Chapter 14

Medicaid Provider Manual

Dental

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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 beneficiaries enrolled in the State of Hawaii Organ and Tissue Transplant (SHOTT) program. Dental claims for SHOTT enrollees should be submitted to Hawaii Medicaid's third party transplant administrator .The transplant administrator uses Hawaii Medicaid's policies and 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.

14.25 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 www.himed-questffs.org.

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.
- 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:

• group health plans • self-insured plans • managed care organizations • 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.

14.4 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.

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

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.

14.5 CLAIM SUBMITTAL

Claims may be submitted electronically via Clearinghouse, the HDS 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 two-visit endodontic procedure must be billed out upon completion on the second visit. A crown must be billed out 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 dentist
- Mailing address
- NPI
- Tax ID Number
- Servicing Provider (Please print name of servicing provider)

Do not code for multiple units on a single line item. When billing for three D0230 radiographic image(s), post them on three separate lines instead of one line posted as D0230 x 3. Claims are processed by line item rather than utilizing the modifier for number of units.

14.5.2 Billing Information for FQHC's

Federal Qualified Health Centers (FQHC) must submit procedure code D9999, which is used to cover Children's preventive/restorative benefits. FQHCs are required to submit the appropriate dental procedure codes for dentures for children to be reimbursed at the full rate. For adult emergency dental services, the FQHCs must submit procedure code D0140 and ICD-9 diagnosis code 525.9 for these adult emergency claims.
For service dates on and after October 1, 2015, use ICD-10 diagnosis code K08.9.

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 delayed or rejected claims:

For adult individuals 21 years of age and older, the ICD-9 diagnosis code 525.9 must be entered in the "Remarks" section of the claim submission, followed by the description - "Emergency Services 525.9." For service dates on and after October 1, 2015, use ICD-10 diagnosis code K08.9

Entering code "525.9" or the code "K08.9" on the claim form certifies that the rendered service was for an emergent situation. Before certifying this, be sure that the service was performed for the control of pain, for the treatment of infection, or for the management of trauma. Use the Remarks section of the claim form to provide a brief narrative which includes the clinical diagnosis and the treatment performed. Payment is based on medical necessity 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.

Services requiring prior authorization must be approved before services are rendered. Provision of services before receipt of the required prior authorization will result in the possible rejection of the claim and denial of payment. 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.

Clinical Oral Evaluation

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0140 Limited oral evaluation-problem focused 1. Limited to one per day. 2. Relating to a dental emergency only, should not be submitted if the patient is undergoing comprehensive care.		

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

D0120 Periodic oral evaluation-established patient

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

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.

D0210 Intraoral-complete series of radiographic images

1. Limited to one complete series per 5 service years.
2. Intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

D0220 Intraoral-periapical first radiographic image

1. Limited to one per day.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0230 Intraoral-periapical each additional radiographic image 1. Not to exceed 4 per day.		
D0240 Intraoral-occlusal radiographic image 1. Not to exceed 1 per day.		
D0270 Bitewing-single radiographic image **D0272** Bitewing-two radiographic images **D0274** Bitewing-four radiographic images 1. Limited to 2 times per service year and service dates no less than 4 months apart.		
D0290 Posterior-anterior or lateral skull and facial bone survey radiographic image 1. Limited to one per day.		Prior authorization
D0310 Sialography 1. Limited to one per day. 2. Dental reviewed, justification for this procedure is required.		Narrative
D0330 Panoramic radiographic image 1. Limited to one every 2 service years. Cannot be used with D0210. 2. Covered for Oral Surgeons when extracting tooth/teeth (regardless of frequency limit).		

Dental Code Exception: 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 prior authorization is required.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D0340 Cephalometric radiographic image		Prior authorization
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 **D0365** Cone beam CT capture and interpretation with field of view of one full dental arch - mandible **D0366** Cone beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium **D0367** Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium		Prior authorization, Narrative
1. Covered only when other radiographic/diagnostic imaging is not sufficient for proper diagnosis and/or treatment.		
Tests and Examinations		
D0470 Diagnostic casts		Prior authorization, Narrative
1. The narrative must indicate medical necessity.		

