DENTAL SERVICES COVERAGE POLICY

Introduction

Dental services are a benefit to eligible recipients under the Rhode Island Medicaid Dental Services Program.

General Policy Requirements

The Medicaid Program will only reimburse providers for medically necessary services. The Medicaid Program conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the Medicaid Program, trained medical consultants, and independent State and private agencies under contract with the Medicaid Program. Services that are denied by Medicare because they are not medically necessary are not reimbursable by the Medicaid Program.

Providers must bill the Medicaid Program at the same usual and customary rates as charged to the self-pay general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medicaid. Payments to providers will not exceed the maximum reimbursement rate of the Medicaid Program.

Purpose of Coverage Policy

The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for Medicaid under the Medicaid Program. The General Rules for the Medicaid Program and the rules in this policy are to be used together to determine eligibility for services.

Recipient Eligibility

Recipient eligibility should be verified before services are provided to determine dental coverage and limits.

Retroactive Eligibility

Procedures billed retrospectively for recipients who have retroactive eligibility are valid if all conditions for billing are met.

Scope of Services

The Medicaid Program provides payment only for services that are included in the scope of services described in the Office of Health and Human Services (OHHS) Manual at Section 033.20, Section 0348 for the RIte Care Program, or under a waiver program at Section 0398; or for recipients under the age of 21 pursuant to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, for additional services that are not included in the above sections, and that are definable under Section 1905(a) of the federal Social Security Act. Specific details of services covered and limitations thereon are contained in the Medicaid Program Provider Reference Manuals, the Rhode Island Title XIX State Plan, Section 1115 and Section 1915 Waiver requests, and the RIte Care Program Managed Care Plan and Contracts. Payment is not made for services other than those described herein.

Medical Necessity

The Medicaid Program provides payment/allowance for covered services only when the services are determined to be medically necessary.

The term “medical necessity” or “medically necessary service” means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a detrimental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Appeal of Denial of Medical Necessity

Determinations made by the Medicaid Program are subject to appeal by the recipient only. Providers may not appeal denials of Medical Necessity.

Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. The route of appeal for Title XIX recipients is through the OHHS. RiteCare and RIteSmiles participants may first appeal through the managed care plan, or may appeal directly through the OHHS.

Medicaid payments are provided only for covered services that are determined to be medically necessary. No Medicaid payment will be made for a medical procedure of an investigative or experimental nature.

Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the Health Care Quality, Financing and Purchasing Division, and by individuals and organizations under contract to the OHHS. Policies relative to medical necessity are set forth in the OHHS Manual, the Medicaid Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act. Medical necessity can be determined on procedure-by-procedure basis.

Approval of Medical Necessity

The Medicaid Program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the Medicaid Program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medicaid Program will determine the provider's recommendation to be medically necessary. The Medicaid Program is the final arbiter of determination of medical necessity.

Investigative/ Experimental Medical Procedures

Medical procedures of an investigative or experimental nature are not covered by the Medicaid Program.

A service that is furnished for research purposes in accordance with medical standards is considered experimental or investigational. A procedure is determined to be investigative or experimental according to the current judgment of the medical community as evidenced by medical research, studies, journals or treatises.

The Medicaid Program determines whether a treatment, procedure, facility, drug, or supply (each of which is hereafter called a "service") is experimental or investigational. Medicaid uses the following criteria to determine if a service is experimental of investigational:

1. The service is not yet approved by the appropriate governmental regulatory body or the service is approved for a purpose other than the purpose for which it is furnished; or

2. Demonstrated reliable evidence shows the service is (a) the subject of ongoing Phase I or II clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; (b) the subject of a written investigational or research protocol; or (c) the subject of a written informed consent use by the treating facility when the written consent is obtained to assure that the patient acknowledges the non-standard nature of treatment.

Demonstrated Reliable Evidence

Demonstrated reliable evidence means: evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature; and/or final approval of the service from the appropriate governmental regulatory body, demonstrating:

a) definite, measurable, positive effects of the service on health outcomes, with results supported by positive endorsements of national medical bodies or panels regarding their scientific efficacy and rationale; and proof that, over time, the beneficial effects of the service outweigh any harmful effects;

b) risk-benefit ratios as factorable as, if not better than, those of conventional treatments and significant advantages over such conventional treatments;

c) improvement in health outcomes possible under the standard conditions of medical practice, outside the clinical investigatory settings;

d) The service is at least as beneficial in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

Denial of Medical Necessity

When the Medicaid Program is requested to pay directly (fee-for-service) for a particular service for a recipient who has other third-party coverage (such as Medicare or Blue Cross), for that particular service, if the third party denies payment for services based on medical necessity, this determination is adopted by the Medicaid Program. An independent determination of medical necessity is not made in such circumstances. For example, if federal Medicare

determines that a home health service is not medically necessary, then that determination is binding on the Medicaid Program and Medicaid payment of the service cannot be made.

Third Party Liability
The Medicaid Program is the payer of last resort. All third-party programs must be utilized before any payment can be made by the Medicaid Program.

If payment from other third parties is equal to or exceeds the Medicaid Program allowable amount, no payment will be made on the claim by the Medicaid Program. If the third party denies payment for any reason related to non-conformity to the plans policies and/or rules, the EOB will be rendered invalid and the Medicaid Program will not consider the claim for payment

The Medicaid payment is considered payment in full. The Provider is not allowed to bill the recipient for any additional charges not paid for by the program.

Provider Participation
Dental providers must be licensed by the Rhode Island Department of Health, or by the appropriate agency in the state in which they practice, and enrolled in the Medicaid Program to receive reimbursement for dental services.

License renewal
Providers' licenses are renewed biannually by through RIDOH. Providers must forward a copy of the renewed license to DXC. DXC should receive this information at least five business days prior to the expiration date of the license. Failure to do so will result in suspension from the program.

Claims Billing Guidelines
Claims should be filed electronically. For situations that require manual (paper) submission, those claims must be billed on the ADA 2012 dental claim form. Instructions for completing the ADA dental claim form are located EOHHS website. Medicaid will use the Current Dental Terminology (CDT) procedure codes.

Reimbursement Guidelines
The Medicaid Program will not pay for canceled or missed office visits.

Prior Authorization
For some procedures, prior authorization is required before services are performed, unless the service is an emergency. Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies or traumatic injuries. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

Prior authorization does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service. If there is a verifiable emergency service which requires prior authorization, and needs to be done immediately, the procedure should be performed and the PA requested retroactively. The consultants will review these claims and consider them for payment. The Medicaid Program Dental policy designates those codes, which require prior authorization.

Payment for any prior authorization services can only be made if the services are provided while the person remains eligible for the Rhode Island Medicaid Program. If the case is closed after prior authorization has been granted, but before treatment has been completed, only those services provided while the person was eligible can be considered for payment by the Rhode Island Medicaid Program.

Services Reviewed by Medicaid
The Medicaid Program reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.

Consultants
The Office of EOHHS, in consultation with the Rhode Island Dental Association, contracts with General Practice consultants, Oral Surgery consultants, and Orthodontic consultants for professional review of specific services or billings before payment will be authorized by the Medicaid Program.

If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied.

The Rhode Island Dental Association will be requested to provide peer review on specific issues through the regularly established peer review system of the Association. The prevention of fraud and abuse may be pursued at the discretion of the Rhode Island Medicaid Program and is not limited to Rhode Island Dental Association peer review.

Individual Consideration

Requests for payment for dental services listed as “IC”, must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or X-rays. Payment for "IC" procedures will be approved in consultation with a Medicaid dental consultant.

Medicaid Requests for radiographs

Medicaid, in the process of utilization review and/or in determining its responsibility for payment of dental services, may request the treating dentist to submit appropriate radiographs and/or other clinical information, which justifies the treatment to the Medicaid Program. Payment may be denied if the requested radiographs and/or other clinical information are not submitted. Any procedure for which prior authorization was not required must be verified, as necessary, by preoperative and post-operative radiographs or other means prior to payment.

Emergency Dental Services

Payments for emergencies are restricted to services defined as "Emergency Services" (see Definitions of Terms in this section below).

Emergency services do not require prior authorization by Medicaid. Documentation of the need for the emergency services is the responsibility of the provider and subject to audit by Medicaid.

