NEW YORK STATE
MEDICAID PROGRAM

DENTAL

POLICY AND PROCEDURE CODE MANUAL

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Section I - Requirements for Participation in Medicaid

Dental providers must be licensed and currently registered by the New York State Education Department (NYSED), or, if in practice in another state, by the appropriate agency of that state, and must be enrolled as providers in the New York State Medicaid program.

No provider who has been excluded from the Medicaid program may receive reimbursement by the Medicaid program, either directly or indirectly, while such sanctions are in effect.

Qualifications of Specialists

A specialist is one who:

- Is a diplomate of the appropriate American Board; or,
- Is listed as a specialist in the American Dental Directory of the American Dental Association section on "character of practice"; or,
- Is listed as a specialist on the roster of approved dental specialists of the New York State Department of Health (DOH).

All dental providers enrolled in the Medicaid program are eligible for reimbursement for all types of services except for orthodontic care, dental anesthesia and those procedures where a specialty is indicated. ***There is no differential in levels of reimbursement between general practitioners and specialists.***

- Orthodontic care is reimbursable only when provided by a board certified or board eligible orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.
- General anesthesia and parenteral conscious sedation are reimbursable only when provided by a qualified dental provider who has the appropriate level of certification in dental anesthesia by the NYSED. The NYSED issues certificates in three titles:
  i. Dental **General Anesthesia**, which authorizes a licensed dentist to employ general anesthesia, deep sedation, or conscious sedation (parenteral or enteral route with or without inhalation agents); and
  ii. Dental **Parenteral Conscious Sedation**, which authorizes a licensed dentist to employ conscious sedation (parenteral or enteral route with or without inhalation agents); and
  iii. Dental **Enteral Conscious Sedation**, which authorizes a licensed dentist to employ conscious sedation (enteral route only with or without inhalation agents).

  Additional information is located on the New York State Education Department website (NYSED.gov):

  http://www.op.nysed.gov/prof/dent/dentanesthes.htm

Group Providers

A group of practitioners is defined in 18 NYCRR 502.2 as:

> "…two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment)."

Regardless of the arrangement among practitioners (associates, employer-employee, principal-independent contractor), practitioners who practice in a group setting are required to enroll as a group and to comply with the requirements associated with group practices.

Regardless of the nature of the practice (group, employer-employee, associate, etc.), the name, NPI and other required information of the dentist **actually providing the service or treatment** must be entered in the "Servicing Provider" or "Treating Dentist" field on all claims and prior approval requests.

Application of Free Choice

A Medicaid member is guaranteed free choice of a dental provider in obtaining the dental care available under the New York State Medicaid program.

Credential Verification Reviews

Credential Verification Reviews (CVRs) are periodic onsite visits of a provider's place of business to ensure overall compliance with Medicaid regulations. These visits are conducted by the Medicaid program and the Office of the Medicaid Inspector General (OMIG), and assess such areas as:

- provider and staff identification and credentialing
- physical attributes of the place of business
- recordkeeping protocols and procedures regarding Medicaid claiming.

CVRs are conducted for such sites as:

- medical and dental offices
- pharmacies
- durable medical equipment retailers, and
- part time clinics.

CVRs are not performed at hospitals, nursing homes, etc.

Every effort is made to conduct these visits in a professional and non-obtrusive manner. Investigators conducting these reviews will have a letter of introduction signed by the Office of the Medicaid Inspector General and a photo identification card.

(continued on next page)

Should providers, or their staff, have questions regarding these Credential Verification Reviews, they can contact:

The New York State Office of the Medicaid Inspector General
Bureau of Medicaid Investigations
(518) 402-1837

Section II - Dental Services

Dental Care in the Medicaid program shall include only **ESSENTIAL SERVICES** rather than comprehensive care. The provider should use this Manual to determine when the Medicaid program considers dental services "essential". The application of standards related to individual services is made by the DOH when reviewing individual cases.

Children's Dental Services

A child is defined as anyone under age 21 years.

Standards of Quality

Services provided must conform to acceptable standards of professional practice.

Quality of Services Provided
Dental care provided under the Medicaid program must meet as high a standard of quality as can reasonably be provided to the community-at-large. All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association, and must be acceptable to the State Commissioner of Health. Experimental procedures are not reimbursable in the Medicaid program.

Scope of Hospitalization Services

Medicaid members are provided a full range of necessary diagnostic, palliative and therapeutic inpatient hospital care, including but not limited to dental, surgical, medical, nursing, radiological, laboratory and rehabilitative services.

Limitations of Hospitalization
Medicaid utilization review (UR) agents are authorized to review the necessity and appropriateness of hospital admissions and lengths of stay, and to determine Medicaid benefit coverage. These review agents will review inpatient dental services both on a pre-admission and retrospective basis. Emergency admissions may be reviewed retrospectively for necessity and appropriateness.

If you have any questions regarding specific Medicaid hospital review requirements, you may contact the DOH, Bureau of Hospital and Primary Care Services at:

(518) 402-3267

Child/Teen Health Program

Please refer to the EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid), available at the following website:

http://www.emedny.org/ProviderManuals/index.html

Child Health Plus Program

The goal of the Child Health Plus Program is to improve child health by increasing access to primary and preventive health care through a subsidized insurance program. A child eligible for Medicaid is not eligible for Child Health Plus.

For more information on benefits, contact the Child Health Plus Program at:

(800) 698-4543

Dental Mobile Van

The use of mobile vans to provide the operatories for the provision of dental services is commonplace. All claims for services rendered in a mobile unit must have the corresponding Place of Service code which identifies this type of location. That is, the use of a mobile unit (POS - 15). The correct POS code must be reported on every claim. Reporting the incorrect place of service could result in inaccurate payment, audit review and/ or ensuing disallowances.

Please refer to the Centers for Medicare and Medicaid Services website (CMS.gov) for additional information:

Place of Service Code Set - Centers for Medicare & Medicaid Services

Requirements and Expectations of Dental Clinics

- Dental clinics licensed under Article 28 reimbursed on a rate basis or through APG's (i.e., hospital outpatient departments, diagnostic and treatment centers, and dental schools) are required to follow the policies stated in the Dental Policy and Procedure Code Manual and should use this Manual to determine when dental services are considered "essential" by the Medicaid program.
- Except for orthodontic treatment, clinics and schools are exempt from the prior approval procedure because of internal quality assurance processes that insure their compliance with existing Medicaid policy. Prior approval is required for orthodontic services.
- The provision of dental care and services are limited to those procedures presented in the Dental Policy and Procedure Code Manual and are to be provided within the standards and criteria listed in the procedure code descriptions.
- Dental care provided under the Medicaid program includes only *essential services* (rather than "comprehensive" services).
- Non-emergency initial visits should include a cleaning, radiographic images (if required), and a dental examination with a definitive treatment plan. Generally, this should be accomplished in one visit. However, in rare instances, a second visit may be needed for completion of these services. A notation in the record to indicate the necessity for a second visit should be made.

Public health programs in schools, Head-Start Centers, dental schools, clinics treating those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption") and other settings are exceptions that may require more than one visit to complete the above mentioned services.

- Quadrant dentistry should be practiced, wherever practicable, and the treatment plan followed in normal sequence.
- Procedures normally requiring multiple visits (i.e., full dentures, partial dentures, root canals, crowns, etc.) should be completed in a number of visits that would be considered consistent with the dental community at large and the scope of practice of the provider. If additional visits are required, a notation in the member's treatment record to indicate the necessity for each additional visit must be made.
- Procedures normally completed in a single visit (examination, prophylaxis, x-rays, etc.) but which require additional visits must include a notation in the member's treatment record documenting the justification for the additional visit.
- When billing:
  - Other than orthodontic services (D8000 – D8999) there is **NO FEE-FOR-SERVICE (FFS) BILLING**;
  - Prior approval is required for orthodontic services;
  - Certify that the services were provided;
  - For specific instructions, please refer to the Dental Billing Guidelines at:

https://www.emedny.org/ProviderManuals/Dental/index.aspx

Services Not Within the Scope of the Medicaid Program

These services include but are not limited to:

- Dental implants and related services;
- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Molar root canal therapy for members 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis;
- Crown lengthening;
- Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual;

- Dental work for cosmetic reasons or because of the personal preference of the member or provider;
- Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;
- Placement of sealants for members under 5 or over 15 years of age;
- Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210).

Services Which Do Not Meet Existing Standards of Professional Practice Are Not Reimbursable

These services include but are not limited to:

- Partial dentures provided prior to completion of all Phase I restorative treatment which includes necessary extractions, removal of all decay and placement of permanent restorations;
- Other dental services rendered when teeth are left untreated;
- Extraction of clinically sound teeth;
- **Treatment provided when there is no clinical indication of need noted in the treatment record.** Procedures should not be performed without documentation of clinical necessity. Published “frequency limits” are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member;
- Restorative treatment of teeth that have a hopeless prognosis and should be extracted;
- Taking of unnecessary or excessive radiographic images;
- Services not completed and,
- “Unbundling” of procedures.

Other Non-Reimbursable Services

- Treatment of deciduous teeth when exfoliation is reasonably imminent.
- Extraction of deciduous teeth without clinical necessity.

- Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations.

Record Keeping

Health professionals are required to maintain records for each patient that accurately reflect the evaluation and treatment of the patient according to section 29.2(a)(3) of the Rules of the Board of Regents. Please refer to NYSED.gov for further information:

NYS Rules of the Board of Regents: Part 29

The patient's Dental Record is to include:

- Medical History;
- Dental History (including dated treatment plans, identification of all pathology present);
- Dental Charting;
- Radiographs;
- Study Models (if taken);
- Copies of all prescriptions and invoices (pharmacy / lab);
- All correspondences;
- Consultation and referral reports; and,
- Signed consent and HIPAA forms.

Treatment notes are to include the following for each dental appointment:

- Detailed description of all services rendered including the identification of the healthcare professional providing the service(s);
- Date (and time when appropriate) of visit and signature or initials of the team member writing the entry;
- Instructions to the patient;
- Drugs administered / prescription (includes all anesthesia provided);
- Unusual reactions;
- Cancellations / missed appointments;

- Telephone conversations (date and time);
- Patient comments and complaints;
- Referrals made;
- Referrals not followed or refused; and,
- General anesthesia / I.V. sedation reports.
  Note: Reports must include start and stop times for:
  - ✓ Anesthetic provided; and,
  - ✓ Operative treatment provided.

Locum Tenens Arrangements

Federal law requires that payment for services be made to the provider of service. An exception to this requirement may be made when one dentist arranges for another dentist to provide services to his/her patients under a locum tenens arrangement.

The law allows such locum tenens arrangements:

- On an informal, reciprocal basis for periods not to exceed 14 days, or;
- For periods of up to 90 days with a more formal agreement.

Record of either arrangement **must** be maintained **in writing** to substantiate locum tenens payment.

Locum tenens arrangements should not be made with any dentists who are not enrolled or have been disqualified by the New York State Medicaid program.

Miscellaneous Issues

- Radiographic images should be clear and allow for diagnostic assessment. They are performed based on need, age, prior dental history and clinical findings. All radiographic images, whether digitalized or conventional, must be of good diagnostic quality, properly dated and positionally mounted including accurate right/left orientation, and identified with the member's name and provider name and address. The cost of all materials and equipment used shall be included in the fee for the image.

  Medicaid claims payment decisions for types, numbers and frequency of images will be related to the needs of the individual member, dental age, past dental history and, most importantly, clinical findings. Guidelines on the selection of members for Dental radiographic examination can be obtained from the “American Dental Association (ADA)” or the “U.S. Department of Health and Human Services, Food and Drug Administration (FDA)”.

  Good quality, diagnostic, duplicate radiographic images, must be made available for review upon request of the Department of Health or the Office of the Medicaid Inspector General. There is no reimbursement for duplication of images. If original radiographs are submitted, they will be returned after each review. Other types of

images that can be readily reproduced will not be returned. All images must be retained by the provider for a minimum of six years, or the minimum duration prescribed by law, from the date of payment.

- Facilities should use the NYS Medicaid Exclusion List when checking and verifying the credentials of the dental professionals that make up their staff. The NYS Medicaid Exclusion List is currently available at NYS Office of the Medicaid Inspector General (OMIG) website:

  Medicaid Exclusions - New York State Office of the Medicaid Inspector General

Section III - Basis of Payment for Services Provided

It is the provider's responsibility to verify each member's eligibility at EVERY appointment. Even when a service has been prior approved / prior authorized, the provider must verify a member's eligibility via the MEVS before the service is provided and comply with all other service delivery and claims submission requirements described in each related section of the provider manual.

Payment for dental services is limited to the lower of the usual and customary fee charged to the general public or the fee developed by the DOH and approved by the New York State Director of the Budget. The Dental Fee Schedule is available online:

http://www.emedny.org/ProviderManuals/Dental/index.aspx

Payment for Services Not Listed on the Dental Fee Schedule

If an "essential" service is rendered that is not listed in the fee schedule, the fee will be determined by the DOH, which will use the most closely related service or procedure in the fee schedule as the basis for determining such fee.

Payment for Services Exceeding the Published Frequency Limitations

Reimbursement for services that exceed the published frequency limitations but that are determined to be medically necessary following professional review may be considered.

Payment for Orthodontic Care

When Prior Approval is obtained for orthodontic care for severe physically handicapping malocclusions, the care will be reimbursed for an eligible member for a maximum of three years of active orthodontic care plus one year of retention care. Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time. Treatment not completed within the maximum allowed period must be continued to completion without additional compensation from the NYS Medicaid program, the member or family.

Managed Care

If a member is enrolled in a managed care plan which covers the specific care or services being provided, it is inappropriate to bill such services to the Medicaid program on a fee-for-service basis whether or not prior approval has been obtained.

