to one per day.		
D5511 Repair broken complete denture base, mandibular 1. Limited to one service per day.		
D5512 Repair broken complete denture base, maxillary 1. Limited to one service per day.		
D5520 Replace missing or broken teeth – complete denture (each tooth) 1. Limited to three services per day.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5611 Repair resin partial denture base, mandibular 1. Limited to one service per service year.		
D5612 Repair resin partial denture base, maxillary 1. Limited to one service per service year.		
D5621 Repair cast partial framework, mandibular 1. Limited to one service per service year.		
D5622 Repair cast partial framework, maxillary 1. Limited to one service per service year.		
D5630 Repair or replace broken retentive/clasping materials – per tooth 1. Limited to one service per service year.	1-32	
D5640 Replace broken teeth – per tooth 1. Limited to three services per day.	1-32	
D5650 Add tooth to existing partial denture 1. Limited to one service per day.	1-32	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5660 Add clasp to existing partial denture-per tooth 1. Limited to two services per day.	1-32	
D5710 Rebase complete maxillary denture 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent rebases are limited to once every two (2) years.		Prior authorization
D5711 Rebase complete mandibular denture 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent rebases are limited to once every two (2) years.		Prior authorization
D5720 Rebase maxillary partial denture 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent rebases are limited to once every two (2) years.		Prior authorization
D5721 Rebase mandibular partial denture 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent rebases are limited to once every two (2) years.		Prior authorization
D5730 Reline complete maxillary denture (chairside) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5731 Reline complete mandibular denture (chairside) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization
D5740 Reline maxillary partial denture (chairside) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization
D5741 Reline mandibular partial denture (chairside) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization
D5750 Reline complete maxillary denture (laboratory) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization
D5751 Reline complete mandibular denture (laboratory) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5760 Reline maxillary partial denture (laboratory) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization
D5761 Reline mandibular partial denture (laboratory) 1. Allowed one (1) year after final insertion of a new denture. 2. Subsequent relines are limited to once every 24 months.		Prior authorization

14.8.7 Maxillofacial Prosthetics

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5925 through D5999 See specific codes in the current CDT manual.		Prior authorization, Narrative

14.8.8 EPSDT Oral & Maxillofacial Surgery

Oral Surgery
Tooth extraction coverage is 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 without signs of pathology are not covered by Medicaid. This includes the removal of teeth for orthodontic purposes and includes the extraction of asymptomatic third molars in teens and adults.

Submitted pre-operative periapical or panoramic radiographic image(s) must clearly demonstrate the involved tooth/teeth and must accompany all extraction claims except for procedure code D7140. The fee for all oral surgery includes postoperative care for 30 days following surgery (e.g. bleeding, dry socket) by the same dentist/dental office.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7111 Extraction, coronal remnants – primary tooth	A-T	
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A-T, 1-32	
D7210 Surgical removal 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.	A-T, 1-32	Pre-op radiographic image
D7220 Removal of impacted tooth-soft tissue 1. Occlusal surface of tooth covered by soft tissue. 2. Requires mucoperiosteal flap elevation.	A-T, 1-32	Pre-op radiographic image
D7230 Removal of impacted tooth – partially bony 1. Part of crown covered by bone. 2. Requires mucoperiosteal flap elevation and bone removal.	A-T, 1-32	Pre-op radiographic image
D7240 Removal of impacted tooth – completely bony 1. Most or all crown covered by bone. 2. Requires mucoperiosteal flap elevation and bone removal.	A-T, 1-32	Pre-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7241 Removal of impacted tooth – with unusual surgical complications	A-T, 1-32	Pre-op radiographic image, Operative Report

1. Most or all crown covered by 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 course of the surgical procedure.

Dental Code Exceptions: Supernumerary teeth- D7140, D7210, D7220, D7230, D7240, D7241. Clinical circumstances: Tooth may be in a position that detrimentally affects surrounding teeth. Radiographic image(s) must accompany all extraction claims for supernumerary teeth.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
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) should be fully encased in bone (subosseous).	A-T, 1-32	Pre-op radiographic image
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	Pre-op radiographic image, Operative Report
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth 1. Once per tooth per lifetime.	1-32	Pre-op radiographic image, Operative Report