14.8.2 EPSDT Preventive

Dental Prophylaxis/Topical Fluoride Treatment/other Preventive Service
Prophylaxis and topical fluoride are covered two times per service year. When billing for prophylaxis and topical fluoride, use different codes for children between birth and age 14, and beneficiaries between the ages of 15 through 20. Prophylaxis and topical fluoride are not covered for beneficiaries age 21 and over.

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

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.) Prior authorization and a narrative are required.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D1206 Topical application of fluoride varnish		
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	2,3,14,15,18,19 30, 31	

1. A tooth may be resealed every 5 service years if necessary.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
Space Maintenance (Passive Appliances)		
D1510 Space maintainer – fixed unilateral **D1515** Space maintainer – fixed bilateral 1. 4 per 2 service years. 2. Limit 2 per day.	A-T, 2-15, 18-31	
D1550 Re-cement or rebond space maintainer **D1555** Removal of fixed space maintainer 1. Once per year after 6 months from the initial placement.	A-T, 2-15, 18-31	

Dental code exceptions:

D1510, D1515, D1555. Exceeds the frequency coverage limit; and necessary to replace space maintainer if dislodged from tooth (cannot be recemented), lost or broken. A prior authorization is required.

14.8.3 EPSDT Restorative

Routine 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 **D2150** Amalgam – two surfaces, primary or permanent **D2160** Amalgam – three surfaces, primary or permanent **D2161** Amalgam – four or more surfaces, primary or permanent	A-T, 1-32	1. Separate multiple restorations per tooth are not covered. 2. Duplicated restorative surface(s) – one per tooth per 2 years.
D2330 Resin-based composite – one surface, anterior **D2331** Resin-based composite – two surfaces, anterior **D2332** Resin-based composite – three surfaces, anterior **D2335** Resin-based composite – four or more surfaces or involving incisal angle (anterior)	C-H, M-R, 6-11, 22-27	1. Separate multiple restorations per tooth are not covered. 2. Duplicated restorative surface(s) – one per tooth per 2 years.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2391 Resin-based composite – one surface, posterior	A, B, I, J, K, L, S, T 1-5, 12-14, 15-21, 28-32	
D2392 Resin-based composite – two surfaces, posterior		
D2393 Resin-based composite – three surfaces, posterior		
D2394 Resin-based composite – four or more surfaces, posterior		

1. Separate multiple restorations per tooth are not covered.
2. Duplicated restorative surface(s) – one per tooth per 2 years.

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 prior authorization, narrative and radiographic image(s) are required; include the key word "Benefit Exception" in the remarks section.

Crowns

Radiographic images must be submitted with the prior authorization request and are not required when submitting the claim for payment unless requested by the third party administrator.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2740 Crown – porcelain/ceramic substrate **D2750** Crown – porcelain fused to high noble metal **D2790** Crown – full cast high noble metal **D2752** Crown – porcelain fused to noble metal **D2792** Crown – full cast noble metal	2-15, 18-31	Prior authorization, Radiograph

1. Limited to cases involving endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of the clinical crown (anterior).
2. One per tooth every five years.
3. Includes associated temporary crowns.

Dental code exceptions: D2740, D2750, D2752, D2790, 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 and radiographic image(s) are required. Include the key word “Benefit Exception” in the remarks section.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2910 Recement or rebond inlay, onlay, veneer or partial coverage restoration	A-T,1-32	
D2920 Recement or rebond crown 1. One per tooth per day after 6 months from the initial placement.		
D2930 Prefabricated stainless steel crown-primary tooth	A-T	
D2931 Prefabricated stainless steel crown-permanent tooth	2-15, 18-31	
D2932 Prefabricated resin crown	C-H, M-R	
D2933 Prefabricated stainless steel crown with resin window	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 loss of greater than 40% of the clinical crown (anterior). 2. One per tooth per year.	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.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D2950 Core buildup, including any pins when required 1. 1 per tooth every five years.	2-15, 18-31	
D2951 Pin retention-per tooth, in addition to restoration	2-15, 18-31	
D2952 Post and core in addition to crown, indirectly fabricated **D2954** Prefabricated post and core in addition to crown 1. 1 per tooth every five years.	2-15, 18-31	
D2970 Temporary crown (fractured tooth) **(This code ends on 12/31/2015)** 1. Limited to cases involving endodontic treatment, loss of at least one major cusp or loss of not less than 40% of the clinical crown (anterior). 2. A radiographic image and a narrative that details the clinical circumstances of the fractured tooth are required for payment.	2-15, 18-31	Narrative, Radiograph