Dental Services Included in a Facility Rate

Article 28 facilities must adhere to the program policies as outlined in this manual.

- **Hospital In-Patient; Ambulatory Surgery; Emergency Room**
  The "professional component" for dental services can be reimbursed on a fee-for-service basis. Payment for those services requiring prior approval / prior authorization is dependent upon obtaining approval from the Department of Health. Refer to the prior approval section of this manual and the Prior Approval Guidelines located on the eMedNY.org website for additional information on how to obtain prior approval:

  eMedNY : Provider Manuals : Dental

- **Out-Patient Clinic**
  Dental services rendered in outpatient clinics are reimbursed using an "Ambulatory Patient Groups (APG)" payment methodology and include both the facility and professional reimbursement. There is no fee-for-service billing allowed.
- **OMH Psychiatric Centers**
  Dental services are included in the facility rates. Payment for services in such facilities will not be made on a fee-for-service basis.
  It is the responsibility of the facility to make arrangements for the provision of all dental services listed in the Provider Manual either within the facility or with area providers. Claims should not be submitted by either the provider(s) or facility for covered dental services or for transportation.
- **Intermediate Care Facilities (ICF)-DD**
  ICF-DD providers should contact OPWDD for guidance on billing for dental services for their residents.
- **Residential Health Care Facilities (RHCF's)**
  In State
  Dental services are included in the facility rates. Payment for services to residents of such facilities will not be made on a fee-for-service basis.
  It is the responsibility of the facility to make arrangements for the provision of all dental services listed in the Provider Manual either within the facility or with area providers. Claims should not be submitted by either the provider(s) or facility for covered dental services or for transportation.
  Out of State
  It is the responsibility of the out-of-state RHCF to inform the provider if dental services are included in the rate.

Payment in Full

Fees paid by the Medicaid program shall be considered full payment for services rendered. Except for appropriate co-pay's, no additional charge may be made by a provider.
Medicaid members cannot be charged for broken or missed appointments.

Providers are prohibited from charging any additional amount for a service billed to the Medicaid program.
A dentist may enter into a private pay agreement with a Medicaid member. This agreement must be in writing and mutually agreed upon prior to the start of treatment; these guidelines must be followed:

- The member must be informed of **alternative treatment plans**, including procedures covered by the Medicaid Program or procedures that require prior authorization by the NYS DOH, the advantages and disadvantages of each, as well as the expense and financial responsibilities of each (If any of the procedures in the treatment plan require prior approval from the Medicaid Program, the provider is encouraged to submit the necessary forms and documentation for review and determination, which may eliminate the need for a private payment agreement and Medicaid could cover the procedure(s) in full);
- The NYS DOH (Medicaid Program) will not review a prior approval request, or render any opinion, associated with a private pay agreement **after treatment has been started**;
- The member must have **full understanding and consent** that there may be service(s) or alternatives that could be provided through Medicaid coverage **without any expense to them**;
- The **member is responsible for 100% of the entire fee**. There cannot be any payment from Medicaid;
- The provision of this service **might alter future benefits available through Medicaid** (e.g. if payment is made through a private payment agreement for root canal(s) therapy, the member might not qualify for a partial denture and/or crowns for these teeth either now or in the future that they might otherwise be eligible for); and,
- The member may be responsible for any **subsequent or associated expenses** (e.g. If they pay privately for a root canal, they are also responsible for the final restoration of the tooth whether it is with a routine restoration or a crown).

Prepayment Review

The DOH and OMIG reserve the right to pend any claim(s) for review prior to payment without notification.

Third-Party Insurers

Third-party insurers (including Medicare) provide reimbursement for various dental procedures. Since Medicaid is the payer of last resort, the provider must bill the member's third-party payers prior to requesting payment from Medicaid.

Medicaid will reimburse the **difference** only if the total third party payment(s) is (are) less than the lesser of the provider's usual and customary fee charged to the general public or the fee developed by the DOH for that specific procedure code.

Unspecified Procedure Codes

Unspecified procedure codes at the end of each section of the fee schedule are miscellaneous codes applicable to procedures within the scope of the Medicaid program, but for which suitable procedure codes do not currently exist.

Prior Approval / Prior Authorization Requirements

Prior approval / prior authorization does not ensure payment. The provider must verify a member's eligibility before every appointment and comply with all other service delivery and claims submission requirements described in each related section of the provider manual.

Prior authorization is required through the use of the Dispensing Validation System (DVS) when specified. These specifications are indicated after the procedure code description by the following: (DVS REQUIRED)

When DVS is required providers must place the DVS prior authorization number on the claim. If DVS rejects the request due to service limits exceeded, a prior approval is required. The prior approval request must include medical documentation as to why the service limit needs to be exceeded. Prior approval requests received where the provider has not requested prior authorization through DVS will be rejected and returned to the provider.

Procedures that require prior approval, or where a DVS over-ride is required, must not begin until the provider has received approval from the DOH. When any portion of a treatment plan requires prior approval, the **complete treatment plan** listing all necessary procedures, whether or not they require prior approval, must be listed and coded on the prior approval request form. Any completed treatment which is not evident on submitted images should be noted. No treatment other than provision of symptomatic relief of pain and/or infection is to be instituted until such time as cases have been reviewed and a prior approval determination made.

All prior approval requests should include **accurate pretreatment charting** clearly depicting all existing restorations and missing natural teeth. Any existing fixed or removable prosthetic appliances should be noted and their current conditions described and the date of initial placement noted. If applicable, a complete medical history, nutritional assessment, certification of employment and any other pertinent information that will assist in determining the necessity and appropriateness of the proposed treatment plan should be submitted.

The approved treatment plan, in its entirety, must be adhered to. Any alteration of the approved course of treatment may render the entire approval null and void and subject to recoupment. Changes to an approved course of treatment should be submitted to the DOH by using a "prior approval change request form".

The **minimum number of pre-treatment radiographic images needed to clearly show all current conditions and which allow for the proper evaluation and diagnosis of the entire dentition** must accompany all requests for prior approval. Radiographic

images are not routinely required to obtain prior approval for full dentures, sealants, denture re-base etc. The previously referenced guidelines on the selection of members for radiographs should be followed.

Payment for multiple restorations which are placed in teeth subsequently determined to need extraction as part of an approved prosthetic treatment plan is not acceptable if the restorations were provided less than six months prior to the date of the prior approval request for the prosthesis.

When a treatment plan has been denied, services that were a portion of that plan may not be reimbursable, or subsequently prior approved.

For non-emergency treatment, the same prior approval guidelines apply when treatment is being rendered by a specialist. If the member is referred to a specialist for treatment requiring prior approval, the referring provider can obtain the prior approval for use by the specialist, or the specialist can submit his/her own request.

When Prior Approval is required

For professional dental services, payment for those listed procedures where the procedure code number is underlined and listed as (PA REQUIRED) is dependent upon obtaining the approval of the Department of Health **prior** to performance of the procedure. If such prior approval is not obtained, no reimbursement will be made. For information on completion and submission of prior approval requests refer to the Prior Approval Guidelines:

https://www.emedny.org/ProviderManuals/Dental/index.aspx

Prior approval does not guarantee payment. It should be noted that:

- Prior approval requests will automatically be rejected if there is no response to a request for additional information and the provider notified. The request will be reactivated without submitting a new request provided that the information is returned using the "Return Information Routing Sheet" provided with the original request for information;
- Prior approval requests may be denied if there is incomplete or insufficient response to a request for additional information;
- Dental providers may submit documents stored in a digitized format (x-rays, treatment plans, charting, photographs, etc.) as electronic attachments to dental **prior approval requests** when submitted through ePACES. This enhanced feature is currently **only available through ePACES**. The following file formats are currently supported: JPEG; TIF; PNG; and GIF. For more information on ePACES, or to enroll, please contact the eMedNY Call Center at (800) 343-9000;
- Back-dated prior approval can be issued on an exception basis, such as when eligibility has been back-dated and treatment requiring prior approval has already been rendered. The following guidelines apply:
    - The request must be received within 90 days of the date of treatment;
    - There is NO guarantee that the request will be approved or back-dated even if treatment has already begun and / or completed;

- Treatment already rendered will NOT change the review criteria. Approval will not be issued that wouldn't have been approved otherwise;
- The same documentation must be submitted as any other request (complete treatment plan, sufficient radiographic images to allow for the evaluation of the entire dentition, charting etc.) as appropriate for the case;
- Appropriate documentation must be submitted showing that extenuating circumstances existed warranting back-dating of the request as well as the date that the service(s) was (were) performed;
- Actions of either the provider or member do not commit the DOH to any particular course of treatment;
- Approvals will NOT be issued for the convenience of the provider or member, or because the provider forgot or didn't realize that prior approval was required.

Emergency Treatment
The provider should refer to the billing guidelines on the eMedNY.org website for claim submission instructions for emergency services when there is a severe, life threatening, or potentially disabling condition that required immediate intervention:

https://www.emedny.org/ProviderManuals/Dental/index.aspx

Recipient Restriction Program

Medicaid members with any coverage type (i.e. managed care, fee-for-service) will be reviewed and those who have been found to have a demonstrated pattern of abusive behavior will be placed in the recipient restriction program in an effort to control the abuse. Restricted members are monitored by the Office of the Medicaid Inspector General (OMIG). When the member's benefit is administered by a Managed Care Organization (MCO), the MCO is responsible for identifying and restricting the member who is abusing their Medicaid benefit. The MCO is required to report any new, re-restricted or modified restrictions to OMIG for tracking. The recipient restriction program follows the member when a member's coverage changes. If a member is switched to a different managed care plan OMIG will notify the new managed care plan of the existence of the restriction. The restriction process does not force the member to be enrolled in a Medicaid Managed Care Plan.

Utilization Threshold

With the implementation of HIPAA 5010 and D.0 transactions, the NYS Department of Health (DOH) has eliminated the Service Authorization (SA - 278) process. This process required providers to obtain UT service authorizations via the Medicaid Eligibility Verification System (MEVS) prior to the payment of claims. Since service authorization transactions are no longer being supported, the eligibility transaction process will provide information when the member is at limit. Determining a Medicaid member's UT status is critical for accurate billing and payment purposes. The provider risks nonpayment if

eligibility is not verified. If a member has reached the Utilization Threshold limit for any service category, the eligibility response will return an indication of "Limitations" for the applicable Service Type(s).

If a "Limitations" message is returned, one of two options are available.

1. A Threshold Override Application (TOA) may be submitted to request an increase in the member's allowed services.
2. Services provided are exempt from the UT Program.

   For a list of services exempt from the UT Program click on the "Information" tab at the eMedNY.org website.

Section IV - Definitions

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Attending Dentist

The attending dentist is the dentist who is primarily and continuously responsible for the treatment rendered.

Referral

A referral is the direction of a member to another provider for advice or treatment.

Section V - Dental Procedure Codes

General Information and Instructions:

This section lists those procedure codes and nomenclature listed in the "Current Dental Terminology (CDT®)" as published by the "American Dental Association (ADA®)" which are covered services by the NYS Medicaid program. Some procedure descriptions are included for clarification of Medicaid policy. The CDT should be referenced for a full descriptor of each procedure.

The dental procedure codes are grouped into sections as follows:

	Section	Code Series
I.	Diagnostic	D0100-D0999
II.	Preventive	D1000-D1999
III.	Restorative	D2000-D2999
IV.	Endodontics	D3000-D3999
V.	Periodontics	D4000-D4999
VI.	Prosthodontics, removable	D5000-D5899
VII.	Maxillofacial Prosthetics	D5900-D5999
VIII.	Implant Services	D6000-D6199
IX.	Prosthodontics, fixed	D6200-D6999
X.	Oral and Maxillofacial Surgery	D7000-D7999
XI.	Orthodontics	D8000-D8999
XII.	Adjunctive General Services	D9000-D9999
	Miscellaneous Procedures	T1013

Local anesthesia is considered to be part of the procedure(s) and is not payable separately.

1. "(REPORT NEEDED)" / "BY REPORT (BR)" PROCEDURES:
   Procedures that do not have a published fee are indicated as "(BR)". Procedures with or without a published fee that are listed as "(REPORT NEEDED)" require professional review for validation and/or pricing. All claims for these procedures must be submitted with supporting documentation.

   Information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, must be furnished. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices and name/dosage of therapeutic agents) is required. To ensure appropriate payment in the context of current Medicaid fees, bill your usual and customary fee charged to the general public. Claims should only be submitted **AFTER** treatment is completed.

   Operative reports must include the following information:

   a. Diagnosis;
   b. Size, location and number of lesion(s) or procedure(s) where appropriate;

c. Major surgical procedure and supplementary procedure(s);
d. Whenever possible, list the nearest similar procedure by code number;
e. Estimated follow-up period;
f. Operative time;
g. Specific details regarding any anesthesia provided (this should include start - stop times and all medications administered).

If documentation needs to be submitted in support of any "(REPORT NEEDED)" / "By Report (BR)" procedure, the claim **MUST** be submitted on a **paper claim form 'A'** with the documentation as an attachment. Attachments must be on paper the same size as the claim form. This documentation must be maintained in the member's record and made available upon request.

DO NOT SEND RADIOGRAPHIC IMAGES AS A CLAIM ATTACHMENT

If radiographs are needed DOH or OMIG will request that you submit them directly to the reviewing unit.

Claim Form 'A' can be obtained from CSC by calling (800) 343-9000.

