PROVIDER MANUAL FOR

DENTAL SERVICES

Published By:

Division of Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

May 2018

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KEY CONTACTS

Hours for key contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Central Time).

Provider Enrollment

(800) 755-2604
(701) 328-4033

Send written inquiries to:

Provider Enrollment
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

or e-mail inquiries to:

dhsenrollment@nd.gov

Provider Relations

For questions about recipient eligibility, payments, denials or general claims questions:

(701) 328-7098
(877) 328-7098

Send written inquiries to:

Provider Relations
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

or e-mail inquiries to:

mmisinfo@nd.gov

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 755-2604
(701) 328-2347

Send written inquiries to:

Third Party Liability Unit
Medical Services
ND Dept. of Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

or e-mail inquiries to:

medicaidtpl@nd.gov

Coordinated Services Program

Inquiries regarding coordinated services program recipients:

(800) 755-2604
(701) 646-4559

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

(701) 328-4024
(800) 755-2604

Send written inquiries to:

Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Human Services
Dept 325
600 E Boulevard Ave
Bismarck ND 58505-0250

Or e-mail inquiries to:

medicaidfraud@nd.gov

CSHS Inquiries and to obtain forms

Children's Special Health Services
ND Department of Health
Dept 401
600 E Boulevard Ave
Bismarck BD 58505-0200
(701) 328-2436

INTRODUCTION

This billing manual is designed to aid providers in billing the North Dakota Medicaid and Children's Special Health Services (CSHS) programs. Included are general items of interest to providers, specific claim form billing instructions and procedures to follow when voiding and replacing a claim.

When filing claims with the ND Medicaid program, the provider agrees to accept ND Medicaid payment as payment in full. The provider CANNOT BILL the recipient for any part of the bill unless the remittance advice indicates a recipient liability, or a co-payment applies to the services, or it is a non-covered service.

Please contact the Medical Services office with questions. Addresses and telephone numbers are listed in the Key Contacts section of this manual.

Any disputes or questions on claims should be directed to the Provider Relations at 701-328-7098.

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THIRD PARTY LIABILITY (TPL)

In 1986, federal law required state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid.

Providers must obtain information about a member's health care coverage from the member, the member's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits. Providers may also obtain an assignment of benefits from the member to ensure direct payment from the third party payer.

For Medicaid purposes, health insurance is defined as any third party benefit that is available to the eligible Medicaid members for medical treatment and related services.

PRIVATE HEALTH CARE PLANS AND THIRD PARTY PAYERS

Providers and Medicaid eligible members are required to follow the third party payer's policies and procedures to maximize the available benefit. If the third party payer applies a penalty because the member or provider did not follow the third party policies, ND Medicaid will not pay the penalty amount. If the third party payer does not pay anything on the claim because policy and procedures were not followed, ND Medicaid will not pay the claim.

Services for which payment has been denied by the third party payer for reasons other than noncompliance may be eligible for ND Medicaid reimbursement. Explanation of benefits (EOBs) or other documentation is required before payment is authorized.

Third party EOBs and other required documents must be provided on those billings in which the third party has paid less than 80% of the billed charges or when the member is covered by more than one insurance plan and a balance needs to be billed to ND Medicaid.

Payment received from accident liability insurers, i.e. auto, business and homeowners, must be entered on the claim form in the space noted for insurance or other payments. The Explanation of Benefits or other documentation must be included with the claim.

Billing ND Medicaid and another third party for the same service at the same time is considered a violation under Medicaid rules. Medicaid is the payer of last resort and can only be billed after the third party has paid its legal liability.

Medicaid covers co-pays to the extent that the third party payment and the co-pay do not exceed the ND Medicaid allowed amount.

For any claims with TPL, providers must bill their usual and customary charge to ND Medicaid.

If the provider has third party information that is not on ND Medicaid's system, the provider must advise the Medicaid program by sending an EOB from the third party payer. The provider must adequately identify the EOB by writing the provider number, member's name and Medicaid ID number on the EOB. If ND Medicaid has third party information that the provider is not aware of, ND Medicaid will supply the provider with adequate information for the provider to bill the third party if the third party payer is not known to the provider at the time of billing. The Medicaid Fax Number to send EOB's when reporting third party information is (701) 328-1544, attention TPL Unit.

When a third party payer denies a claim, an explanation must accompany the claim.

ND Medicaid requires a provider to make a reasonable attempt to bill a third party payer. If after thirty days no response has been received, the provider can bill ND Medicaid with documentation that the third party was billed. If the claim is submitted to ND Medicaid and Medicaid determines that the third party information was not correct, the billing will be returned to the provider with the correct billing information.

Providers must bill the third party and ND Medicaid. Providers are not allowed to bill the Medicaid member for any balances after payment is received from the third party and ND Medicaid. Medicaid payment is the last adjudication of the claim, and if there is a balance left after Medicaid has made a payment determination, this constitutes a write off to the provider. Medicaid payment is considered payment in full, even if payment is zero.

Providers may bill members to recover payments made by the third party payer directly to the member.