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7280 Surgical access of an unerupted tooth	2-15, 18-31	Pre-op radiographic image
1. 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.		
D7282 Mobilization of erupted or malpositioned tooth to aid eruption	2-15, 18-31	Pre-op radiographic image
1. 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.		
D7283 Placement of device to facilitate eruption of impacted tooth	2-15, 18-31	Pre-op radiographic image
1. 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.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7285 Incisional biopsy of oral tissue – hard (bone, tooth)	1 - 32, UR, UL, LR, LL, UA, LA	Radiographic image, Pathology Report
1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.		
D7286 Incisional biopsy of oral tissue – soft	1 - 32, UR, UL, LR, LL, UA, LA	Pathology Report
1. Requires the submission of the pathology report. 2. Not applicable to the routine removal of the periradicular inflammatory tissues. 3. This service is denied when not submitted with a pathology report.		
D7310 Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	UR, UL, LR, LL	
1. The alveoloplasty is distinct (separate procedure) from extractions. Usually <u>in preparation for a prosthesis</u> 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.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
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	
D7320 Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	UR, UL, LR, LL	Tooth Chart
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	1-32	Tooth Chart
D7410 Excision of benign lesion up to 1.25 cm 1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.	A-T, 1-32	Pathology Report
D7411 Excision of benign lesion greater than 1.25 cm 1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.	A-T, 1-32	Pathology Report

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7510 Incision and drainage of abscess-intraoral soft tissue	A-T, 1-32	Narrative
1. Requires separate surgical procedure involving tissue incision. 2. The narrative must include clinical diagnosis and description of the procedure completed.		
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure	A-T 1 - 32, UR, UL, LR, LL, UA, LA	Narrative
1. The narrative must include a diagnosis and medical/clinical necessity.		
D7970 Excision of hyper-plastic tissue – per arch	UA, LA	Operative Report
1. Limited to edentulous areas.		
D7971 Excision of pericoronal gingiva	1-2, 15-16, 17-18, 31-32	Operative Report
Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. 1. This procedure applies to the excision of tissue distal to the 2nd or 3rd molars.		

14.8.9 Orthodontics

Coverage is limited only to those patients with a history of cleft lip and/or cleft palate, other severe facial birth defects or an injury which requires that the function of speech, swallowing or chewing be restored. For cleft lip and cleft palate clients, it is recommended that they be evaluated at Kapiolani Children's Cleft and Cranial Facial Center (KCCCFC).

Orthodontic services 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 limited (D8010 and D8020), interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment, the reimbursement fee is inclusive of diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), and detailed and extensive oral evaluation – problem focused (D0160). Cephalometric (D0340) and panoramic (D0330) radiographic image(s) are reimbursed separate from the procedure codes identified above.

Providers are required to submit clinical records to the third-party administrator documenting the completion of orthodontic treatment for Phase I (D8010, D8020, D8050 and D8060) and Phase II (D8070, D8080, and D8090) orthodontic procedures. During the course of treatment, the treating provider will provide (to the Dental Consultant) periodic progress/treatment notes for each child undergoing Phase I or II treatment when applicable to client upon request. If the client is not participating in KCCCFC, third party administrator may be requesting clinical records from the treating orthodontists or oral surgeons.

When an orthodontic patient is being seen by a new provider (a different provider than the one which initiated treatment for the client) to continue or complete treatment, reimbursement is made on an individual basis.

