

### Revision Log

Reviewer	Unit	Page #s Changed	Status	Status Date
Nicole Force	EDSTW		F	6/22/09
Carolyn Taylor	MAS		A	6/19/09
Johni Stevens	MPI Unit		R	6-16-09
Arla Farmer	Policy		R	6/10/09
Nicole Force	EDSTW		U	5/15/09
Carolyn Taylor	MAS		A	4/21/09
Jeanne Siroky	Policy		W	02/11/2009
Arla Farmer	Policy	See 3.2.8.1 – Limitations on dentures (track changes didn't work)	R	03/24/2009
Johni Stevens	MPI Unit		R	3/31/09
Arla Farmer	Policy		A	4/17/09

#### EDS Technical Writer Directions for Pre-DHW review:

Step 1 Technical Writer inputs section # and inserts to appropriate section.

Step 2 Technical Writer notifies DHW the documents are ready for review.

#### DHW Directions for use:

Step 1 Enter your name in the Reviewer column.

Step 2 Enter your unit in the Unit column (e.g., MAS, Policy, SURS/Fraud, EDS).

Step 3 Enter the status of the document using one of the following status codes.

**W** Working

**R** Ready for next review

**A** Approved and ready for EDS

Notes: The file begins in working status. When you are finished with the file, change the status to **R**. If you give final approval, change the status to **A**. You do not have to create a new row, just change the status on the row where your name is.

Do not work a file if someone else has it is in Working status.

Check the status of the file each time you open it and close it.

Step 4 Enter the date depending on the status of the document using MM/DD/YY format:

**W** the date you begin working on the file

**R** the date the file is ready for the next reviewer

**A** the date the file receives final approval

Step 5 When you change the status from Working to Ready, e-mail the next person to receive the file (i.e. SME notifies SURS; SURS notifies SME; SME notifies Carolyn Taylor, etc.).

Step 6 If you give final approval (i.e., the file is ready for EDS), enter an A in the status column and email Carolyn Taylor.

Step 7 Carolyn will move the document to the drive shared with EDS and will notify Elaine Mattson that the section is approved and ready for EDS.

**EDS Technical Writer Directions for Post-DHW review:**

- Step 1 Enter your name in the Reviewer column.
- Step 2 Enter EDSTW in the Unit column.
- Step 3 Use the “Save As” feature to create a different file.
- Step 4 Accept changes and format document.
- Step 5 Enter page #s updated in Page Change column.
- Step 6 When all changes have been completed, Create PDF.
- Step 7 Enter the status of the document using one of the following status codes.
  - U** Updated for QA review
- Step 8 Enter the date depending on the status of the document using MM/DD/YY format:
  - U** the date the file is updated for QA review
- Step 9 Notify reviewers that document is ready for QA.

**EDS QA Directions for review:**

- Step 1 Open the DHW file (with track changes) & the PDF file.
- Step 2 Enter your name in the Reviewer column.
- Step 3 Enter EDSQA in the Unit column.
- Step 4 Compare track changes in WORD document to PDF version to ensure all changes were accepted.
  - a. If yes, continue to Step 5
  - b. If no, return to Technical Writer for updates
- Step 5 Enter the status of the document using one of the following status codes.
  - Q** PDF quality reviewed
- Step 6 Enter the date depending on the status of the document using MM/DD/YY format:
  - Q** the date the PDF file was quality reviewed
- Step 7 Notify Technical Writer the file is ready for publication

**EDS Technical Writer Directions for Post-QA review**

- Step 1 Enter the status of the document using one of the following status codes.
  - F** Finalized for publication
- Step 2 Enter the date depending on the status of the document using MM/DD/YY format:
  - F** the date the file is finalized for publication
- Step 3 Notify System Technical Writer the Provider Handout is ready to include in the Master CD.

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## 3.1 Introduction

### 3.1.1 General Policy

This section covers all Medicaid services provided by dentists and denturists as deemed appropriate by the Idaho Department of Health and Welfare (IDHW). It addresses the following:

- Dental guidelines.
- Denturist guidelines.
- Claims billing.
- Claims payment.
- Prior authorization.

See *Section 2 General Billing Information* for information on electronic billing.

### 3.1.2 Participant Eligibility

#### 3.1.2.1 Medicaid Basic Plan and Pregnant Women (PW) Program

Children and adults who are eligible under the Medicaid Basic Plan, including pregnant women eligible for the Pregnant Women (PW) Program, are covered under a dental insurance program called Idaho Smiles. This provider handbook does not apply to participants who are covered under Idaho Smiles.

Contact Idaho Smiles Customer Service toll free at (800) 936-0978, by e-mail at [dentalservices@bcidaho.com](mailto:dentalservices@bcidaho.com), or online at [www.bcidaho.com](http://www.bcidaho.com) and click on the *Idaho Smiles Dental Care* link for Idaho Smiles eligibility, benefits, and claims processing information.

**Note:** Participants' identification numbers for both Idaho Smiles and Medicaid are the same. If a participant does not have an Idaho Smiles insurance card, or they have a card but Idaho Smiles cannot verify their eligibility, you can still use their Medicaid identification (MID) number with the Medicaid electronic point of sale (POS) device, EDS software PES, or Medicaid Automated Voice Information System (MAVIS) at (800) 685-3757 toll free, to determine eligibility. The eligibility response from EDS will indicate which dental program the participant is on:

- If the EDS response indicates the participant is eligible for the Medicaid Basic Plan or the Pregnant Women (PW) Program, **bill Idaho Smiles** for dental services.
- If the EDS response indicates the participant is eligible for Medicaid, without mention of the Medicaid Basic Plan or the PW Program, **bill EDS** for dental services.