Providers cannot refuse services because a Medicaid eligible member has third party coverage. Providers cannot demand payment, and require the member to bill the third party, unless specific terms of the third party require that benefits be paid to the member. ND Medicaid may be billed only to the extent there is a member legal obligation to pay.

MEMBER COOPERATION WITH TPL BILLING

If a Medicaid member is non-cooperative or fails to cooperate with the third party payer, the provider may contact the applicable County Social Service office or the TPL Unit at 701-328-2347 or medicaidtpl@nd.gov for assistance.

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SERVICES TO AN INDIVIDUAL WITH A DEVELOPMENTAL DISABILITY

Individuals with a developmental disability (DD) may require an extra amount of time and a greater number of personnel in order to provide routine dental care. The Department will provide additional compensation to dentists who treat individuals who need extra care; therefore, providers will receive the standard fee for the dental services provided plus a special payment for the extra time needed.

The policy does not require providers to document the extra time required to provide services to DD recipients. The provider is to use procedure code D9920 and enter the extra usual and customary charge associated with the services provided to the DD recipient. Procedure Code D9920 does require a service authorization (SA) effective October 1, 2015. The Department will pay the extra charge based on the established fee schedule.

If the provider provides a service to an individual with a Developmental Disability who requires extra time, the dental provider will need to contact the DD provider. If the DD provider concurs that the recipient requires extra time, the dental provider must submit the Request for Extra Time Individuals with Developmental Disabilities form (SFN 64). The Medical Services Division will reach out to verify the information. The form is available on our website at http://www.nd.gov/eforms. The form may be downloaded for provider use.

Any additional questions regarding this policy can be addressed by contacting Provider Relations at (701) 328-7098.

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ANESTHESIA GUIDELINES

North Dakota Medicaid will reimburse procedure codes D9222 deep sedation/general anesthesia – first 15 minutes and D9223 deep sedation/general anesthesia – each 15 minute increment when the service is one of the following:

- Extraction must be imbedded in soft tissue and/or bone (No prior authorization required)
- Full mouth extractions with alveolplasty for full denture placement (No prior authorization required)
- Complex medical history (No prior authorization required)

Dental procedures D9239 intravenous moderate (conscious) sedation/analgesia – first 15 minutes and D9243 intravenous moderate (conscious) sedation/analgesia – each 15 minute increment will be reimbursed by ND Medicaid for the following surgical dental procedures D7210 – D7999. This policy does not apply to recipients with a developmental disability.

- D9223 is allowed up to eight units and must all be billed on one line
- D9243 is allowed up to eight units and must be billed on one line

North Dakota Medicaid does not reimburse for code D9248 (Non-intravenous conscious sedation).

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DENTAL SERVICE AUTHORIZATION (SA)

A service authorization (SA) must be obtained for procedures for ND Medicaid eligible recipients before services are started. The Department may refuse payment for any covered service or procedures for which a SA is required but not obtained. Retro service authorizations may be submitted for consideration up to 90 days from the date of service.

1. Since endodontics could be an emergency service, no prior treatment request is required for recipients under 21. X - rays should accompany the retro authorization.

2. All SA forms submitted must use appropriate codes, procedures and usual and customary fees.

3. If a web-based SA is submitted, all supporting documentation must be attached to the SA electronically.

4. When information is needed to determine approval or denial is not submitted with a request, it will be returned to the provider for the required information.

5. No payment for dental services which require a service authorization will be made unless a dental SA is on file with the Department PRIOR to the date the service is started showing that the work plan was approved for the codes and procedures submitted on the claim.

6. Once the SA is submitted, the Department's dental consultant will review the plan and either approve or deny the services listed on the SA. LIST ONLY THE SERVICES THAT NEED PRIOR APPROVAL. The SA will then be returned to the provider with an approval/denial notation. When the services are approved, specific time limits within which the approved services must be performed will be entered in the remarks section of the SA. Also included will be a service authorization number.

7. Approval of the SA is only for the dental treatment plan. THIS APPROVAL DOES NOT GUARANTEE PAYMENT OR ENSURE THE ELIGIBILITY OF THE INDIVIDUAL AT THE TIME DENTAL PROCEDURES ARE COMPLETED. Payment will be based on the fee schedule on the date of service.

8. The North Dakota Department of Human Services reserves final authority to approve or deny any submitted dental treatment plan.

9. Submit completed SA to: Dental Consultant
Medical Services Division
Department of Human Services
600 E Boulevard Ave; Dept 325
Bismarck ND 58505-0250

CLINICAL ORAL EXAMINATIONS

If oral examinations exceed frequency limitations, then service authorization is required. Frequency limitations include one exam per year for recipients 21 and over and two exams per year for recipients under the age of 21. Exams D0120, D0145, D0150, D0160, and D0180 apply to the frequency limitations. Exams D0140, D0160, and D0170 require documentation.

DIAGNOSTIC IMAGING

ND Medicaid covers one panoramic radiographic image (D0330) every five years. A service authorization must be submitted if more than one panoramic radiographic image is needed within a five-year time frame.