Since payment is made in full at the beginning of the treatment, it is understood that the client will receive the complete 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.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8010 Limited orthodontic treatment of the primary dentition 1. Limited to patients with history of cleft lip and/or cleft palate, other severe facial birth defects or an injury for which the function of speech, swallowing, or chewing must be restored. 2. Used for Phase I limited orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization
D8020 Limited orthodontic treatment of the transitional dentition 1. Limited to patients with history of cleft lip and/or cleft palate, other severe facial birth defects or an injury for which the function of speech, swallowing, or chewing must be restored. 2. Used for Phase I limited orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization
D8050 Interceptive orthodontic treatment of the primary dentition 1. Limited to patients with history of cleft lip and/or cleft palate or other severe facial birth defects or an injury for which the function of speech, swallowing, or chewing must be restored. 2. Used for Phase I interceptive orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8060 Interceptive orthodontic treatment of the transitional dentition 1. Limited to patients with history of cleft lip and/or cleft palate or other severe facial birth defects or an injury for which the function of speech, swallowing, or chewing must be restored. 2. Used for Phase I interceptive orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization
D8070 Comprehensive orthodontic treatment of the transitional dentition 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. 2. Used for Phase II comprehensive orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization
D8080 Comprehensive orthodontic treatment of the adolescent dentition 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. 2. Used for Phase II comprehensive orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8090 Comprehensive orthodontic treatment of the adult dentition 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. 2. Used for Phase II comprehensive orthodontic treatment. 3. Includes pre-orthodontic treatment visit (D8660).		Prior authorization
D8660 Pre-orthodontic treatment examination to monitor growth and development 1. One per lifetime. 2. The narrative must indicate that treatment was not started. 3. The provider has not been previously reimbursed for limited (D8010, 8020) interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment. 4. Includes consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (D9310).		Prior authorization, Narrative

14.8.10 Adjunctive General Services

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9110 Palliative (emergency) treatment of pain – minor procedure	A-T, 1-32, UR, UL, LR, LL UA, LA	Narrative
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 one treatment per tooth per year. 5. Requires the performance of a treatment intervention to alleviate pain. May not be applied for consultation or issuance of prescription medication alone. 6. May not be billed with another treatment service performed on the same date.		
D9230 Inhalation of nitrous oxide/analgesia, anxiolysis		Supporting Documentation
Services are covered when the following conditions are met: 1. Providers must be in accordance with the current State of Hawaii administrative rules and licensing standards for dentistry and sedation. 2. Limited to children under 13 years of age and as an adjunct to local anesthesia associated with oral surgery or operative dentistry. 3. Supporting documentation must be maintained in the dental record that includes all of the following: a. Brief statement justifying the clinical necessity for use on the specific patient. b. Sedation record. c. List of clinical procedures performed.		

Dental Code Exception: D9230 inhalation of nitrous oxide/analgesia. Clinical Circumstance: Patients age 13 years and older; and procedure is necessary due to the patient being uncooperative and/or combative to the extent that safety is an issue with patient or staff. A prior authorization is recommended.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9239 intravenous moderate (conscious) sedation/analgesia– first 15 minutes **D9243** Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		Supporting Documentation

Intravenous (IV) and Intramuscular (IM) Sedation Performed in the Office Setting- services are covered when the following conditions are met:

1. Providers must be in accordance with the current State of Hawaii administrative rules and licensing standards for dentistry and sedation.
2. The patient's medical/dental condition is such that IV/IM sedation can be safely performed in the office setting and that the patient can be safely sedated to perform the dental procedure.
3. Supporting clinical documentation must be submitted with the claim that clearly substantiates that:
   a. The patient is combative/uncooperative.
   b. The dental procedure cannot be performed safely without sedation.
4. Supporting clinical documentation should be maintained and include the following:
   a. Medical history
   b. Sedation record
   c. Diagnosis
   d. Pre-surgical radiographic image(s)

Exclusions

Intravenous (IV) and Intramuscular (IM) Sedation performed in the office setting are not covered and not separately reimbursable in the following situations:

- IV/IM sedation is offered to patient or requested by the patient to lower anxiety.
- IV/IM sedation is primarily for patient comfort.
- No supporting documentation for IV/IM sedation is submitted with the claim.