Procedures Never Considered Emergencies

The following procedures are never considered to be of an emergency nature:

- Appliances (not related to immediate trauma/injury)
- Dentures, full or partial
- Exostosis (Tori) removal
- Flippers (stay plates)
- Frenectomy, Frenulectomy
- Gingivectomy, Gingivoplasty
- Remake or repair of Archwire
- Space maintainers
- Tissue Conditioning

Services Considered Part of Total Treatment - Not Separate Services

The following services do not warrant an additional fee and are considered to be either a service that is included in the examination, part of another service, or included in routine post-op or follow-up care:

- Alveolectomy, in Conjunction with Extractions
- Analgesia
- Cardiac Monitoring
- Diagnostic Cast construction (study models)
- Diagnostic Photographs
- Dietary Counseling
- Direct and Indirect Pulp Capping
- Dressing Change
- Electrosurgery
- Equilibration of Occlusion
- File Broken Tooth
- Local Anesthesia
- Medicated Pulp Chambers
- Odontoplasty
- Oral Hygiene Instruction
- Periodontal Charting, Probing
- Post Extraction Treatment for Alveolitis
- Pulp Vitality Tests
- Special Infection Control Procedures

- Surgical procedure for isolation of tooth with rubber dam
- Surgical Splint Construction
- Surgical Stent Construction
- Suture Removal

Definition of Terms

Emergency Services are covered services requiring immediate treatment. This includes services to control hemorrhage, relieve pain, and/or eliminate acute infection. This includes immediate treatment of injuries to both dentition and supporting structures, but does not include permanent restorations.

The emergency rule applies only to covered services. Some non-covered services may meet the criteria of emergency, but it is not intended to extend to those non-covered services. Routine dental treatment of incipient decay does not constitute emergency care.

Preventive Services
This includes the following services:

- Oral Prophylaxis (cleaning of teeth)
- Topical Fluoride Treatment
- Placement of Sealants
- Space maintainers for prematurely lost primary posterior teeth

Therapeutic Services
This includes the following services:

- Pulp therapy of permanent and primary teeth - restricted to recipients under age 21
- Restorations of primary and permanent teeth using amalgam, composite materials and/or stainless steel or polycarboxylate
- Subgingival scaling and curettage
- A removable prosthesis when masticatory function is impaired such as is found with less than six (6) opposing teeth

Covered Services
Covered Services are those services that will be reimbursed to a provider for an eligible recipient as defined in the Dental Services Provider Reference Manual.

General Anesthesia
General Anesthesia is defined as a controlled state of unconsciousness including the inability to independently maintain an airway or to respond purposefully to physical stimulation or verbal command – ***restricted to recipients under age 21 only.***

The use of the following drugs either alone or in combination with other drugs is conclusively presumed to produce general anesthesia:

- Ultra short acting barbiturates including but not limited to sodium methohexital, thiopental, thiamylal other general anesthetics including, but not limited to, ketamine or etomidate

Sedation
Sedation involves the administration of a sedative drug intravenously (in a single injection or injected over an extended period), intramuscularly, submucosally, or subcutaneously.

Restricted to individuals under age 21
Services with this limitation can only be provided under the Rhode Island Medicaid Dental Services Program to individuals who have not attained their 21st birthday prior to the delivery of the service.

Services Not Covered

Procedure codes not listed in the Medicaid Dental Fee Schedule are services not covered under the Medicaid Dental Services Program. The following general categories of dental services are not covered, except if deemed medically necessary for patients less than 21 years of age.

- Crowns (Types: ceramco, gold, or other full cast, and porcelain fused to metal)
- Crowns for Bicuspids and Molars
- Desensitization
- Extensive Periodontal Surgery
- Fixed Bridges
- Implants
- Occlusal Equilibration
- Root Canal Therapy for Bicuspids and Molars

Nursing Home Services

Payment is covered for Medicaid recipients for dental services provided in a nursing home or long-term care facility by reporting the appropriate code in addition to the code for actual dental services performed. Fees for all endodontic and oral surgery procedures include the fee for the examination and necessary X-rays.

Mobile Dental Services in Nursing Homes - Please see separate Certification Standards

Covered Services

The following dental services and procedure codes are covered by the Medicaid Program with limitations, where noted.

Explanation of Symbols and Tooth Numbering System –

Age Restriction –
• <21 = Service can only be provided to recipients under age 21, N = No age restrictions

Prior Authorization –
• Y = PA is Required, N = No PA is Required

Anterior Teeth –
• will include teeth number 6-11, D-G and 22- 27, N-Q

Posterior Teeth –
• will include all others not considered anterior teeth

DIAGNOSTIC SERVICES

Clinical Oral Examinations

A Comprehensive Oral Evaluation is defined as the first exam for a new patient in the dental office. This replaced the initial Oral Exam and each recipient is limited to one Comprehensive Oral Exam per lifetime from the same provider. Each exam after the Comprehensive exam will be paid on the basis of a periodic exam.

The codes in this section have been revised to recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately

	Age Restriction	PA Requirement
D0120 Periodic Oral Evaluation	**N**	**N**

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

Periodic exams are allowed twice per calendar year, per recipient.

D0140 Limited Oral Evaluation - problem focused **N** **N**

An evaluation or re-evaluation limited to a specific oral health problem. This may require interpretation of information acquired through additional diagnostic procedures. Emergency examinations based on documented need are allowed per emergency episode. Definitive procedures may be required on the same date as the evaluation. Do not bill for an emergency examination for each visit during the treatment.

Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.

D0145 Oral Evaluation for a Patient Under the Age of Three Years and Counseling with Primary Caregiver **<3** **N**

D0150 Comprehensive Oral Evaluation **N** **N**

Replaces the former Initial Oral Evaluation procedure- Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions, including periodontal charting, hard and soft tissue anomalies, complex temporomandibular dysfunction, facial pain of unknown origin, severe systemic diseases requiring multidisciplinary consultation, etc.

D0160 Detailed and Extensive Oral Evaluation – problem focused, by report **N** **N**

A detailed and extensive problem-focused evaluation of a specific oral health issue. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required based on the findings of a Comprehensive Oral Evaluation. The condition requiring this type of evaluation should be described and documented.

D0180 Comprehensive Periodontal Evaluation **<21** **N**

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer screening.

RADIOGRAPHS / DIAGNOSTIC IMAGING

Radiographs / diagnostic imaging are appropriate only for clinical reasons as determined by a dentist. The films should be of diagnostic quality and properly identified and dated. The results are a part of the patient's clinical record and the original films should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

Radiographs

The Medicaid Program will allow items in accordance with the provisions of Dental Services policy, with the following limitations:

Intraoral-complete series (D0210) are allowed once every 1460 days (four years).

Panoramic films (D0330) are limited to one every 1460 days (four years).

Ideally, Intraoral-complete series and Panoramic Radiographs should be performed in alternate years.

X-rays for routine screening, i.e., Bitewing services - single film (D0270), two films (D0272), three films (D0273) and four films (D0274), are allowed once every calendar year, per client. D0274 cannot be performed with D0272 on the same day.

Payment for some or all multiple X-rays of the same tooth or area may be denied if Medicaid determines the number to be excessive.
The total payment for periapical and/or other radiographs cannot exceed the payment for a complete intraoral series.

D0210 Intraoral-complete series (including bitewings). The number of films required is dependent upon age of patient -in no case are less than eight films required. Adults and children over 12 require 12-20 films, as is appropriate. Limited to one every 1460 days (four years)

X-rays and/or other diagnostic verification are required with the claim when requesting prior authorization for the following procedures:

- Endodontic procedures
- Fixed prosthodontics
- Oral Surgical procedures
- Orthodontic requests
- Periodontal treatment
- Removable prosthodontics

X-rays should be:

- Originals or duplicates
- Mounted
- In envelope, stapled to invoice
- Clearly labeled with dentist's name, address, patient's name, and date

	Age Restriction	PA Requirement
D0210 Intraoral - complete series (including bitewings)	**N**	**N**
D0220 Intraoral - periapical - first film	**N**	**N**
D0230 Intraoral - periapical - each additional film	**N**	**N**
D0240 Intraoral - occlusal film	**N**	**N**
D0250 Extraoral - first film	**N**	**N**
D0260 Extraoral - each additional film	**N**	**N**
D0270 Bitewing - single film	**N**	**N**
D0272 Bitewings - two films	**N**	**N**
D0273 Bitewings – three films	**N**	**N**
D0274 Bitewings - four films	**N**	**N**
D0290 Posterior-anterior or lateral skull and facial bone survey film	**N**	**Y**
D0310 Sialography	**N**	**Y**
D0320 Temporomandibular joint arthrogram, including injection	**N**	**Y**
D0321 Other temporomandibular joint films, by report	**N**	**Y**
D0322 Tomographic survey	**N**	**Y**
D0330 Panoramic film	**N**	**N**
D0340 Cephalometric film	**<21**	**Y**

TESTS AND LABORATORY EXAMINATIONS

The following procedures have no prior authorization or age limitations and will be priced individually based on submission and review of all medical information.

	Age Restriction	PA Requirement
D0502 Other oral pathology procedures, by report	**N**	**N**
Refers to gross and microscopic evaluations of presumptively abnormal tissue(s).		
D0999 Unspecified diagnostic procedure, by report	**N**	**N**
Used for procedures which are adequately described by a code. Describe procedure.		

CARIES RISK ASSESSMENT

The following codes are non-paying codes used to express level of risk and will be used to authorize selected preventive procedures appropriate for medium and high-risk patients. It is anticipated that providers will use a Caries Risk Assessment form and this will be available for review as needed.