DENTAL PROPHYLAXIS

If dental prophylaxis exceeds frequency limitations then service authorization is required. Frequency limitations include one prophy per calendar year for recipients 21 and over and two prophy's per calendar year for recipients under the age of 21. Codes D1110, D1120, D1206, D1208 and D4910 apply to the frequency limitations.

* This service will not be allowed to be billed for individuals with upper and lower dentures.

CROWNS-SINGLE RESTORATION ONLY

Crowns for all recipients, except stainless steel crowns, must be service authorized. For adults, ND Medicaid covers anterior crowns only and there must be a root canal on the tooth for consideration of a crown. A radiograph and a SA must be sent for all crowns except stainless steel crowns.

D2950, D2952 and D2954, if needed, must be submitted on the same SA as a crown even if the crown doesn't require a SA. A core build up and a post and core should never be performed on the same tooth.

ENDODONTIC THERAPY

Service authorization is required for root canals for adults 21 and over. Only anterior root canals (D3310) for adults 21 and over are covered by ND Medicaid. For adults

ND Medicaid covers re-treatments of anterior teeth (D3346) and does require service authorization. For recipients under the age of 21, ND Medicaid covers re-treatment of bicuspid root canals and molar root canals (D3347 and D3348).

NON SURGICAL PERIODONTAL SERVICE

Periodontal scaling per quadrant (D4341) on one to three teeth, per quadrant (D4342) requires service authorization. When submitting a service authorization please submit probing depths and radiographs, probing depths must be 5 millimeters or greater. Periodontal scaling cannot be billed in addition to a prophy on the same date of service. Periodontal maintenance (D4910) applies to frequency limitations and requires a service authorization if the recipient's frequency limitations have been met or exceeded.

DENTURES (complete and partials)

Lost

If an adult (ages 21 and over) loses his or her denture prior to the five year limitation, Medicaid will not cover another pair. Exceptions to this may be granted to DD patients if documentation on the SA justifies the exception.

If lost in a facility (i.e. hospital or nursing home) it is the responsibility of the facility to replace them.

Stolen

A SA must include a copy of the police report.

Breaks

A SA must indicate why the denture was not repairable.

*All dentures should be billed on the date of placement.

Complete Dentures

Immediate dentures (D5130 and D5140 – lifetime limit of 1) require a service authorization.

If the dentures being placed are replacement dentures, a service authorization is required. There is a 5-year limitation to replace dentures. ALL claims for replacement dentures must indicate the age of the current denture and the reason for replacement.

D5130 and D5140 should not be billed for replacement.
D5110 and D5120 always require a service authorization.

Partial Dentures

All partial dentures must be service authorized. There is a 5-year limitation on replacement of partial dentures. Replacement of partial dentures before the 5-year time limit requires a service authorization. ALL claims for replacement partial dentures must indicate the age of the current partial denture and the reason for replacement.

The service authorization must also indicate the teeth included in the partial denture. ND Medicaid does not cover missing posterior teeth. In order for partial dentures to be covered for adults, the partial denture must include at least one anterior tooth.

INTERIM PROSTHESIS

Flippers are covered once every 5 years. These must be service authorized and must include at least one anterior tooth.

Interim complete dentures are non-covered by ND Medicaid.

PROSTHODONTICS, FIXED

These require a service authorization for recipients under the age of 21 and are non-covered for adults age 21 and over.

DENTAL EXTRACTIONS

Dental extractions that are attempted but unable to be completed must be billed under dental code D7999 with a tooth number and dental record documentation.

ORTHODONTICS

Orthodontic treatment requires a service authorization and is only allowed/reimbursed for recipients under the age of 21.

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ORTHODONTIC PROCEDURES

The Department does not reimburse interceptive or comprehensive orthodontic treatment unless referred by ND Health Tracks, EPSDT.

Dentists must submit a service treatment authorization requests for interceptive or comprehensive orthodontia services.

The Department has defined treatment options for orthodontia services in order to clarify those options and reimbursement for those services by ND Medicaid. They are as follows:

(1) Interceptive orthodontic treatment under the ND Medicaid program will include only treatment of anterior or posterior crossbite and minor treatment for tooth guidance in the transitional dentition. Interceptive treatment is not part of the comprehensive treatment plan.

(2) Comprehensive orthodontic treatment includes treatment of transitional or adolescent dentition; requires 20 or more points on an evaluation; and is begun when a child is approximately 10 years old or older but no older than 20 years of age. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

(a) Phase I orthodontic treatment is part of a comprehensive treatment of the transitional dentition; requires 20 or more points on an evaluation; and is begun when a child is approximately 7 or 8 years of age.

- Special consideration may be given if the points are between 18 and 20.
- X-rays and a narrative description of the malocclusion may be required for review by the department's dental consultant.
- Phase I & II included in code D8090
- Codes D8070 and D8080 should only be used if recipient is in the middle of treatment
- One retainer is included in the costs

(b) Phase II orthodontic treatment is part of a comprehensive treatment of transitional/adolescent dentition; is automatically service approved if Phase I is service approved; and, therefore, does not require points or a separate prior approval.