Dental services requiring general anesthesia being performed in a hospital based setting

1. General anesthesia ("GA") for dental services is only covered when administered in a hospital based setting and the following conditions are met:
   a. Prior authorization is obtained from the dental and medical plan (except for urgent or Emergency Services). All providers requesting a prior authorization for GA, must first submit the request to the third party administrator for review and approval. Upon approval for GA, the provider will submit the approved prior authorization to the appropriate medical health plan for final review and approval;
   b. Prior to pursuing GA services on a referral for dental services in a hospital-based setting under general anesthesia, an evaluation by a dentist with similar specialty training may occur.
   c. Dental services for an individual cannot be safely performed in an office setting due to underlying medical conditions. May include but are not limited to the following conditions:

      - developmental disabilities
      - intellectual disability
      - cerebral palsy
      - autism
      - other types of medical conditions that may affect one's mental and/or physical capacities

      Or

      Dental services for an individual cannot be safely performed in an office setting due to being extremely uncooperative, fearful, anxious, and physically resistant, and when extensive oral treatment is necessary and postponement of treatment may result in adverse effects upon patient's medical or dental condition.

      Or

      Local anesthesia is ineffective or contraindicated for dental treatment of individual.

      Or

      An individual with sustained extensive orofacial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

   d. Dental treatment cannot be performed safely or effectively in an office using adjunctive techniques or modalities such as behavioral management techniques, protective stabilizations, medications, caries arrest (Silver Diamine Fluoride) applications, nitrous oxide or conscious sedation.

2. Supporting clinical documentation must be submitted with the prior authorization and include the following:
   a. Dental diagnosis of patient;
   b. Narrative that indicates why the medical/dental management of the patient requires GA be used to safely perform the dental procedure(s).
   c. Narrative/report that clearly substantiates that medical/dental management of the patient requires that GA be used on patient to safely perform the dental procedure(s). This includes but are not limited to failed or contraindicated use of local anesthesia, nitrous oxide, conscious sedation, and/or protective stabilization on patient; and
   d. A treatment plan itemizing a list of clinical procedures that will be performed under GA. If a provider cannot formulate a treatment plan based on patient's medical condition or behavior management issues, clinically justify the use of GA with dentistry in patient's case. The referring provider should maintain the referral report on file.

Note: GA approval does not guarantee that all services completed in the operating room will be covered. The provider should discuss with their patients that some dental procedures may not be covered by Medicaid.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		Narrative

Code D9310 is limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist 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.

1. Dental specialist billing the consultation code may provide treatment for which the consultation is obtained.
2. Limited to formally trained dental specialists for specialties as recognized by the American Dental Association.
3. The narrative must include the name of the referring provider and purpose of consultation. Appropriate referrals are an integral part of complete quality health care management.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9420 Hospital or ambulatory surgical center call 1. Dental reviewed – reason for the hospital call.		Narrative
D9440 Office visit – after regularly scheduled hours 1. Code D9440 is only billable in conjunction with an emergency service. This code should only be used when the dentist is returning to the office for an unscheduled emergency visit after the office has closed for the day. Emergency services performed during this visit may be billed separately. 2. A narrative describing the circumstances must be included with the claim, including the time of day the service was performed. 3. Dental reviewed-office hours for the day of treatment and time of treatment.		Narrative
D9999 Unspecified adjunctive procedure, by report 1. Used to cover children preventive/restorative benefits provided by FQHCs.		

14.9 ADULT DENTAL SERVICES (21 YEARS OF AGE AND OLDER) FOR EMERGENCY TREATMENT

Adult individuals 21 years of age or older are eligible for dental coverage limited to the treatment of dental emergencies and specific procedures necessary for the control or relief of dental pain, bleeding, elimination of infection of dental origin, management of trauma and/or treatment of acute injuries to teeth and supporting structures.

Services eligible for reimbursement are limited to basic diagnostic services associated with a beneficiary's emergent condition, chief complaint, and intervention. Restorative dentistry and prosthetics are excluded. Examples of emergency services include:

1. Extractions
2. Incision and Drainage of abscesses
3. Excision of pericoronal gingival
4. Surgical removal of residual roots
5. Closure of oroantral fistulas
6. Other medically necessary emergency dental services

Reference section 14.6 , page 12 for information on how to bill for emergency services.

Emergency Treatment

Please refer to section 14.6, page 12 for information on how to bill for emergency services.