D0601 Caries risk assessment and documentation, with a finding of low risk. Using recognized assessment tools
D0602 Caries risk assessment and documentation, with a finding of medium risk. Using recognized assessment tools
D0603 Caries risk assessment and documentation, with a finding of high risk. Using recognized assessment tools

DENTAL PROPHYLAXIS

PREVENTIVE SERVICES
Prophylaxis - Allowed twice every calendar year.

D1110 Prophylaxis – adult **>12** **N**
A dental prophylaxis performed on transitional or permanent dentition, which includes scaling and/or polishing procedures to remove coronal plaque, calculus and stains.

D1120 Prophylaxis – child **<13** **N**
Refers to a routine dental prophylaxis performed on primary or transitional dentition only.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

Topical Fluoride Treatment (Office Procedure)

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

Allowed twice every calendar year for recipients less than 21 years of age and for recipients 21 years and older if any of the following medical conditions apply;

Covered for recipients 21 years of age or older only who also have medical or dental conditions that significantly interrupt the flow of saliva. These conditions may include, but are not limited to, radiation therapy, tumors, and certain drug treatments, such as some psychotropic medications and certain diseases and injuries. When used as a preventive measure only, topical fluoride treatment for recipients 21 years or older is not a covered benefit of the Rhode Island Medicaid Program.

Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or "swish".

D1206 Topical Fluoride Varnish (prophylaxis not included) **N*** **N**
Therapeutic application for moderate to high caries risk patients.

D1208 Topical Application of Fluoride **N*** **N**

- One of the following caries risk assessment procedure codes **must** be listed on claims submitted for topical application of fluoride procedure code D1206 or D1208 when used for adults. The codes should be billed at zero dollars ($0). It is required for providers to complete a caries risk assessment form and this will be available for post-procedural review.
    - **D0602 – Caries risk assessment and documentation, with a finding of moderate risk**
    - **D0603 – Caries risk assessment and documentation, with a finding of high risk**

OTHER PREVENTIVE SERVICES

Sealants

Sealants are covered only for permanent molars for patients less than 21 years of age. One treatment per tooth every five years. When billing for this service, the occlusal surface must be reported on the claim form.

	Age Restriction	PA Requirement
D1351 Sealant - per tooth	**<21**	**N**

Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

- ***Payment for sealant is not allowed when an occlusal restoration exists.***
- ***Payment for a sealant is not allowed on teeth #1, 16, 17, and 32.***

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Space Maintenance

Service is limited to recipients under 21 years of age. Space maintainers (fixed and/or removable) will not be replaced if lost or damaged. Medicaid will only pay once for recementation of any space maintainer (D1550). Passive appliances are designed to prevent tooth movement.

D1510 Space maintainer - fixed - unilateral	**<21**	**N**
D1515 Space maintainer - fixed - bilateral	**<21**	**N**
D1520 Space maintainer - removable - unilateral	**<21**	**N**
D1525 Space maintainer - removable - bilateral	**<21**	**N**
D1550 Recementation of space maintainer	**<21**	**N**

RESTORATIVE SERVICES

**** Local anesthesia is considered part of restorative procedures.***

- A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial.)
- A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.
- A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.
- A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.
- A one-surface anterior proximal restoration is one in which the neither lingual nor facial margins of the restoration extends beyond the line angle.
- A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.
- A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.
- A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal edge is involved.

D2140 Amalgam - one surface, primary or permanent	**N**	**N**
D2150 Amalgam - two surfaces, primary or permanent	**N**	**N**
D2160 Amalgam - three surfaces, primary or permanent	**N**	**N**
D2161 Amalgam - four or more surfaces, primary or permanent	**N**	**N**

All adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

Filled or Unfilled Resin Restorations

RESIN-BASED RESTORATIONS - DIRECT

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

	Age Restriction	PA Requirement
D2330 Resin - one surface, anterior	**N**	**N**
D2331 Resin - two surfaces, anterior	**N**	**N**
D2332 Resin - three surfaces, anterior	**N**	**N**
D2335 Resin - four or more surfaces or involving incisal angle	**N**	**N**
D2390 Resin, anterior-primary	**<21**	**Y**

Full resin-based composite coverage of tooth.

Restorative Procedures-Posterior Resins
Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. May not be used to replace existing non-carious amalgam restorations

Guidelines
- Frequency limitation for each tooth- **once every 24 months**, unless prior authorization is provided
- May not be performed as a preventative procedure
- Removal of non-carious or non-defective amalgam restorations and replacement with composite resin is not a covered benefit and subject to post-procedural review
- Removal and replacement of amalgam restorations solely for esthetic concerns is not a covered benefit and subject to post- procedural review
- Removal and replacement of amalgam restorations based on a perceived health benefit is not a covered benefit and subject to post-procedural review.

D2391 Resin-based - one surface, posterior	**N**	**N**
D2392 Resin-based - two surfaces, posterior	**N**	**N**
D2393 Resin-based - three surfaces, posterior	**N**	**N**
D2394 Resin-based – four or more surfaces, posterior	**N**	**N**

Providers are advised that amalgam restorations have a strong record of longevity and composite restorations should be performed only if the anticipated longevity is comparable. As part of treatment decision, providers are advised to inform patients about the longevity of this type of restoration and the Medicaid billing limitation.

INDIVIDUAL CROWNS

Please note: This information also refers to the codes on the following page.

Payment for crowns for:

- posterior primary teeth for recipients under the age of 21 is limited to stainless steel crowns. (D2930)
- posterior permanent teeth for all recipients, regardless of age is limited to stainless steel crowns. (D2931)
- anterior teeth for recipients over age 20 is limited to prefabricated resin crowns. (D2932)
- anterior teeth for recipients under the age of 21 is limited to procedure codes D2710 – D2792

Other Related Limitations

- Payment for preparation of the gingival tissue and any temporary restorations needed are included in the fee for the final crown.
- Retention pins are limited to two per tooth in addition to restoration during a 365-day period.
- The Medicaid Program will only pay once per tooth per calendar year for recementation of inlays and crowns (D2910 & D2920).

CROWNS - SINGLE RESTORATIONS ONLY

Classification of Metals

The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined based on the percentage of metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 60% (> 40% Au); noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) > 25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

	Age Restriction	PA Requirement
D2710 Crown - resin (indirect)	**<21**	**N**
D2720 Crown - resin with high noble metal	**<21**	**N**
D2721 Crown - resin with predominantly base metal	**<21**	**N**
D2722 Crown - resin with noble metal	**<21**	**N**
D2740 Crown - porcelain/ceramic substrate	**<21**	**N**
D2750 Crown - porcelain fused to high noble metal	**<21**	**N**
D2751 Crown - porcelain fused to predominantly base metal	**<21**	**N**
D2752 Crown - porcelain fused to noble metal	**<21**	**N**
D2790 Crown - full cast high noble metal	**<21**	**N**
D2791 Crown - full cast predominantly base metal	**<21**	**N**
D2792 Crown - full cast noble metal	**<21**	**N**

OTHER RESTORATIVE SERVICES

D2910 Recement inlay	**N**	**N**
D2920 Recement crown	**N**	**N**
D2930 Prefabricated stainless steel crown - primary tooth	**<21**	**N**
D2931 Prefabricated stainless steel crown – permanent posterior tooth	**N**	**N**
D2932 Prefabricated resin crown – permanent anterior	**>20**	**N**
D2933 Prefabricated stainless steel crown with resin window	**<21**	**N**

Open-face stainless steel crown with aesthetic resin facing or veneer.

D2940 Sedative filling — **N** — **N**

Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.

D2950 Core buildup, including any pins — **N** — **N**

Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.

D2951 Pin retention - per tooth, in addition to restoration — **N** — **N**

D2952 Cast post and core in addition to crown — **<21** — **N**

Cast post and core is separate from crown.

D2954 Prefabricated post and core in addition to crown — **N** — **N**

Core is built around a prefabricated post. This procedure includes the core material.

D2980 Crown repair, by report — **N** — **Y**

Includes removal of crown, if necessary. Describe procedure.

D2999 Unspecified restorative procedure, by report — **N** — **Y**

Use for procedure which is not adequately described by a code. Describe procedure. (Based on Individual Consideration (IC) upon submission and review of all necessary medical information...)

ENDODONTICS

**** Local anesthesia is considered part of endodontic procedures.***

Includes primary teeth with no permanent successor and permanent teeth.

Complete root canal therapy: Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

Pulp Capping
Direct and indirect pulp caps are included in the restoration fee. No additional payment will be made.

PULPOTOMY
Therapeutic pulpotomy, excluding final restoration, are limited to recipients under age 21.

Therapeutic pulpotomy (D3220) is allowed only for calcium hydroxide pulpotomy on permanent teeth with vital exposed pulps, incompletely formed root apices, and formocresol pulpotomy on deciduous teeth.

Recipients are limited to one (1) pulpotomy per deciduous tooth per lifetime.