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	A-T	
D3222 Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development 1. 1 per tooth per lifetime.	2-15, 18-31	
D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	C-H, M-R	Prior authorization, Pre-op radiograph
D3240 Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration) 1. One per tooth per lifetime.	A, B, I-L, S,T	
D3310 Endodontic therapy – anterior tooth (excluding final restoration)	6-11, 22-27	Post-op radiograph
D3320 Endodontic therapy – bicuspid tooth (excluding final restoration)	4, 5,12,13, 20, 21, 28, 29	

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3330 Endodontic therapy – molar (excluding final restoration)	2, 3,14,15, 18,19, 30,31	Post-op radiograph

1. One per tooth per lifetime.
2. Final post-operative radiographic image must demonstrate final and complete obturation of the root canal system.
3. 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.

D3346 retreatment of previous root canal therapy-anterior	6-11, 22-27	Prior authorization, Pre-op radiograph
D3347 retreatment of previous root canal therapy-bicuspid	4, 5,12,13, 20, 21, 28, 29	
D3348 retreatment of previous root canal therapy-molar	2, 3,14,15, 18,19, 30,31	

1. Retreatment of RCT is covered only for special circumstances.
2. A prior authorization is required and the request will be reviewed on an individual basis.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D3351 Apexification/ recalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc.) 1. One per tooth per lifetime.	2-15, 18-31	Pre-op radiograph
D3352 Apexification/ recalcification-interim medication replacement 1. One 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. One per tooth per lifetime.	2-15, 18-31	Post-op radiograph
D3410 Apicoectomy - anterior **D3421** Apicoectomy - bicuspid (first root) **D3425** Apicoectomy - molar (first root) 1. One per tooth per lifetime.	6-11, 22-27 4, 5,12,13, 20, 21, 28, 29 2, 3,14,15, 18,19, 30,31	Prior authorization, Pre-op radiograph

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 **D4342** Periodontal scaling and root planing – one to three teeth per quadrant	UL, UR, LL, LR 1-32	Prior authorization, Periodontal chart, Narrative, Radiograph
1. Limited to once every 24 months per quadrant/teeth/tooth. 2. Periodontal pocket depth measurements must be documented within 6 months of the date of service and show 4mm or greater. 3. The narrative must detail special circumstances and include a periodontal diagnosis. 4. Services are benefited on an individual basis.		
D4355 Full Debridement to enable comprehensive evaluation and diagnosis		Prior authorization
D4910 Periodontal maintenance		Prior authorization, Periodontal chart

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

14.8.6 Prosthodontics (Removable)

Dentures
Denture benefits allow beneficiaries one (1) set of prosthetic appliances in any five (5) year period.

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.

Prior authorization must be submitted and must include documentation of missing teeth. 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 and must be laboratory processed (in-office and other cold cure relines are not covered). 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 **D5120** Complete denture - mandibular		Prior authorization, Documentation of missing teeth
1. Limited one per five years. 2. Tooth chart and/or current radiographic image(s) with labeled teeth numbers are acceptable to document missing teeth. Documentation should be dated and reflect the current status of the dentition.		
D5130 Immediate denture – maxillary **D5140** Immediate denture - mandibular		Prior authorization, Documentation of missing teeth
1. Limited one per five years. 2. Tooth chart and/or current radiographic image(s) with labeled teeth numbers are acceptable to document missing teeth. Documentation should be dated and reflect the current status of the dentition.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) **D5212** Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) **D5213** Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) **D5214** Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		Prior authorization, Documentation of missing teeth