2. DENTAL SITE IDENTIFICATION:
Certain procedure codes require specification of surface, tooth, quadrant or arch when billing. These specifications are indicated after the procedure code description by the following abbreviations:

Specify surface:	(SURF)
Specify tooth:	(TOOTH)
Specify quadrant:	(QUAD)
Specify arch:	(ARCH)

- When more than one specification is required, both specifications are included, for example: (SURF/TOOTH).
- Only the dental site information required should be provided. Prior approval requests and/or claims may be rejected when extraneous or incorrect site information is included. Multiple submission of codes that do not require site designation should be entered on a single line with the site designation (e.g. tooth, arch, quad) left blank and the number of times performed entered. A report or narrative should be submitted where applicable.
- "Unspecified" procedure codes at the end of each section should not be used for supernumerary teeth.
- Refer to the Dental Billing Guidelines, Appendix B, "Code Sets" found at https://www.emedny.org/ProviderManuals/Dental/index.aspx for valid values.

3. "ESSENTIAL" SERVICES:
   When reviewing requests for services the following guidelines will be used:
   Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible.

   Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration. Treatment is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. If the total number of teeth which require, or are likely to require treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

   Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact).

   One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement.

4. INTERRUPTED TREATMENT:

Claims must be submitted when the product or service is **completed and delivered** to the member with the appropriate procedure code using the date that the service is actually completed and delivered as the date of service.

However, in those cases involving multiple appointments to complete the service or product, and the service or product cannot be completed or delivered, or the member loses eligibility prior to the completion of the service or delivery of the product, then the appropriate billing code listed below may be used with the date of the "decisive appointment" as the date of service.

If the "decisive appointment" (listed below) has not been met, or the member was not eligible on the date of the "decisive appointment", no compensation is available.

Medicaid Fee-For-Service Providers:

The "billing code" in the chart on page 26 can be used with the date of the "decisive appointment" as the date of service if:

- The service is completed and delivered, but the member lost fee-for-service Medicaid eligibility after the date of the "decisive appointment" (e.g. lost Medicaid entirely or was switched to a managed care plan) but prior to the date of delivery; or,
- The service is NOT completed and delivered (e.g. member died, detained for an indefinite period, etc.) after the date of the decisive appointment. It must be documented that every reasonable attempt was made to complete and deliver the service.

All claims submitted using the interrupted treatment billing codes will be pended for manual review. Payment in full may be considered if the supporting documentation demonstrates that the service was completed and delivered.

Payment, either in full or pro-rated, may be considered if the service is NOT completed and delivered. The amount of compensation will be determined based on the documentation provided.

Managed Care Plans:

All Medicaid Managed Care plans, Essential Plans and Family Health Plus plans offering dental services, must continue to cover any remaining treatments required to complete the procedures listed below if a managed care enrollee is disenrolled from the plan for any reason (including, but not limited to, losing Medicaid eligibility, transferring to another plan or voluntary disenrollment) after a decisive appointment. Such coverage is required even if the member does not qualify for guaranteed eligibility.

Type of Service	Approved Multiple Visit Procedures	Billing Code	Decisive Appointment
Space Maintainers	D1510, D1515	D0999	Tooth preparation
Crowns	D2710-D2792 D2952	D2999	Tooth preparation or final post pattern fabrication and final impression
Root Canal Therapy	D3310-D3348	D3999	Pulp extirpation or debridement to at least the apical 1/3 of all canals
Complete Dentures	D5110-D5120	D5899	Final impression
Partial Dentures	D5211-D5214	D5899	Final impression
Denture Repair	D5510-D5660	D5899	Acceptance of the prosthesis for repair
Denture Rebase or Relining	D5710-D5721 D5750-D5761	D5899	Final impression
Other Prosthetic Services	D5820-D5821	D5899	Final impression
Maxillofacial Prosthetics	D5911-D5988	D5999	Final impression
Fixed Prosthetics	D6210-D6252 D6545-D6792	D6999	Preparation and impression of all abutment teeth
Orthodontic Retention	D8680	D8999	Final impression
Occlusal Guards	D9940	D9999	Final impression

CODE **DESCRIPTION**

I. DIAGNOSTIC D0100 - D0999

CLINICAL ORAL EVALUATIONS

The codes in this section 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, which includes diagnosis and treatment planning, is the responsibility of the dentist and must be documented in the treatment record. 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.

Includes charting, history, treatment plan, and completion of forms.

Orthodontist should **ONLY** use procedure code D8660 for examinations prior to starting active care.

D0120 **Periodic oral evaluation - established patient** $25.00
Recall dental examinations shall be limited to one per six-month period and shall include charting and history necessary to update and supplement initial oral examination data.

D0140 **Limited oral evaluation - problem focused** $14.00
Not used in conjunction with a regular appointment. Cannot be billed with any other evaluation procedure, including but not limited to D9310 and D9430. Not intended for follow-up care.

D0145 **Oral evaluation for a patient under three years of age and counseling with primary caregiver** $30.00
Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

D0150 **Comprehensive oral evaluation – new or established patient** $30.00
Can only be billed once per provider-member relationship.

D0160 **Detailed and extensive oral evaluation - problem focused, by report** (REPORT NEEDED) (BR)
This procedure will not be reimbursed if performed within ninety days of a consultation or any other evaluation by the same provider.

CODE **DESCRIPTION**

DIAGNOSTIC IMAGING

Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality and properly identified and dated.

If you are ordering a CT, CTA, MRI, MRA, Cardiac Nuclear, or PET procedure, you or your office staff are required to obtain an approval number through the radiology prior approval program. For additional information refer to:

http://www.emedny.org/ProviderManuals/Radiology/index.html

Note: The radiology prior approval program does not include procedure code D0367, cone beam computed tomography. For more information see description of D0367.

IMAGE CAPTURE WITH INTERPRETATION

D0210 **Intraoral - complete series of radiographic images** $50.00

Minimum of 14 periapical radiographic images and posterior bitewing images. Reimbursable every three years if clinically indicated. A provider will not be reimbursed for an intraoral complete series prior to the complete eruption of a member's permanent second molars. Exceptions may be situations including orthodontic consultation, juvenile periodontitis, and other suspected, extensive pathological conditions, which require documentation that should accompany a claim as an attachment. An attachment should contain the clinical findings including the nature and complexity of the member's condition indicating that additional radiographic images would have high probability of affecting the diagnosis and treatment of a clinical problem.

D0220 **Intraoral - periapical first radiographic image** $8.00

To be billed only for the FIRST periapical image and **ONLY** when periapical images are taken. Cannot be used in conjunction with any other type of images on the same date of service (e.g. bitewing, occlusal, panoramic etc.). If another type of radiograph is taken on the same day, all the periapical films must be reported as D0230 (intraoral – periapical each additional radiographic image).

D0230 **Intraoral - periapical each additional radiographic image** $5.00

When periapical images are taken in conjunction with bitewing(s), occlusal or panoramic images, use procedure code D0230 for **ALL** periapical images including the first periapical image.

The total fee for ALL intraoral radiographic images (including the first periapical image) may not exceed the total fee allowed for a complete intraoral series.

D0240 **Intraoral - occlusal radiographic image** (ARCH) $15.00

One maxillary and one mandibular radiographic image are allowed within three years. May be supplemented by necessary intraoral periapical or bitewing images.

CODE	DESCRIPTION	
D0250	**Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector**	$25.00

These images include, but are not limited to: Lateral Skull; Posterior-Anterior Skull; Submentovertex; Waters; Reverse Tomes; Oblique Mandibular Body; Lateral Ramus. Not reimbursable for Temporomandibular Joint images.

D0251	**Extra-oral posterior dental radiographic image**	$12.00

Image is limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.
Maximum of two images.
Not reimbursable for Temporomandibular Joint images.

Bitewings are allowed no more than once in six months for each member.
The procedure code is an indication of the number of images performed. Leave the "Times Performed" on the claim form blank or enter "1".

D0270	**Bitewing – single radiographic image**	$8.00
D0272	**Bitewings – two radiographic images**	$14.00
D0273	**Bitewings – three radiographic images**	$20.00
D0274	**Bitewings – four radiographic images**	$24.00
D0290	**Posterior-anterior or lateral skull and facial bone survey radiographic image**	$72.00

3 images minimum. Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons in conjunction with surgical treatment. Not to be used in place of, or in conjunction with, D0340 unless surgical case. Documentation of necessity must be submitted with claim.

D0310	**Sialography**	$41.00
D0320	**Temporomandibular joint arthrogram**, **including injection**	$174.00
D0321	**Other temporomandibular joint radiographic images, by report** (PER JOINT) (REPORT NEEDED)	$29.00
D0330	**Panoramic radiographic image**	$35.00

Reimbursable every three years if clinically indicated. For use in routine caries determination, diagnosis of periapical or periodontal pathology **only** when supplemented by other necessary radiographic intraoral images (bitewing and/or periapical), completely edentulous cases, diagnosis of impacted teeth, oral surgery treatment planning, or diagnosis of children with mixed dentition. Postoperative panoramic images are reimbursable for post-surgical evaluation of fractures, dislocations, orthognathic surgery, osteomyelitis, or removal of unusually large and/or complex cysts or neoplasms. Panoramic radiographic images are not required or reimbursable for post orthodontic documentation. Panoramic images are **not** reimbursable when an intraoral complete series or panoramic image has been taken within **three years,** except for the diagnosis of a new condition (e.g. traumatic injury).

CODE	DESCRIPTION	
D0340	**2D cephalometric radiographic image – acquisition, measurement and analysis**	$55.00

Image of the head made using a cephalostat to standardize anatomic positioning, and with reproducible x-ray beam geometry.
Reimbursable every three years if clinically indicated. Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons for the diagnosing and treatment of a physically handicapping malocclusion. Cephalometric images are not required by the DOH for routine post-orthodontic documentation and are not routinely reimbursable. A tracing and analysis is **required** and is not payable separately. Use D0250 if a tracing and analysis is not performed.

D0350 **2D oral/facial photographic image obtained intra-orally or extra-orally** $12.00

Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons. For orthodontic cases, the images comprising this procedure code are defined on page 59 under section XI. ORTHODONTICS.

D0367 **Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium** (PA REQUIRED) $279.00

Includes axial, coronal and sagittal data.
Includes all interpretation.
Reimbursement is limited to enrolled oral and maxillofacial surgeons once per five (5) years in an **office-based setting**. There is no professional reimbursement for facility place of service. Facility reimbursement is through APG.
A panoramic radiograph (D0330) or similar film, along with documentation of medical necessity, must be submitted with requests for prior approval.
Approval is limited to those cases demonstrating significant risk for a complication such as nerve injury or jaw fracture as well as pathology or trauma workups.

D0470 **Diagnostic casts** $34.00

Reimbursement is limited to enrolled orthodontists or oral and maxillofacial surgeons. Includes both arches when necessary.

ORAL PATHOLOGY LABORATORY

These are procedures generally performed in a pathology laboratory and do not include the removal of the tissue sample from the patient. For removal of tissue sample, see codes D7285 and D7286.
Reimbursement for procedure codes D0470, D0485 and D0502 are limited to enrolled Oral Pathologists.

D0474	**Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.**	$87.00
D0485	**Consultation, including preparation of slides from biopsy material supplied by referring source**	$87.00
D0502	**Other oral pathology procedures, by report** (REPORT NEEDED)	(BR)
D0999	**Unspecified diagnostic procedure, by report** (REPORT NEEDED)	(BR)

CODE **DESCRIPTION**

II. PREVENTIVE D1000 - D1999

DENTAL PROPHYLAXIS

Dental prophylaxis is reimbursable in addition to an initial dental examination and recall examinations once per six (6) month period. Prophylaxis cannot be used in conjunction with periodontal maintenance (D4910) or in conjunction with scaling and root planning (D4341) on the same date of service.

D1110 **Prophylaxis – adult** $45.00
For members 13 years of age and older.

D1120 **Prophylaxis – child** $43.00
For members under 13 years of age.

An additional prophylaxis may be considered within a twelve month period for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"). The additional prophylaxis should be submitted using procedure code D1999. Documentation supporting necessity must be submitted with the claim. Reimbursement will not be considered if performed within a four-month interval of D1110, D1120, D1999 (used as an additional prophylaxis), or D4910.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

Topical fluoride treatment is reimbursable when professionally administered in accordance with appropriate standards. Fluoride treatments that are not reimbursable under the program include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration, applications of aqueous sodium fluoride or treatment for desensitization. There must be a minimum interval of three (3) months between all fluoride treatments (D1206 and/or D1208).

D1206 **Topical application of fluoride varnish** $30.00
Reimbursable once per three (3) month period for members between 6 months and 6 years of age (inclusive). For individuals 7 years of age and older D1206 is **only** approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease. Reimbursable to physicians, nurse practitioners, and physician assistants under CPT code 99188.

D1208 **Topical application of fluoride – excluding varnish** $14.00
Reimbursable once per six (6) month period for members between 1 and 20 years of age (inclusive). Fluoride must be applied separately from prophylaxis paste. For individuals 21 years of age and older D1208 is **only** approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.

CODE **DESCRIPTION**

OTHER PREVENTIVE SERVICES

D1320 **Tobacco counseling for the control and prevention of oral disease.** $10.00

Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.

Reimbursement for smoking cessation counseling (SCC) must meet the following criteria:

- SCC must be provided face-to-face by either a dentist or by a dental hygienist that is supervised by the dentist;
- SCC must be billed by either an office-based dental practitioner or by an Article 28 clinic that employs a dentist;
- Dental practitioners can only provide individual SCC services, which must be greater than three minutes in duration, NO group sessions are allowed;
- Dental claims for SCC must include the CDT procedure code D1320 (tobacco counseling for the control and prevention of oral disease);
- In a dental office or an Article 28 clinic, SCC should only take place during a dental visit as an adjunct when providing a dental service and NOT billed as a stand-alone service;
- A dental practitioner will be allowed to provide two smoking cessation counseling sessions to a Medicaid member within any 12 continuous months;
- Smoking Cessation Counseling complements existing Medicaid covered benefits for prescription and non-prescription smoking cessation products including nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the counter nicotine patches and gum;
- To receive reimbursement for SCC services the following information **must** be documented in the patient's dental record:
  - ✓ At least 4 of 5 A's: smoking status and if yes, willingness to quit;
  - ✓ If willing to quit, offer medication as needed, target date for quitting, and follow-up date (with documentation in the record that the follow-up occurred);
  - ✓ If unwilling to quit, the patient's expressed roadblocks;
  - ✓ Referrals to the New York State Smoker's Quitline and/or community services to address roadblocks and for additional cessation resources and counselling, if needed.