- Code D8670 included with D8090

As with all services, the child must be eligible at the beginning of each treatment or service.

PROVIDERS MUST USE THE MALOCCLUSION INDEX TO EVALUATE THE NEED FOR ORTHODONTIC TREATMENT OF ND MEDICAID RECIPIENTS.

The Health Tracks Comprehensive Orthodontic Screening form (SFN 61) is available online at http://www.nd.gov/eforms.

The Orthodontic Screening Guide can be found online at www.ndhealth.gov/oralhealth/orthodontics.htm.

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GENERAL TIPS FOR BILLING

1. Bill usual and customary charges for each service.

2. It is important that all pertinent blocks on the claim form be completed. Omission of data may result in claim processing denials, delays or return of the claim.

3. Insure that all information on a claim form is **LEGIBLE**.

4. All monetary amounts must be entered without dollar signs, decimal points, or spaces. The amounts must be shown as dollars and cents. EX: Twenty dollars would be shown as 2000.

5. Strive for accuracy. Careful erasing is acceptable. Correction tapes can be used. Do not overlap information from one column to another. DO NOT USE RED PEN, INK OR HIGHLIGHTERS.

6. All dates entered should be entered as MMDDCCYY (month, day, year). EX: January 1, 2010 should be shown as 01012010. Do not use hyphens, dashes, or spaces between segments.

7. Claims **MUST** be filed with the Department within one year from the date of service.

8. For unspecified services use code D9999 and attach a report.

9. PLEASE CHECK BLOCK 1, DENTIST'S STATEMENT OF ACTUAL SERVICES TO DIFFERENTIATE THE BILLING FORM FROM THE PRETREATMENT ESTIMATE FORM.

10. Insurance payments must be deducted from the total charges billed in the appropriate block and an Explanation of Benefits (EOB) must be sent with the claim or claim will be denied.

11. If billing for a service that was service authorized, the authorization number must be on the claim or the claim will be denied.

12. If a claim spans to two forms please label each page (ex. Page 1 of 2 and Page 2 of 2).

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GENERAL TIPS FOR VOIDING AND REPLACING A CLAIM

CMS 1500 Claim Form Instructions November 2015

Replacing a Claim

A claim replacement may be submitted to modify a previously paid claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

- Field 22: Enter the Resubmission Code of 7 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).

    - If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
    - If replacing a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

    Example:
    Legacy ICN: 1015015320010
    Replaced Legacy ICN: 10**20**15015320010

Voiding a Claim

Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

- Field 22: Enter the Resubmission Code of 8 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).

    - If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.
    - If voiding a claim processed in the ND Legacy MMIS insert the century code in the 3rd and 4th positions of the ICN. Enter the 15-digit ICN for the previously processed claim.

    Example:
    Legacy ICN: 1015015320010
    Replaced Legacy ICN: 10**20**15015320010

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- ∇ Member Inquiry
- ∇ Payment Inquiry
- ∇ Service Authorization Inquiry
- ∇ Claims Status

AVRS Access Telephone Numbers (available 24/7)
Toll Free: 877-328-7098
Local: 701-328-7098

Providers are granted access to the Automated Voice Response System (AVRS) by entering the new ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One PIN number is assigned to each Medicaid ID number.

Touch Tone Phone Entry	Function
*	Repeat the options
9 (nine)	Return to main menu
0 (zero)	Transfer to Provider Call Center (M-F 8am – 5pm CT) –or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVR system at any point to speak with a Provider Call Center customer service representative. The call center is available during regular business hours from 8am to 5pm Central Time, Monday through Friday, and observes the same holidays as the State of North Dakota. Providers may also elect to leave a voicemail message at any time when the call center is not available. Except during heavy call times, provider voice mail messages will be responded to in the order received on the following business day during regular business hours.

AVRS Options	Secondary Selections
Option 1: **Member** **Inquiry**	Callers may select any of the following options: ▪ Eligibility/Recipient Liability ▪ Primary Care Provider (PCP) ▪ Coordinated Services Program (CSP) enrollment ▪ Third Party Liability (TPL) ▪ Vision ▪ Dental ▪ Service Authorizations
Option 2: **Payment**	Remittance Advice payment information is available for the specific time frame entered.
Option 3: **Claims Status**	Claim information is available based upon the Member ID number entered, including: ▪ TCN (Transaction Control Number) ▪ Billed Amount ▪ Claim Submit Date ▪ Date(s) of Service ▪ Claim Status (paid, denied, suspended) ▪ Paid Amount (if applicable)
Option 4: **Service Authorization** **Inquiry**	Service Authorization information is available based upon the Member ID number entered, including: ▪ Service Authorization (SA) Number ▪ Date(s) of Service ▪ Authorization Status

HEALTHY STEPS

Healthy Steps benefit information is available by calling Delta Dental of Minnesota at 1-855-648-1406.