1. Limited one per five years.
2. Tooth chart and/or current radiographic images(s) with labeled teeth numbers are acceptable to document missing teeth. Documentation should be dated and reflect the current status of the dentition.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5410 Adjust complete denture-maxillary **D5411** Adjust complete denture-mandibular **D5421** Adjust partial denture-maxillary **D5422** Adjust partial denture-mandibular 1. Limited one per day.		
D5510 Repair broken complete denture base **D5520** Replace missing or broken teeth – complete denture (each tooth) 1. Three per day.		
D5610 Repair resin denture base **D5620** Repair cast framework **D5630** Repair or replace broken clasp 1. One per day.		
D5640 Replace broken teeth – per tooth 1. Three per day.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5650 Add tooth to existing partial denture 1. One per day.		
D5660 Add clasp to existing partial denture 1. Two per day.		
D5710 Rebase complete maxillary denture **D5711** Rebase complete mandibular denture **D5720** Rebase maxillary partial denture **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
D5750 Reline complete maxillary denture (laboratory) **D5751** Reline complete mandibular denture (laboratory) **D5760** Reline maxillary partial denture (laboratory) **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 two (2) years.		Prior authorization

14.8.7 Maxillofacial Prosthetics

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D5925 through D5999		Prior authorization, Narrative

See specific codes in the current CDT manual.

1. A detailed narrative/report is required with the prior authorization and with the submission of a claim.
2. Dental reviewed - for confirmation of completed procedure.
3. A narrative/report is required at the time the claim is submitted.

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 periapical or panoramic radiographic image(s) must clearly demonstrate the involved tooth/teeth and must accompany all extraction claims except for procedure code D7140.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7111 Extraction, coronal remnants – deciduous tooth	A-T	
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) 1. One per lifetime.	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. One per lifetime. 2. Requires removal of bone and /or sectioning of teeth. 3. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Radiograph

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
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	Radiograph
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	Radiograph
D7240 Removal of impacted tooth – completely bony 1. Most or all 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	Radiograph
D7241 Removal of impacted tooth – with unusual surgical complications 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. One per lifetime. 4. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Radiograph

Dental code exceptions: Supernumerary teeth- D7140, D7210, D7220, D7230, D7240, D7241. Clinical circumstances: Tooth may be in a position that detrimentally affects surrounding teeth.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7250 Surgical 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). 4. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Radiograph
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-T, 1-32	Radiograph, Operative Report
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth 1. 1 tooth per lifetime. 2. Dental reviewed – for description of the procedure completed.	A-T, 1-32	Radiograph, Operative Report
D7280 Surgical access of an unerupted tooth **D7282** Mobilization of erupted or malpositioned tooth to aid eruption **D7283** Placement of device to facilitate eruption of impacted tooth 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.	2-15, 18-31	Prior authorization, Radiograph

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7285 Incisional biopsy of oral tissue – hard (bone, tooth)	2-15, 18-31	Radiograph, Pathology report
1. Requires the submission of the pathology report.		
D7286 Incisional biopsy of oral tissue – soft	2-15, 18-31	Pathology report
1. Requires the submission of the pathology report. 2. Not applicable to the routine removal of the periradicular inflammatory tissues.		
D7310 Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	UR, UL, LR, LL	Prior authorization
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	1-32	Prior authorization
D7320 Aveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	UR, UL, LR, LL	Prior authorization
D7321 Aveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	1-32	Prior authorization
1. 4 per day.		

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7410 Excision of benign lesion up to 1.25 cm **D7411** Excision of benign lesion greater than 1.25 cm 1. Requires the submission of the pathology report.		Pathology Report
D7510 Incision and drainage of abscess-intraoral soft tissue 1. Requires separate surgical procedure involving tissue incision and drain placement.	A-T, 1-32	Operative Report
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure 1. One per lifetime. 2. The narrative must include a diagnosis and medical/clinical necessity.	A-T, 1-32	Narrative
D7970 Excision of hyper-plastic tissue – per arch 1. Limited to edentulous areas.	UA, LA	Operative Report
D7971 Excision of pericoronal gingiva 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.	1, 2, 15, 16, 17, 18, 31-32	Operative Report

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 and treated at the Kapiolani Children's Cleft and Cranial Facial Center (KCCCFC) during orthodontic treatment.

