SECTION 2

DENTAL SERVICES

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1 GENERAL POLICY

Dental services, as specified in this section, are a covered service of the Utah Medicaid Program. References: 42 C.F.R. 440.100, 440.120, 442.457, 442.458, 447.341, 483.460; Utah Department of Health Rule R455-20B.

1 - 1 Credentials

Dentists licensed in the state where the services are provided may be reimbursed for services.

1 - 2 Billing

Dental services are billed using ADA accepted dental claim forms. Medicaid can only accept up to 18 procedure code lines per claim form.

Effective 10/1/2003, Medicaid will accept the most current dental forms, ADA versions 1999 and 2002, discontinuing the 1994 version. Requiring current ADA form formats facilitates the entry of data into the computer and increases efficiency and cost effectiveness of the claims adjudication process. Medicaid accepts dental claims electronically in the ANSI X12N 837 format, version 4010. All other means of electronic submission will be discontinued, i.e. Medicaid Bulletin Board, diskette, etc. For additional information concerning electronic billing, see SECTION 1, Chapter 11-19 (1) Electronic Data Exchange: UHIN, of this manual.

1 - 3 Definitions

Adult: A person who is 21 years of age or older on the date of service.

Child: A person who is age 20 or under on the date of service.

Dental Services: Diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession.

Dentist: An individual licensed to practice dentistry.

Emergency services: Treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

Anterior Tooth: Tooth numbers 6 through 11; 22 through 27; C through H; and M through R.

Posterior Tooth: Tooth numbers 1 through 5; 12 through 21; 28 through 32 and A through B; I through L; and S through T.

Prior authorization: Prior authorization is approval given by the Division of Health Care Financing prior to dental services being rendered.

If a dental code requires prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services. Emergency services may be approved after the service is given if adequate documentation of the emergency is included with the request.

1 - 4 Covered Services and Limitations

Dental services covered by Medicaid are described in Chapters 1 - 5 through 1 - 18. Services ***not*** described, or listed in Chapter 2, Non-Covered Services, are ***not*** covered. Services covered for all patients are listed under the general service heading.

1 - 5 Diagnostic Services

Codes D0120, D0140, D0150 are covered.

Medicaid will reimburse for only one evaluation (D0140, D0120, or D0150) per patient per day, even if more than one provider is involved from the same office or clinic. Multi-exams for the same date of service are not covered.

Code D0140 is **not** to be billed with numerous fillings, multi-tooth extractions, prophy and fluoride treatments, relines, root canals, reline, denture appointments, nor regular examinations. A comprehensive oral evaluation is a covered service payable one time only per provider.

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A periodic oral evaluation is a covered service and may be performed twice in a calendar year per patient. This is allowed two times by the same provider, or one time when it is performed in addition to a previously administered comprehensive oral evaluation.

1 - 6 Radiographic Services

The following types of radiographic procedures are covered: Bitewing; Periapical; Full Mouth Series; Panoramic.

1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. If the number of x-rays exceed 12 per visit, they rebundle into code D0210, full mouth series.
2. A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210.
3. Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series.
4. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
5. Panoramic x-rays and full series x-rays should not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.

1 - 7 Preventive Services

A prophylaxis, with or without fluoride, is covered two times a calendar year per provider for children. For adult coverage only the prophylaxis is covered. Oral debridement may be done once per year and in conjunction with a prophylaxis in cases requiring subgingival scaling.

Space maintainers are covered for children.

For children 18 and under, occlusal sealants on the permanent molars and pre-molars (bicuspids) are covered.

1 - 8 Restorative Services

Routine amalgam filings on posterior teeth and composite resin fillings on anterior teeth are covered.

Composite resin restorations on anterior teeth and the occlusal and buccal surfaces only, amalgam restorations, pin retention, stainless steel crowns, core buildups, prefabricated post and core, and recementation of crowns are covered services.

Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It **is** allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent.

Porcelain fused to base metal crowns on permanent anterior teeth are covered for children and requires **written prior approval** as described in Chapter 5, Dental Procedure Codes, Restorative Services.

Medicaid will not reimburse for a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth.

1 - 9 Endodontics

Root canal therapy is a covered benefit for children, age 20 years and younger, excluding third molars. Root canal therapy is covered for adults excluding second and third molars.

Therapeutic pulpotomy is covered for primary teeth only. Root canal therapy for primary teeth is excluded.

First Stage Endodontic Procedures

1. Billing for Completed Root Canal

   Root canals are to be billed after the canals have been completely obturated with the final filling. Billing for services which have not been completed is considered fraud.

   X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.

2. Billing the Patient when Root Canal Incomplete

   When a Medicaid patient has the first stage endodontic procedures done for pain relief and fails to return for subsequent appointments, the dentist cannot bill Medicaid for a completed therapeutic pulpotomy. A provider may bill the Medicaid patient ONLY IF the provider scrupulously follows the process described in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients. The process requires a written agreement with the patient in advance of treatment. This may also help prevent no-shows for root canal appointments. Two of the exceptions to the prohibition on billing patients are described below:

   A. The dental provider may bill a patient for broken appointments under the conditions specified in SECTION 1, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met. Briefly, the conditions require a written agreement with the patient regarding broken appointments. Refer to SECTION 1, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, for complete instructions.