#### 3.1.2.2 Medicaid Enhanced Plan

Medicaid participants who are on Medicaid's Enhanced Plan are eligible for dental benefits as outlined in *Section 3.2 Covered Benefits and Limitations*. Bill EDS for dental services for Medicaid Enhanced Plan participants.

#### 3.1.2.3 Qualified Medicare Beneficiary (QMB) Program

Participants eligible under only the QMB Program, with no other active Medicaid eligibility, are not eligible for dental benefits.

#### 3.1.2.4 Medicare-Medicaid Coordinated Plan (MMCP)

Participants on the MMCP have denture benefits through their insurance carrier; contact the participant's insurance carrier for more information.

### 3.1.2.5 *Healthy Connections (HC) Program*

Healthy Connections is Idaho Medicaid's primary care case management (PCCM) model of managed care. Dental services do not require an HC referral.

### 3.1.3 **Tamper Resistant Prescription Requirements**

To comply with federal regulations, Idaho Medicaid will only pay for outpatient drugs reimbursed on a fee-for-service basis when the prescription for the covered drug is tamper-resistant. If Medicaid pays for the drug on a fee-for-service basis, and the prescription cannot be faxed, phoned or electronically sent to the pharmacy, then providers must ensure that the prescription meets all three requirements for tamper-resistant paper.

Any written prescription presented to a pharmacy for a Medicaid participant must be written on a tamper-resistant prescription form that contains all of the following:

1. One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
2. One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
3. One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

**Note:** The intent of this requirement is to reduce forged and altered prescriptions and to deter drug abuse. Emergency fills for prescriptions written on non-tamper resistant pads are permitted as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription within 72 hours after the date on which the prescription was filled. In an emergency situation, this allows a pharmacy to telephone a prescriber to obtain a verbal order for a prescription written on a non-compliant prescription pad. The pharmacy must document the call on the face of the written prescription.

### 3.1.4 **Reimbursement**

Medicaid reimburses dentists on a fee-for-service basis at usual and customary fees, up to the Medicaid maximum allowance. If the provider accepts any Medicaid payment for a covered service, the Medicaid payment must be accepted as payment in full and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount.

Dentists may make arrangements for private payment with families for services that are not covered by Medicaid if the patient or financially responsible party is informed that the services are not covered by Medicaid before they are rendered (preferably in writing).

To obtain a copy of the Idaho Medicaid dental reimbursement schedule, write to:

**Division of Medicaid  
Attn: Dental Unit  
PO Box 83720  
Boise, ID 83720-0036**

Or access it online at:

<http://www.healthandwelfare.idaho.gov/Providers/MedicaidProviders/MedicaidFeeSchedule/tabid/268/Default.aspx>. Click *Dental* under *Current Fee Schedules* on the right side of the screen.

#### 3.1.4.1 **Non-Covered Services**

Non-covered services are procedures not recognized by the American Dental Association (ADA) or services not listed in this handbook.

## 3.2 Covered Benefits and Limitations

### 3.2.1 Overview

This portion of the handbook lists the dental services that are covered for participants on the Medicaid Enhanced Plan with specific limitations and exclusions. See the most recent *Current Dental Terminology (CDT)* reference manual published by the American Dental Association (ADA) for full definitions.

*Section 3.2.3 Children's Dental Services through 3.2.11 Adjunctive General Services D9000 – D9999:* Services provided to children ages 0 - 21 (through the month of their 21<sup>st</sup> birthday).

*Section 3.2.13 Adult Dental Services:* Services provided to adults who have completed the month of their twenty-first birthday.

### 3.2.2 Descriptive Codes

#### 3.2.2.1 Designation of Teeth

**01 - 32** Permanent teeth.

**A - T** Deciduous (primary teeth).

#### 3.2.2.2 Areas of the Oral Cavity

**00** Whole of the oral cavity.

**01** Maxillary area.

**02** Mandibular area.

**10** Upper right quadrant.

**20** Upper left quadrant.

**30** Lower left quadrant.

**40** Lower right quadrant.

For examples, refer to the most current version of the *Current Dental Terminology (CDT)* reference manual.

**Supernumerary Teeth:** Services on supernumerary teeth require prior authorization from the Medicaid Dental Unit. See *Section 3.4 Prior Authorization*, for more information.

### 3.2.3 Children's Dental Services

The following examinations are not allowed in combination on the same day:

Dental Code	Description
<b>General Oral Evaluations</b>	
<b>D0120</b>	Periodic oral evaluation. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. One Periodic examination is allowed every six months. Includes periodontal screening.
<b>D0140</b>	Limited oral evaluation, problem focused. An evaluation or re-evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc. This code is not to be billed when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam.
<b>D0150</b>	Comprehensive oral evaluation, new, or established patient. One comprehensive examination is allowed every 12 months. Six months must lapse before a periodic exam can be paid. Documentation must identify the medical need for a comprehensive level of evaluation. A notation of <i>Comprehensive Exam or Eval</i> , is not sufficient documentation for payment. A thorough evaluation with findings must be recorded. This code is used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions; other unusual circumstances; or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history, and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), and hard and soft tissue anomalies, etc.
<b>D0160</b>	Detailed and extensive oral evaluation, problem focused. A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc. One detailed and extensive oral evaluation is allowed every 12 months.
<b>D0170</b>	Re-evaluation limited, problem focused. Established participant, not post-operative visit. Assessing the status of a previously existing condition. For example: <ul style="list-style-type: none"> <li>• A traumatic injury where no treatment was rendered but the patient needs follow-up monitoring.</li> <li>• Evaluation for undiagnosed continuing pain.</li> <li>• Soft tissue lesion requiring follow-up evaluation.</li> </ul>
<b>Radiographs/Diagnostic Images</b>	
<b>D0210</b>	Intraoral, complete series (including bitewings). Complete series x-rays are allowed only once in a 36 month period. A complete intraoral series consists of 14 periapicals and one series of 4 bitewings.
<b>D0220</b>	Intraoral periapical, first film.
<b>D0230</b>	Intraoral periapical, each additional film.
<b>D0240</b>	Intraoral, occlusal film.