CODE **DESCRIPTION**

Smoking cessation services are included in the prospective payment system (PPS) rate for those FQHCs that do not participate in APG reimbursement.

Dentists should be aware of the following guideline for smoking cessation counseling:

The Clinical Practice Guideline, "Treating Tobacco Use and Dependence: 2008 Update" demonstrated that efficacious treatments for tobacco users exist and should become a part of standard care giving.

This guideline recommends that a practitioner should follow the "5 A's" of treating tobacco dependence, which include:

1. **Ask:** Ask the patient about tobacco use at every visit, and document the response.
2. **Advise:** Advise the patient to quit in a clear and personalized manner.
3. **Assess:** Assess the patient's willingness to make a quit attempt at this time.
4. **Assist:** Assist the patient to set a quit date and make a quit plan; offer medication as needed.
5. **Arrange:** Arrange to follow-up with the patient within the first week, either in person or by phone, and take appropriate action to assist them.

For patients not ready to make a quit attempt, clinicians should use a brief intervention designed to promote the motivation to quit. Content areas that should be addressed can be captured by the "5 R's":

1. **Relevance:** Encourage the patient to state why quitting is relevant to them, being as specific as possible.
2. **Risks:** Ask the patient to identify potential negative consequences of their tobacco use, including acute, environmental, and long-term risks.
3. **Rewards:** Ask the patient to identify potential benefits, such as improved health, saving money, setting a good example for children, and better physical performance.
4. **Roadblocks:** Ask the patient to identify barriers (e.g., fear of withdrawal, weight gain, etc.), and provide treatment and resources to address them.
5. **Repetition:** The motivational intervention should be repeated every time the patient is seen.

Research suggests that the "5 R's" enhance future quit attempts. Additional information is available in Chapter 3 of the guideline, titled Clinical Interventions for Tobacco Use and Dependence.

CODE	DESCRIPTION	
D1351	**Sealant – per tooth** (TOOTH) (DVS REQUIRED)	$35.00

Mechanically and/or chemically prepared enamel surface sealed to prevent decay. ***Refer to the "Prior Approval/Prior Authorization Requirements" section for use of DVS.*** Application of sealant is restricted to previously unrestored permanent first and second molars that exhibit no signs of occlusal or proximal caries for members **between 5 and 15 years of age** (inclusive). **Buccal and lingual grooves are included in the fee**. The use of opaque or tinted sealant is recommended for ease of checking bond efficacy. Reapplication, if necessary, is permitted **once every five (5) years.**

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Only fixed appliances are reimbursable. Documentation including pre-treatment images to justify all space maintenance appliances must be available upon request. Space maintenance should not be provided as an isolated service. All carious teeth must be restored before placement of any space maintainer. The member should be practicing a sufficient level of oral hygiene to ensure that the space maintainer will not become a source of further carious breakdown of the dentition. All permanent teeth in the area of space maintenance should be present and developing normally.

Space maintenance in the deciduous dentition (defined as prior to the interdigitation of the first permanent molars) can generally be considered.

Space maintenance in the mixed dentition initiated within one month of the necessary extraction will be reimbursable on an individual basis. Space maintenance in the mixed dentition initiated more than one month after the necessary extraction, with minimum space loss apparent, may be reimbursable.

D1510	**Space maintainer – fixed - unilateral** (QUAD)	$116.00
D1515	**Space maintainer – fixed - bilateral** (ARCH)	$174.00
D1550	**Re-cement or re-bond space maintainer**	$19.00
D1999	**Unspecified preventive procedure, by report**	(BR)

CODE **DESCRIPTION**

III. RESTORATIVE D2000 - D2999

The maximum fee for restoring a tooth with either amalgam or composite resin material will be the fee allowed for placement of a four-surface restoration. With the exception of the placement of reinforcement pins (use code D2951), fees for amalgam and composite restorations include tooth preparation, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases, curing and pulp capping.

Restorations placed solely for the treatment of abrasion, attrition, erosion or abfraction and are not associated with the treatment of any other pathology are beyond the scope of the program and will not be reimbursed. Restorative procedures should not be performed without documentation of clinical necessity. Published "frequency limits" are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member.

For codes D2140, D2330 and D2391, only a single restoration will be reimbursable per surface. Occlusal surface restorations including all occlusal pits and fissures will be reimbursed as one-surface restorations whether or not the transverse ridge of an upper molar is left intact. Codes D2150, D2160, D2161, D2331, D2332, D2335, D2781, D2392, D2393, and D2394 are compound restorations encompassing 2, 3, 4 or more contiguous surfaces. Restorations that connect contiguous surfaces must be billed using the appropriate multi-surface restorative procedure code.

AMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	**Amalgam - one surface, primary or permanent** (SURF/TOOTH)	$50.00
D2150	**Amalgam - two surfaces, primary or permanent** (SURF/TOOTH)	$67.00
D2160	**Amalgam - three surfaces, primary or permanent** (SURF/TOOTH)	$82.00
D2161	**Amalgam - four or more surfaces, primary or permanent** (SURF/TOOTH)	$98.00

RESIN-BASED COMPOSITE-RESTORATIONS DIRECT

D2330	**Resin-based composite - one surface, anterior** (SURF/TOOTH)	$50.00
D2331	**Resin-based composite - two surfaces, anterior** (SURF/TOOTH)	$73.00
D2332	**Resin-based composite - three surfaces, anterior** (SURF/TOOTH)	$87.00
D2335	**Resin-based composite - four or more surfaces or involving incisal angle (anterior)** (SURF/TOOTH)	$98.00
D2390	**Resin-based composite crown, anterior** (TOOTH)	$98.00
D2391	**Resin-based composite; one surface, posterior** (SURF/TOOTH)	$50.00

Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.

D2392	**Resin-based composite - two surfaces, posterior** (SURF/TOOTH)	$67.00

CODE	DESCRIPTION	
D2393	**Resin-based composite - three surfaces, posterior** (SURF/TOOTH)	$82.00
D2394	**Resin-based composite - four or more surfaces, posterior** (SURF/TOOTH)	$98.00

CROWNS - SINGLE RESTORATIONS ONLY

The materials used in the fabrication of a crown (e.g. all-metal, porcelain, ceramic, resin) is at the discretion of the provider. The crown fabricated must correctly match the procedure code approved on the Prior Approval.

Crowns will not be routinely approved for a molar tooth in those members age 21 and over which has been endodontically treated without prior approval from the Department of Health.

Crowns include any necessary core buildups.

D2710	**Crown – resin-based composite** (**indirect**) (laboratory) (TOOTH) (PA REQUIRED)	$290.00
	Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth.	
D2720	**Crown – resin with high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2721	**Crown – resin with predominantly base metal** (TOOTH) (PA REQUIRED)	$500.00
D2722	**Crown – resin with noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2740	**Crown – porcelain/ceramic substrate** (TOOTH) (PA REQUIRED)	$500.00
D2750	**Crown – porcelain fused to high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2751	**Crown – porcelain fused to predominately base metal** (TOOTH) (PA REQUIRED)	$500.00
D2752	**Crown – porcelain fused to noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2780	**Crown – ¾ cast high noble metal** (TOOTH) (PA REQUIRED)	$400.00
D2781	**Crown – ¾ cast predominantly base metal** (TOOTH) (PA REQUIRED)	$400.00
D2782	**Crown – ¾ cast noble metal** (TOOTH) (PA REQUIRED)	$400.00
D2790	**Crown – full cast high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2791	**Crown – full cast predominately base metal** (TOOTH) (PA REQUIRED)	$500.00
D2792	**Crown – full cast noble metal** (TOOTH) (PA REQUIRED)	$500.00
D2794	**Crown – Titanium**	$500.00

CODE **DESCRIPTION**

OTHER RESTORATIVE SERVICES

For all prefabricated crowns (D2930, D2931, D2932, D2933, D2934) there must be supporting documentation substantiating the need for the crown (e.g. radiographic images, photographs).

D2920 **Re-cement or re-bond crown** (TOOTH) $30.00
Claims for recementation of a crown by the original provider within one year of placement, or claims for subsequent recementations of the same crown, will be pended for professional review. Documentation to justify the need and appropriateness of such recementations may be required as a condition for payment.

D2930 **Prefabricated stainless steel crown - primary tooth** (TOOTH) $116.00

D2931 **Prefabricated stainless steel crown - permanent tooth** (TOOTH) $116.00

D2932 **Prefabricated resin crown** (TOOTH) $116.00
Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction. This procedure is limited to one occurrence per tooth within two years. If replacement becomes necessary during that time, claims submitted will be pended for professional review. To justify the appropriateness of replacements, documentation must be included as a claim attachment. Placement on deciduous anterior teeth is generally not reimbursable past the age of five (5) years of age.

D2933 **Prefabricated stainless steel crown with resin window** (TOOTH) $130.00
Restricted to primary anterior teeth, permanent maxillary bicuspids and first molars.

D2934 **Prefabricated esthetic coated stainless steel crown – primary tooth** (TOOTH) $130.00

D2951 **Pin retention - per tooth, in addition to restoration** (TOOTH) $29.00
Reimbursement is allowed once per tooth regardless of the number of pins placed.

D2952 **Post and core in addition to crown, indirectly fabricated** (TOOTH) $125.00

D2954 **Prefabricated post and core in addition to crown** (TOOTH) $125.00
There is no separate reimbursement for the core material.

D2955 **Post removal** (TOOTH) $95.00

D2980 **Crown repair necessitated by restorative material failure** (TOOTH) (REPORT NEEDED) (BR)

D2999 **Unspecified restorative procedure, by report** (REPORT NEEDED) (BR)

CODE **DESCRIPTION**

IV. ENDODONTICS D3000 - D3999

All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one pre-treatment radiographic image demonstrating the need for the procedure, and one post-treatment radiographic image that demonstrates the result of the treatment, must be maintained in the member's record.

Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.

If a non-covered surgical procedure (e.g. crown lengthening, D4249) is required to properly restore a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement.

Pulp capping, either direct or indirect, is not reimbursable.

Molar endodontic treatment, retreatment or apical surgery is not approvable as a routine procedure. Prior approval requests will be considered for members under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those members age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or; where there is a documented medical condition which precludes extraction.

PULPOTOMY

D3220 **Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament** (TOOTH) $87.00

To be performed on primary or permanent teeth **up until the age of 21 years**.
This is not to be considered as the first stage of root canal therapy.
Pulp capping (placement of protective dressing or cement over exposed or nearly exposed pulp for protection from injury or as an aid in healing and repair) is not reimbursable.
This procedure code may not be used when billing for an "emergency pulpotomy", which should be billed as palliative treatment.

CODE	DESCRIPTION	

ENDODONTIC THERAPY ON PRIMARY TEETH

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

D3230	**Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$150.00
D3240	**Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$235.00

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

Includes primary teeth without succedaneous teeth and permanent teeth.

D3310	**Endodontic therapy – anterior tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$250.00
D3320	**Endodontic therapy – bicuspid tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$300.00
D3330	**Endodontic therapy – molar (excluding final restoration)** (TOOTH) (PA REQUIRED)	$400.00

ENDODONTIC RETREATMENT

D3346	**Retreatment of previous root canal therapy - anterior** (TOOTH) (PA REQUIRED)	$250.00
D3347	**Retreatment of previous root canal therapy - bicuspid** (TOOTH) (PA REQUIRED)	$300.00
D3348	**Retreatment of previous root canal therapy - molar** (TOOTH) (PA REQUIRED)	$400.00

APEXIFICATION / RECALCIFICATION PROCEDURES

D3351 **Apexification / recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH) $82.00

Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographic images.
(This procedure includes first phase of complete root canal therapy.)

D3352 **Apexification / recalcification - interim medication replacement** (TOOTH) $80.00

For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.
There may be several of these visits.
The published fee is the maximum reimbursable amount regardless of the number of visits.

CODE	DESCRIPTION	
D3353	**Apexification / recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH)	$103.00

Includes the 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 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. Performed as a separate surgical procedure and includes periapical curettage.

D3410	**Apicoectomy - anterior** (TOOTH) (PA REQUIRED)	$160.00
D3421	**Apicoectomy - bicuspid (first root)** (TOOTH) (PA REQUIRED)	$160.00

If more than one root is treated, see D3426.

D3425	**Apicoectomy - molar (first root)** (TOOTH) (PA REQUIRED)	$180.00

If more than one root is treated, see D3426.

D3426	**Apicoectomy (each additional root)** (TOOTH) (PA REQUIRED)	$60.00
D3430	**Retrograde filling - per root** (TOOTH) (PA REQUIRED)	$50.00

OTHER ENDODONTIC PROCEDURES

D3999	**Unspecified endodontic procedure, by report** (REPORT NEEDED)	(BR)

CODE	DESCRIPTION	

V. PERIODONTICS D4000 - D4999

SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)

Reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. The provider must submit documentation (including photographs) demonstrating the need for this treatment as an attachment to a paper claim.