   B. The dental provider may bill a Medicaid patient who fails to complete therapeutic pulpotomy when ALL FOUR conditions of SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met. For your convenience, those conditions are repeated in Chapter 3, Dental Spend-ups. A dentist who fails to comply exactly with the Medicaid process for billing a patient is disqualified from billing the patient.

   C. A dentist who has the required agreement with the patient may bill the patient under CDT-3 code, D3221, pulpal debridement - primary and permanent teeth, for the relief of acute pain prior to conventional root canal therapy. Medicaid does not cover code D3221. This is why the dentist may bill the patient for the procedure provided there is the required agreement in place and the patient fails to complete endodontic treatment. **Code D3221 cannot be used by a provider who completes endodontic treatment and bills Medicaid**.

   D. If the dentist has the required agreement with the patient, the dentist may collect the fee for D3221, pulpal debridement, at the time of service. The dentist must refund the fee when the root canal was finished and Medicaid is billed.

   E. If the dentist has the required agreement with the patient, did not collect a fee for D3221, pulpal debridement, at the time of service, and the patient fails to return, the dentist may bill the patient for the service.

   F. If the dentist did not obtain the required agreement with the patient in advance of treatment, the dentist may NOT subsequently bill the patient under D3221.

1 - 10 Periodontics

A gingivectomy for patients who use anticonvulsant medication is a covered service which requires telephone prior authorization. A "Full mouth debridement", code D4355, is available one time per year if subgingival calculus is present and may be billed in conjunction with a prophylaxis on the same date of service.

1 - 11 Prosthodontics

All denture services described in this chapter require written **prior authorization**. Refer to criteria in Chapter 5, Dental Procedure Codes, Prosthodontics. Medicaid expects prosthetic appliances to last five years. Dentures and partial denture replacements are reimbursable less than five years from the initial placement if necessitated by an extraction.

Prosthodontic services covered:

1. Complete dentures, includes routine post-delivery care and adjustments for six months.
2. Immediate dentures, includes routine post-delivery care and adjustments and soft liners for six months.
3. Partial dentures.
4. Relines, D5750 and D5751. Medicaid covers only hard relines completed by a laboratory and will reimburse for only two relines per year per arch.

Medicaid does **not** pay for temporary stayplate partials or temporary dentures.

*** * Additional Requirements For A Resident of a Nursing Facility or Intermediate Care Facility for the Mentally Retarded Who Need Prosthetic Services**

For residents of nursing facilities and Intermediate Care Facilities for the Mentally Retarded, the staff physician *or* nursing facility dental consultant must add documentation supporting medical need and expected results in the patient's medical record for audit purposes. The additional information should include the following six items:

1. The ability of the patient to adjust to and utilize the denture;
2. The ability of the patient to retain and care for the denture;
3. The patient's desire for a denture;
4. Anticipated result of denture placement, i.e., improved nutrition, improved health, etc.;
5. Assessment of patient's health and nutrition status; and
6. Whether the patient can be expected to wear the denture.

NOTE: The dentures for a nursing home patient must have identification on the appliance to indicate to which patient they belong.

1 - 12 Denture Adjustments, Repairs, Relines

Denture adjustments are a covered service only when performed by a dentist who did not provide the denture. Other services include: repair broken denture base, repair or replace broken clasps, replace tooth, add tooth, reline denture, and rebase denture.

1 - 13 Oral Surgery

Extractions are a covered service. Extractions include simple, surgical, soft tissue impactions, partial bony impactions, and full bony impactions.

General dentists may be reimbursed for extractions, incision and drainage, and frenulectomies for ankyloglossia. Some oral surgery codes are only payable to an oral surgeon.

Surgery for emergency treatment of traumatic injury requires prior authorization within three working days following the incident.

Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus is covered.

1 - 14 Orthodontia

Prior is authorization required. Send pre-treatment models, panoramic x-rays, and requested codes on ADA form. Medicaid only covers comprehensive treatment. Patients must score 30 or more using the Saltzman's Index. The Saltzmann's Index means the "Handicapping Malocclusion Assessment Record" by J. A. Salzmann, used for assessment of handicapping malocclusion, as adopted by the board of directors of the American Association of Orthodontists and the Council on Dental Health of the American Dental Association.

Medicaid provides orthodontia services for Medicaid eligible children who have a handicapping malocclusion due to birth defects, accidents, or abnormal growth patterns of such severity that it renders them unable to masticate, digest, or benefit from their diet.

Reimbursement is made using D8080 which includes banding and adjustments. At the completion of treatment the provider may bill a retention code using D8680, orthodontic retention (removal of appliance, construction and placement of retainer(s)).

Non-Covered Services

1. Limited orthodontic and removable appliance therapies are not benefits.
2. Removable appliances in conjunction with fixed banded treatment are not covered.
3. Habit control appliances are not a benefit.
4. Orthodontic services for cosmetic or esthetic reasons.