Dental Code	Description
D0270	Bitewing, single film. Total of four bitewings allowed every six months.
D0272	Bitewings, two films. Total of four bitewings allowed every six months.
D0273	Bitewings, three films. Total of four bitewings allowed every six months.
D0274	Bitewings, four films. Total of four bitewings allowed every six months.
D0277	Vertical bitewings, seven to eight films. Allowed every six months. Does not constitute a full mouth intraoral radiographic series.
D0330	Panoramic film. Panorex, panelipse, or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 36 month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings or periapicals are allowed in addition to a panoramic film.
D0340	Cephalometric film. Allowed once in a twelve month period.
<b>Test And Laboratory Examination</b>	
D0460	Pulp vitality tests. Includes multiple teeth and contralateral comparison(s), as indicated. Allowed once per visit, per day.
D0470	Diagnostic casts.
<b>Diagnostic</b>	
D0999	Unspecified diagnostic procedure, by report. Narrative required when prior authorizing. Prior authorization is required.

### 3.2.4 Preventive Procedures D1000 - D1999

Medicaid provides no additional allowance for a cavitron or ultrasonic prophylaxis.

Dental Code	Description
<b>Dental Prophylaxis</b>	
D1110	Prophylaxis, adult (age 12 and older). A prophylaxis is allowed once every six months. Removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your participant needs this procedure more frequently, request prior authorization.
D1120	Prophylaxis, child/young adult (under age 12). A prophylaxis is allowed once every six months. Removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your participant needs this procedure more frequently, request prior authorization.
<b>Topical Fluoride Treatments:</b> Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or swish.	
D1203	Topical application of fluoride, one treatment (child). Prophylaxis not included. Allowed once every six months for participants up to age 21.
<b>Other Preventive Services</b>	
D1351	Sealant— per tooth. Mechanically and/or chemically prepared enamel surface. Allowed for participants up to age 21. Limited to once per tooth, every three years. Tooth designation required. A sealant is not allowed in addition to an occlusal restoration on the same tooth.
<b>Space Management Therapy:</b> Space maintainers are allowed to hold space for missing teeth for participants up to age 21. No reimbursement is allowed for removing maintainers, unless by dentist other than providing dentist. Vertical space maintainers are not covered.	
D1510	Space maintainer, fixed, unilateral. Limited up to age 21. Only allowed once, per tooth space. Tooth space designation required.

Dental Code	Description
D1515	Space maintainer, fixed, bilateral. Allowed for participants up to age 21. Only allowed once per arch. Arch designation required.
D1520	Space maintainer, removable, unilateral. Allowed once every two years. Allowed for participants up to age 21. Arch designation required.
D1525	Space maintainer, removable, bilateral. Allowed once every two years. Allowed for participants up to age 21. Arch designation required.
D1550	Re-cementation of space maintainer. Allowed for participants up to age 21. Only allowed once per arch. Arch designation required.

### 3.2.5 Restorative Procedures D2000 - D2999

All restorations must be documented in the participant's record to include: procedure, surface(s), and tooth number (if applicable). This record must be maintained for a period of five years in hard copy form.

When a multi-surface restoration is billed, the surfaces listed on the claim form must equal the number of surfaces billed. Failure to identify all the surfaces billed will result in denial of service.

#### 3.2.5.1 Posterior Restoration

A one surface posterior restoration is one in which the restoration involves only one of the five surface classifications: Mesial, distal, occlusal, lingual, or facial, including buccal or labial.

A two surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three surface posterior restoration is one in which the restoration extends to three of the five surface classifications.

A four or more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

#### 3.2.5.2 Anterior Proximal Restoration

A one surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extends beyond the line angle.

A two surface anterior proximal restoration is one in which either the lingual or facial margins of the restoration extends beyond the line angle.

A three surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.

A four or more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved.

#### 3.2.5.3 Amalgams and Resin Restorations

Reimbursement for pit restoration is allowed as a one surface restoration.

Adhesives (bonding agents), liners, bases, and the adjustment and/or polishing of sealant and restorations are included in the allowance for the major restoration.

Liners and bases are included as part of the restoration. If pins are used, they should be reported separately.

#### 3.2.5.4 Crowns

When submitting for prior authorization you must include one of the following:

- An x-ray showing the root canal.
- An x-ray with a written justification detailing the amount of tooth structure missing.

- An x-ray with a written explanation of definitive symptoms of a vertical fracture.

**Note:** Requests for re-doing crowns must be submitted for prior authorization and include x-ray and justification.

### 3.2.5.5 Local Anesthesia

Local anesthesia is considered to be part of restorative procedures and therefore is not a separately billable service.