D4210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant** (QUAD) (REPORT NEEDED)	$100.00
D4211	**Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant** (QUAD) (REPORT NEEDED)	$65.00

If a **non-covered** surgical procedure (e.g. crown lengthening, D4249) is required to properly restore a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement.

NON-SURGICAL PERIODONTAL SERVICES

D4341	**Periodontal scaling and root planing – four or more teeth per quadrant** (QUAD)	$45.00
D4342	**Periodontal scaling and root planing – one to three teeth per quadrant** (QUAD)	$30.00

For periodontal scaling and root planning (D4341 and D4342) to be considered, the diagnostic materials must demonstrate the following, consistent with professional standards:

- Clinical loss of periodontal attachment, and;
  - Periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated, and/or;
  - Radiographic evidence of crestal bone loss and changes in crestal lamina dura, and/or;
  - Radiographic evidence of root surface calculus.

The provider must keep in the treatment record detailed documentation describing the need for periodontal scaling and root planing, including a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (e.g., color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility.

(continued on next page)

CODE **DESCRIPTION**

Treatment **per quadrant** is limited to **once every two (2) years**. For consideration of more frequent treatment prior approval with supporting documentation is required. Reimbursement for D4341 and/or D4342 is limited to no more than **two quadrants** on a **single date of service**.

In exceptional circumstances, consideration may be given for reimbursement for more than two quadrants on a single date of service (e.g. treatment under anesthesia). These claims should be submitted using procedure code D4999 with documentation supporting both the need for treatment and the exceptional circumstances present.

Prophylaxis or periodontal maintenance (e.g. D1110, D1120, D4910) **will not** be reimbursed on the same date of service as periodontal scaling and root planning (D4341, D4342).

OTHER PERIODONTAL SERVICES

D4910 **Periodontal maintenance** $45.00

This procedure is for members who have previously been treated for periodontal disease with procedures such as scaling and root planing (D4341 or D4342). D4910 cannot be used in conjunction with, or billed within six (6) months of any other prophylaxis procedure (e.g. D1110). Reimbursement for D4910 is limited to once per six (6) months and cannot be used in conjunction with D4341 or D4342 on the same date of service.

D4999 **Unspecified periodontal procedure, by report** (BR)
(REPORT NEEDED)

CODE **DESCRIPTION**

VI. PROSTHODONTICS (Removable) D5000 - D5899

Full and/or partial dentures are covered when they are required to alleviate a serious health condition or one that affects employability. Complete dentures and partial dentures will not be replaced for a minimum of eight (8) years from initial placement except when they become unserviceable through trauma, disease or extensive physiological change. Prior approval requests for premature replacement will not be reviewed without supporting documentation of medical necessity. Dentures which are lost, stolen or broken will not be replaced unless there exists a serious health condition that has been verified and documented.

General Guidelines for All Removable Prosthesis:

- Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable or cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within 6 months of the delivery of a new prosthesis. Only “tissue conditioning” (D5850 or D5851) is payable within six (6) months prior to the delivery of a new prosthesis;
- Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This includes rebasing, relining, adjustments and repairs.
- Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service. Prophylaxis and/or scaling and root planing is only payable when performed on natural dentition;
- "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking any final impressions. Generally, it is expected that tissues will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review;
- The use of dental implants and implant related prosthetic services are considered beyond the scope of the program;
- Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment," claims should be submitted following the guidelines for "Interrupted Treatment";
- Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments or advance payments are prohibited;

CODE	DESCRIPTION

- All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the member's treatment record to be made available upon request in support of any treatment provided, and;
- The total cost of repairs should not be excessive and should not exceed 50% of the cost of a new prosthesis. If the total cost of repairs is to exceed 50% of the cost of a new prosthesis, a prior approval request for a new prosthesis should be submitted with a detailed description of the existing prosthesis and why any replacement would be necessary per Medicaid guidelines and would be more appropriate than repair of the existing prosthesis.

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

Radiographs are not routinely required to obtain prior approval for full dentures. The guidelines published by the ADA and the U.S. Department of Health and Human Services on the use of x-rays should be followed. For more information refer to the following websites: www.ADA.org or www.HHS.gov

D5110	**Complete denture – maxillary** (PA REQUIRED)	$560.00
D5120	**Complete denture – mandibular** (PA REQUIRED)	$560.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

Requirements for the placement of partial dentures are:

- All phase I restorative treatment which includes extractions, removal of all decay and restoration with permanent filling materials, endodontic therapy, crowns, etc. must be completed prior to taking the final impression(s) for partial denture(s).
- Reimbursement for removable partial dentures includes a minimum of two clasps. The total number of clasps is dictated by the retentive requirements of each case, with no additional payment for necessary supplemental clasps;
- Partial dentures can be considered for ages 15 years and above; an “Interim Prosthesis” (procedure codes D5820 and/or D5821) can be considered for individuals 5 to 15 years of age.

D5211	**Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)** (PA REQUIRED)	$350.00
D5212	**Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)** (PA REQUIRED)	$350.00
D5213	**Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)** (PA REQUIRED)	$560.00
D5214	**Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)** (PA REQUIRED)	$560.00
D5225	**Maxillary partial denture - flexible base (including any clasps, rests and teeth)** (PA REQUIRED)	$560.00
D5226	**Mandibular partial denture - flexible base (including any clasps, rests and teeth)** (PA REQUIRED)	$560.00

CODE	DESCRIPTION	

ADJUSTMENTS TO DENTURES

Adjustments within six months of the delivery of the prosthesis are considered part of the payment for the prosthesis. Adjustments (procedure codes D5410, D5411, D5421, and D5422) are not reimbursable on the same date of service as the initial insertion of the prosthetic appliance **OR;** on the same date of service as any repair, rebase, or reline procedure code.

D5410	**Adjust complete denture - maxillary**	$25.00
D5411	**Adjust complete denture - mandibular**	$25.00
D5421	**Adjust partial denture - maxillary**	$25.00
D5422	**Adjust partial denture - mandibular**	$25.00

PROSTHETIC APPLIANCE REPAIRS

Limitation: The total cost of repairs should not be excessive and should not exceed 50% of the cost of a new prosthesis. If the total cost of repairs is to exceed 50% of the cost of a new prosthesis, a prior approval request for a new prosthesis should be submitted with a detailed description of the existing prosthesis and why any replacement would be necessary per Medicaid guidelines and would be more appropriate than repair of the existing prosthesis.

REPAIRS TO COMPLETE DENTURES

D5510	**Repair broken complete denture base** (ARCH)	$65.00
D5520	**Replace missing or broken teeth - complete denture (each tooth)** (TOOTH)	$42.00

REPAIRS TO PARTIAL DENTURES

D5610	**Repair resin denture base** (ARCH)	$67.00
D5620	**Repair cast framework** (ARCH)	$120.00
D5630	**Repair or replace broken clasp - per tooth** (TOOTH)	$130.00
D5640	**Replace broken teeth - per tooth** (TOOTH)	$60.00
D5650	**Add tooth to existing partial denture** (TOOTH)	$65.00
D5660	**Add clasp to existing partial denture - per tooth** (TOOTH)	$102.00

DENTURE REBASE PROCEDURES

Rebase procedures are not payable within six months prior to the delivery of a new prosthesis. Only “tissue conditioning” (D5850 and D5851) is payable within six months prior to the delivery of a new prosthesis.

D5710	**Rebase - complete maxillary denture** (PA REQUIRED)	$170.00
D5711	**Rebase - complete mandibular denture** (PA REQUIRED)	$170.00
D5720	**Rebase - maxillary partial denture** (PA REQUIRED)	$174.00
D5721	**Rebase - mandibular partial denture** (PA REQUIRED)	$174.00

CODE	DESCRIPTION	

DENTURE RELINE PROCEDURES

Reline procedures are not payable within six months prior to the delivery of a new prosthesis. For cases in which it is impractical to complete a laboratory reline, prior approval for an office ("chairside" or "cold cure") reline may be requested with credible documentation which would preclude a laboratory reline. Only "tissue conditioning" (D5850 and D5851) is payable within six months prior to the delivery of a new prosthesis.

D5730	**Reline complete maxillary denture (chairside)** (PA REQUIRED)	$125.00
D5731	**Reline complete mandibular denture (chairside)** (PA REQUIRED)	$125.00
D5740	**Reline maxillary partial denture (chairside)** (PA REQUIRED)	$85.00
D5741	**Reline mandibular partial denture (chairside)** (PA REQUIRED)	$85.00
D5750	**Reline complete maxillary denture (laboratory)**	$170.00
D5751	**Reline complete mandibular denture (laboratory)**	$170.00
D5760	**Reline maxillary partial denture (laboratory)**	$125.00
D5761	**Reline mandibular partial denture (laboratory)**	$125.00

INTERIM PROSTHESIS

Reimbursement is limited to once per year and only for children between 5 and 15 years of age. Codes D5820 and D5821 are not to be used in lieu of space maintainers. All claims will be pended for professional review prior to payment.

D5820	**Interim partial denture (maxillary)**	$174.00
D5821	**Interim partial denture (mandibular)**	$174.00

OTHER REMOVABLE PROSTHETIC SERVICES

Codes D5850 and D5851 are for treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration. This is the **ONLY** type of reline reimbursable within six (6) months prior to the delivery of a new prosthesis. Insertion of tissue conditioning liners in existing dentures will be limited to once per denture unit. D5850 and D5851 are not reimbursable under age 15 and should be billed one time at the completion of treatment, regardless of the number of visits involved.

D5850	**Tissue conditioning, maxillary**	$25.00
D5851	**Tissue conditioning, mandibular**	$25.00
D5899	**Unspecified removable prosthodontic procedure, by report** (REPORT NEEDED)	(BR)

CODE	DESCRIPTION	
	VII. MAXILLOFACIAL PROSTHETICS D5900 - D5999	
D5911	**Facial moulage (sectional)** (REPORT NEEDED)	$116.00
D5912	**Facial moulage (complete)** (REPORT NEEDED)	$174.00
D5913	**Nasal prosthesis** (REPORT NEEDED)	(BR)
D5914	**Auricular prosthesis** (REPORT NEEDED)	(BR)
D5915	**Orbital prosthesis** (REPORT NEEDED)	$957.00
D5916	**Ocular prosthesis** (REPORT NEEDED)	$957.00
D5919	**Facial prosthesis** (REPORT NEEDED)	(BR)
D5922	**Nasal septal prosthesis** (REPORT NEEDED)	(BR)
D5923	**Ocular prosthesis, interim** (REPORT NEEDED)	$435.00
D5924	**Cranial prosthesis** (REPORT NEEDED)	(BR)
D5925	**Facial augmentation implant prosthesis** (REPORT NEEDED)	(BR)
D5926	**Nasal prosthesis, replacement** (REPORT NEEDED)	(BR)
D5927	**Auricular prosthesis, replacement** (REPORT NEEDED)	(BR)
D5928	**Orbital prosthesis, replacement** (REPORT NEEDED)	(BR)
D5929	**Facial prosthesis, replacement** (REPORT NEEDED)	(BR)
D5931	**Obturator prosthesis, surgical** (REPORT NEEDED)	(BR)
D5932	**Obturator prosthesis, definitive** (REPORT NEEDED)	(BR)
D5933	**Obturator prosthesis, modification** (REPORT NEEDED)	(BR)
D5934	**Mandibular resection prosthesis with guide flange** (REPORT NEEDED)	(BR)
D5935	**Mandibular resection prosthesis without guide flange** (REPORT NEEDED)	(BR)
D5936	**Obturator prosthesis, interim** (REPORT NEEDED)	(BR)
D5937	**Trismus appliance (not for TMD treatment)** (REPORT NEEDED)	$145.00
D5951	**Feeding aid** (REPORT NEEDED)	$435.00
D5952	**Speech aid prosthesis, pediatric** (REPORT NEEDED)	(BR)
D5953	**Speech aid prosthesis, adult** (REPORT NEEDED)	(BR)
D5954	**Palatal augmentation prosthesis** (REPORT NEEDED)	(BR)
D5955	**Palatal lift prosthesis, definitive** (REPORT NEEDED)	(BR)
D5958	**Palatal lift prosthesis, interim** (REPORT NEEDED)	(BR)
D5959	**Palatal lift prosthesis, modification** (REPORT NEEDED)	(BR)
D5960	**Speech aid prosthesis, modification** (REPORT NEEDED)	(BR)
D5982	**Surgical stent** (REPORT NEEDED)	(BR)
D5983	**Radiation carrier** (REPORT NEEDED)	(BR)
D5984	**Radiation shield** (REPORT NEEDED)	(BR)
D5985	**Radiation cone locator** (REPORT NEEDED)	(BR)
D5986	**Fluoride gel carrier** (per arch) (ARCH)	$10.00
D5987	**Commissure splint** (REPORT NEEDED)	(BR)
D5988	**Surgical splint** (REPORT NEEDED)	(BR)
D5999	**Unspecified maxillofacial prosthesis, by report** (REPORT NEEDED)	(BR)

CODE	DESCRIPTION

VIII. IMPLANT SERVICES D6000 - D6199

Implants and all related services are considered beyond the scope of the NYS Medicaid program.

CODE **DESCRIPTION**

IX. PROSTHODONTICS, FIXED D6200 - D6999

Fixed bridgework is generally considered beyond the scope of the NYS Medicaid program. The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization. In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth. The fabrication of a fixed bridge is generally considered for members with no recent caries activity (no initial restorations placed during the past year), no unrestored carious lesions, no significant periodontal bone loss in the same arch and no posterior tooth loss with replaceable space in the same arch.

The replacement of a missing tooth or teeth with a fixed partial denture will not be approved under the Medicaid program when either no replacement or replacement with a removable partial denture could be considered appropriate based on Medicaid prosthetic guidelines.