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FEES

Fee schedules can be accessed by clicking on the following link: **http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html**

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GENERAL PRINCIPLES OF DENTAL RECORD DOCUMENTATION

1. The dental record should be complete and legible.
2. The dental record should include:
   a. Patient name and demographic information (patient name must be identified on each page)
   b. Medical and dental history, including medication prescription history
   c. Progress and treatment notes
   d. Diagnostic records and radiographs
   e. Treatment plan
   f. Patient complaints and resolutions
3. The information in the dental record should be dated, signed and handwritten in ink by the person rendering the service. It can also be computer printed.
4. Appropriate health risk factors should be identified.
5. The patient's progress, response to and changes in treatment and revision of diagnosis should be documented.
6. The information contained in the dental record should not contain many abbreviations.
7. The identifying practitioner should be clearly noted in the dental record.
8. The CPT, CDT and ICD-10 codes reported on the CMS-1500 claim form, ADA dental claim form or UB-04 claim form must be supported by the documentation in the dental record.
9. Any services rendered in the outpatient hospital or ambulatory surgical center must be supported by an operative report showing medical necessity of the services performed.

Source: ada.org

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CDT CODE ON DENTAL PROCEDURES AND NOMENCLATURE

CATEGORY OF SERVICE		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.	Oral and Maxillofacial Surgery	D7000-D7999
XI.	Orthodontics	D8000-D8999
XII.	Adjunctive General Services	D9000-D9999

PROCEDURES WITH TIME LIMITATIONS

The following procedures are limited as to the frequency they are paid for by the North Dakota Medicaid program. Exceptions may be granted by our dental consultant based on medical necessity. Providers must submit a service authorization request form prior to treatment and indicate the medical reason.

D0120, D0150, D0160 & D0180	Child	2 per year
	Adult	1 per year only
D0330	panoramic radiographic image - child	Once per 5 years
D0330	panoramic radiographic imagine - adult	Once per 5 years
D1110 & D4910	prophylaxis - adult	1 per year
D1120	prophylaxis - child	2 per year
D1206	topical application of fluoride varnish	two times per year under 21
D1208	topical application of fluoride - excluding varnish	two times per year
D5110 & D5120	replacement dentures	Once per 5 years
D5130	immediate denture - maxillary	Lifetime of limit of 1
D5140	immediate denture – mandibular	Lifetime of limit of 1
D5211-D5281	partial dentures	Once per 5 years
D5730-D5761	reline of immediate/emergency denture	1 per year
	reline of other dentures	Once per 2 years
D5820 & D5821	flippers	Once per 5 years

Restrictions/limits for certain codes are identified by the symbols "*"immediately following the code number.

EXPLANATION OF SYMBOLS

♦	Requires service authorization
*	Frequency limits
⮙	Service covered for individuals under 21 years of age only
✧	These codes are included with extractions and cannot be billed separately.

BILLING CODES

Providers must bill their usual and customary charges.

I. D0100 – D0999 DIAGNOSTIC

Clinical Oral Examinations	
Code	**Description**
D0120 *	periodic oral examination – established patient
D0140	limited oral evaluation – problem focused
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 *	comprehensive oral evaluation - new or established patient
D0160 *	detailed and extensive oral evaluation – problem focused, by report
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit)
D0180*	comprehensive periodontal evaluation – new or established patient
Radiographs	
D0210	intraoral – complete series of radiographic images
D0220	intraoral – periapical first radiographic image
D0230	intraoral – periapical each additional radiographic image (max of 5)
D0240	intraoral – occlusal radiographic image (max of 2)
D0270	bitewing – single radiographic image
D0272	bitewings – two radiographic images
D0273	bitewings – three radiographic images
D0274	bitewings – four radiographic images
D0322	tomographic survey
D0330 *	panoramic radiographic image – 5 years
D0340 ♦	2D cephalometric radiographic image – acquisition, measurement and analysis.
D0365 ♦	cone beam CT capture and interpretation with field view of one full dental arch - mandible
D0366 ♦	cone beam CT capture and interpretation with field view of one full dental arch – maxilla, with or without cranium
D0367 ♦	cone beam CT capture and interpretation with field view of both jaws; with or without cranium
D0369 ♦	maxillofacial MRI capture and interpretation
Tests and Laboratory Examinations	
D0470	diagnostic casts

II. D1000 – D1999 PREVENTIVE

Dental Prophylaxis

Code	Description
D1110 *	prophylaxis – adult – 1 per year (permanent dentition)
D1120 * ⅄	prophylaxis – child – 2 per year

Topical Fluoride Treatment

Code	Description
D1206 * ⅄	topical application of fluoride varnish
D1208 *	topical application of fluoride – excluding varnish

Other Preventive Services

Code	Description
D1351 ⅄	sealant – per tooth
D1352 ⅄	preventative resin restoration in a moderate to high caries risk patient – permanent tooth
D1353 ⅄	sealant repair – per tooth
D1354	interim carries arresting medicament application
D1575 ⅄	distal shoe space maintainer – fixed – unilateral; under 21 only

Space Maintenance (Passive Appliances)

Code	Description
D1510⅄	space maintainer – fixed, unilateral
D1515⅄	space maintainer – fixed – bilateral
D1520⅄	space maintainer – removable – unilateral
D1525⅄	space maintainer – removable – bilateral
D1550⅄	re-cement or re-bond space maintainer
D1555⅄	removal of fixed space maintainer