Dental Code	Description
<b>Amalgam Restorations</b>	
D2140	Amalgam, one surface, primary, or permanent. Tooth designation required.
D2150	Amalgam, two surfaces, primary, or permanent. Tooth designation required.
D2160	Amalgam, three surfaces, primary, or permanent. Tooth designation required.
D2161	Amalgam, four or more surfaces, primary, or permanent. Tooth designation required.
<b>Resin Restorations:</b> Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, and adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Report glass ionomers with these codes when used as restorations. If pins are used, report them separately.	
D2330	Resin-based composite, one surface, anterior. Tooth designation required.
D2331	Resin-based composite, two surfaces, anterior. Tooth designation required.
D2332	Resin-based composite, three surfaces, anterior. Tooth designation required.
D2335	Resin-based composite, four or more surfaces, or involving incisal angle (anterior). Tooth designation required.
D2390	Resin-based composite crown, anterior. Full resin-based composite coverage of tooth. Tooth designation required.
D2391	Resin-based composite, one surface, posterior. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Tooth designation required.
D2392	Resin-based composite, two surfaces, posterior. Tooth designation required.
D2393	Resin-based composite, three surfaces, posterior. Tooth designation required.
D2394	Resin-based composite, four or more surfaces, posterior. Tooth designation required.
<b>Crowns:</b> Prior authorization is required for codes <b>D2710 - D2792</b> .	
D2710	Crown, resin-based composite (indirect). Tooth designation required.
D2721	Crown, resin with predominantly base metal. Tooth designation required.
D2750	Crown, porcelain fused to high noble metal. Tooth designation required.
D2751	Crown, porcelain fused to predominantly base metal. Tooth designation required.
D2752	Crown, porcelain fused to noble metal. Tooth designation required.
D2790	Crown, full cast high noble metal. Tooth designation required.
D2791	Crown, full cast predominantly base metal. Tooth designation required.
D2792	Crown, full cast noble metal. Tooth designation required.
<b>Other Restorative Services</b>	
D2920	Re-cement crown. Tooth designation required.
D2930	Prefabricated stainless steel crown, primary tooth. Tooth designation required.
D2931	Prefabricated stainless steel crown, permanent tooth. Tooth designation required.
D2932	Prefabricated resin crown. Tooth designation required.
D2940	Sedative filling. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Tooth designation required. Surface is not required.

Dental Code	Description
D2950	Core buildup, including any pins. Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Tooth designation required. Limited to two pins per tooth.
D2951	Pin retention, per tooth, in addition to restoration. Tooth designation required. Limited to two pins per tooth.
D2954	Prefabricated post and core in addition to crown. This procedure includes the core material. Tooth designation required.
D2955	Post removal (not in conjunction with endodontic therapy). For removal of posts (e.g., fractured posts) and not to be used in conjunction with endodontic retreatment. Tooth designation required.
D2980	Crown repair. Includes removal of crown, if necessary. Tooth designation required.
D2999	Unspecified restorative procedure, by report. Narrative and tooth designation required.

### 3.2.6 Endodontics D3000 - D3999

**Note:** Pulpotomies and root canal procedures cannot be paid with the same date of service for the same tooth. Local anesthesia is considered to be part of endodontic procedures.

Dental Code	Description
<b>Pulp Capping</b>	
D3110	Pulp cap, direct (excluding final restoration). Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair. Tooth designation required.
<b>Pulpotomy</b>	
D3220	Therapeutic pulpotomy (excluding final restoration), removal of pulp coronal to the dentinocemental junction and application of medicament. Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Once per tooth. Tooth designation required.
D3221	Pulpal debridement, primary, and permanent teeth. For relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day. Tooth designation required.
<b>Root Canal Therapy:</b> Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Root canal therapy (includes treatment plan, x-rays, clinical procedures, and follow-up care) is for permanent teeth only. Separate charges are allowable for open and drain, if the procedure is done on different days.	
D3310	Anterior (excluding final restoration). Tooth designation required.
D3320	Bicuspid (excluding final restoration). Tooth designation required.
D3330	Molar (excluding final restoration). Tooth designation required.
D3346	Retreatment of previous root canal therapy, anterior. Tooth designation required.
D3347	Retreatment of previous root canal therapy, bicuspid. Tooth designation required.
D3348	Retreatment of previous root canal therapy, molar. Tooth designation required.
<b>Apicoectomy/Periradicular Services</b>	
D3410	Apicoectomy/periradicular surgery, anterior. Surgery on root of anterior tooth. Does not include placement of retrograde filling material. Tooth designation required.

Dental Code	Description
D3421	Apicoectomy/periradicular surgery, bicuspid (first root). Surgery on one root of a bicuspid. Does not include placement of retrograde filling material. Tooth designation required.
D3425	Apicoectomy/periradicular surgery, molar (first root). Surgery on one root of a molar tooth. Does not include placement of retrograde filling material. Tooth designation required.
D3426	Apicoectomy/periradicular surgery (each additional root). For bicuspids and molar surgeries when more than one root is treated during the same procedure. Does not include retrograde filling material placement. Tooth designation required.
D3430	Retrograde filling, per root. For placement of retrograde filling material during periradicular surgery procedures. Tooth designation required.
D3999	Unspecified endodontic procedure, by report. Narrative and tooth designation required. Prior authorization is required.

### 3.2.7 Periodontics D4000 - D4999

Dental Code	Description
<b>Surgical Services (including usual postoperative care):</b> Local anesthesia is considered to be part of periodontal procedures.	
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant. Quadrant designation(s) required.
D4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or bounded teeth spaces per quadrant. Quadrant designation(s) required.
<b>Non-Surgical Periodontal Service</b>	
D4320	Provisional splinting, intracoronal. This is an interim stabilization of mobile teeth.
D4321	Provisional splinting, extracoronal. This is an interim stabilization of mobile teeth.
D4341	Periodontal scaling and root planing—four or more contiguous teeth or bounded teeth spaces per quadrant. Allowed once in a 12 month period. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature.  Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.  Quadrant designation required.
D4342	Periodontal scaling and root planing, one to three teeth, per quadrant. Allowed once in a 12 month period.  Quadrant designation required.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Allowed once in a 12 month period.
<b>Other Periodontal Services</b>	
D4910	Periodontal maintenance. This procedure is instituted following periodontal therapy (surgical and/or non-surgical periodontal therapies exclusive of D4355) and continues for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and/or polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Allowed once in a three month period.
D4999	Unspecified periodontal procedure, by report. Narrative is required.  This code must be prior authorized.