For a member under the age of 21 or one whose pulpal anatomy precludes crown preparation of abutments without pulp exposure, acid etched cast bonded bridges ("Maryland Bridges") may be approved only for the replacement of a single missing maxillary anterior tooth, two adjacent missing maxillary anterior teeth, or two adjacent missing mandibular incisors. The same guidelines as previously listed apply. Abutments for resin bonded fixed partial dentures (i.e. "Maryland Bridges") should be billed using code D6545 and pontics using code D6251.

The materials used in the fabrication of a crown (e.g. all-metal, porcelain, ceramic, resin) is at the discretion of the provider. The crown fabricated must correctly match the procedure code approved on the Prior Approval.

FIXED PARTIAL DENTURE PONTICS

D6210	**Pontic - cast high noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6211	**Pontic - cast predominately base metal** (TOOTH) (PA REQUIRED)	$400.00
D6212	**Pontic - cast noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6214	**Pontic - titanium** (TOOTH) (PA REQUIRED)	$400.00
D6240	**Pontic - porcelain fused to high noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6241	**Pontic - porcelain fused to predominately base metal** (TOOTH) (PA REQUIRED)	$400.00
D6242	**Pontic - porcelain fused to noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6245	**Pontic - porcelain/ceramic** (TOOTH) (PA REQUIRED)	$400.00
D6250	**Pontic - resin with high noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6251	**Pontic - resin with predominately base metal** (TOOTH) (PA REQUIRED) Limited to the pontic for resin bonded fixed partial dentures (i.e. "Maryland Bridges").	$400.00
D6252	**Pontic - resin with noble metal** (TOOTH) (PA REQUIRED)	$400.00

CODE	DESCRIPTION	
FIXED PARTIAL DENTURE RETAINERS-INLAYS/ONLAYS		
D6545	**Retainer - cast metal for resin bonded fixed prosthesis** (TOOTH) (PA REQUIRED) Limited to abutment for resin bonded fixed partial dentures (i.e. “Maryland Bridges”).	$145.00
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6720	**Retainer crown - resin with high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6721	**Retainer crown - resin with predominately base metal** (TOOTH) (PA REQUIRED)	$500.00
D6722	**Retainer crown - resin with noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6740	**Retainer crown - porcelain/ceramic** (TOOTH) (PA REQUIRED)	$500.00
D6750	**Retainer crown - porcelain fused to high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6751	**Retainer crown - porcelain fused to predominantly base metal** (TOOTH) (PA REQUIRED)	$500.00
D6752	**Retainer crown - porcelain fused to noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6780	**Retainer crown - ¾ cast high noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6781	**Retainer crown - ¾ cast predominately base metal** (TOOTH) (PA REQUIRED)	$400.00
D6782	**Retainer crown - ¾ cast noble metal** (TOOTH) (PA REQUIRED)	$400.00
D6783	**Retainer crown - ¾ porcelain/ceramic** (TOOTH) (PA REQUIRED)	$400.00
D6790	**Retainer crown – full cast high noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6791	**Retainer crown - full cast predominantly base metal** (TOOTH) (PA REQUIRED)	$500.00
D6792	**Retainer crown – full cast noble metal** (TOOTH) (PA REQUIRED)	$500.00
D6794	**Retainer crown - titanium** (TOOTH) (PA REQUIRED)	$500.00
OTHER FIXED PARTIAL DENTURE SERVICES		
D6930	**Re-cement or re-bond fixed partial denture** (QUAD)	$45.00
D6980	**Fixed partial denture repair necessitated by restorative material failure** (QUAD) (REPORT NEEDED) For sectioning of a fixed partial denture, use procedure code D9120.	(BR)
D6999	**Unspecified, fixed prosthodontic procedure, by report** (REPORT NEEDED)	(BR)

CODE **DESCRIPTION**

X. ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

All surgical procedures include the surgery and the follow-up care for the period indicated after the procedure description (e.g. (POST OPERATIVE CARE: 7 DAYS)**). Necessary follow-up care beyond the listed period should be billed using codes D7999, D9110 or D9430.**

When multiple surgical procedures are performed on the same quadrant or arch, the claim may be pended for professional review. When extensive multiple surgical procedures are performed at the same operative session, the total reimbursement requested will be evaluated on a case by case basis, with possible reduction or denial of one or more of the billed procedures. Removal of bilateral tori or bilateral impactions and multiple extractions performed at the same operative session are examples of exceptions due to the independence of the individual procedures.

When a provider performs surgical excision and removal of tumors, cysts and neoplasms, the extent of the procedure claimed must be supported by information in the member's record. This includes radiographic images, clinical findings, and operative and histopathologic reports. To expedite review and reimbursement, this material (except radiographs) should be submitted on **paper claims** for procedures that have no established fee and are priced "By Report."

EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7111 **Extraction, coronal remnants – deciduous tooth** $35.00

D7140 **Extraction, erupted tooth or exposed root (elevation and/or forceps removal)** (TOOTH) (POST OPERATIVE CARE: 10 DAYS) $50.00

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7210 **Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated** (TOOTH) (POST OPERATIVE CARE: 10 DAYS) $85.00

Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Prior approval is required if performed more than four (4) times within twelve (12) months from the date of the first surgical extraction (D7210).

D7220 **Removal of impacted tooth - soft tissue** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 10 DAYS) $100.00

D7230 **Removal of impacted tooth - partially bony** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 10 DAYS) $180.00

D7240 **Removal of impacted tooth - completely bony** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 10 DAYS) $300.00

CODE	DESCRIPTION	
D7241	**Removal of impacted tooth - completely bony, with unusual surgical complications** (TOOTH) (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7250	**Surgical removal of residual tooth roots (cutting procedure)** (TOOTH) (POST OPERATIVE CARE: 10 DAYS)	$58.00

Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

OTHER SURGICAL PROCEDURES

D7260	**Oroantral fistula closure** (QUAD 10 or 20) (POST OPERATIVE CARE: 14 DAYS)	$200.00
D7261	**Primary closure of sinus perforation** (QUAD 10 or 20) (POST OPERATIVE CARE: 14 DAYS)	$200.00
D7270	**Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth** (TOOTH) (POST OPERATIVE CARE: 30 DAYS)	$114.00

Includes splitting and/or stabilization.

D7272	**Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)** (TOOTH) (POST OPERATIVE CARE: 30 DAYS)	$150.00
D7280	**Surgical access of an unerupted tooth** (TOOTH) (POST OPERATIVE CARE: 14 DAYS)	$290.00

An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

D7283	**Placement of device to facilitate eruption of impacted tooth** (TOOTH) (POST OPERATIVE CARE: 14 DAYS)	$50.00

Report the surgical exposure separately using D7280.

D7285	**Biopsy of oral tissue - hard (bone, tooth)** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$104.00

Claims must be submitted on paper with a copy of the operative report, including the description and location of the lesion and pathology report.

D7286	**Biopsy of oral tissue – soft** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$84.00

Claims must be submitted on paper with a copy of the operative report, including the description and location of the lesion and pathology report.

D7290	**Surgical repositioning of teeth** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 60 DAYS)	$145.00

ALVEOPLASTY - SURGICAL PREPARATION OF RIDGE

D7310	**Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant** (QUAD) (POST OPERATIVE CARE: 14 DAYS)	$70.00

This procedure will be reimbursed when additional surgical procedures above and beyond the removal of the teeth are required to prepare the ridge for dentures. Not reimbursable in addition to surgical extractions in the same quadrant. Claims should be submitted on the same invoice as extractions to expedite review.

CODE	DESCRIPTION	
D7311	**Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant** (QUAD) (POST OPERATIVE CARE: 14 DAYS) This procedure will be reimbursed when additional surgical procedures above and beyond the removal of the teeth are required to prepare the ridge for dentures. Not reimbursable in addition to surgical extractions in the same quadrant. Claims should be submitted on the same invoice as extractions to expedite review.	$50.00
D7320	**Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant** (QUAD) (POST OPERATIVE CARE: 14 DAYS) The fee for each quadrant includes the recontouring of both osseous and soft tissues in that quadrant. Will not be reimbursed in conjunction with procedure code D7310 in the same quadrant.	$115.00
D7321	**Alveoloplasty not in conjunction with extractions – one to three or tooth spaces, per quadrant** (QUAD) (POST OPERATIVE CARE: 14 DAYS) The fee for each quadrant includes the recontouring of both osseous and soft tissues in that quadrant. Will not be reimbursed in conjunction with procedure code D7311 in the same quadrant.	$75.00

VESTIBULOPLASTY

Vestibuloplasty may be approved when a denture could not otherwise be worn.

D7340	**Vestibuloplasty - ridge extension (secondary epithelialization)** (ARCH) (PA REQUIRED) (POST OPERATIVE CARE: 60 DAYS)	$300.00
D7350	**Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)** (ARCH) (PA REQUIRED) (POST OPERATIVE CARE: 60 DAYS)	$400.00

SURGICAL EXCISION OF SOFT TISSUE LESIONS (INCLUDES NON-ODONTOGENIC CYSTS)

All claims for D7410, D7411, and D7412, should be submitted with a copy of the operative report and all claims for D7413, D7414, and D7415 should be submitted with a copy of the pathology and operative report(s). All operative reports must include a description of the lesion and its location.

D7410	**Excision of benign lesion up to 1.25 cm** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$101.00
D7411	**Excision of benign lesion greater than 1.25cm** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)
D7412	**Excision of benign lesion complicated** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)
D7413	**Excision of malignant lesion up to 1.25cm** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7414	**Excision of malignant lesion greater than 1.25cm** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)

CODE	DESCRIPTION	
D7415	**Excision of malignant lesion complicated** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

Claims must be submitted with a copy of the pathology and operative report(s) and must include a description of the lesion and its location. Reimbursement for routine or surgical extractions includes removal of tooth, soft tissue associated with the root and curettage of the socket. Periapical granulomas at the apex of decayed teeth will not be separately reimbursed in addition to the tooth extraction.

D7440	**Excision of malignant tumor - lesion diameter up to 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7441	**Excision of malignant tumor -lesion greater than 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)
D7450	**Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$84.72
D7451	**Removal of benign odontogenic cyst or tumor-lesion greater than 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)
D7460	**Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$101.00
D7461	**Removal of benign nonodontogenic cyst or tumor - greater than 1.25 cm** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7465	**Destruction of lesion(s) by physical or chemical methods, by report** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)

EXCISION OF BONE TISSUE

D7471	**Removal of lateral exostosis (maxilla or mandible)** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 21 DAYS)	(BR)
D7472	**Removal of torus palatinus** (REPORT NEEDED) (POST OPERATIVE CARE: 21 DAYS)	(BR)
D7473	**Removal of torus mandibularis** (QUAD 30 or 40) (REPORT NEEDED) (POST OPERATIVE CARE: 21 DAYS)	(BR)
D7485	**Surgical reduction of osseous tuberosity** (QUAD 10 or 20) (REPORT NEEDED) (POST OPERATIVE CARE: 21 DAYS)	(BR)
D7490	**Radical resection of maxilla or mandible** (ARCH) (REPORT NEEDED) (POST OPERATIVE CARE: 180 DAYS)	(BR)

SURGICAL INCISION

Reimbursement for incision and drainage procedures includes both the insertion and the removal of all drains.

D7510	**Incision and drainage of abscess – intraoral soft tissue** (QUAD) (POST OPERATIVE CARE: 10 DAYS) (REPORT NEEDED)	$70.00
D7511	**Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)** (QUAD) (REPORT NEEDED)	(BR)

CODE	DESCRIPTION	
D7520	**Incision and drainage of abscess – extraoral soft tissue** (QUAD) (POST OPERATIVE CARE: 21 DAYS)	$140.00
D7521	**Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)** (QUAD) (REPORT NEEDED)	(BR)
D7530	**Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 21 DAYS)	(BR)
D7540	**Removal of reaction-producing foreign bodies – musculoskeletal system** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
	The report must include a description of the foreign body and its location.	
D7550	**Partial ostectomy / sequestrectomy for removal of non-vital bone** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
	The report must include a description of the surgical site.	
D7560	**Maxillary sinusotomy for removal of tooth fragment or foreign body** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$435.00
	Includes closure of oroantral communication when performed concurrently.	

TREATMENT OF FRACTURES – SIMPLE

D7610	**Maxilla - open reduction (teeth immobilized if present)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1,160.00
D7620	**Maxilla - closed reduction (teeth immobilized if present)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$435.00
D7630	**Mandible - open reduction (teeth immobilized if present)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1,305.00
D7640	**Mandible - closed reduction (teeth immobilized if present)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$435.00
D7650	**Malar and/or zygomatic arch - open reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$725.00
D7660	**Malar and/or zygomatic arch - closed reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7670	**Alveolus - closed reduction, may include stabilization of teeth** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$203.00
D7671	**Alveolus - open reduction, may include stabilization of teeth** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7680	**Facial bones – complicated reduction with fixation and multiple surgical approaches** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)

TREATMENT OF FRACTURES-COMPOUND

Reimbursement for codes D7710-D7740 includes splint fabrication when necessary.

D7710	**Maxilla – open reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7720	**Maxilla - closed reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$580.00

CODE	DESCRIPTION	
D7730	**Mandible - open reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7740	**Mandible - closed reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$580.00
D7750	**Malar and/or zygomatic arch - open reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7760	**Malar and/or zygomatic arch - closed reduction** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7770	**Alveolus – open reduction stabilization of teeth** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7771	**Alveolus - closed reduction stabilization of teeth** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7780	**Facial bones – complicated reduction with fixation and multiple surgical approaches** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

Routine services for treatment of temporomandibular joint, myofacial pain and related disorders are generally considered beyond the scope of the program. Reimbursement for temporomandibular joint dysfunctions will be permitted only in the specific conditions wherein a definitive diagnosis corroborates necessary treatment. Appropriate documentation (e.g., operative report, procedure description) should accompany all claims as attachments.