	Age Restriction	PA Requirement
D3220 Therapeutic pulpotomy (excluding final restoration)	**<21**	**N**

Removal of pulp coronal to the dentinocemental junction and application of medicament Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.
- To be performed on primary or permanent teeth.
- This is not to be construed as the first stage of root canal therapy.
- ***Limited to <21 only***

ENDODONTIC SERVICES (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

Root Canal Therapy
Separate reimbursement for open and drain or pulpotomy procedures are only allowed when the root canal is not completed. In that circumstance, these procedures will be reimbursed as a palliative treatment (D9110). Root canal therapy is limited to one (1) procedure per tooth, per recipient, per lifetime.

Root canal therapy is limited to permanent teeth, and only if the treatment will lead to a favorable prognosis. The only time that root canal therapy may be performed on primary teeth is: (1) when there is no permanent successor; and (2) on primary second molars prior to eruption of the first permanent molar.

The fee for endodontic procedures is inclusive of all examinations and diagnostics. On patients age 21 and older, anterior root canals will only be paid for (1) if all three anterior teeth are present in the involved arch, or (2) if the involved tooth cannot be added to an existing or proposed partial denture and the tooth will not need a post and core and/or crown to be restored.

D3310 Anterior (excluding final restoration)	**N**	**N**
D3320 Bicuspid (excluding final restoration) - *limited to recipients <21*	**<21**	**N**
D3330 Molar (excluding final restoration) - *limited to recipients <21*	**<21**	**N**

APEXIFICATION/RECALIFICATION PROCEDURES
Apexification is limited to a maximum of five treatments on permanent teeth only and is limited to recipients under age 21.

D3351 Apexification/recalcification - initial visit **<21** **N**
(Apical closure/calcific repair of perforations, root resorption, etc.) Includes opening tooth, Pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.)

D3352 Apexification/recalcification - interim medication replacement **<21** **N**
(Apical closure/calcific repair of perforations, root resorption, etc.) for visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.

D3353 Apexification/recalcification - final visit **<21** **N**
(Includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)

APICOECTOMY/PERIRADICULAR SERVICES
Periradicular surgery is a term used to describe surgery to the root surface, (e.g., Apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement. For surgery on root of anterior tooth. Does not include placement of retrograde filling material.

	Age Restriction	PA Requirement

D3421 Apicoectomy/Periradicular surgery- bicuspid (first root) **<21** **N**
For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3425 Apicoectomy/Periradicular surgery - molar (first root) **<21** **N**
For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3426 Apicoectomy/Periradicular surgery (each additional root) **<21** **N**
Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

D3430 Retrograde filling - per root **<21** **N**
For placement of retrograde filling material during Periradicular surgery procedures. If more than one filling placed in one root-report as D3999 and describe.

D3450 Root amputation - per root **<21** **N**
Root resection of a multirooted tooth while leaving the crown. If the crown is sectioned, see D3920.

OTHER ENDODONTIC PROCEDURES

D3920 Hemisection (including any root removal), not including root canal therapy **<21** **N**
Includes separation of a multirooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.

D3999 Unspecified endodontic procedure, by report **N** **Y**
Used for procedure that is not adequately described by a code. Describe procedure.

PERIODONTAL SERVICES

Surgical Services (Including usual postoperative care)
Periodontal scaling and root planing (D4341) is allowed once every two years. Periodontal charting and X-rays are required. Pockets must be 4mm or greater. See complete guidelines below.

Records must document the clinical indications for periodontal scaling and root planing and for gingival curettage. Periodontal maintenance procedures (D4910) are allowed once every six months after D4341 and will not be paid during the 6-month period immediately after D4341

Gingival Flap (D4240) and Osseous surgery (D4260) are allowed once every three years unless there is a documented medical indication.

Cavitron scaling/gross scaling does not qualify for a separate reimbursable fee; the fee is included as part of the global periodontal procedures.

***Gingivectomy or Gingivoplasty is not covered for those recipients 21 years of age or older except in cases of medically induced gingival hyperplasia, e.g., dilantin hyperplasia.**

D4210 Gingivectomy or Gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant **Y*_(see above)_** **N**
Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. Performed in shallow to moderate suprabony pockets after adequate initial preparation, for suprabony pockets, which need access for restorative density, when moderate gingival enlargements or aberrations are present, and when there is asymmetrical or unesthetic gingival topography.

D4211 Gingivectomy or Gingivoplasty – one to three teeth, per quadrant **Y*_(see above)_** **N**
See D4210 descriptor.

D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant **<21** **N**
Involves surgical debridement of the root surface and the removal of granulation tissue following the resection or reflection of soft tissue flap. Osseous recontouring is not accomplished in conjunction with the procedure. May include open flap

curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of probing attachment, need to maintain esthetics, and need for increased access to the root surface and alveolar bone.

	Age Restriction	PA Requirement
D4241 Gingival flap procedure, including root planing - one to three teeth, per quadrant	**<21**	**N**

See D4240 descriptor.

D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	**<21**	**N**

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) or non-supporting bone. Other separate procedures including, but not limited to, D3450, D3920, D4263, D4264, D4266, D4267, and D7140 may be required concurrent to D4260.

D4261 Osseous surgery (including flap entry and closure)-one to three teeth, per quadrant see D4260 descriptor.	**<21**	**N**

D4263 Bone replacement graft - first site in quadrant	**<21**	**N**

Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. The procedure does not include flap entry and closure and is reported in addition to a procedure that includes flap entry and closure, including, but not limited to D4240, D4260.

D4264 Bone replacement graft - each additional site in quadrant	**<21**	**N**

Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. This code is used if performed concurrently with D4263 - bone replacement graft - first site, per quadrant and allows reporting of the exact number of sites involved.

D4266 Guided tissue regeneration - resorbable barrier, per site,	**<21**	**N**

A membrane is placed over the roof surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.

D4267 Guided tissue regeneration - nonresorbable barrier, per site, per tooth (includes membrane removal)	**<21**	**N**

Used to regenerate lost or injured periodontal tissue by directing differential tissue responses. A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure requires subsequent surgical procedures to remove the membranes and/or to correct the gingival contours. Guided tissue regeneration may be used in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.

D4270 Pedicle soft tissue graft procedure	**<21**	**N**

A pedicle flap of gingival tissue can be raised from an edentulous ridge, adjacent teeth, or from the existing gingival tissue on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.

D4273 Subepithelial connective tissue graft procedures	**<21**	**N**

This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull, to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingival and/or mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure. After the graft is placed on the recipient site, it is covered with the retained overlying flap.

	Age Restriction	PA Requirement
D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	**<21**	**N**

Performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.

ADJUNCTIVE PERIODONTAL SERVICE

D4320 Provisional splinting – intracoronal **<21** **N**
An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose.

D4321 Provisional splinting – extracoronal **<21** **N**
An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint, by report.

Periodontal Scaling and Root Planing Guidelines

- *Scaling and root planing for adults is permitted with prior authorization. Approval will indicate which quadrant(s) are approved as applicable.
- Prior authorization should be submitted to provide evidence of medical necessity and prognosis.
- For D4341 and D4342, Prior authorization requires submission of full mouth probing depths and radiographs.
- Expectation is moderate bone loss with radiographic calculus
- For D4346, radiographs only are required, with expectation of radiographic calculus. Photographs will also be accepted if radiographs do not adequately reflect the level of calculus.
- Only 2 quadrants are permitted per visit for D4341; It is anticipated that providers will perform 2 quadrants at a visit unless chart notes reflect high degree of complexity. **Applicable to all ages.**

D4341 Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant **N** **N***
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

D4342 Periodontal scaling and root planing – one to three teeth, per quadrant **N** **N***
See 4341 descriptor.

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation. *Allowed once every 720 days (two years), prior authorization required, requiring either radiographs or clinical photographs illustrating visible calculus deposits.PA required for all ages* **N** **Y**

D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis **<21** **N**
The removal of subgingival and/or supragingival plaque and calculus. This procedure does not preclude the need for additional procedures.

D4381 Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report **<21** **Y**
Synthetic fibers or other approved delivery devices containing controlled-release chemotherapeutic agent(s) are inserted into a periodontal pocket. Short-term use of the timed-release therapeutic agent as supplemental or adjunctive therapy provides for reduction of subgingival flora.

This procedure does not replace conventional or surgical therapy required for debridement, resective procedures or for regenerative therapy.

The use of controlled-release chemotherapeutic agents is an adjunctive procedure for specific sites that are unresponsive to conventional therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy.

OTHER PERIODONTAL SERVICES

	Age Restriction	PA Requirement
D4910 Periodontal maintenance	**<21**	**N**

For patients who have previously been treated for periodontal disease. Typically, maintenance starts after completion of active (surgical or nonsurgical) periodontal therapy and continues at varying intervals, determined by the clinical diagnosis of the dentist, for the life of the dentition. It includes removal of the supra and subgingival microbial flora and calculus, site specific scaling and root planing where indicated, and/or polishing the teeth. When new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

D4999 Unspecified periodontal procedure, by report **Y** **N**

Used for a procedure that is not adequately described by a code. Describe procedure and submit appropriate medical documentation.