### 3.2.8 Prosthodontics D5000 - D6999

#### 3.2.8.1 Removable Prosthodontics D5000 - D5899

Complete dentures placed immediately must be of structure and quality to be considered the final prosthesis. Transitional or interim treatment dentures are not covered. No additional reimbursements are allowed for denture insertions. Routine post-delivery care, including complete and partial denture adjustments and relines, are considered part of the initial denture construction service for six months after delivery of the dentures. A separate exam fee will not be allowed during that time for problems related to the dentures.

**Note:** Claims for full, immediate, or partial dentures should not be billed to Medicaid until they are delivered to the participant.

The impression date may only be used for billing when partial or complete dentures are delivered during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period.

#### Limitations on Dentures:

- The Medicaid Dental Program covers only one partial or complete denture per arch, every five calendar years. *A participant who receives a partial denture, and then needs a full denture, is allowed both within a 5-year period.*
- Replacement of lost or broken dentures within the five year period are not covered.
- Partial dentures for children under the age of 12 require prior authorization.
- When billing for flippers, use the appropriate ADA interim partial denture code. Do not bill a partial denture code for flippers. Interim partial dentures require prior authorization for children up to age 21.

**Note:** Flippers or interim partial dentures are not covered for adults.

**Undelivered Dentures:** Laboratory and professional fees may be paid under procedure code **D5899**, with prior authorization, for an undelivered partial or complete denture if the participant meets one of the following conditions:

- The participant decided not to complete the partial or complete denture.
- The participant returned the denture(s) within 90 days of delivery because they were dissatisfied with the denture(s).
- The participant left the state.
- The participant cannot be located.
- The participant is deceased.

You must obtain prior authorization before you can bill procedure code **D5899**. See *Section 3.4 Prior Authorization*, of this provider handbook for instructions on submitting a Request for Prior Authorization. If approved, bill procedure code **D5899** using a separate line for each arch and include the prior authorization number on your claim.

Dentists and denturists who have already received payment for dentures, but were unable to deliver the dentures for any of the reasons stated above, must refund the entire Medicaid payment, and then request prior authorization for **D5899**. Failure to follow this process with undelivered dentures is considered accepting payment for services not rendered.

#### Dentures Delivered and Returned by Participant:

Dentures provided by a dentist: Medicaid's payment for dentures includes routine adjustments up to six months from the date dentures were placed in the mouth. Participants are expected to notify the provider

of any problems they are having with the denture(s) and return to the provider for needed adjustments within the six month period.

If a participant returns unsatisfactory dentures within the six month adjustment period, the provider should notify the Medicaid Dental Unit at: **(208) 364-1839**. Participants who do not return unsatisfactory dentures to the dentist within six months of placement are not eligible for another denture or set of dentures for five years.

Dentures provided by a denturist: When a denturist provides dentures, the 90 day unconditional Guarantee of Denturist Services, as outlined in *IDAPA 24.16.01.476 Guarantee of Denturist Services, and Idaho Statute Title 54, Chapter 3320 Guarantee on Services*, applies. Notify the Dental Unit at **(208) 364-1839** if the participant returns denture(s) within 90 days of delivery, and refund 100 percent of Medicaid's payment to Medicaid. Participants who return unsatisfactory dentures to a denturist after the 90 day guarantee on services period are not eligible for additional dentures for five years.

**Note:** Local anesthesia is considered to be part of removable prosthodontic procedures.

Dental Code	Description
<b>Complete Dentures:</b> This includes six months of routine post-delivery care following placement.	
D5110	Complete denture, maxillary.
D5120	Complete denture, mandibular.
D5130	Immediate denture, maxillary.
D5140	Immediate denture, mandibular.
<b>Partial Dentures:</b> This includes six months of care following placement.	
D5211	Maxillary partial denture, resin base. Includes any conventional clasps, rests, and teeth.
D5212	Mandibular partial denture, resin base. Includes any conventional clasps, rests, and teeth.
D5213	Maxillary partial denture, cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
D5214	Mandibular partial denture, cast metal framework with resin denture bases. Includes any conventional clasps, rests, and teeth.
<b>Adjustments to Complete And Partial Dentures:</b> Adjustments done during the first six months following placement are included in complete/partial fee allowance.	
D5410	Adjust complete denture, maxillary.
D5411	Adjust complete denture, mandibular.
D5421	Adjust partial denture, maxillary.
D5422	Adjust partial denture, mandibular.
<b>Repairs to Complete Dentures</b>	
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth), six tooth maximum. Tooth designation required.
<b>Repairs to Partial Dentures</b>	
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.

Dental Code	Description
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
<b>Denture Relining:</b> No allowance for relines for the first six months following placement of denture and then only once every two years. Relines done during the first six months following placement are included in complete/partial fee allowance.	
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).
<b>Interim Prostheses Prior:</b> Authorization is required for codes D5820 and D5821.	
D5820	Interim partial denture (maxillary). Includes any necessary clasps and rests.
D5821	Interim partial denture (mandibular). Includes any necessary clasps and rests.
<b>Other Removable Prosthetic Services</b>	
D5850	Tissue conditioning, maxillary, per denture unit.
D5851	Tissue conditioning, mandibular, per denture unit.
D5899	Unspecified removable prosthodontic procedure, by report. Narrative required when prior authorizing. Use <b>D5899</b> to report, <i>Unable to deliver full or partial denture</i> , and include invoice listing lab and professional fees and the arch designation. Prior authorization is required.