D7810	**Open reduction of dislocation** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1450.00
D7820	**Closed reduction of dislocation** (REPORT NEEDED) (POST OPERATIVE CARE: 7 DAYS)	$140.00
D7830	**Manipulation under anesthesia** (REPORT NEEDED) (POST OPERATIVE CARE: 7 DAYS)	$174.00
D7840	**Condylectomy** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1740.00
D7850	**Surgical discectomy; with/without implant** (POST OPERATIVE CARE: 90 DAYS)	$870.00
D7852	**Disc repair** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1,044.00
D7854	**Synovectomy** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$812.00
D7856	**Myotomy** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7858	**Joint reconstruction** (REPORT NEEDED) (POST OPERATIVE CARE: 120 DAYS)	$2,900.00
D7860	**Arthrotomy** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$870.00
D7865	**Arthroplasty** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$2,030.00
D7870	**Arthrocentesis** (REPORT NEEDED) (POST OPERATIVE CARE: 7 DAYS)	$116.00
D7872	**Arthroscopy - diagnosis, with/without biopsy** (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	$725.00
D7873	**Arthroscopy - surgical: lavage and lysis of adhesions** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$725.00
D7874	**Arthroscopy - surgical: disc repositioning and stabilization** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$1,044.00

CODE	DESCRIPTION	
D7875	**Arthroscopy - surgical: synovectomy** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$1,044.00
D7876	**Arthroscopy - surgical: discectomy** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$1,044.00
D7877	**Arthroscopy - surgical: debridement** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$1,044.00
D7880	**Occlusal orthotic appliance, by report** (REPORT NEEDED) (POST OPERATIVE CARE: 10 DAYS)	(BR)
	Reimbursable only when performed in conjunction with a covered surgical procedure. Not used for "night guards", "occlusal guards", bruxism appliances, or other TMJ appliances.	
D7899	**Unspecified TMD therapy, by report** (REPORT NEEDED)	(BR)

REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions.

D7910	**Suture of recent small wounds up to 5 cm** (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	$100.00

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)

Excludes closure of surgical incisions.

Utilized in situations requiring unusual and time-consuming techniques of repair to obtain the maximum functional and cosmetic result. The extent of the procedure claimed must be supported by information in the operative report.

D7911	**Complicated suture - up to 5 cm** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$125.00
D7912	**Complicated suture - greater than 5 cm,** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	(BR)

OTHER REPAIR PROCEDURES

D7920	**Skin graft (identify defect covered, location and type of graft)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7940	**Osteoplasty - for orthognathic deformities** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
	Use to report genioplasty.	
D7941	**Osteotomy - mandibular rami** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1,450.00
D7943	**Osteotomy - mandibular rami with bone graft; includes obtaining the graft** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$2,175.00
D7944	**Osteotomy - segmented or subapical** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1160.00
D7945	**Osteotomy - body of mandible** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$1102.00

CODE	DESCRIPTION	
D7946	**LeFort I (maxilla-total)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$2,175.00
D7947	**LeFort I (maxilla-segmented)** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$2,900.00
	When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report" using procedure code D7999.	
D7948	**LeFort II or LeFort III (osteoplasty of facial bones for midface hyperplasia or retrusion) - without bone graft** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$2,900.00
D7949	**LeFort II or LeFort III with bone graft** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	$3,480.00
D7950	**Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report** (REPORT NEEDED) (POST OPERATIVE CARE: 90 DAYS)	(BR)
D7960	**Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure** (ARCH) (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	$190.00
	Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment.	
D7970	**Excision of hyperplastic tissue- per arch** (ARCH) (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	$150.00
D7971	**Excision of pericoronal gingiva** (TOOTH) (REPORT NEEDED) (POST OPERATIVE CARE: 10 DAYS)	$60.00
	All claims will be pended for professional review.	
D7972	**Surgical reduction of fibrous tuberosity** (QUAD) (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	(BR)
D7980	**Sialolithotomy** (POST OPERATIVE CARE: 14 DAYS)	$290.00
D7981	**Excision of salivary gland, by report** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7982	**Sialodochoplasty** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	$826.00
D7983	**Closure of salivary fistula** (REPORT NEEDED) (POST OPERATIVE CARE: 30 DAYS)	(BR)
D7990	**Emergency tracheotomy**	$725.00
D7991	**Coronoidectomy** (REPORT NEEDED) (POST OPERATIVE CARE: 60 DAYS)	$551.00
D7997	**Appliance removal (not by dentist who placed appliance), includes removal of archbar** (REPORT NEEDED) (POST OPERATIVE CARE: 14 DAYS)	(BR)
	Not for removal of orthodontic appliances. Includes both arches, if necessary.	
D7998	**Intraoral placement of a fixation device not in conjunction with a fracture** (REPORT NEEDED)	(BR)
	Includes both arches, if necessary.	
D7999	**Unspecified oral surgical procedure, by report** (REPORT NEEDED)	(BR)

CODE **DESCRIPTION**

XI. ORTHODONTICS D8000 - D8999

ELIGIBILITY

Eligibility is limited to members who:

1. are under 21 years of age;
2. meet financial standards for Medicaid eligibility; and,
3. exhibit a **SEVERE PHYSICALLY HANDICAPPING MALOCCLUSION**.

Orthodontic care for severe physically handicapping malocclusions is a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 21st birthday. Treatment of cleft palate or approved orthognathic surgical cases may be approved after the age of 21 or for additional treatment time.

With the exception of D8210, D8220 and D8999, orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which have met the qualifications of the DOH and are enrolled with the appropriate specialty code.

CODE **DESCRIPTION**

PRIOR APPROVAL

The following orthodontic procedures codes require prior approval: D8010, D8020, D8030, D8040, D8050, D8060, D8070, D8080, D8090, D8670, and D8680.

The following documentation must be submitted along with the prior approval request:

- Pages 1 and 2 of the completed and signed "Handicapping Labio-Lingual (HLD) Index Report". The HLD Index Report is available on the internet at: https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_NY.pdf
- A panoramic and/or mounted full mouth series of intra-oral radiographic images;
- A cephalometric radiographic image with teeth in centric occlusion and cephalometric analysis / tracing;
- Photographs of frontal and profile views;
- Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view;
- Maxillary and mandibular occlusal photographs;
- Photos of articulated models can be submitted optionally *(Do **NOT** send stone casts).*

Subjective statements submitted by the provider or others must be substantiated by objective documentation such as photographs, radiographic images, credible medical documentation, etc. verifying the nature and extent of the severe physical handicapping malocclusion. **Requests where there is significant disparity between the subjective documentation (e.g. HLD index report and narrative) and objective documentation (e.g. photographs and/or radiographic images) will be returned for clarification without review.**

Requests for continuation of orthodontic treatment which was begun **without** prior approval from the DOH or a NYS Medicaid Managed Care Plan will be evaluated using the same criteria and guidelines to determine if a severe physically handicapping malocclusion **currently** exists. A completed HLD index report based on the current dentition, and all of the required documentation (listed above) must be submitted along with the prior approval request. If continuation of treatment is denied, debanding and retention might be approvable using procedure code D8690.

Orthognathic Surgical Cases with Comprehensive Orthodontic Treatment

- Members must be at least 15 years of age for case consideration;
- The surgical consult, complete treatment plan and approval for surgical treatment (if necessary) must be included with the request for orthodontic treatment;
- Prior approval and documentation requirements are the same as those for comprehensive treatment;
- A statement signed by the parent/guardian and member that they understand and accept the proposed treatment, both surgical and orthodontic, and understand that approval for orthodontic treatment is contingent upon completion of the surgical treatment.

CODE **DESCRIPTION**

LIMITED EXTENDED COVERAGE

Regardless of whether the dental benefit is administered through Managed Care or through fee-for-service, when eligibility is lost after active orthodontic treatment has been initiated, fee-for-service Medicaid will provide for up to:

- Two (2) quarterly payments; or,
- One (1) quarterly payment and retention; or,
- Retention alone.

The treating orthodontist may decide to complete active treatment (including retention care), initiate retention care to preserve current status, or remove the appliances in cases of minimal progress during active therapy. At least thirty (30) days of treatment must have been provided following the loss of eligibility. When billing for the limited extended coverage, submit a paper claim **to Computer Sciences Corporation (CSC)** using procedure code D8999, the last date of eligibility as the date of service and identify the stage of treatment when eligibility was lost (e.g. 2nd quarter of second year; 1st quarter of third year, etc.). The maximum benefit for limited extended coverage is only payable one (1) time during the course of orthodontic treatment.

If approval for orthodontic treatment was issued through Medicaid Managed Care (MMC) a copy of the authorization for treatment and remittance statement(s) must also be included. Only those cases previously approved for comprehensive orthodontic treatment (D8070, D8080, or D8090) in which appliances have been placed and activated are eligible for the "Limited Extended Coverage" benefit. Claims for the "Limited Extended Coverage" benefit MUST be submitted within 9 months of the loss of eligibility. Claims submitted for payment beyond that time range will be subject to denial.

CONTINUATION OF ACTIVE ORTHODONTIC TREATMENT WHEN THE MEMBER'S MEDICAID COVERAGE CHANGES

When a member undergoing active orthodontic treatment that was authorized by MMC Plan (or their vendor) has coverage changed to fee-for-service Medicaid, a prior approval for continued treatment is required from the fee-for-service program. A prior approval request for continuation of orthodontic care (D8670) should be submitted to Computer Sciences Corporation (CSC) with the following documentation:

- A copy of the original Medicaid Managed Care Plan authorization or approval for comprehensive orthodontic treatment;
- A copy of the remittance statement from the Medicaid Managed Care Plan;
- All pre-treatment records and recent progress photographs depicting the current dentition; and,
- A brief narrative describing the services already rendered (e.g. Initial placement of orthodontic appliances and two quarters of D8670 have been paid by Healthplex).

Orthodontic coverage for procedure codes D8670 and D8680 is subject to the member's eligibility under the FFS Medicaid Program. If a member's coverage is changed back to

CODE **DESCRIPTION**

managed care a request for these orthodontic services will need to be submitted to the member's Managed Care Plan.

MEDICAID MEMBERS CANNOT BE BILLED

- By enrolling in the Medicaid program, a provider agrees to accept payment under the Medicaid program as payment in full for services rendered.
- There is no separate billing for the replacement of broken appliances such as bands, brackets or arch wires.
- Medicaid payment for orthodontic services represents payment in full for the entire treatment protocol, regardless of the type of appliances used. Separately billing the member for any portion of orthodontic treatment is prohibited.
- Orthodontists must offer Medicaid members the same treatment options offered to the majority of patients in the provider's practice with similar treatment needs (e.g., orthodontists may not restrict Medicaid members to metal brackets if non-Medicaid patients are routinely provided other types of devices (e.g. bonded "clear" brackets, "Damon®" brackets, clear appliance therapy, bite plates or removable appliances) and may not charge Medicaid members for the use of these other techniques and/or devices.
- Reimbursement for orthodontic services includes the placement and **removal** of all appliances and brackets. Should it become necessary to remove the bands due to non-compliance or elective discontinuation of treatment by the provider, parent, guardian or member the appliance(s) must be removed at no additional charge to either the member, family or Medicaid**.**

DISCONTINUATION OF TREATMENT

In cases where treatment is discontinued, a "Release from Treatment" form **must** be provided by the dental office which documents the date and the reason for discontinuing care. The release form must be reviewed and signed by the parent/guardian and member. The "Release from Treatment" form must indicate that all those involved understand future orthodontic treatment will not be covered by Medicaid. A copy must be sent to DOH.

Behavior Not Conducive to Favorable Treatment Outcomes

It is the expectation that the case selection process for orthodontic treatment take into consideration the member's ability over the course of treatment to:

- Tolerate orthodontic treatment;
- Comply with necessary instructions for home care (e.g. wear elastics, headgear, removable appliance, etc.)
- Keep multiple appointments over several years;
- Maintain an oral hygiene regimen;
- Be cooperative and complete all needed preventive and treatment visits.

(continued on next page)

CODE **DESCRIPTION**

If it is determined that the member is exhibiting non-compliant behavior (e.g. multiple missed orthodontic and general dental appointments, continued poor oral hygiene, and/or failure to maintain the appliances and/or untreated dental disease) a letter **must** be sent to the parent/guardian that documents the factors of concern and the corrective actions needed and that failure to comply can result in discontinuation of treatment. A copy **must** be sent to the DOH.

If orthodontic treatment is discontinued for cause, the parent/guardian and/or member must sign a statement indicating they understand treatment is being discontinued prior to completion; the reason(s) for discontinuation of treatment; and, that it will jeopardize their ability to have further orthodontic treatment provided through the NYS Medicaid Program. The treating orthodontist must make reasonable provisions to provide necessary treatment during the transition of care to another provider or for debanding. Dismissal of a member (patient) from a practice is a medico-legal issue; therefore, the treating orthodontist should seek an appropriate legal counsel at their own discretion.

All approved courses of comprehensive orthodontic treatment must be concluded in a manner acceptable to the DOH and the DOH must be notified. Appropriate means of concluding treatment include:

- Successful completion of treatment and the issuance of a prior approval by the DOH for debanding and/or retention;
- Notification that treatment is being discontinued for cause and that the parent/guardian and/or member have been appropriately notified, or;
- Loss of eligibility and utilization of the “Limited Extended Coverage” benefit to conclude treatment.