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

Removable Prosthodontics

- Removable prosthodontics is limited to the replacement of permanent teeth. X-rays are required.
- Recipients are allowed one (1) set of partial and/or complete dentures during an 1825-day (5-year) period from any provider.
- Adjustments to dentures during the 183-day (6-month) period following delivery of dentures to recipients are included in the fee. Adjustments are allowed once per year thereafter.
- After the initial 183-day (6-month) period from delivery, a reline is allowed once per year as deemed medically necessary.
- A rebase will be covered 730 days (2 years) from the date of delivery of the dentures and then once every 2 years as deemed medically necessary.
- Dentures will not be replaced if lost or damaged for a period of 5 years from the time the dentures were first fabricated.
- Interim partial dentures (D5820 & D5821) will only be considered to replace a missing permanent anterior tooth in a patient under 21 years of age. These procedures require a Prior Authorization.

* ***Local anesthesia is considered part of removable Prosthodontic procedures***.

D5110 Complete denture - maxillary	**N**	**N**
D5120 Complete denture - mandibular	**N**	**N**

PARTIAL DENTURE (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211 Maxillary partial denture - resin base - (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with resin or wrought wire clasps.	**N**	**N**
D5212 Mandibular partial denture - resin base - (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with acrylic resin clasps.	**N**	**N**
D5213 Maxillary partial denture - case metal framework with resin - denture bases (including any conventional clasps, rests and teeth)	**<21**	**N**
D5214 Mandibular partial denture - case metal framework with resin – denture bases (including any conventional clasps, rests and teeth)	**<21**	**N**
D5410 Adjust complete denture - maxillary	**N**	**N**

	Age Restriction	PA Requirement
D5411 Adjust complete denture - mandibular	**N**	**N**
D5421 Adjust partial denture - maxillary	**N**	**N**
D5422 Adjust partial denture - mandibular		
REPAIRS TO COMPLETE DENTURES	**N**	**N**
D5511 Repair broken complete denture base, mandibular	**N**	**N**
D5512 Repair broken complete denture base, maxillary	**N**	**N**
D5520 Replace missing or broken teeth - complete denture (each tooth)	**N**	**N**
REPAIRS TO PARTIAL DENTURES		
D5611 Repair resin denture base, mandibular	**N**	**N**
D5612 Repair resin denture base, maxillary	**N**	**N**
D5621 Repair cast partial framework, maxillary	**N**	**N**
D5622 Repair cat partial framework, mandibular	**N**	**N**
D5630 Repair or replace broken clasp	**N**	**N**
D5640 Replace broken teeth - per tooth	**N**	**N**
D5650 Add tooth to existing partial denture	**N**	**N**
D5660 Add clasp to existing partial denture	**N**	**N**
DENTURE REBASE PROCEDURES		
Rebase - process of refitting a denture by replacing the base material.		
D5710 Rebase complete maxillary denture	**N**	**Y**
D5711 Rebase complete mandibular denture	**N**	**Y**
D5720 Rebase maxillary partial denture	**N**	**Y**
D5721 Rebase mandibular partial denture	**N**	**Y**
DENTURE RELINE PROCEDURES		
Reline - process of resurfacing the tissue side of a denture with new base material.		
D5740 Reline maxillary partial denture (chair side)	**N**	**N**
D5741 Reline mandibular partial denture (chair side)	**N**	**N**
D5750 Reline complete maxillary denture (laboratory)	**N**	**N**
D5751 Reline complete mandibular denture (laboratory)	**N**	**N**
D5760 Reline maxillary partial denture (laboratory)	**N**	**N**
D5761 Reline mandibular partial denture (laboratory)	**N**	**N**

OTHER REMOVABLE PROSTHETIC SERVICES
A provisional prosthesis designed for use over a limited period, after which it is to be replaced by a more definitive restoration.

D5810 Interim complete denture (maxillary)	**<21**	**Y**
D5811 Interim complete denture (mandibular)	**<21**	**Y**
D5820 Interim partial denture (maxillary) Includes any necessary clasps and rests.	**<21**	**Y**
D5821 Interim partial denture (mandibular) Includes any necessary clasps and rests.	**<21**	**Y**
D5862 Precision attachment, by report	**<21**	**Y**

Each set of male and female components should be reported as one precision attachment. Describe the type of attachment used.

D5899 Unspecified removable prosthodontic procedure, by report	**N**	**Y**

Use for a procedure which is not adequately described by a code. Describe procedure.

MAXILLOFACIAL PROSTHETICS *-these services should be billed to the medical carrier using CPT codes. Contact Medicaid Provider Services for further information.*

IMPLANT SERVICES
Implants are not a covered service.

FIXED PROSTHODONTICS

**** Local anesthesia is considered part of Fixed Prosthodontic procedures***.

- Permanent bridges will be allowed for anterior permanent teeth only. ***Recipients must be less than 21 years of age.***
- Permanent bridges will be allowed for a maximum of four (4) units. If greater than four units, a partial denture should be billed.
- If anterior and posterior teeth are missing, a partial denture should be provided and billed.

Prosthodontics, fixed - each abutment and each pontic constitutes a unit in a fixed partial denture.

The words “bridge” and “bridgework” have been replaced by the statement “fixed partial denture” throughout this section.

Classification of Metals - The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined based on the percentage of noble metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt)>60% (with at least 40% Au); noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) >25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

	Age Restriction	PA Requirement
FIXED PARTIAL DENTURE PONTICS	**<21**	**N**
D6211 Pontic - cast predominantly base metal	**<21**	**N**
D6212 Pontic - cast noble metal	**<21**	**N**
D6240 Pontic - porcelain fused to high noble metal	**<21**	**N**
D6241 Pontic - porcelain fused to predominantly base mental	**<21**	**N**
D6242 Pontic -porcelain fused to noble metal	**<21**	**N**
D6250 Pontic - resin with high noble metal	**<21**	**N**
D6251 Pontic - resin with predominantly base metal	**<21**	**N**
D6252 Pontic - resin with noble metal	**<21**	**N**
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6720 Crown - resin with high noble metal	**<21**	**N**
D6721 Crown - resin with predominantly base metal	**<21**	**N**
D6722 Crown - resin with noble metal	**<21**	**N**
D6750 Crown - porcelain fused to high noble metal	**<21**	**N**
D6751 Crown - porcelain fused to predominantly base metal	**<21**	**N**
D6752 Crown - porcelain fused to noble metal	**<21**	**N**
D6780 Crown - 3/4 cast high noble metal	**<21**	**N**
D6790 Crown - full cast high noble metal	**<21**	**N**
D6791 Crown - full cast predominantly base metal	**<21**	**N**
D6792 Crown - full cast noble metal	**<21**	**N**
OTHER FIXED PARTIAL DENTURE SERVICES		
D6999 Unspecified, fixed prosthodontic procedure, by report	**N**	**Y**

ORAL SURGERY SERVICES

- **Tooth replantation (D7270) is allowed only in cases of traumatic avulsion of a permanent anterior tooth where there are good indications of success.**

- **A biopsy (D7285 & D7286) will only be allowed with verification of the presence of inflammation, interference with dental function, or suspicion of a malignancy.**

- **Skin grafts (D7920) are not allowed in conjunction with a vestibuloplasty.**

- **For recipients 21 years of age and older, procedures D7950 and D7955 are only allowed for reconstruction secondary to tumor surgery.**

- **For recipients 21 years of age and older, excision of hyperplasic tissue (D7970) is only allowed when the condition was caused by denture irritation.**

- **The fee for all oral surgical procedures is inclusive of all examinations and diagnostics, with the following exceptions:**

    1. One panoramic film will be allowed for patients presenting with bilateral problems and no panoramic film is available.

    2. One panoramic film will be allowed if the patient is presenting with bilateral impacted third molars.

    3. One panoramic film will be allowed if the radiographs from the referring dentist are not of diagnostic quality. A copy of the film
    4. must be sent to the primary care dentist.

    5. One panoramic film will be allowed if the patient is a self- referral with no primary care dentist.

Certain oral surgery procedures are considered in-plan services for recipients enrolled in RiteCare, Rhody Health and Rhody Health Options. These procedure must be billed directly to the health plans. It is the providers' responsibility to contact the health plan(s) directly for claim submission guidelines. For a complete list of codes, please see the EOHHS website.

***** Extractions are limited to once per tooth per recipient's lifetime.***

Oral surgical procedures that can be provided by dental surgeons (enrolled as physicians) within the scope of their licensure will be considered on a PA basis for individuals under age 21. Payment will be made in accordance with the Medicaid Surgical Fee Schedule.