Combined Orthodontic/Surgical Treatment Cases

Medicaid requires that a licensed orthodontic specialist and a licensed maxillofacial oral specialist be used to treat combined orthodontic/surgical cases. Reimbursement will not be made to general dentists who perform the orthodontic or surgical treatment for combined orthodontic/surgical cases.

1 - 15 Emergency Services

Emergency services are reimbursable to dentists and oral/maxillofacial surgeons. If the service requires prior authorization, and authorization cannot be obtained prior to service due to the emergent nature of the services provided, the request and documentation may be submitted within three days following the services. Emergency services may be approved after the service is given when adequate documentation of the emergency is included with the request. The dentist or oral/maxillofacial surgeon shall submit the following documents with the prior authorization request: the operation report, discharge summary, pathology report, x-ray report, and laboratory report if available.

The fee for emergency dental care services is global. It includes necessary laboratory and preoperative work, placement of sutures, packing, removal of sutures and office calls.

Non-covered Emergency Services

Examples of services that are not covered under "emergency services" are: a patient complaint that does not meed the definition of an emergency services; chronic conditions without sudden acute symptoms; multiple, serial extractions; teeth that are abscessed, but do not have sudden acute onset of symptoms (pain or swelling).

When the patient requests a non-covered service, the patient may be billed, as long as the requirements for billing non-covered services to Medicaid patients are met [SECTION 1 of this manual, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services].

1 - 16 Hospitalization for Dental Services

Hospitalization to perform dental services is a covered service on an *outpatient basis only*. The provider must document the need for the hospitalization. Refer to Chapter 5, Dental Procedure Codes, General Anesthesia.

1 - 17 I.V. Sedation

I.V. sedation is a covered service and does not require prior authorization when performed by a dentist with state licensure to perform I.V. sedation or by a nurse anesthetist. I.V. sedation requires prior authorization when performed by a nurse anesthetist. I.V. sedation does not include intra oral injections for sedation.

Document in the patient's record the physical or mental disability or other medical condition which necessitates use of I.V. sedation. NOTE: Anxiety does not qualify as a medical condition.

1 - 18 General Anesthesia

General anesthesia is a covered service. **Prior authorization** requirements are based on the patient's age and whether or not the patient has a documented physical or mental disability. Criteria are described in Chapter 5, Dental Procedure Codes, General Anesthesia.

General anesthesia for removal of erupted teeth is not a covered service, except when medically necessary.

If an emergent or urgent situation exists, the provider may telephone for a pending request for a prior authorization. The provider must submit the necessary documentation within twenty-one days.

General anesthesia may be performed by a dentist or oral surgeon possessing the proper Class IV permit under State Licensure. The provider may choose to perform his or her own anesthesia with the support staff required by State Licensing or may elect to have another properly licensed individual perform the anesthesia.

Anesthesia providers, CRNA or anesthesiologists, billing for dental services should use code 41899 with the appropriate "P" modifier (Physical Status) and the actual anesthesia time in minutes. Prior Authorization is required under certain conditions. Refer to the Dental or Oral Surgeon Provider Manuals for criteria. For electronic submissions, report anesthesia minutes using the MJ qualifier. For paper claims, report anesthesia minutes in Box 24G of the CMS-1500 form by putting an "M" before the number of minutes.

1 - 19 Oral Sedation

Medicaid covers intramuscular and intra oral injections for sedation only under code D9248, non-intravenous conscious sedation, which includes the sedative drug. Behavior management, D9920, is **not** covered. Nitrous Oxide analgesia is **not** covered. Oral sedation medications are covered under the Medicaid pharmacy program by prescription only, but oral sedation under code D9630, is **not** covered.

1 - 20 After Hours Office Visit

Code D9440, Office visit, after regularly scheduled hours, is allowed for use for visits occurring after the regular business day (8 a.m. to 5 p.m.), typically in connection with an emergency appointment. If an appointment is scheduled in the course of normal business procedures, it is not allowed under this code. This includes lunch, afternoons breaks, and visits after normal hours when the dentist sees the patient following the normal closing hour. This code may be used only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which can not be scheduled. Scheduled appointments are not allowed reimbursement under this code.

1 - 21 Billing for Supernumerary Teeth

Medicaid supports the nomenclature approved by the ADA for identifying supernumerary teeth. Please bill using the following tooth identifiers for supernumerary teeth:

Upper Right **Deciduous Teeth** **Upper Left**

Tooth #	A	B	C	D	E	F	G	H	I	J
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Lower Right **Deciduous Teeth** **Lower Left**

Tooth #	T	S	R	O	P	Q	N	M	L	K
Supernumerary #	TS	SS	RS	OS	PS	QS	NS	MS	LS	KS

Upper Right **Permanent Teeth** **Upper Left**

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Lower Right **Permanent Teeth** **Lower Left**

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

2 NON-COVERED SERVICES

Medicaid does **NOT** cover the following dental services:

1. Multiple surface composite resin fillings on posterior teeth
2. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth
3. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex.
4. Root canal therapy on primary teeth or permanent third molars, and second molars for non-pregnant adults
5. Fixed bridges or pontics
6. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperiosteal implants
7. Tooth transplantation
8. Ridge augmentation
9. Osteotomies
10. Vestibuloplasty
11. Alveoloplasty
12. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
13. Treatment of temporomandibular joint syndrome or its prevention, sequela, subluxation, therapy, arthrostomy, meniscectomy or condylectomy
14. House calls
15. Consultation or second opinions not requested by Medicaid
16. Processing claim forms
17. Charges for laboratory tests or pathology reports (The laboratory or pathologist must bill the charges directly to Medicaid.)
18. Services which require a prior authorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service which meets the conditions of Chapter 1 - 14, Emergency Services.
19. General anesthesia for removal of an erupted tooth.
20. Periodontal scaling, root planing, and periodontal surgery.

21. Oral sedation and behavior management fees. Medicaid will pay a pharmacy to dispense orally administered medications.

22. Temporary dentures or temporary stayplate partial dentures

23. Maxillary or Mandibular frenectomies.

24. Limited orthodontic treatment, including removable appliance therapies.

25. Removable appliances in conjunction with fixed banded treatment.

26. Habit control appliances.

3 DENTAL SPEND-UPS

Medicaid clients in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered services.

The only dental procedures which a Medicaid client may choose to upgrade are as follows:

- Covered amalgam fillings to non-covered composite resin fillings
- Covered stainless steel crowns to non-covered porcelain or cast gold crowns
- Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab prepared facings)

Do not bill Medicaid for the non-covered service, but bill Medicaid for the covered service (amalgam or stainless steel crown) and record the actual upgraded services rendered in the patient chart with a note of the spend-up code billed to Medicaid.

Patient Choice of a Non-Covered Service which is an Upgrade from a Covered Service.

Generally, a provider may not bill a Medicaid patient for the difference between the Medicaid payment and the provider's usual and customary fee, as the Medicaid payment is considered payment in full. However, when a patient requests a service not covered by Medicaid, such as a non-covered composite resin filling instead of a covered silver filling, a provider may bill the Medicaid patient when ALL FOUR conditions of SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 9, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services, are met. For your convenience, those conditions are repeated below:

a. The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.)
b. The patient is advised prior to receiving a non-covered service that Medicaid will not pay for the service.
c. The patient agrees to be personally responsible for the payment.
d. The agreement is made in writing between the provider and the patient which details the service and the amount to be paid by the patient.

The patient makes the choice. The dentist cannot mandate nor insist the covered procedure be upgraded.

Unless all four conditions are met, the provider may not bill the patient for the non-covered service, even if the provider chooses not to bill Medicaid. Further, the patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

The amount paid by the patient is **the difference between the provider's usual and customary charge for the non-covered service and the provider's usual and customary charge for the covered service**. For example, if the usual and customary charge for a two surface amalgam filling is $50, and the patient wants a two surface composite filling with the regular fee of $75, the patient would be responsible to pay an additional $25.

The amount the patient must pay is **not** the difference between the Medicaid payment for the service and the usual and customary fee for the requested upgraded service. For example, Medicaid pays $39.60 for a two surface amalgam filling, even though the provider's usual and customary charge might be $50. The provider accepts $39.60 as payment in full and cannot bill the patient for the $10.40 difference between the Medicaid fee and the usual and customary fee. If the patient wants a two surface composite filling with the regular fee of $75, the patient would be responsible to pay the difference of an additional $25. The patient is **not** responsible to pay the difference between the Medicaid payment for the covered service and the usual and customary fee for the requested upgraded service. (In this example, the patient is **not** responsible to pay the difference of $35.40 between the Medicaid payment of $39.60 and the usual and customary fee of $75.00.)

4 DENTAL INCENTIVE PROGRAMS

Effective July 1, 1997, Medicaid began new reimbursement programs for dentists. The programs are the result of an increase in funding from the 1997 legislature and recommendations made to Medicaid by a Dental Task Force composed of dentists, Medicaid staff, and client representatives. The intent of the programs is to increase access to dental service and reward dentists who treat a significant number of Medicaid clients.

A. Dental Providers in Urban Counties

Urban counties include those in the Wasatch front: Salt Lake, Weber, Davis, and Utah Counties. Medicaid will increase the reimbursement on all covered services by 20% for participating urban providers who are willing to treat 100 or more individual Medicaid clients in the course of a year.

Certain dentists may already be above the 100 clients in a year level. Dentists in this group will receive the 20% increase automatically. Remember, 100 Medicaid clients per year is only two per week. Other dentists who are willing to sign an agreement to see 100 or more Medicaid clients during the next year will also receive the 20% for all services.

The 20% differential increase began with Medicaid eligible services performed after July 1, 1997. Semiannually, Medicaid will track the clients being treated and will notify dentists by letter if there will be any change in their reimbursement rates. Providers must treat 50 Medicaid eligible individuals each six months, which averages only two (2) patients per week, to remain eligible. If a dentist falls behind in these averages, he will lose the 20% increased payment differential until he brings the level of service up to the required level and reapplies for the differential.