III. D2000 - D2999 RESTORATIVE

* Overlapping surfaces are not allowed

Amalgam Restorations (Including Polishing)

Code	Description
D2140	amalgam – one surface, primary or permanent
D2150	amalgam – two surfaces, primary or permanent
D2160	amalgam – three surfaces, primary or permanent
D2161	amalgam – four or more surfaces, primary or permanent

Resin–Based Composite Restorations – Direct

Code	Description
D2330	resin-based composite – one surface, anterior
D2331	resin-based composite – two surfaces, anterior
D2332	resin-based composite – three surfaces, anterior
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2391	resin-based composite – one surface, posterior
D2392	resin-based composite – two surfaces, posterior
D2393	resin-based composite – three surfaces, posterior
D2394	resin-based composite – four or more surfaces, posterior

Crowns – Single Restorations Only

X-Rays and SA required on all crowns except stainless steel

Code	Description
D2710 ♦	crown – resin-based composite (indirect)
D2720 ♦	crown – resin with high noble metal
D2721 ♦	crown – resin with predominantly base metal
D2722 ♦	crown – resin with noble metal
D2740 ♦	crown – porcelain/ceramic substrate
D2750 ♦	crown – porcelain fused to high noble metal
D2751 ♦	crown – porcelain fused to predominantly base metal
D2752 ♦	crown – porcelain fused to noble metal
D2790 ♦	crown – full cast high noble meta
D2791 ♦	crown – full cast predominantly base metal
D2792 ♦	crown – full cast noble metal

**** No permanent crowns for primary teeth ****

Other Restorative Services

Code	Description
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	re-cement or re-bond crown
D2930	prefabricated stainless steel crown – primary tooth
D2931	prefabricated stainless steel crown – permanent tooth
D2932⅄	prefabricated resin crown
D2933	prefabricated stainless steel crown with resin window
D2934⅄	prefabricated esthetic coated stainless steel crown – primary tooth
D2940	protective restoration
D2950 ♦	core buildup, including any pins, when required
D2951	pin retention – per tooth, in addition to restoration 5 per tooth
D2952 ♦	cast post and core in addition to crown, indirectly fabricated
D2954 ♦	prefabricated post and core in addition to crown
D2955⅄	post removal

IV. D3000 - D3999 ENDODONTICS

Pulp Capping

Code	Description
D3110	pulp cap – direct (excluding final restoration)

Pulpotomy

Code	Description
D3220⅄	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament
D3221⅄	pulpal debridement, primary and permanent teeth

Endodontic Therapy on Primary Teeth

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling

Code	Description
D3230⅄	pulpal therapy (resorbable filling) – anterior primary tooth (excluding final restoration)
D3240⅄	pulpal therapy (resorbable filing) – posterior primary tooth (excluding final restoration)

Endodontic Therapy (Including Treatment Plan, Clinical Procedures, Follow-Up Care)

Includes primary teeth without succedaneous teeth and permanent teeth.
Apicoectomy is not intended for routine treatment, but will be reviewed on a case-by-case basis, where such apicoectomies will result in greater cost effectiveness.

Code	Description
D3310 ♦	endodontic therapy, anterior tooth (excluding final restoration)
D3320⅄	endodontic therapy bicuspid tooth (excluding final restoration)
D3330⅄	endodontic therapy molar tooth (excluding final restoration)
D3333	Internal root repair of perforation defects
D3346 ♦	retreatment of previous root canal therapy – anterior
D3347⅄	retreatment of previous root canal therapy – bicuspid
D3348⅄	retreatment of previous root canal therapy – molar
D3351⅄	apexification/recalcification – initial visit (apical closure/calcific repair of perforations root resorption, etc.)
D3352⅄	apexification/recalcification – interim medication replacement
D3353⅄	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)

V. D4000 - D4999 PERIODONTICS

* D4341, D4342 and D4910 – the medical record must reflect a probing depth of 5 millimeters or greater in order to be considered medically necessary. The depth chart must be no more than 1 year old and the name and date of service must be legible.

Code	Description
D4210 ♦	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded space per quadrant
D4211 ♦	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded space per quadrant
D4212 ♦ ⅄	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth; under 21 only
D4341 ♦	periodontal scaling and root planning – four or more contiguous teeth per quadrant (SA for adults only)
D4342 ♦	periodontal scaling and root planning – one to three teeth per quadrant (SA for adults only)
D4346 ♦	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis
Other Periodontal Services	
Code	**Description**
D4910 *	periodontal maintenance

VI. D5000 - D5899 PROSTHODONTICS (REMOVABLE)

The Department has established limits on frequency of most dentures. Replacement will be limited to one every five years. Relining and rebasing of immediate dentures is limited to once within one year after initial placement; other relining and rebasing is limited to once every two years. Exceptions based on medical necessity can be submitted on a PTAR.