14.9.1 Diagnostic

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0140 Limited oral evaluation – problem focused	A-T, 1-32 UR, UL, LR, LL UA, LA	1. Relating only to a dental emergency. 2. Limited to one per day. 3. Third party administrator may require documentation of findings, diagnosis and treatment plan.
D0220 Intraoral – periapical first radiographic image		1. Images must be of diagnostic quality and clinically necessary. 2. One per day.
D0230 Intraoral – periapical each additional radiographic image		1. Images must be of diagnostic quality and clinically necessary. 2. Not to exceed 4 per day.
D0330 Panoramic radiographic image		An adult claim for D0330 may be reimbursed under the following clinical circumstances: 1. Images must be of diagnostic quality and clinically necessary. 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 multiple quadrants and it is not practical to take multiple (5 or more) periapical images. d. Other circumstances deemed necessary by the Dental Review.

14.9.2 Oral & Maxillofacial Surgery

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	A-T, 1-32	
D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated 1. Requires removal of bone and/or sectioning of tooth. 2. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Pre-op radiographic image
D7220 Removal of impacted tooth – soft tissue 1. Occlusal surface of tooth covered by soft tissue. 2. Requires mucoperiosteal flap elevation. 3. One per lifetime. 4. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Pre-op radiographic image
D7230 Removal of impacted tooth – partially bony 1. Part of crown covered by bone. 2. Requires mucoperiosteal flap elevation and bone removal. 3. One per lifetime. 4. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Pre-op radiographic image

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7240 Removal of impacted tooth – completely bony	A-T, 1-32	Pre-op radiographic image
1. Most or all crown covered by bone. 2. Requires mucoperiosteal flap elevation and bone removal.		
D7241 Removal of impacted tooth – completely bony, with unusual surgical complications	A-T, 1-32	Pre-op radiographic image, Operative Report
1. Most or all crown covered by 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 course of the surgical procedure.		
D7250 Removal of residual tooth roots (cutting procedure)	A-T, 1-32	Pre-op radiographic image
1. Includes cutting of soft tissue and bone, removal of tooth structure and closure. 2. Tooth root(s) should be fully encased in bone (sub-osseous).		
D7260 Oroantral fistula closure		Radiographic image, Narrative
1. Dental reviewed – for description of the procedure completed. 2. Not applicable to an iatrogenic sinus exposure by the treating dentist.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7270 Tooth reimplantation and / or stabilization of accidentally evulsed or displaced tooth 1. Once per tooth per lifetime. 2. Dental reviewed – for description of the procedure completed.	1-32	Radiographic image, Operative report
D7285 Incisional biopsy of oral tissue – hard (bone, tooth) 1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.		Pathology Report
D7286 Incisional biopsy of oral tissue-soft 1. Not applicable to the routine removal of the periradicular inflammatory tissues, by report. 2. Requires the submission of the pathology report. 3. This service is denied when not submitted with a pathology report.		Pathology Report
D7410 Excision of benign lesion up to 1.25 cm 1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.		Pathology Report
D7411 Excision of benign lesion greater than 1.25 cm 1. Requires the submission of the pathology report. 2. This service is denied when not submitted with a pathology report.		Pathology Report

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7510 Incision and drainage of abscess – intraoral soft tissue	A-T, 1-32	Narrative
1. Requires separate surgical procedure involving tissue incision and drain placement as clinically necessary. 2. The narrative must include: clinical diagnosis and description of the procedure completed.		
D7970 Excision of hyperplastic tissue – per arch	UA, LA	Operative Report
1. Limited to edentulous areas.		
D7971 Excision of pericoronal gingiva	1, 2, 15, 16, 17, 18, 31-32	Operative report
Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted / impacted teeth. 1. This procedure applies to excision of tissue distal to the 2nd or 3rd molars.		

14.9.3 Adjunctive General Services

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9110 Palliative (emergency)treatment of dental pain – minor procedure	A-T, 1-32 UR, UL, LR, LL UA, LA	Narrative
1. Billable only once per visit regardless of the number of teeth treated. 2. 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. 3. Limited to one treatment per tooth per year. 4. Requires the performance of a treatment intervention to alleviate pain. May not be applied for consultation or issuance of prescription medication alone. 5. May not be billed with another treatment service performed on the same date.		

Dental Code Exception: D9230 inhalation of nitrous oxide/analgesia. Clinical Circumstance: Patients age 13 years and older; and procedure is necessary due to the patient being uncooperative and/or combative to the extent that safety is an issue with patient or staff. A prior authorization is recommended.