Oral surgeons are exempt from the 100 patient minimum if they agree to be on a referral list available to dentists and Medicaid staff. To receive the 20% increase, they must sign and return the Medicaid agreement letter on which they agree to accept Medicaid referrals.

B. Dental Providers in Rural Counties

Dentists outside of the Wasatch front (which includes all counties EXCEPT Salt Lake, Weber, Davis, and Utah Counties) automatically receive a 20% increase in reimbursement. This increase is to encourage dentists in rural areas to treat Medicaid clients and thereby improve access for clients residing outside of the Wasatch front areas.

C. The increases outlined in paragraphs A and B are mutually exclusive. A dentist in one of the four Wasatch Front counties can get a 20% increase by seeing the designated number of Medicaid clients. Dentists in other counties will receive a 20% increase regardless of the number of Medicaid patients.

D. Bill your usual and customary fee for a dental service provided to a Medicaid client. If you have signed the Medicaid dental agreement, you will receive either 120% of the amount listed on the reimbursement schedule or the amount you billed for the service provided, whichever amount is less.

E. The Agreement Letter is included with this manual. If you wish to sign up for the 20% incentive immediately, you may fax a completed copy of the attached agreement to Medicaid at 1-801-538-6805.

MEDICAID AGREEMENT LETTER

DENTIST

I agree to provide eligible dental services to an average of two (2) Medicaid eligible clients per week. I recognize that this agreement will result in an increase in the Medicaid payment amount of 20% for services rendered on or after July 1, 1997, and that initially these payments will be made on a prospective basis based on my Medicaid payments for the previous quarter.

Payment of the additional 20% will begin for the payment cycle after this signed agreement has been received by the Bureau of Medicaid. Rural providers are not eligible for the additional 20% volume payment, they will receive an automatic 20% because they are providing services in a rural area.

_____ _____

Dentist's Signature Date

_____

Medicaid Provider Number

ORAL SURGEON

I agree to have my name included on a referral list for Medicaid clients, and will accept Medicaid referrals. I understand that this agreement will result in a 20% increase on the Medicaid payment schedule for all Medicaid client services. Rural providers are not eligible for the additional 20% referral list payment, they will receive an automatic 20% because they are providing services in a rural area.

_____

Oral Surgeon's Signature Date

_____

Medicaid Provider Number

Please return signed form to:

Medicaid Provider Enrollment
Box 143106
Salt Lake City UT 84114-3106

Fax line 538-6805

IF YOU ARE NOT CURRENTLY A MEDICAID PROVIDER AND WISH TO APPLY TO BE ONE, PLEASE CALL the Medicaid Information Line: 538-6155 or 1-800-662-965.

5 DENTAL PROCEDURE CODES, LIMITS AND CRITERIA

5 - 1 Table Headings Defined

Code The code is the Health Common Procedure Code System (HCPCS) code used by Medicaid to identify the item or the "Y" code assigned by Medicaid. The procedure codes listed are the only ones accepted by Medicaid. Medicaid replaces the initial '0' of the ADA dental codes with a 'D'. For example, the ADA code 00120 is equivalent to the Medicaid code D0120. Refer to the code tables which follow.

Age, PG "0 - 20" : This entry in the **Age, PG** column means payment will be made only if :
(1) the patient's age on the date of service falls within the age range specified [For example, "0 - 20" means from birth through age 20]
OR
(2) the patient is a pregnant woman.

"all": This entry in the **Age, PG** column means Medicaid covers the service or procedure from birth through any age, including non-pregnant adults.

Criteria The criteria listed are required by Medicaid before the item will be reimbursed and include criteria used by Medicaid staff to review a request for prior authorization.

Limits Any limits applicable to a procedure code.

P A **P A**, Prior Authorization, is approval given by the Division of Health Care Financing prior to dental services being rendered. If Prior Authorization is required for a procedure, code letter **T** or **W** will be in the P A column. If there is no letter in this column, prior authorization is not required. Refer to the Utah Medicaid Provider Manual, SECTION 1, Chapter 9, Prior Authorization, for additional information, on the prior approval process.

When a dental code requires prior authorization, the procedure must be authorized by Medicaid BEFORE the service is given, except for emergency services. For authorization of emergency services, refer to Chapter 1 - 14, Emergency Services.

T - Telephone Prior Authorization: Call Medicaid Information and follow the telephone menu prompts. In the Salt Lake City area, call **538-6155**.
In Utah, Idaho, Wyoming, Colorado New Mexico, Arizona, and Nevada, call toll-free: **1-800-662-9651**.
From other states, call **1-801-538-6155**.

W - Written Prior Authorization: Send written requests to:

MEDICAID PRIOR AUTHORIZATION
BOX 143103
SALT LAKE CITY UT 84114-3101

or use FAX NUMBER: **(801) 538-6382**

Coding Notes

Codes newly added to the list are in bold print.
A vertical line in the margin indicates where text or a descriptor changed for an existing code.
An asterisk (*) marks where a code is newly removed.