### 3.2.8.2 Maxillofacial Prosthetics D5900 - D5999

Dental Code	Description
<b>Maxillo-Facial Prosthetics:</b> Prior authorization is required for codes D5931 - D5999.	
D5931	Obturator prosthesis, surgical. Narrative required when prior authorizing.
D5932	Obturator prosthesis, definitive. Narrative required when prior authorizing.
D5933	Obturator prosthesis, modification. Narrative required when prior authorizing.
D5934	Mandibular resection prosthesis with guide flange. Narrative required when prior authorizing.
D5935	Mandibular resection prosthesis without guide flange. Narrative required when prior authorizing.
D5936	Obturator prosthesis, interim. Narrative required when prior authorizing.
D5951	Feeding aid. Narrative required when prior authorizing.
D5952	Speech aid prosthesis, pediatric. Narrative required when prior authorizing.
D5953	Speech aid prosthesis, adult. Narrative required when prior authorizing.
D5954	Palatal augmentation prosthesis. Narrative required when prior authorizing.
D5955	Palatal lift prosthesis, definitive. Narrative required when prior authorizing.
D5958	Palatal lift prosthesis, interim. Narrative required when prior authorizing.
D5959	Palatal life prosthesis, modification. Narrative required when prior authorizing.
D5960	Speech aid prosthesis, modification. Narrative required when prior authorizing.
D5982	Surgical stent. Narrative required when prior authorizing. Surgical stent is generally included in reimbursement for the surgical procedure.

Dental Code	Description
D5988	Surgical splint. Narrative required when prior authorizing.
D5999	Unspecified maxillofacial prosthesis, by report. Narrative is required when prior authorizing.

### 3.2.8.3 Fixed Prosthodontics D6200 - D6999

Dental Code	Description
<b>Other Fixed Partial Denture Services:</b> Procedure codes <b>D6210</b> through <b>D6920</b> are not a Medicaid covered benefit. Local anesthesia is considered to be part of fixed prosthodontic procedures.	
D6930	Re-cement fixed partial denture.
D6980	Fixed partial denture repair.
D6999	Unspecified fixed prosthodontic procedure, by report. Narrative and prior authorization are required.

### 3.2.9 Oral Surgery D7000—D7999

Extraction codes include services for local anesthesia, suturing, and routine preoperative and postoperative care.

**Note:** For oral and maxillofacial surgeons, most surgical procedures in the **D7911—D7996** category can be converted to the CPT coding system and can be submitted electronically or using a CMS-1500 claim form. Use your medical provider number on these claims.

Dental Code	Description
<b>Simple Extraction</b>	
D7111	Extraction, coronal remnants, deciduous tooth. Removal of soft tissue, retained coronal remnants. Tooth designation required.
D7140	Extraction, erupted tooth, or exposed root (elevation and/or forceps removal). Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary. Tooth designation required.
<b>Surgical Extractions</b>	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone, and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Tooth designation required.
D7220	Removal of impacted tooth, soft tissue. Occlusal surface of tooth covered by soft tissue. Requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth, partially bony. Part of crown covered by bone. Requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth, completely bony. Most or all of crown covered by bone. Requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth, completely bony, with unusual surgical complications. Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.

Dental Code	Description
<b>Other Surgical Procedures</b>	
<b>D7270</b>	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. Includes splinting and/or stabilization. Tooth designation required.
<b>D7280</b>	Surgical access of an unerupted tooth. 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. Tooth designation required. Limited to participants less than 21 years of age.
<b>D7286</b>	Biopsy of oral tissue, soft. For surgical removal of an architecturally intact specimen only. This code is not to be used at the same time as codes for apicoectomy/periradicular curettage.
<b>D7287</b>	Exfoliative cytological sample collection. For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.
<b>Alveoloplasty, Surgical Preparation of Ridge for Dentures</b>	
<b>D7320</b>	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant. No extractions performed in an edentulous area. Quadrant designation is required.
<b>Excision of Bone Tissue</b>	
<b>D7471</b>	Removal of lateral exostosis (maxilla or mandible). Arch designation required.
<b>Surgical Incision</b>	
<b>D7510</b>	Incision and drainage of abscess, intraoral soft tissue. Involves incision through mucosa, including periodontal origins.
<b>D7511</b>	Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces).
<b>D7521</b>	Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces).
<b>Repair of Traumatic Wounds:</b> Excludes closure of surgical incisions.	
<b>D7910</b>	Suture of recent small wounds up to 5 cm.
<b>Other Repair Procedures</b>	
<b>D7960</b>	Frenulectomy (frenectomy or frenotomy), separate procedure. The frenum may be excised when the tongue has limited mobility, for large diastemas between teeth, when the frenum interferes with a prosthetic appliance, or when it is the etiology of periodontal tissue disease.
<b>D7970</b>	Excision of hyperplastic tissue, per arch. Arch designation required.
<b>D7971</b>	Excision of pericoronal gingiva. Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. Arch designation required.
<b>D7999</b>	Unspecified oral surgery procedure, by report. Narrative required when prior authorizing. Prior authorization is required.