D9239 intravenous moderate (conscious) sedation/analgesia first 15 minutes 1. Refer to Sedation section for limitations on page 46-47. 2. Dental reviewed – see criteria in Section 14.8.10, page 44.		
D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment 1. Refer to Sedation section for limitations on page 46-47. 2. Dental reviewed – see criteria in Section 14.8.10, page 44.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9310 Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician		Narrative
Code D9310 is limited to cases in which a patient has been referred by a dentist to a formally trained dental specialist 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. 1. Dental specialist billing the consultation code may provide treatment for which the consultation is obtained. 2. Limited to formally trained dental specialists for specialties as recognized by the American Dental Association. 3. One per day. 4. Dental reviewed – for referring provider and purpose of consultation.		
D9420 Hospital or ambulatory surgical center call		Narrative
1. The narrative must include the reason for the hospital call.		
D9440 Office visit – after regularly scheduled hours		Narrative
1. Code D9440 is only billable in conjunction with an emergency service. This code should only be used when the dentist is returning to the office for an un-scheduled emergency visit after normal business hours. Emergency services performed during this visit may be billed separately. 2. A narrative describing the circumstances must be included with the claim, including the time of day the service was performed and documentation of business hours. 3. Dental reviewed-office hours for the day of treatment and time of treatment.		

14.10 TELE-DENTISTRY SERVICES

"Telehealth" means 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 an enabling technology intended to facilitate access for patients who would otherwise not receive services without the provider being physically present. "Teledentistry" is a form of telehealth and is referred to in this section to differentiate it from any medical claim processing procedure.

14.10.1 Reimbursement for Procedures Related to Fee-for-Service (FFS) Teledentistry Services

1. Eligible Dental Providers for Hawaii Medicaid
   Dental providers who are eligible to bill Hawaii Medicaid are also eligible providers to bill for telehealth. The criteria for eligible dental providers are the same regardless whether or not telehealth is utilized (e.g., DDS or DMD).

2. Eligible Dental Sites
   The criteria for eligible dental sites are the same regardless whether or not telehealth is utilized.

3. Eligible Codes
   The eligible codes for reimbursement will remain consistent with Memo QI-1702A (see Attachment A with the addition of code D0145. All eligible codes are subject to the processing policies as defined in Chapter 14 of the Medicaid Dental Provider Manual.

4. Billing Procedure
   All claims submitted for services enabled by teledentistry must include the individual NPI of the dentist providing services. In addition:
   a. The reimbursement fee schedule is based on the location of the eligible Medicaid provider at the time of service.
   b. All claims for services provided through telehealth technology must be identified by the applicable teledentistry CDT code D9995 (teledentistry-synchronous; real-time encounter) or D9996 (teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review). Both D9995 and D9996 have no fees assigned and are used to identify that the dental service was delivered via telehealth.
   c. All claims must indicate the treatment location of the patient at the time of service (originating site) in the "Remarks" section of the claim form. Treatment location is the location of the patient on the service date defined in Section 14.10.1.6 below.

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

   - Only one claim is allowed for each patient visit.

   - The service date on the claim is the date that the patient was treated at the originating site regardless of whether or not asynchronous or synchronous technology was utilized.

   - 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 actually seen), a notation in clinical records should explain the discrepancy for auditing purposes.

14.10.1.6 Treatment Location

The treatment location is the location of the patient where services were performed on the service date. Location information should include the name of the entity (for example: Roosevelt High School) and address (1120 Nehoa Street, Honolulu, 96822). If patients were visited at their primary place of residence then only the place of residence (e.g. Kihei Pua Emergency Shelter, Hale Makua Nursing home, private residence, etc.) needs to be indicated, and no address information is required.

14.10.2 Reimbursement for Procedures Related to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)Teledentistry Services

1. Eligible Dental Providers for Hawaii Medicaid
   Dental providers who are eligible to bill Hawaii Medicaid are also eligible providers to bill for telehealth. The criteria for eligible dental providers are the same regardless whether or not telehealth is utilized (e.g., DDS or DMD).