DIAGNOSTIC SERVICES

References: Chapter 1 - 5, Diagnostic Services
Chapter 1 - 15, Emergency Services

Code	Description	Age, PG	Criteria	PA	Limits
D0120	Periodic oral evaluation	All			Two per calendar year per provider, or one per calendar year per provider in addition to a comprehensive oral evaluation.
D0140	Limited oral evaluation - problem focused (previously code D0130, emergency exam)	All	Allows the dentist to be paid for examining, prescribing or referring the patient.		**Limited to diagnosing in the presence of immediate pain and not in conjunction with other dental treatment. See 1-5 diagnostic services on page 3.**
D0150	Comprehensive oral evaluation- new or established patient	All			One time only per provider

RADIOGRAPHS

Reference: Chapter 1 - 6, Radiographic Services

Code	Description	Age, PG	Criteria	PA	Limits
D0210	Intraoral - complete series (including bitewings)	All			
D0220	Intraoral - periapical - first film	All			1. Medicaid considers it standard practice to bill for a full mouth series if more than 12 periapicals are taken during a single visit. 2. Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series. 3. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D0230	Intraoral - periapical - each additional film	All			
D0270	Bitewing - single film	All			
D0272	Bitewings - two films	All			
D0274	Bitewings - four films	All			

D0330	Panoramic film	All		1. May be billed with bitewings. 2. A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210. 3. Panoramic x-rays and full series x-rays should not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.

PREVENTIVE SERVICES

Reference: Chapter 1 - 7, Preventive Services

Code	Description	Age, PG	Criteria	PA	Limits
D1110	Prophylaxis - adult	16 and older			Two per calendar year
D1120	Prophylaxis - child	0 - 20			Two per calendar year, with or without fluoride
D1203	Topical application of fluoride (prophylaxis not included) - child	0 - 20			Two per calendar year
D1351	Sealant - per tooth	0 - 18	1st and 2nd permanent molars or premolars (bicuspids)		
D1510	Space maintainer - fixed - unilateral	0 - 20			
D1515	Space maintainer - fixed - bilateral	0 - 20			
D1520	Space maintainer - removable - unilateral	0 - 20			
D1525	Space maintainer - removable - bilateral	0 - 20			
D1550	Recementation of space maintainer	0 - 20			

RESTORATIVE SERVICES

Reference: Chapter 1 - 8, Restorative Services

Code	Description	Age, PG	Criteria	PA	Limits
D2140	Amalgam - one surface, primary or permanent	All			
D2150	Amalgam - two surfaces, primary or permanent	All			
D2160	Amalgam - three surfaces, primary or permanent	All			
D2161	Amalgam - four or more surfaces, primary or permanent	All			
D2330	Composite resin - one surface anterior	All			Primary or permanent anterior teeth only
D2331	Composite resin - two surfaces anterior	All			Primary or permanent anterior teeth only
D2332	Composite resin - three surfaces anterior	All			Primary or permanent anterior teeth only
D2335	Composite resin - four or more surfaces	All			Primary or permanent anterior teeth only
D2391	Resin-based composite - one surface posterior	All			Limited to occlusal and buccal surfaces
D2751	Crown - porcelain fused to base metal crown, permanent anterior teeth	0-20	Provider must send 1. Completed ADA form and 2. Periapical x-rays	W	Permanent anterior teeth only
D2920	Re-cement crown	All			

Code	Description	Age, PG	Criteria	PA	Limits
D2930	Prefabricated stainless steel crown - primary teeth	0-20	Medicaid will not reimburse for a primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth.		Teeth letters A - T
D2931	Prefabricated stainless steel crown - permanent teeth	All	Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It is allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent.		Teeth numbers 2 - 15 and 18 - 31
D2950	Core build-up including any pins	All			Teeth numbers 2 - 15 and 18 - 31
D2951	Pin retention per tooth in addition to restoration	All			Teeth numbers 2 - 15 and 18 - 31
D2954	Prefabricated post and core in addition to crown	All			Teeth numbers 2 - 15 and 18 - 31
D2980	Crown repair, by report	All			

ENDODONTICS

Reference: Chapter 1 - 9, Endodontics

Code	Description	Age, PG	Criteria	PA	Limits
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 20			Primary teeth only
D3310	Endodontic therapy - Anterior, excluding final restoration	All			Permanent teeth
D3320	Endodontic therapy - Premolar (bicuspid), excluding final restoration	All			Permanent teeth
D3330	Endodontic therapy - Molars, excluding final restoration	All			Root canal therapy is a covered benefit excluding third molars. Second and third molars are also excluded for pregnant women and adults age 21 and older. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D3410	Apicoectomy - anterior	All			
D3421	Apicoectomy - bicuspid (first root)	All			
D3425	Apicoectomy - molar (first root)	All			Excludes permanent third molars for children and second and third molars for pregnant women.
D3426	Apicoectomy - each additional root including retrofill	All			Excludes permanent third molars for children and second and third molars for pregnant women.
D3430	Retrograde filling - per root	All			Excludes permanent third molars for children and second and third molars for pregnant women.