Allowance for surgical assistance is restricted to services by dentists and physicians. Surgical assistance will be allowed only when the assistant's services qualify as a dental or medical necessity. Only one surgical assistant will be allowed. Primary surgeons, assistant surgeons, and anesthesiologists must bill separately for their services. Oral surgical assistance will be allowed in the same manner as physician surgical assistance.

EXTRACTIONS *(includes local anesthesia, suturing, if needed, and routine postoperative care)*

	Age Restriction	PA Requirement
D7111 Coronal remnants – primary teeth - Includes soft tissue-retained coronal remnants	**N**	**N**
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) Includes routine removal of tooth structure and closure, as necessary	**N**	**N**

SURGICAL EXTRACTIONS (*includes local anesthesia, suturing, if needed, and routine postoperative care)*

	Age Restriction	PA Requirement
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth Includes cutting of gingiva and bone, removal of tooth structure, and closure.	**N**	**N**
D7220 Removal of impacted tooth - soft tissue Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	**N**	**N**
D7230 Removal of impacted tooth - partially bony Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	**N**	**N**
D7240 Removal of impacted tooth - completely bony Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	**N**	**N**
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	**N**	**N**
D7250 Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure, and closure.	**N**	**N**
OTHER SURGICAL PROCEDURES		
D7260 Oroantral fistula closure Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.	**N**	**N**
D7270 Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus - Includes splinting and/or stabilization.	**<21**	**N**
D7280 Surgical exposure of unerupted tooth An incision is made and the tissue is reflected and bone removed as necessary to expose the crown.This procedure may include but is not limited to situations whereby an attachment is placed to facilitate eruption.	**<21**	**N**
D7285 Biopsy of oral tissue - hard (bone, tooth) For surgical removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular curettage.	**N**	**N**
D7286 Biopsy of oral tissue - soft (all others) For surgical removal of specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage. For surgical oral pathology procedures, See D0502.	**N**	**N**
ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES		
D7320 Alveoloplasty not in conjunction with extractions - per quadrant No extractions performed in an edentulous area.	**N**	**N**
VESTIBULOPLASTY		
D7340 Vestibuloplasty - ridge extension (secondary epithelialization)	**N**	**Y**
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplasic issue).	**N**	**Y**
SURGICAL EXCISION OF SOFT TISSUE LESIONS		
D7410 Excision of benign lesion diameter up to 1.25 cm	**N**	**N**
D7411 Excision of benign lesion diameter greater than 1.25 cm		

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

	Age Restriction	PA Requirement
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm	**N**	**N**
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm	**N**	**N**
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	**N**	**N**
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	**N**	**N**
D7461 Removal of nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm	**N**	**N**

EXCISION OF BONE TISSUE

D7471 Removal of lateral exostosis –(maxilla or mandible)	**N**	**N**
D7490 Radical resection of mandible with bone graft	**N**	**N**

Partial resection of mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.

SURGICAL INCISION

D7510 Incision and drainage of abscess - intraoral soft tissue	**N**	**N**

Involves incision through mucosa, including periodontal origins.

D7520 Incision and drainage of abscess - extraoral soft tissue Involves incision through skin.	**N**	**N**
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	**N**	**N**
D7540 Removal of reaction-producing foreign bodies-musculoskeletal system	**N**	**N**

May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone

D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone	**N**	**N**

Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.

D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body	**N**	**N**

TREATMENT OF FRACTURES – SIMPLE

D7610 Maxilla - open reduction (teeth immobilized, if present)	**N**	**N**

Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.

D7620 Maxilla - closed reduction (teeth immobilized, if present)	**N**	**N**

No incision required to reduce fracture. See D7610 if interosseous fixation is applied.

D7630 Mandible - open reduction (teeth immobilized, if present)	**N**	**N**

Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required to reduce fracture.

D7640 Mandible - closed reduction (teeth immobilized, if present)	**N**	**N**

No incision required to reduce fracture. See D7630 if interosseous fixation is applied.

D7650 Malar and/or zygomatic arch - open reduction	**N**	**N**
D7660 Malar and/or zygomatic arch - closed reduction	**N**	**N**
D7670 Alveolus –closed reduction, may include stabilization of teeth	**N**	**N**

Teeth may be wired, banded or splinted together to prevent movement.

D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches	**N**	**N**

Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.

TREATMENT OF FRACTURES - COMPOUND

D7710 Maxilla - open reduction-Surgical incision required to reduce fracture	**N**	**N**

	Age Restriction	PA Requirement
D7720 Maxilla - closed	**N**	**N**
D7730 Mandible - open reduction-Surgical incision required to reduce fracture	**N**	**N**
D7740 Mandible - closed reduction	**N**	**N**
D7750 Malar and/or zygomatic arch - open reduction-Surgical incision required to reduce fracture	**N**	**N**
D7760 Malar and/or zygomatic arch - closed reduction	**N**	**N**
D7770 Alveolus - open reduction stabilization of teeth	**N**	**N**
Fractured bone(s) are exposed to mouth or outside the face; see D7670. Surgical incision required to reduce fracture		
D7780 Facial bones - complicated reduction with fixation and multiple surgical	**N**	**Y**
Approachs Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.		

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS
Procedures which are an integral part of a primary procedure should not be reported separately.

D7810 Open reduction of dislocation - Access to TMJ via surgical opening.	**N**	**N**
D7820 Closed reduction of dislocation - Joint manipulated into place; no surgical Exposure	**N**	**N**
D7830 Manipulation under anesthesia	**N**	**N**
Usually done via general anesthesia or intravenous sedation.		
D7840 Condylectomy	**<21**	**N**
Surgical removal of all or portion of the mandibular condyle (separate procedure).		
D7850 Surgical discectomy, with/without implant - Excision of the intra-articular disc of a joint	**<21**	**N**
D7852 Disc repair	**<21**	**Y**
Repositioning and/or sculpting of disc; repair of perforated posterior attachment		
D7854 Synovectomy - Excision of a portion or all of the synovial membrane of a joint	**<21**	**Y**
D7856 Myotomy - Cutting of muscle for therapeutic purposes (separate procedure).	**<21**	**Y**
D7858 Joint reconstruction	**<21**	**Y**
Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.		
D7860 Arthrotomy - Cutting into joint (separate procedure).	**<21**	**N**
D7865 Arthroplasty	**<21**	**Y**
Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).		
D7870 Arthrocentesis - Withdrawal of fluid from a joint space by aspiration.	**<21**	**N**
D7872 Arthroscopy - diagnosis, with or without biopsy	**<21**	**Y**
D7873 Arthroscopy – surgical: lavage and lysis of adhesions	**<21**	**Y**
Removal of adhesions using the arthroscope and lavage of the joint cavities.		
D7874 Arthroscopy – surgical: disc repositioning and stabilization	**<21**	**Y**
Repositioning and stabilization of disc using arthroscopic techniques.		
D7875 Arthroscopy – surgical: synovectomy	**<21**	**Y**
Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.		
D7876 Arthroscopy – surgical: discectomy	**<21**	**Y**
Removal of disc and remodeled posterior attachment via the arthroscope.		
D7877 Arthroscopy – surgical: debridement	**<21**	**Y**
Removal of pathologic hard and/or soft tissue using the arthroscope.		

	Age Restriction	PA Requirement
D7880 Occlusal orthotic device, by report	**<21**	**Y**
Presently includes splints provided for treatment of temporomandibular joint dysfunction		
D7899 Unspecified TMD therapy, by report	**<21**	**Y**
Used for procedure that is not adequately described by a code. Describe procedure.		
REPAIR OF TRAUMATIC WOUNDS		
Excludes closure of surgical incisions		
D7910 Suture of recent small wounds up to 5 cm	**N**	**N**
COMPLICATED SUTURING (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)		
Excludes closure of surgical incisions		
D7911 Complicated suture - up to 5 cm	**N**	**N**
D7912 Complicated suture - greater than 5 cm	**N**	**N**
OTHER REPAIR PROCEDURES		
D7920 Skin graft (identify defect covered, location and type of graft)	**N**	**N**
D7940 Osteoplasty - for orthognathic deformities	**<21**	**N**
Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.		
D7941 Osteotomy –mandibular rami	**<21**	**N**
D7943 Osteotomy – mandibular rami with bone graft; includes obtaining the graft	**<21**	**N**
D7944 Osteotomy - segmented or subapical - per sextant or quadrant	**<21**	**N**
D7945 Osteotomy - body of mandible	**<21**	**N**
Surgical section of the lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care		
Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.		
D7947 LeFort I (maxilla - segmented)	**<21**	**N**
When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be “by report.”		
D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) -without bone graft	**<21**	**N**
Surgical section of upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation; routine wound closure and normal post-operative follow-up care.		
D7949 LeFort II or LeFort III - with bone graft-Includes obtaining autografts.	**<21**	**N**
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones – autogenous or nonautogenous, by report	**N**	**N**
Includes obtaining autograft and/or allograft material and ridge augmentation/sinus lift procedure.		
D7955 Repair of maxillofacial soft and hard tissue defect	**N**	**N**
Various soft tissue-grafting procedures may be used alone or in combination with autograft, allograft, or alloplastic materials to augment or repair the defect and restore anatomic structure to required form and function. These procedures may require multiple surgical approaches.		