### 3.2.10 Orthodontics D8000 - D8999

Dental Code	Description
<p><b>Orthodontics:</b> Prior authorization requests need to be submitted to Department of Health and Welfare (DHW) prior to providing orthodontia. Limited to participants age 0-21 years who meet the eligibility requirements, and the Handicapping Malocclusion Index as evaluated by the Idaho Medicaid dental consultants. Transfers: Participants already in orthodontic treatment who transfer to Idaho Medicaid must have their continuing treatment justified and authorized by the Idaho Medicaid dental consultants.</p>	
<p><b>Limited Orthodontics:</b> Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. Monthly adjustments are not a covered benefit for limited orthodontics.</p>	
D8010	Limited orthodontic treatment of the primary dentition. Justification and treatment plan required when prior authorizing.
D8020	Limited orthodontic treatment of the transitional dentition. Justification and treatment plan required when prior authorizing.
D8030	Limited orthodontic treatment of the adolescent dentition. Justification and treatment plan required when prior authorizing.
D8040	Limited orthodontic treatment of the adult dentition. Justification and treatment plan required when prior authorizing.
<p><b>Comprehensive Orthodontic Treatment:</b> The coordinated diagnosis and treatment leading to the improvement of a participant's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances, and can also include removable appliances, headgear, and maxillary expansion procedures. Must score at least eight points on the state's Handicapping Malocclusion Index.</p>	
D8070	Comprehensive orthodontic treatment of the transitional dentition. Models, panorex, and treatment plan are required when prior authorizing.
D8080	Comprehensive orthodontic treatment of the adolescent dentition, up to 16 years of age. Models, panorex, and treatment plan are required when prior authorizing.
D8090	Comprehensive orthodontic treatment of the adult dentition, 16-21 years of age. Justification required. Models, panoramic film, and treatment plan are required when prior authorizing.
<p><b>Minor Treatment To Control Harmful Habits</b></p>	
D8210	Removable appliance therapy. Removable indicates participant can remove; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two adjustments when prior authorizing. Replacement appliances are not covered.
D8220	Fixed appliance therapy. Fixed indicates participant cannot remove appliance; includes appliances for thumb sucking and tongue thrusting. Justification required when prior authorizing. Will be allowed up to two adjustments when prior authorizing. Replacement appliances are not covered.
<p><b>Other Orthodontic Services</b></p>	
D8670	Periodic orthodontic treatment visit. Adjustments monthly. When utilizing treatment codes D8050 and D8060, a maximum of ten adjustments will be allowed. When utilizing treatment codes D8070, D8080, or D8090, a maximum of 24 adjustments over two years will be allowed (12 per year) when prior authorizing. When utilizing treatment codes D8210 or D8220, two adjustments will be allowed per treatment, when prior authorizing.
D8680	Orthodontic retention, removal of appliances, construction, and placement of retainer(s). Allowed once, per arch, per lifetime. Replacement appliances are not covered unless prior authorized. Includes both upper and lower retainer if applicable.
D8691	Repair of orthodontic appliance. Limited to one occurrence.
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers.

Dental Code	Description
D8999	Unspecified orthodontic procedure, by report. Narrative is required when prior authorizing. No payment for lost or destroyed appliances. Prior authorization is required.

### 3.2.11 Adjunctive General Services D9000 - D9999

Dental Code	Description
<b>Unclassified Treatment</b>	
D9110	Palliative (emergency) treatment of dental pain, minor procedure (open and drain abscess, etc.). This is typically reported on a per visit basis for emergency treatment of dental pain. Tooth or quadrant designation required. This code is allowed once per day. Treatment must actually be provided when billing this code. Open and drain is included in the fee for root canal when performed during the same sitting. This code is not allowed with a restoration on the same day.
<b>Anesthesia</b>	
D9220	Deep sedation/general anesthesia, first 30 minutes. Not included as general anesthesia are: tranquilization, nitrous oxide, enteral, or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents. 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 patient. Anesthesia services are considered completed when the patient 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.
D9221	Deep sedation/general anesthesia, each additional 15 minutes.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide. Allowed once, per day.
D9241	Intravenous conscious sedation/analgesia, first 30 minutes. Provider certification required. 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 patient. Anesthesia services are considered completed when the patient 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.
D9242	Intravenous conscious sedation/analgesia, each additional 15 minutes. Provider certification required.
D9248	Non-intravenous conscious sedation. A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. Not covered on same day as D9220, D9230, or D9241. Provider certification required.
<b>Professional Consultation</b>	
D9310	Consultation—diagnostic service provided by a dentist or physician other than the requesting dentist or physician. A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician.
<b>Professional Visits</b>	
D9410	House/extended care facility call. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day, per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code <b>D9420</b> .

Dental Code	Description
<b>D9420</b>	Hospital calls. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day, per participant. Not covered for routine preoperative and postoperative. If procedures are done in other than hospital or surgery center use procedure code <b>D9410</b> .
<b>D9430</b>	Office visit for observation (during regularly scheduled hours). No other services performed.
<b>D9440</b>	Office visit, after regularly scheduled hours.
<b>Miscellaneous Services</b>	
<b>D9920</b>	Behavior management. This code is to be used only when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill, and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant, per day. Describe the highest level of behavior management technique used for the participant in the comments field of paper or electronic claim. Comments such as "additional staff time," "hand over mouth," or "papoose board" will be sufficient. When physical restraint(s), otherwise known as Protective Stabilization, are used, document the following information in the patient's record (not on the claim form): <ul style="list-style-type: none"> <li>• An Informed Consent form of provider's choice</li> <li>• Indication for stabilization</li> <li>• Duration of application</li> <li>• Behavior management technique used</li> </ul> <b>Note:</b> Providers should not bill Medicaid for Behavior Management, for basic behavior guidance techniques such as positive reinforcement, parental presence or absence, or voice control methods of behavior management.
<b>D9930</b>	Treatment of complications (post-surgical), unusual circumstances.
<b>D9940</b>	Occlusal guard, removable dental appliances, which are designed to minimize the effects of bruxism (tooth grinding) and other occlusal factors. No payment for replacement of lost or destroyed appliances.
<b>D9942</b>	Repair and/or reline of occlusal guard.
<b>D9951</b>	Occlusal adjustment, limited. May also be known as equilibration, reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a per-visit basis. Allowed once every 12 months. This should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removal prosthodontics.
<b>D9952</b>	Occlusal adjustment, complete. Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study casts mounted on an articulating instrument may be used for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma, when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma. Prior authorization is required.
<b>D9999</b>	Unspecified adjunctive procedure, by report. Narrative required when prior authorizing. Prior authorization is required.