Complete Dentures (Including Routine Post Delivery Care)
There is a 5-year time limitation to replace dentures.
All dentures do require SA. ALL claims for replacement dentures must indicate the age of the current denture and the reason for replacement on the SA.

Code	Description
D5110 ♦	complete denture – maxillary
D5120 ♦	complete denture – mandibular
D5130 ♦	immediate denture – maxillary; lifetime limit of 1
D5140 ♦	immediate denture – mandibular; lifetime limit of 1

Partial Dentures (Including Routine Post Delivery Care)

There is a five-year time limitation on replacement partial dentures. Replacement of partial dentures before the 5-year time limit requires prior approval. ALL claims for replacement partial dentures must indicate the age of the current partial denture and the reason for replacement. We do not cover missing posterior teeth. For adults, partial dentures must include at least one anterior tooth.

Code	Description
D5211 ♦	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 ♦	mandibular partial denture – resin base (including any conventional clasps, rests and teeth
D5213 ♦	maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214 ♦	mandibular partial denture – cast metal framework resin denture bases (including any conventional clasps, rests and teeth)
D5221 ♦	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222 ♦	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5223 ♦	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5224 ♦	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5225 ♦	maxillary partial denture – flexible base (including any clasps, rests and teeth)
D5226 ♦	mandibular partial denture – flexible base (including any clasps, rests and teeth)
D5281 ♦	removable unilateral partial denture – one piece cast metal (including clasps and teeth)

Adjustments To Dentures

Included in cost of denture/partial if performed by treating dentist or dental office.

Code	Description
D5410	adjust complete denture – maxillary
D5411	adjust complete denture – mandibular
D5421	adjust partial denture – maxillary
D5422	adjust partial denture – mandibular

Repairs to Complete Dentures

Code	Description
D5511	repair broken complete denture base, mandibular
D5512	repair broken complete denture base, maxillary
D5520	replace missing or broken teeth – complete denture (each tooth)

Repairs to Partial Dentures

Code	Description
D5611	repair resin partial denture base, mandibular
D5612	repair resin partial denture base, maxillary
D5621	Repair cast partial framework, mandibular
D5622	repair cast partial framework, maxillary
D5630	repair or replace broken clasp – per tooth
D5640	replace broken teeth – per tooth
D5650	add tooth to existing partial denture

D5660	add clasp to existing partial denture – per tooth

Denture Rebase Procedures

There is a two-year time limitation on rebasing complete dentures. There is a one-year time limitation on immediate dentures.

Code	Description
D5710 ♦	rebase complete maxillary denture
D5711 ♦	rebase complete mandibular denture
D5720 ♦	rebase maxillary partial denture
D5721 ♦	rebase lower (mandibular) partial denture

Denture Reline Procedures

There is a two-year time limitation on relining complete dentures. There is a one-year time limitation on immediate dentures.

EXCEPTIONS on time limitations may be granted based on medical necessity PTAR required and medical reason indicated.

Code	Description
D5730	reline complete maxillary denture (chairside)
D5731	reline complete mandibular denture (chairside)
D5740	reline maxillary partial denture (chairside)
D5741	reline mandibular partial denture (chairside)
D5750	reline complete maxillary denture (laboratory)
D5751	reline complete mandibular denture (laboratory)
D5760	reline maxillary partial denture (laboratory)
D5761	reline mandibular partial denture (laboratory)

Interim Prosthesis (Temporary)

Code	Description
D5820 ♦	interim partial denture (maxillary) – flipper once per 5 years
D5821 ♦	interim partial denture (mandibular) – flipper once per 5 years

Other Removable Prosthetic Services

Code	Description
D5850	tissue conditioning, maxillary
D5851	tissue conditioning, mandibular
D5863 ♦	overdenture – complete maxillary
D5864 ♦	overdenture – partial maxillary
D5865 ♦	overdenture – complete mandibular
D5866 ♦	overdenture – partial mandibular
D5986 ♦	fluoride gel carrier

Maxillofacial prosthetics section requires SA.

VII. D6000 – D6199 IMPLANT SERVICES

Implants

Code	Description
D6096 ♦	remove broken implant retaining screw

VIII. D7000 - D7999 ORAL AND MAXILLOFACIAL SURGERY

Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Post Operative Care)

Code	Description
D7111	extraction, coronal remnants – deciduous tooth
D7140	extraction, erupted tooth or exposed root (evaluation and/or forceps removal)

Surgical Extractions (Includes Local Anesthesia Suturing, If Needed, And Routine Post Operative Care)

Code	Description
D7210	extraction erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated
D7220	removal of impacted tooth – soft tissue
D7230	removal of impacted tooth – partially bony
D7240	removal of impacted tooth – completely bony
D7241	removal of impacted tooth – completely bony, with unusual surgical complications
D7250	removal of residual tooth roots (cutting procedure)