	Age Restriction	PA Requirement
D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure	**N**	**N**

The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.

D7970 Excision of hyperplastic tissue - per arch	**N**	**N**
D7971 Excision of pericoronal gingiva	**<21**	**N**

Surgical removal of inflammatory of hypertrophied tissues surrounding partially erupted/impacted teeth.

D7980 Sialolithotomy	**N**	**N**

Surgical procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.

D7981 Excision of salivary gland, by report	**N**	**N**
D7982 Sialodochoplasty	**<21**	**Y**

Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.

D7983 Closure of salivary fistula	**<21**	**Y**

Surgical closure of an opening between a salivary duct and/or gland and the cutaneous surface, or an opening into the oral cavity through other than the normal anatomic pathway.

D7990 Emergency tracheotomy	**N**	**N**

Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.

ORTHODONTIC SERVICES

Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age 21. The HLD (RI Mod) Index (Handicapping Labio-lingual Deviation Index) is applied to each individual case by Board qualified orthodontic consultants to identify those cases that clearly demonstrate medical necessity by determining the degree of the handicapping malocclusion. The HDL Index is a tool that has proven to be successful in identifying a large range of very disfiguring malocclusions and two known destructive forms of malocclusion (deep destructive impinging bites and destructive individual anterior crossbite). *Please see example HDL scoring sheet at the end of this section.*

Handicapping Malocclusion

An occlusion that has an adverse effect on the quality of a person's life that could include speech, function or esthetics that could have sociocultural consequences. Examples would be significant discrepancies in the relationships of the jaws and teeth in anteroposterior, vertical or transverse directions.

Medically Necessary

When a situation exists, that could have a detrimental effect on the structures that support the teeth, and if damaged sufficiently, could lead to the loss of function.

Allowance may continue for orthodontic services on recipients losing EPSDT eligibility (reaching their 21st birthday) under the following circumstances:

1. Eligibility for Medicaid is maintained;

2. The request for prior authorization is approved and the work is initiated prior to the recipient's 21st birthday.

Prior Authorization Requests

All requests for prior authorization of payment must include the diagnosis, length, and type of treatment. Records, which include diagnostic casts (study models), cephalometric film, panoramic film or a complete series of intraoral radiographs, and diagnostic photographs, must be submitted for full orthodontic treatment review.

Orthodontic treatment will be approved only where there is evidence of a favorable prognosis and a high probability of patient compliance in completing the treatment program.

Payment for Orthodontic Records

If an orthodontic case is not approved for payment, Medicaid will pay the orthodontist a fee for examination and records when a claim is submitted using procedure code **D8660**. ***This is limited to once every two (2) years.*** This code is tied to each distinct Prior Authorization (PA) request for full orthodontic treatment. If a subsequent request is received in less than two years, and denied at that time, an allowance would not be made. If a subsequent request is received in less than two years and approved because of changes in the child's mouth, an allowance would be made.

If an orthodontist sees a patient for an examination only, and the patient does not proceed with diagnostic records, Medicaid will pay for a Comprehensive Oral Evaluation.

Post-treatment maintenance retainers will not be replaced if lost or damaged.

Orthodontic Services Claims Coding and Reimbursement

DENTITION

Primary Dentition: Teeth developed and erupted first in order of time.

Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth AND PRIOR to cessation of growth; that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

LIMITED ORTHODONTIC TREATMENT

Orthodontic treatment with a limited objective, not involving the entire dentition. May be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego therapy that is more comprehensive.

	Age Restriction	PA Requirement
D8010 Limited orthodontic treatment of the primary dentition	**<21**	**Y**
D8020 Limited orthodontic treatment of the transitional dentition	**<21**	**Y**
D8030 Limited orthodontic treatment of the adolescent dentition	**<21**	**Y**
D8040 Limited orthodontic treatment of the adult dentition	**<21**	**Y**

INTERCEPTIVE ORTHODONTIC TREATMENT

Orthodontic therapy that reduces or eliminates the severity of an existing malocclusion. It most often involves early correction of vertical, horizontal, or anteroposterior skeletal discrepancies. Included would be such procedures as distalization, protraction, expansion, space maintenance, and in control of harmful oral habits.

D8050 Interceptive orthodontic treatment of the primary dentition	**<21**	**Y**
D8060 Interceptive orthodontic treatment of the transitional dentition	**<21**	**Y**
D1515 Space maintainer, fixed bilateral	**<21**	**N**

COMPREHENSIVE ORTHODONTIC TREATMENT

The coordinated diagnosis and treatment leading to the improvement of a patient's dentofacial deformity or dentoalveolar skeletal discrepancies including anatomical, functional and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patients' needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. Orthodontic treatment involves the placement of bands or bonded brackets for at least a two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient. Comprehensive treatment ends when the entire adult dentition (except third molars) has been placed in proper occlusion.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When billing for comprehensive orthodontia treatment services, the following codes will be used, as appropriate:

Units	Transitional	Adolescent	Adult	Age Restriction	PA Requirement
Procedure code: 1	**D8070**	**D8080**	**D8090**	**<21**	**Y**
	Procedure codes - 1st 6 months				
1-6	**D8071**	**D8081**	**D8091**	**<23***	**Y**
	Procedure codes - 2nd 6 months				
1-6	**D8072**	**D8082**	**D8092**	**<23***	**Y**
	Procedure codes - 3rd 6 months				
1-6	**D8073**	**D8083**	**D8093**	**<23***	**Y**
	Procedure codes - 4th 6 months				
1-6	**D8074**	**D8084**	**D8094**	**<23***	**Y**

****applies only if recipients >20 meet all of the following conditions:***

1. Eligibility for Medicaid is maintained;
2. The request for prior authorization is approved and the work is initiated *prior* to the recipient's 21st birthday.

TREATMENT FOR CORRECTION OF HARMFUL HABITS

	Age Restriction	PA Requirement
D8210 Removable appliance therapy Includes appliances for thumb sucking and tongue thrusting.	**<21**	**Y**
D8220 Fixed appliance therapy Includes appliances for thumb sucking and tongue thrusting.	**<21**	**Y**

OTHER ORTHODONTIC SERVICES

D8660 Pre-Orthodontic treatment visit Payment for orthodontic records when an orthodontic case is not approved.	**<21**	**N**
D8670 Periodic Orthodontic treatment visit (as part of contract)	**<21**	**N**
D8680 Orthodontic retention (removal of appliances, construction and placement of retainers)	**<21**	**N**
D8695 Removal of fixed orthodontic appliances – other than at conclusion of treatment	**<21**	**N**
D8999 Unspecified orthodontic procedure, by report	**<21**	**Y**

Used for procedure, that is not adequately described by a code. Describe procedure and submit appropriate documentation.

Full course orthodontic treatment usually involves the placement of bands or bonded brackets for a minimum two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley Appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When an appliance is provided in conjunction with a full course of treatment, a separate prior authorization request will be required for the provision of the special appliance. Payment will be processed when the special appliance has actually been provided to the patient.

The following codes should be utilized when requesting the appliances listed below:

D1510 Space maintainer - fixed - unilateral	**<21**	**N**
D1515 Space maintainer - fixed - bilateral	**<21**	**N**
D1520 Space maintainer - removable - unilateral	**<21**	**N**
D1525 Space maintainer - removable - bilateral	**<21**	**N**
D1550 Recementation of space maintainer	**<21**	**N**
D1515 Orthodontic - Space Maintainer, fixed bilateral	**<21**	**N**
D8020 Orthodontic-Head Gear Therapy	**<21**	**Y**
D8030 Orthodontic-Minor Tooth Movement with Hawley Appliance	**<21**	**Y**
D8060 Orthodontic-Maxillary Expansion Appliance	**<21**	**Y**
D8220 Orthodontic-Tongue Guard Fixed/Removable	**<21**	**Y**
D8680 Orthodontic-Tooth Retainer	**<21**	**N**

Requests for payment can only be submitted after placement of permanent bands / wires and completion of six-month time intervals.

Orthodontic services and supplies authorized for eligible recipients will be allowed only as long as they remain eligible for the Medicaid Program and continue to meet the age limitations.