Orthodontic services require a prior authorization that includes medical and 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, KCCCFC will provide (to the Dental Consultant) periodic progress/treatment notes for each child undergoing Phase I or II treatment when applicable to client. 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 submitted. Audits may be performed to verify that treatments are completed. Cases in which treatment is not completed will result in recoupment of funds.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8010 Limited orthodontic treatment of the primary dentition **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. Include, diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation-problem focused (D0160), and braces if necessary.		Prior authorization
D8050 Interceptive orthodontic treatment of the primary dentition **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. Include, diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation-problem focused (D0160), and braces if necessary.		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8070 Comprehensive orthodontic treatment of the transitional dentition		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. Include, diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation- problem focused (D0160), and braces if necessary.		
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. Include, diagnostic casts (D0470), photographic images (D0350), pre-orthodontic treatment visit (D8660), detailed and extensive oral evaluation-problem focused (D0160), and braces if necessary.		Prior authorization

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D8660 Pre-orthodontic treatment examination to monitor growth and development		Narrative

1. The narrative must indicate that subsequent patient treatment was not implemented or started.
2. A prior authorization for orthodontic treatment must be approved.
4. The provider is not reimbursed for limited (D8010, 8020) interceptive (D8050 and D8060) and comprehensive (D8070, D8080, and D8090) orthodontic treatment.

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, the area of the oral cavity and/or teeth involved and the specific treatment involved.
4. Limited to one treatment per tooth per year.

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.
   a. The child's medical/dental condition is such that inhalation of nitrous oxide, oral surgery/operative dentistry can be safely performed in the office setting.
   b. The child must be able to correctly use the mask and inhale, and follow instructions of the dentist.
3. Supporting documentation must be maintained in the dental record that includes all of the following:
   a. Brief statement justifying the medical need for use on the specific patient;
   b. Sedation record.
   c. An itemized 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. Note: refer to the qualifications to administer nitrous oxide for coverage. A prior authorization is recommended.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9241 Intravenous-moderate (conscious) sedation/analgesia, anxiolysis - first 30 minutes **(This code ends on 12/31/2015)**		Supporting Documentation
D9242 Intravenous-moderate (conscious) sedation/analgesia - each additional 15 minutes **(This code ends on 12/31/2015)**		
D9243 Intravenous moderate (conscious) sedation/analgesia –each 15 minutes increment **(This code starts from 1/1/2016)**		

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.
3. The medical/dental management of the patient requires that the patient be sedated to safely perform the dental procedure.
4. Supporting clinical documentation must be submitted with the claim that clearly and legibly substantiates:
   a. That the patient is combative; or
   b. That the patient is uncooperative and that in the provider's judgment, the dental procedure cannot be performed safely without sedation.
5. Supporting clinical documentation must be submitted with the claim and include all of the following:
   a. Medical history
   b. Sedation record
   c. Diagnosis
   d. Pre-surgical radiographic image(s)
   e. Post-operative reports

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. 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, or 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. This can be a result of an acute infection, allergy to local anesthesia, or anatomical variation.

      Or

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

   c. Dental treatment cannot be performed safely or effectively in an office using adjunctive techniques or modalities such as behavioral management techniques, protective stabilizations, medications, nitrous oxide or conscious sedation.

2. Supporting clinical documentation must be submitted with the prior authorization and include the following:
   a. Medical diagnosis of patient;
   b. Medical clearance by primary physician;
   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.

Note: GA approval does not purport that all services completed in the operating room will be covered; rather, services will require a prior authorization (PA) if known prior to treatment. A retroactive PA may be submitted for non-covered services not known prior to treatment. 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. The dental specialist billing the consultation code may provide the treatment for which the consultation is obtained. A written report of the consultation results must be returned to the referring dentist and documented in the patient's record. Not applicable for patients seen at long term care facilities.

1. Dental specialist billing the consultation code may provide treatment for which the consultation is obtained.
2. Limited to formally trained dental specialists.
3. One per day.
4. Dental reviewed – for referring provider and purpose of consultation.

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D9420 Hospital or ambulatory surgical center call 1. One per day. 2. 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, 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 surgical intervention. Restorative dentistry and prosthetics are excluded. Reference section 14.6 Emergency Treatment Claim Submission.