Treatment must continue to a point satisfactory to the DOH, regardless of the length of time treatment is required and even if all Medicaid benefits have been exhausted, without charge to the NYS Medicaid Program, the member or family. **Failure to conclude treatment in an acceptable manner can result in the recovery of the entire cost of the complete course of treatment.**

“BY REPORT” CODES THAT ARE ALSO “PA OPTIONAL”

For those procedures listed in this manual and/ or on the Dental Fee Schedule without a published fee (D8210 and D8220) **and** are listed as both “(REPORT NEEDED, PA OPTIONAL)”:

- Procedures can be reviewed for appropriateness and tentatively priced before treatment is initiated by submitting a prior approval request.

- OR -

- Procedures can be priced after treatment without prior approval as a “By Report” based on documentation submitted with the claim substantiating a qualifying physically handicapping malocclusion.

CODE **DESCRIPTION**

ORTHODONTIC RECORDS TAKEN THAT ARE NOT REQUIRED BY DOH

The NYS Medicaid Program will reimburse for those services that are medically necessary, are an integral part of the actual treatment, or that are required by the Department. Orthodontic records taken for the provider's records, such as photographs (D0350), models (D0470) or radiographic images (including a FMS (D0210), panoramic (D0330) and cephalometric (D0340)) are not required by the Department and are considered part of the reimbursement for the treatment and are not payable separately. The provider can take these records as part of the treatment records, but they cannot charge the NYS Medicaid Program, the member or family. Payment may be considered on an exceptional basis if there is documentation of medical necessity.

LIMITED ORTHODONTIC TREATMENT

The submitted records must demonstrate a physically handicapping malocclusion indicating the need for limited orthodontic treatment. Procedure codes D8030 and D8040 cannot be substituted for procedure codes D8070, D8080, and D8090 if a member does not qualify for comprehensive orthodontic treatment as per NYS Medicaid criteria. Reimbursement will be determined based on supporting documentation submitted.

D8010	**Limited orthodontic treatment of the primary dentition** (PA REQUIRED)	(BR)
D8020	**Limited orthodontic treatment of the transitional dentition** (PA REQUIRED)	(BR)
D8030	**Limited orthodontic treatment of the adolescent dentition** (PA REQUIRED)	(BR)
D8040	**Limited orthodontic treatment of the adult dentition** (PA REQUIRED)	(BR)

CODE	DESCRIPTION	

INTERCEPTIVE ORTHODONTIC TREATMENT

Interceptive orthodontics is an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of dental crossbite or recovery of space loss where overall space is inadequate. When initiated during the incipient stages of a developing problem, interceptive orthodontics may reduce the severity of the malformation and mitigate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive therapy. HLD Index Report is not required when submitting a prior approval request for interceptive orthodontic treatment.

If comprehensive treatment is required following a course of interceptive treatment, a period of 12 to 18 months should be allowed prior to requesting comprehensive treatment to provide for stabilization of the result.

D8050	**Interceptive orthodontic treatment of the primary dentition** (PA REQUIRED)	(BR)
D8060	**Interceptive orthodontic treatment of the transitional dentition** (PA REQUIRED)	(BR)

CODE **DESCRIPTION**

COMPREHENSIVE ORTHODONTIC TREATEMENT

- With the exception of cleft palate and other surgical cases, only members with late mixed dentition or permanent dentition will be considered for the initiation of comprehensive orthodontic treatment.
- Reimbursement for codes D8070, D8080 or D8090 is limited to once in a lifetime as initial payment for an approved course of orthodontic treatment. The member's dentition will determine the single code to be used and can only be billed when all appliances have been placed and active treatment has been initiated. **The placement of the component parts (e.g. brackets, bands) does not constitute commencement of active treatment.**
- For quarterly payment, see procedure code D8670. Reimbursement for comprehensive orthodontic treatment is ALL INCLUSIVE and covers ALL orthodontic services, both fixed and removable that needs to be provided to correct the orthodontic condition.
- A prior approval request for continuation of comprehensive orthodontic treatment (2nd year, 3rd year and retention) must be submitted annually to the DOH along with a progress report and photographs of the current conditions to assess the progress of treatment and determine if additional treatment time (up to a maximum of three (3) years) is warranted.
- Requests to RESTART comprehensive orthodontic treatment on a member for which Medicaid FFS paid the original comprehensive code (D8070, D8080, or D8090), but who now has Managed Care coverage, should be submitted to the Manage Care plan or their vendor.
- As of 10/01/2012, orthodontic treatment is a covered benefit under Medicaid Managed Care Plans. All prior approvals for orthodontic treatment that were reviewed and approved on 10/1/12 and after, are subject to member's eligibility under the FFS (fee-for-service) Medicaid program. Providers are responsible for checking the member's Medicaid eligibility PRIOR to rendering services.
- As previously indicated on page 14 of this manual:
  "If a member is enrolled in a managed care plan which covers the specific care or services being provided, it is inappropriate to bill such services to the Medicaid program on a fee-for-service basis whether or not prior approval has been obtained."

D8070	**Comprehensive orthodontic treatment of the transitional dentition** (PA REQUIRED)	$986.00
D8080	**Comprehensive orthodontic treatment of the adolescent dentition** (PA REQUIRED)	$986.00
D8090	**Comprehensive orthodontic treatment of the adult dentition** (PA REQUIRED)	$986.00

CODE **DESCRIPTION**

MINOR TREATMENT TO CONTROL HARMFUL HABITS

The following procedures (D8210 and D8220) include appliances for habits such as thumb sucking and tongue thrusting. They do not have a published fee and are listed as both "(REPORT NEEDED, PA OPTIONAL)". These procedure codes can be used by all enrolled dentists regardless of specialty.

- Procedures can be reviewed for appropriateness and tentatively priced before treatment is initiated by submitting a prior approval request.

- OR –

- Procedures can be priced after treatment without prior approval as a "By Report" based on documentation submitted with the claim substantiating a qualifying physically handicapping malocclusion.

D8210 **Removable appliance therapy** (REPORT NEEDED, PA OPTIONAL) (BR)
D8220 **Fixed appliance therapy** (REPORT NEEDED, PA OPTIONAL) (BR)

OTHER ORTHODONTIC SERVICES

D8660 **Pre-orthodontic treatment examination to monitor growth and development** $29.00

Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin. Diagnostic procedures are documented separately.

- Orthodontist specialty designation required.
- May not be reimbursed in conjunction with other examination codes.
- Cannot be reimbursed after active orthodontic treatment has begun.

D8670 **Periodic orthodontic treatment visit (as part of contract)** $232.00 (PA REQUIRED)

The member must have been seen and actively treated at least once during the quarter. Cannot be used for "observation". This code requires prior approval and can be billed quarterly for a maximum of twelve (12) payments and can only be billed a maximum of four (4) times in a twelve-month period beginning 90 days after the date of service on which orthodontic appliances have been placed and active treatment begun and at the end of each subsequent quarter. Claims billed more frequently will result in an automatic systems denial. In the event that eligibility is lost during a quarter, at least one month of active treatment must have elapsed to qualify for payment under the "limited extended coverage" benefit.

D8680 **Orthodontic retention (removal of appliances**, **construction and placement of retainer(s))** (PA REQUIRED) $174.00

Includes all follow-up visits needed for observation and adjustments.

Requests must be submitted and approval obtained **PRIOR** to the removal of appliances. Any request denied or otherwise returned for insufficient results will require the re-application of all appliances, if necessary, and continuation of care without additional compensation. Payment will not be made for retention (D8680) for a case that had been debanded without Medicaid prior authorization.

CODE	DESCRIPTION	
D8690	**Orthodontic treatment (alternative billing to a contract fee)** (REPORT NEEDED)	(BR)

Services provided by an orthodontist other than the original treating orthodontist.

This is limited to transfer care and removal of appliances.

D8692 **Replacement of lost or broken retainer** (REPORT NEEDED) $145.00

This procedure will be reimbursed once per lifetime and includes both arches, if necessary. Must be within one year of D8680 having been paid by Medicaid. Appliances which do not fit will not be replaced. The following documentation is required when submitting a claim for a replacement retainer (D8692):

- Copy of a signed statement from patient / parent detailing the circumstances of how the appliance was lost or broken;
- Copy of patient's treatment record; and,
- Copy of dental laboratory bill, if available.

D8999 **Unspecified orthodontic procedure, by report** (REPORT NEEDED) (BR)

CODE **DESCRIPTION**

XII. ADJUNCTIVE GENERAL SERVICES D9000 - D9999

UNCLASSIFIED TREATMENT

D9110 **Palliative (emergency) treatment of dental pain - minor procedure** (REPORT NEEDED) $25.00

Not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations when the procedure does not add significantly to the length of time and effort of the treatment provided during that particular visit.

When billing, the provider must document the nature of the emergency, the dental site and the specific treatment involved.

Not to be used for denture adjustments (Refer to procedure codes D5410 – D5422).

D9120 **Fixed partial denture sectioning** (QUAD) (REPORT NEEDED) (BR)

ANESTHESIA

The cost of analgesic and anesthetic agents is included in the reimbursement for the dental service. The administration of nitrous oxide is not separately reimbursable. Reimbursement for general anesthesia, intravenous (parenteral) sedation and anesthesia time is conditioned upon meeting the definitions listed below.

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and not dependent upon the route of administration.

Anesthesia time should be commensurate with the treatment performed.

Anesthesia time is divided into 15 minute units for billing purposes; the number of such units should be entered in the "Times Performed" field of the claim form using the appropriate code (D9223, D9243).

D9223 **Deep sedation/general anesthesia – each 15 minute increment** $76.00

Requires SED certificate in "General Anesthesia"

D9243 **Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment** $76.00

Requires SED certificate in "General Anesthesia"

CODE **DESCRIPTION**

D9310 **Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician** $30.00
(REPORT NEEDED)

The consulted provider must be enrolled in one of the dental specialty areas recognized by the NYS Medicaid program and the claim must include the NPI of the referring provider. The referring provider cannot be from the same group as the consulting provider.

The report should include:

- A copy of the written request from the referring provider identifying the issue for which they are seeking advice and counsel; and,
- A copy of the written evaluation back to the referring provider with the findings, recommendations, and advice and counsel on how the referring provider should proceed. This should occur prior to the start of any treatment by the specialist.

If the consultant provider assumes the management of the member after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographic images) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by the same provider within 180 days of an examination or an office visit for observation (D9430). An exception can be made if a subsequent consultation is held for a distinctly different condition, supported by documentation.

PROFESSIONAL VISITS

D9410 **House/extended care facility call** (REPORT NEEDED) $50.00

Per visit, regardless of number of members seen and represents the total extra charge permitted, is not applicable to each member seen at such a visit. The report must list all Medicaid covered patients seen at the facility on the date of service.

Fee-for-service reimbursement will not be made for those individuals who reside in facilities where dental services are included in the facility rate. In those cases, reimbursement must be sought directly from the facility.

D9420 **Hospital or ambulatory surgical center call** (REPORT NEEDED) $75.00

Per visit, per member (to be added to fee for service). This service will be recognized only for professional visits for pre-operative or operative care. Post-operative visits are not reimbursable when related to procedures with assigned follow-up days. Hospital calls are not reimbursable for hospital-based providers.

Payable only when provided in a FACILITY where professional services are not included in the rate. Please submit documentation that services were provided in a hospital, such as a copy of the hospital notes/record.

CODE **DESCRIPTION**

D9430 **Office visit for observation (during regularly scheduled hours) – no other services performed** (REPORT NEEDED) $20.00

The provider must be enrolled in one of the dental specialty areas recognized by the NYS Medicaid program. Used to monitor the status of a member following an authorized phase of **surgical** treatment that are required beyond the post-operative care period for that procedure. Not be used for orthodontic retention follow-up visits. Reimbursement includes the prescribing of medications and is limited to two instances per clinical episode.

May also be used for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption") where definitive treatment cannot be performed due to the member's behavior. This is a "stand-alone" procedure and cannot be billed on the same date of service with any other procedure code. Limited to four (4) instances per year per member. Please include a report or narrative describing the circumstances involved.

D9440 **Office visit - after regularly scheduled hours** (REPORT NEEDED) $20.00

Cannot be billed in conjunction with an examination, observation or consultation. Please include a report or narrative describing the circumstances involved.

DRUGS

D9610 **Therapeutic parenteral drug, single administration** (BR) (REPORT NEEDED)

Please submit with an itemized invoice indicating name and dosage of drug(s) administered.

MISCELLANEOUS SERVICES

D9920 **Behavior management, by report** $29.00

This is a per visit incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population. This fee will be paid in addition to the normal fees for specific dental procedures. For purposes of the NYS Medicaid program, the developmentally disabled population (OPWDD members) for which procedure code D9920 may be billed is limited to those who receive ongoing services from community programs operated or certified by the New York State Office for People with Developmental Disabilities (OPWDD). These individuals are identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"). A "Medical Immobilization/Protective Stabilization (MIPS)" form (Institutions only) also qualifies for use of this procedure code.

Not billable as a "stand-alone" procedure; another clinical service must be provided on the same date.

Not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia.

Does not require a report.

CODE	DESCRIPTION	
D9940	**Occlusal guard, by report** (REPORT NEEDED) Report must include documentation of necessity, associated laboratory receipts and a copy of treatment/progress notes indicating the date of insertion.	$145.00
D9999	**Unspecified adjunctive procedure, by report** (REPORT NEEDED)	(BR)

CODE **DESCRIPTION**

MISCELLANEOUS PROCEDURES

T1013 **Sign Language or Oral Interpretive Services** (REPORT NEEDED) $11.00

For patients with limited English proficiency defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff.

The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI).

Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013- sign language and oral interpretation services and is billable during a medical/dental visit. Limited to two (2) units:
One Unit: Includes a minimum of eight (8) and up to 22 minutes;
Two Units: Includes 23 or more minutes.

Documentation of necessity must be submitted as an attachment to a paper claim.