2. Eligible Dental Sites
   The criteria for eligible dental sites are the same regardless whether or not telehealth is utilized. Dental sites that qualify for FQHC Prospective Payment System (PPS) reimbursement (e.g. service sites registered as Medicaid providers and issued a HRSA Notice of Award identifying the specific service location address) also qualify for telehealth enabled PPS reimbursement. In order to qualify for PPS reimbursement for telehealth enabled services, the patient must be at an eligible FQHC/RHC site.

3. Eligible Codes
   The eligible codes for reimbursement for dental providers at the remote site will remain consistent with Memo QI-1702A (see Attachment A) with the addition of code D0145. All eligible codes are subject to the processing policies as defined in Chapter 14 of the Medicaid Provider Manual.

4. Billing Procedure
   All claims for services provided through telehealth technology must be identified by the applicable teledentistry CDT code D9995 (teledentistry-synchronous; real-time encounter) or D9996 (teledentistry-asynchronous; information stored and forwarded to dentist for subsequent review). Both D9995 and D9996 have no fees assigned and are used to identify that the dental service was delivered via telehealth. In addition, the following information must be included on the claim form when submitting for PPS:

   a. CDT code D9999 must be used to identify the claim for PPS payment. D9999 is used to identify the originating site as an eligible PPS dental site.

   b. All claims must be billed using the FQHC provider number and or the organizational NPI.

   c. All dental codes and fees describing the services provided must be included on the claim form.

   d. Only one PPS telehealth encounter by a FQHC dentist per originating site per day.

All claims must indicate the treatment location in the "Remarks" section of the claim form. Treatment location is the location of the patient on the service date defined in Section 14.10.2.9 below.

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

   - Only one claim is allowed for each patient visit.

   - The service date on the claim is based on the date that the patient was treated at the originating site regardless of whether or not asynchronous or synchronous technology was utilized.

   - 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 actually seen) , a notation in clinical records should explain the discrepancy for auditing purposes.

6. Effective Date
   Telehealth services rendered by an FQHC that meet the above criteria will be eligible for the PPS reimbursement effective July 1, 2018.

7. Non-Telehealth Enabled Services

   - When non-telehealth enabled services (e.g. D1120 Prophylaxis – child) are performed on the same service date as telehealth enabled services listed on Attachment A, reimbursement of the claim will be made at the PPS rate and not in addition to the PPS rate. The claim submission must include all services performed and follow the billing procedure described in item "4. Billing Procedure" of this section(14.10.2).

   - Medicaid eligible dental procedures not listed on Attachment A that are performed at eligible originating dental sites by a dental hygienist, but not in conjunction with telehealth enabled services will be reimbursed at the FFS rate unless a DDS or DMD was also physically present with the patient on the date of service. Example: D1120 , D1351 claim submission for services performed by a hygienist without a DDS or DMD physically present will be reimbursed at FFS.

8. FFS Billing
   All procedures performed at non-eligible dental sites that do not meet the requirements as defined in Section 14.10.2.2 will be reimbursed at the FFS rate.

   a. Claims for services enabled by telehealth technology must be identified by the applicable teledentistry CDT code D9995 or D9996.

   b. All claims should be submitted without code D9999.

   c. All claims must include treatment location information as described in Section 14.10.2.9.

   d. Each eligible billable procedure and fee must be indicated on the claim form.

   e. FFS billing must be submitted under the individual dental provider's number or NPI with payment made to the FQHC. FFS claims cannot be submitted using the FQHC service provider number.

14.10.2.9 Treatment Location

The treatment location is the location of the patient where services were performed on the service date. Location information should include the name of the entity (for example: Roosevelt High School) and address (1120 Nehoa Street, Honolulu, 96822). If patients were visited at their primary place of residence then only the place of residence (e.g. Kihei Pua Emergency Shelter, Hale Makua Nursing home, private residence, etc.) needs to be indicated, and no address information is required.

.

14.10.3 Attachment A

Attachment A
CDT Codes approved for Teledentistry

CDT	Description
D0120	Periodic oral evaluation - established patient
D0145	Oral evaluation for a patient under 3 years of age and counseling with 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