Emergency Treatment

Emergency treatment may be charged once per tooth per benefit year. These services may control bleeding, relieve pain, eliminate acute infection, and/or treat injuries to the teeth or supporting structures. Examples of emergency services include:

1. Extractions
   a. No prior authorization required for the following procedure codes: D7140; D7210; D7220; D7230; D7240; D7241; D7250
   b. Periapical or panoramic radiographic image(s) clearly showing the involved tooth/teeth must accompany the claim except for procedure code D7140. If the radiographic image is not attached to the claim, the payment will default to the extraction fee of D7140.
2. Incision and drainage of abscesses
3. Excision of pericoronal gingiva
4. Surgical removal of residual tooth roots
5. Closure of oroantral fistulas
6. Gingivectomy for gingival hyperplasia associated with medical conditions or treatment
7. Other medically necessary emergency dental services

Please refer to section 14.6, page 11 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 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. One per day.		
D0230 Intraoral – periapical each additional radiographic image 1. Not to exceed 4 per day.		
D0330 Panoramic radiographic image An adult claim for D0330 may be reimbursed under the following clinical circumstances: 1. 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) 1. One per lifetime.	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. One per lifetime. 3. Dental reviewed – for use of appropriate extraction code.	A-T, 1-32	Radiograph
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	Radiograph
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	Radiograph

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7240 Removal of impacted tooth – completely bony	A-T, 1-32	Radiograph
1. Most or all 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.		
D7241 Removal of impacted tooth – completely bony, with unusual surgical complications	A-T, 1-32	Radiograph
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. One per lifetime 4. Dental reviewed – for use of appropriate extraction code.		
D7250 Surgical removal of residual tooth roots (cutting procedure)	A-T, 1-32	Radiograph
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). 3. Dental reviewed – for use of appropriate extraction code.		
D7260 Oroantral fistula closure		Radiograph, 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. 1 tooth per lifetime. 2. Dental reviewed – for description of the procedure completed.	1-32	
D7285 Biopsy of oral tissue – hard (bone, tooth) 1. Requires the submission of the pathology report.		Pathology Report
D7286 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.		Pathology Report

Code	Valid Tooth/Quad/Arch	Submission Requirement(s)
D7410 Excision of benign lesion up to 1.25 cm **D7411** Excision of benign lesion greater than 1.25 cm 1. Requires the submission of the pathology report.		Pathology report
D7510 Incision and drainage of abscess – intraoral soft tissue 1. Requires separate surgical procedure involving tissue incision and drain placement. 2. Dental reviewed – for description of the procedure completed.	A-T, 1-32	Narrative
D7970 Excision of hyperplastic tissue – per arch 1. Limited to edentulous areas.	UA, LA	Operative report
D7971 Excision of pericoronal gingiva 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.	1, 2, 15, 16, 17, 18, 31-32	Operative report

14.9.3 Adjunctive General Services

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

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

1. Billable only once per visit regardless of the number of teeth treated.
2. Not covered if performed within 14 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, the area of the oral cavity and/or teeth involved and the specific treatment involved.
4. Limited to one treatment per tooth per year.

Dental Code Exception: D9230 inhalation of nitrous oxide/analgesia, anxiolysis. Clinical Circumstance: Procedure is necessary due to the patient being uncooperative and/or combative to the extent that safety is an issue with patient or staff. Note: refer to the qualifications to administer nitrous oxide for coverage. A prior authorization is recommended.

D9241 Intravenous-moderate (conscious) sedation/analgesia - first 30 minutes
(This code ends on 12/31/2015)

D9242 Intravenous-moderate (conscious) sedation/analgesia - each additional 15 minutes
(This code ends on 12/31/2015)

D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minutes increment
(This code starts from 1/1/2016)

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. The dental specialist billing the consultation code may provide the treatment for which the consultation is obtained. A written report of the consultation results must be returned to the referring dentist and documented in the patient's record. Not applicable for patients seen at long term care facilities.

1. Dental specialist billing the consultation code may provide treatment for which the consultation is obtained.
2. Limited to formally trained dental specialists.
3. One per day.
4. Dental reviewed – for referring provider and purpose of consultation.

D9420 Hospital or ambulatory surgical center call		Narrative

1. One per day.
2. Dental reviewed – reason for hospital call.

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

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 un-scheduled 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.