Rhode Island Executive Office of Health and Human Services
Medicaid Program

CLIENT NAME	CLIENT DATE OF BIRTH	CLIENT ID
PROVIDER NAME	PROVIDER PHONE #	DATE OF EXAM

PART 1. TREATMENT REQUESTED

FULL TREATMENT ☐	INTERCEPTIVE TREATMENT ☐	TRANSFER CASE ☐
REQUIRES MAXILLO-FACIAL SURGERY? ☐	NO ☐	
YES		
PLEASE EXPLAIN:		

PART 2. DIAGNOSTIC INFORMATION

STAGE OF DENTITION:	PRIMARY	PERMANENT ☐	MIXED ☐
SKELETAL CLASSIFICATION:			
CLASS 1 ☐	CLASS 2 ☐		CLASS 3 ☐
POSTERIOR CROSSBITE (Indicate teeth involved below)	YES ☐		NO ☐

Please refer to the ADA Glossary of Clinical and Administrative Terms @ www.ada.org for definitions:			***LOCATION in Mouth***
ECTOPIC ERUPTION (EXCLUDING 3RDs):	YES ☐	NO ☐	
MISSING (indicate teeth)	YES ☐	NO ☐	
IMPACTED (indicate teeth)	YES ☐	NO ☐	
ANKYLOSED (indicate teeth)	YES ☐	NO ☐	
SUPERNUMERARY (indicate teeth)	YES ☐	NO ☐	

SEVERE TRAUMATIC DEVIATION- Please explain:

PART 3. BRIEF INITIAL OPINIONS

RESTORATIONS COMPLETE: YES ☐ ☐ NO
If no, please explain plan:

In approving orthodontic treatment, factors other than functional need will be considered. These other factors include the following:

	GOOD	FAIR	POOR
Current Oral Hygiene			
Patient's willingness and ability to meet appointments			
Patient's ability to follow instructions and cooperate to the end of the lengthy treatment period			
Patient's ability to maintain an acceptable level of oral hygiene, which is vital to success of orthodontic treatment during the treatment period			

PART 4.HLD INDEX (Please complete the following PARTS A & B--See instructions below for scoring guidelines)

PART A.		**Requesting Dentist**	**Reviewer**
1. CLEFT LIP & PALATE DEFORMITIES: Indicate with an X			
2. IMPACTED ANTERIOR TEETH when extraction is not indicated: Indicate with an X			
3. DEEP IMPINGING OVERBITE: Indicate with an X only if tissue damage is present			
4. ANTERIOR CROSSBITE: Indicate with an X only if tissue destruction is present			
5. OVERJET in mm (> 9 mm) - Indicate with an X			
6. REVERSE OVERJET (MANDIBULAR PROTRUSION) (> 3.5 mm) Indicate with an X			
PART B.		**Requesting Dentist**	**Reviewer**
7. OVERJET in mm (= to or < 9 mm)			
8. SEVERE TRAUMATIC DEVIATION: must document in PART 2.- Score 15 points			
9. OVERBITE in mm	x1=		
10. REVERSE OVERJET (MANDIBULAR PROTRUSION) in mm (= to or < 3.5 mm)	x5=		
11. OPENBITE in mm	x4=		
12. ANTERIOR CROWDING Score 1 point for maxillary and 1 point for mandibular -- maximum # of 10 points	x5=		
13. ECTOPIC ERUPTION: count each tooth Do not score both anterior crowding & anterior ectopic eruption, use more severe of two.	x3=		
14. POSTERIOR UNILATERAL CROSSBITE: Score 4 points			
TOTAL POINTS- PART B.			

Treatment Narrative: Please provide any additional information that will substantiate your treatment request.

PLEASE NOTE: The HLD scoring is a guideline for your use and is a reference for the Rhode Island Medicaid Program consultant. You will still be required to submit photographs and supporting radiographs. The Rhode Island Medicaid Program will make the final decision regarding medical necessity and scoring criteria.

I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I certify that I performed the above noted examination on this client.

TREATING PROVIDER'S SIGNATURE	PRINT NAME	DATE

FOR REVIEW PURPOSES ONLY:

RHODE ISLAND MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATION INDEX SCORING INSTRUCTIONS

The intent of the HLD Index is to measure the presence or absence and the degree of the handicap caused by the components of the Index, and not to diagnose "malocclusion". All measurements are made with a Boley Gauge scaled in millimeters. Absence of any conditions must be recorded by entering "0". (Refer to attached score sheet.) The following information should help clarify the categories on the HLD Index:

PART A. Note: 1 – 6 - If any one of these conditions exist, it is automatically considered to be a severe handicapping malocclusion and is indicated by an "X" and scored no further.

1. Cleft Palate Deformities: Indicate an "X" on the score sheet. (This condition is considered to be handicapping malocclusion.)
2. Impacted Anterior Teeth: Indicate an "X" on the score sheet when there is/are anterior tooth or teeth (incisors and cuspids) is/are impacted (soft or hard tissue) and not indicated for extraction and treatment planned to be brought into occlusion.
3. Deep Impinging Overbite: Indicate an "X" on the score sheet when lower incisors are damaging the soft tissue of the palate. **This should only be marked if there is tissue laceration and/or clinical attachment loss is present. Palatal indentations are not considered tissue destruction. Photographic documentation must be present.**
4. Crossbite of Individual Anterior Teeth: Indicate an "X" on the score sheet when destruction of soft tissue is present. **This should only be marked if there is clinical attachment loss and/or recession of the gingival margin is present. Photographic documentation must be present.** 5. Overjet in Millimeters: Indicate an "X" on the score sheet if the overjet measures greater than 9 millimeters. This is recorded with the patient in the centric relationship and should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. The measurement could apply to a protruding single tooth as well as to the whole arch.
5. Reverse Overjet (Mandibular Protrusion) > 3.5 Millimeters: Measured from the labial of the lower incisor to the labial of the upper incisor. Indicate an "X" on the score sheet if a reverse overjet of greater than 3.5 millimeters is present.
6. **PART B. Complete 7. - 13. If case does not qualify in 1 – 6 above. The total score in Part B. will determine if the case qualifies for orthodontic treatment. A score of 26 or more qualifies for authorization. Completion instructions are below.**
7. Overjet equal to or less than 9mm: Overjet is recorded as in condition #5 above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.
8. Severe Traumatic Deviations: Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. The presence of severe traumatic deviations is indicated by a score of 15 on the score sheet.
9. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
10. Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. The measurement is entered on the score sheet and multiplied by 4. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
11. Reverse Overjet (Mandibular Protrusion) equal to or less than 3.5mm: Mandibular protrusion (reverse overjet) is recorded as in condition #6 above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5)
12. Anterior Crowding: Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points each for maxillary and mandibular anterior crowding. If condition No. 13, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. **Do not score both conditions.**
13. Ectopic Eruption: Count each tooth, excluding third molars. Enter the number of teeth on the score sheet and multiply by 3. In condition No. 12, anterior crowding, is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. **Do not score both conditions.**
14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the score sheet.

ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

	Age Restriction	PA Requirement
D9110 Palliative (emergency) treatment of dental pain-minor procedure	**N**	**N**

This is typically reported on a "per visit" basis for emergency treatment of dental pain.

ANESTHESIA

General anesthesia and IV sedation are limited to recipients <21. General anesthesia is paid for the first 15 minutes (D9222) and up to three (3) subsequent 15 minute increments (D9223) on the same day of service for services rendered in the office setting. The same guidelines apply to IV moderate sedation procedures D9239 and D9243. Anesthetic Management is limited to one (1) method per patient for the same day of service.

Providers are required to submit a copy of their permit to administer anesthesia and/or sedation to Medicaid, upon request.

D9212 Trigeminal divisional block anesthesia	**<21**	**N**
D9222 Deep sedation/general anesthesia – first 15 minutes	**<21**	**N**
D9223 Deep sedation/general anesthesia – each subsequent 15 minutes increment	**<21**	**N**
D9230 Analgesia, anxiolysis, inhalation of nitrous oxide	**<21**	**N**
D9239 Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	**<21**	**N**
D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	**< 21**	**N**

PROFESSIONAL CONSULTATION

D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	**N**	**N**

Type of service provided by a dentist or dental specialist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate source. The dentist may initiate diagnostic and/or therapeutic services.

PROFESSIONAL VISITS

D9410 House call / Extended Care Facility Call **N** **N**

Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate procedure codes for actual services performed.

D9420 Hospital call **N** **N**

May be reported when providing treatment in hospital or ambulatory surgicenter, in addition to reporting appropriate codes for actual services performed.

DRUGS

D9610 Therapeutic drug injection, by report **N** **Y**

Includes antibiotics, intravenous, or injection of sedative.

D9630 Other drugs and/or medicaments, by report **N** **Y**

Includes, but not limited to, oral antibiotics, oral analgesics, oral sedatives, and topical fluoride dispensed in the office for home use; does not include writing prescriptions.

MISCELLANEOUS SERVICES

	Age Restriction	PA Requirement
D9910 Application of desensitizing medicament	**<21**	**Y**

Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.

D9920 Behavior Management, Dental	**N**	**N**

For patients whose medical status and/or behavior require special management techniques for the safe delivery of necessary oral health services. To be reported in addition to treatment provided.

D9930 Treatment of complications (post-surgical) - unusual circumstances, by report	**N**	**Y**

For example, treatment of a dry socket following extraction or removal of bony sequestrum.

D9940 Occlusal guard, by report	**<21**	**Y**

Removable dental appliance which is designed to minimize the effects of bruxism (grinding) and other occlusal factors.