PERIODONTICS

Reference: Chapter 1 - 10, Periodontics

Code	Description	Age, PG	Criteria	PA	Limits
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth Spaces per quadrant	All	For drug-induced gingival hyperplasia only. (such as Dilantin and Cyclosporin)	T	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0-17	Must have subgingival calculus present	T	Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	18 and older	Must have subgingival calculus present		Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling.

PROSTHODONTICS

References: Chapter 1 - 11, Prosthodontics
Chapter 1 - 12, Denture Adjustments, Repairs, Relines
Chapter 1 - 15, Emergency Services

Code	Description	Age, PG	Criteria	PA	Limits
NOTE: For residents of nursing facilities and Intermediate Care Facilities for the Mentally Retarded, refer to additional information to be included with prior authorization in Chapter 1 - 11, Prosthodontics. Medicaid expects removable appliance to last at least five years before replacement.					
D5110	Complete denture - maxillary (includes routine post-delivery care **and adjustments for six months**)	All	Provider must know age of dentures and reasons dentures cannot be repaired or relined. Replacement is not a benefit when: 1. Due to neglect or abuse of the existing denture OR 2. The existing denture can be relined for proper fit.	T	Dentures less than five years old should be repaired or relined.
D5120	Complete denture - mandibular (includes routine post-delivery care **and adjustments for six months**)	All	Same as D5110 above.	T	Same as D5110 above
D5130	Immediate denture - maxillary (includes routine post-delivery care **and adjustments and soft liners for six months**)	All	Prior authorization must be obtained before removing teeth in preparation for the immediate denture. Provider must send: 1. Completed ADA form and 2. Panorex or full mouth mounted periapical x-rays.	W	
D5140	Immediate denture - mandibular (includes routine post-delivery care **and adjustments and soft liners for six months**)	All	Same as D5130 above.	W	
D5211	Maxillary partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	All	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 5. Provider must send the	W	Non-emergency

Code	Description	Age, PG	Criteria	PA	Limits
			following: A. Completed ADA form identifying missing teeth; B. Mounted periapical x-rays or Panorex; C. List of teeth to be replaced.		
D5211	Maxillary partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	All	Same criteria as D5211 above, Non-Emergency, PLUS one of the following: 1. Tooth is fractured or avulsed, or 2. Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim.	T	Emergency - anterior #6-11 only
D5212	Mandibular partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	All	Same criteria as D5211 above, Non-Emergency.	W	Non-Emergency
D5212	Mandibular partial denture - resin base, (including clasps, rests, and teeth) "Flipper"	All	Same criteria as D5211 above, Emergency.	T	Emergency - anterior #22-27 only
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	All	1. Prior authorization must be obtained before fabricating the partial denture. 2. There must be an anterior tooth missing or the partial denture must restore mastication ability. 3. If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4. There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5. Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6. Provider must send the following: A. Completed ADA form identifying missing teeth; B. Mounted periapical x-rays or Panorex; C. List of teeth to be replaced.	W	
D5214	Mandibular partial denture cast metal framework	All	Same criteria as D5213	W	

Code	Description	Age, PG	Criteria	PA	Limits
D5410	Adjust complete denture - maxillary	All	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5411	Adjust complete denture - mandibular	All	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5421	Adjust partial denture - maxillary	All	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5422	Adjust partial denture - mandibular	All	Payable to dentist who did not originally provide the denture.		May be payable to originating dentist six months post delivery
D5510	Repair broken complete denture base	All			
D5520	Replace missing or broken teeth - complete denture (each tooth)	All			
D5630	Repair or replace broken clasp	All			
D5640	Replace broken or missing tooth - per tooth (partial denture)	All			
D5650	Add tooth to existing partial denture	All			
D5750	Reline complete maxillary denture (laboratory)	All	Medicaid covers only hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines should be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions.		Medicaid will not pay for more than two relines per year per arch.
D5751	Reline complete mandibular denture (laboratory)00	All	See criteria above.		See limit above.
D5760	Reline maxillary partial denture (laboratory)	All			
D5761	Reline mandibular partial denture (laboratory)	All			

ORAL SURGERY SERVICES

Reference: Chapter 1 - 13, Oral Surgery

Code	Description	Age, PG	Criteria	PA	Limits
D7111	Extraction, coronal remnants - deciduous tooth	all			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal	all			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of the tooth	all			
D7220	Removal of impacted tooth - soft tissue	all			
D7230	Removal of impacted tooth - partially bony	all			
D7240	Removal of impacted tooth - completely bony	all			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	all			
D7280	Surgical access of an unerupted tooth	all			
D7286	Biopsy of oral tissue - soft	all			
D7410	Excision of benign lesion up to 1.25 cm	all			
D7471	Removal of lateral exostosis (maxilla or mandible)	all	Must be done in conjunction with a new denture or partial denture fabrication	W	
D7510	Incision and drainage of abscess - intraoral soft tissue	all			
D7960	Frenulectomy (Frenectomy)	all	Ankyloglossia (lingual only)	T	
D9310	Consultation	all			
D9420	Hospital Call	all		T	