Other Surgical Procedures

Code	Description
D7260 ♦	oroantral fistula closure
D7261 ♦	primary closure of a sinus perforation
D7270 ♦	tooth re-implantation and/or stabilization of accidentally envulsed or displaced tooth
D7280 ♦	exposure of an unerupted tooth
D7283 ♦	placement of device to facilitate eruption of impacted tooth
D7285 ♦	incisional biopsy of oral tissue – hard (bone, tooth)
D7286 ♦	incisional biopsy of oral tissue – soft
D7290 ♦	surgical repositioning of teeth
D7291 ♦	transseptal fiberotomy/supra crestal fiberotomy, by report
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant
D7299	Non-surgical sialolithotomy

Alveoloplasty – Surgical Preparation of Ridge For Dentures

Code	Description
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7311	alveoloplasty in conjunction with extractions, one to three teeth or tooth spaces, per quadrant
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
D7321	alveoloplasty not in conjunction with extractions, one to three teeth or tooth spaces, per quadrant

Vestibuloplasty

Code	Description
D7340	vestibuloplasty – ridge extension (secondary epitheliaization)
D7350	vestibuloplasty – ridge extension (including soft issue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

Surgical Excision of Soft Tissue Lesions

Code	Description
D7410	excision of benign lesion up to 1.25 cm
D7411	excision of benign lesion greater than 1.25 cm
D7412	excision of benign lesion, complicated
D7413	excision of malignant lesion up to 1.25 cm
D7414	excision of malignant lesion greater than 1.25 cm
D7415	excision of malignant lesion, complicated

Surgical Excision of Intra-Osseous Lesions

Code	Description
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm

Excision of Bone Tissue

Code	Description
D7471	removal of lateral exostosis (maxilla or mandible)

Surgical Incision

Code	Description
D7510	incision and drainage of abscess – intraoral soft tissue
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	incision and drainage of abscess – extraoral soft tissue
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue

Reduction Of Dislocation And Management Of Other Temporomandibular Joint Dysfunctions

Code	Description
D7810 thru D7899	must be submitted on SA and written report prior to treatment

D7910 ✦	suture of recent small wounds up to 5 cm
D7911 ✦	complicated suture – up to 5 cm
D7912 ✦	complicated suture – greater than 5 cm
D7999	Unspecified oral surgery procedure, by report
✦ These codes are included with extractions	

IX. D8000 - D8999 ORTHODONTICS – under 21 only

Interceptive Orthodontic Treatment

Code	Description
D8060 ♦	interceptive orthodontic treatment of the transitional dentition

Comprehensive Orthodontic Treatment

Code	Description
D8070 ♦	comprehensive orthodontic treatment of the transitional dentition
D8080 ♦	comprehensive orthodontic treatment of the adolescent dentition
D8090 ♦ •	comprehensive orthodontic treatment of the adult dentition

Minor Treatment To Control Harmful Habits

Code	Description
D8210 ♦	removable appliance therapy
D8220 ♦	fixed appliance therapy

Other Orthodontic Services

Code	Description
D8660	pre-orthodontic treatment examination to monitor growth and development
D8681	removable orthodontic retainer adjustment included in delivery of service unless over 1 year old or was made by another dentist
D8692 ⅄	replacement of lost or broken retainer
D8695 ⅄	removal of fixed orthodontic appliances for reasons other than completion of treatment

- D8070 & D8080 are included in this code

X. D9000 - D9999 ADJUNCTIVE GENERAL SERVICES

ANESTHESIA GUIDELINES

*Please refer to guideline above.

Code	Description
D9110	palliative (emergency) treatment of dental pain – minor procedure
Anesthesia	
Code	**Description**
D9210	local anesthesia not in conjunction with operative or surgical procedure
D9211	regional block anesthesia
D9212	trigeminal division block anesthesia
D9215	local anesthesia in conjunction with operative or surgical procedures
D9222	deep sedation/general anesthesia – first 15 minutes

D9223	deep sedation/general anesthesia – each 15 minute increment
D9230	analgesia, anxiolysis, inhalation of nitrous oxide/analgesia, anxiolysis
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment

Professional Consultation

Code	Description
D9310	consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment (telephone consult not covered. If the consulting provider provides the treatment, it will be considered a referral; no consultation fee will be allowed.)

Professional Visits

Code	Description
D9410	house/extended care facility call
D9420	hospital or ambulatory surgical center
D9440	office visit – after regularly scheduled hours, requires description

Drugs

Code	Description
D9610	therapeutic parenteral drug, single administration
D9612	therapeutic parenteral drugs, two or more administrations, different medications

Miscellaneous Services

Code	Description
D9910	application of desensitizing medicament
D9920 ♦	behavior management, by report (D.D. patients only; if medically necessary)
D9930	treatment of complications (post-surgical) – unusual circumstances, by report
D9940 ♦	occlusal guard, by report
D9943	occlusal guard adjustment. Included in delivery of service unless is over 1 year old or was made by another dentist
D9950 ♦ ⅄	occlusion analysis – mounted case
D9951 ♦ ⅄	occlusal adjustment – limited by report
D9952 ♦ ⅄	occlusal adjustment – complete by report
D9999	unspecified adjunctive procedure, by report

♦ Requires Prior Authorization
* Frequency Limits
⅄ Service Covered for individuals under 21 years of age only
✦ These codes are included with extractions and cannot be billed separately.

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