ORTHODONTICS

Reference: Chapter 1 - 14, Orthodontia

Code	Description	Age, PG	Criteria	PA	Limits
D0470	Study models (for orthodontic request only)	**0-20**			
D8080	Comprehensive orthodontic treatment of the adolescent dentition (global fee covering all modalities during treatment)	**0-20**	Provider must send: 1. Prior authorization ADA form, 2. Trimmed study models and wax bite, and 3. Panorex X-ray if there are missing/impacted teeth.	W	
D8670	Periodic orthodontic treatment visit (global fee covering all modalities during treatment)	**0-20**	Prior authorized with D8080 above, quarterly, eight times in two years.	W	
D8680	Orthodontic retention	**0-20**	Prior authorized at the completion of orthodontic treatment	W	
D8692	Replacement Retainer	**0-20**	This service is limited to one per lifetime for those who are receiving orthodontic treatment paid by Utah Medicaid.	W	Not payable as initial retainer

I.V. SEDATION

Reference: Chapter 1 - 17, I.V. Sedation

Code	Description	Age, PG	Criteria	PA	Limits
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	All	Document in the patient's record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition.		Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	All	Same as D9241		Same as D9241

I.M. or INTERORAL SEDATION

Reference: Chapter 1 - 19, Oral Sedation

Code	Description	Age, PG	Criteria	PA	Limits
D9248	Non-intravenous conscious sedation	All	The code is covered for intramuscular and intra oral injections for sedation only and includes the sedative drug. Document in the patient's record the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition.		Prior authorization is not required when service is performed by a dentist with state licensure to perform I.V. sedation.

GENERAL ANESTHESIA

References: Chapter 1 - 18, General Anesthesia
Chapter 1 - 16, Hospitalization

Code	Description	Age, PG	Criteria	PA	Limits
D9220	Deep sedation/general anesthesia - first 30 minutes	0 - 4	For patient 4 years of age or younger, prior approval is not required.		
D9220	Deep sedation/general anesthesia - first 30 minutes	5 and older	Patient is at least 5 years of age with a physical or mental disability. Document the physical or mental disability which justifies the use of general anesthesia.		
D9220	General anesthesia first 30 minutes, in office	5 - 8	Patient is 5 - 8 years of age and without physical or mental disability, the patient must have a documented condition such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia.		
D9220	Deep sedation/general anesthesia - first 30 minutes	9 and older	Patient is at least 9 years of age and without physical or mental disability, the patient must have a documented condition such as such as a failure and inability to treat when using a pre-medication which justifies the use of general anesthesia, OR in conjunction with the extraction of a partial or full boney impacted third molar.		
D9221	Deep sedation/general anesthesia - each additional 15 minutes	All			Must be billed in conjunction with D9220 above.

Y1899, dental general anesthesia, is to be used by anesthesiologists and surgical centers for the facility charge for all patients. Please note the prior approval requirements for each age group. Anesthesiologists using Y1899 must follow the billing instructions in the Utah Medicaid Provider Manual for Physician Services, SECTION 3, Anesthesiology.

Code	Description	Age, PG	Criteria	PA	Limits
41899	Unlisted Maxillofacial procedure (Dental general anesthesia: hospital, surgical center, or facility charge)	0 - 4	For patient 4 years of age or younger, prior approval is not required.		
41899	Unlisted Maxillofacial procedure (Dental general anesthesia: hospital, surgical center, or facility charge)	5 & older	Patient 5 years of age or older with a physical or mental disability. Document the physical or mental disability which justifies the use of general anesthesia.	T	
41899	Unlisted Maxillofacial procedure (Dental general anesthesia: hospital, surgical center, or facility charge)	5 - 8	Patient 5-8 years of age and without a physical disability. The patient must have a documented condition, such as a treatment failure and/or the inability to treat when using a pre-medication, which justifies the use of general anesthesia.	T	
41899	Unlisted Maxillofacial procedure (Dental general anesthesia: hospital, surgical center, or facility charge)	9 & older	Patient 9 years of age or older and without physical or mental disability. The patient must have a documented condition, such as a treatment failure and/or inability to treat when using a pre-medication, which justifies the use of general anesthesia. Not applicable for third molar removal. The provider must send the following: 1. A completed ADA form with a proposed treatment plan requesting a hospital setting, and 2. X-rays when applicable.	W	

OTHER PROCEDURES

Reference: Chapter 1 - 20, After Hours Office Visit

Code	Description	Age, PG	Criteria	PA	Limits
D9440	Office visit - after regularly scheduled hours	All	For use only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which can not be scheduled.		Document time in patient's record
D9999	Unspecified adjunctive procedure, by report	All		T	

SECTION 2 INDEX
Alphabetical

SECTION 2 INDEX
Numerical by Code