### 3.2.12 Pregnant Women (PW) Dental Services

Women who are eligible under the PW program are covered by a dental insurance program called Idaho Smiles.

Contact Idaho Smiles Customer Service for Idaho Smiles eligibility, benefits, and claims processing information at **(800) 936-0978** or by e-mail by going to **www.bcidaho.com** and clicking on the *Idaho Smiles Dental Care* link.

### 3.2.13 Adult Dental Services

A Medicaid participant is considered to be an adult as of the first day, of the first month, after their 21<sup>st</sup> birthday.

Services for Medicaid adult participants are currently limited to the tables below.

Codes in the tables below may have abbreviated descriptions: See *Sections 3.2.1 Overview* through *3.2.11 Adjunctive General Services D9000 – D9999*, for more information on guidelines and limitations.

Dental Code	Description
<b>General Oral Evaluations</b>	
<b>D0120</b>	Periodic oral evaluation. An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. One periodic examination is allowed every six months. Includes periodontal screening.
<b>D0140</b>	Limited oral evaluation, problem focused. An evaluation or re-evaluation limited to a specific oral health problem or complaint. Not to be used when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc. This code is not to be billed when a participant returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic exam.
<b>D0150</b>	Comprehensive oral evaluation, new or established patient. One comprehensive examination is allowed every 12 months. Six months must lapse before a periodic exam can be paid. Documentation must identify the medical need for a comprehensive level of evaluation. A notation of, <i>Comprehensive exam or eval</i> , is not sufficient documentation for payment. A thorough evaluation with findings must be recorded. Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.
<b>Radiographs/Diagnostic Images</b>	
<b>D0210</b>	Intraoral, complete series (including bitewings). Complete series x-rays are allowed only once in a 36 month period. A complete intraoral series consists of 14 periapicals and one series of four bitewings.
<b>D0220</b>	Intraoral periapical, first film.
<b>D0230</b>	Intraoral periapical, each additional film.
<b>D0270</b>	Bitewing, single film. Total of four bitewings allowed every six months.
<b>D0272</b>	Bitewings, two films. Total of four bitewings allowed every six months.
<b>D0273</b>	Bitewings, three films. Total of four bitewings allowed every six months.
<b>D0274</b>	Bitewings, four films. Total of four bitewings allowed every six months.

Dental Code	Description
D0277	Vertical bitewings, seven to eight films. Allowed every six months. Does not constitute a full mouth intraoral radiographic series.
D0330	Panoramic film. Panorex, panelipse, or orthopantograph are also allowed under this code. Panoramic-type films are allowed once in a 36 month period. This time limitation does not apply to preoperative or postoperative surgery cases. Doing both a panoramic film and an intraoral complete series is not allowed. Up to four bitewings or periapicals are allowed in addition to a panoramic film.
<b>Dental Prophylaxis</b>	
D1110	Prophylaxis, allowed once every six months. Removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors. If your participant needs this procedure more frequently, request prior authorization.
<b>Fluoride Treatments</b>	
D1204	Topical application of fluoride, one treatment. Prophylaxis not included. Allowed once every six months for participants age 21 and older.
<b>Amalgam Restorations</b>	
D2140	Amalgam, one surface, primary, or permanent. Tooth designation required.
D2150	Amalgam, two surfaces, primary, or permanent. Tooth designation required.
D2160	Amalgam, three surfaces, primary, or permanent. Tooth designation required.
D2161	Amalgam, four or more surfaces, primary, or permanent. Tooth designation required.
<b>Resin Restorations</b>	
D2330	Resin based composite, one surface, anterior. Tooth designation required.
D2331	Resin based composite, two surfaces, anterior. Tooth designation required.
D2332	Resin based composite, three surfaces, anterior. Tooth designation required.
D2335	Resin based composite, four or more surfaces, or involving incisal angle anterior. Tooth designation required.
D2390	Resin based composite crown, anterior. Fill resin-based composite coverage of tooth. Tooth designation required.
D2391	Resin based composite, one surface posterior. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Tooth designation required.
D2392	Resin based composite, two surfaces, posterior. Tooth designation required.
D2393	Resin based composite, three surfaces, posterior. Tooth designation required.
D2394	Resin based composite, four or more surfaces, posterior. Tooth designation required.
<b>Other Restorative Services</b>	
D2920	Re-cement crown. Tooth designation required.
D2931	Prefabricated stainless steel crown, permanent tooth. Tooth designation required.
D2940	Sedative filling. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration. Tooth designation is required. Surface is not required.
D2999	Unspecified restorative procedure by report. Narrative and tooth designation required.
<b>Pulpotomy</b>	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament. Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Once per tooth. Tooth designation required.
D3221	Pulpal debridement, primary, and permanent teeth. For relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day. Tooth designation required.

Dental Code	Description
<b>Periodontal Services</b>	
<b>D4341</b>	<p>Periodontal scaling and root planing, four or more teeth per quadrant. Allowed once in a 12 month period. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature.</p> <p>Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.</p> <p>Quadrant designation required.</p>
<b>D4342</b>	<p>Periodontal scaling and root planing, one to three teeth, per quadrant. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure is indicated for participants with periodontal disease and is therapeutic, not prophylactic, in nature.</p> <p>Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. Allowed once in a 12 month period. Quadrant designation required.</p>
<b>D4355</b>	<p>Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis. The gross removal of plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Allowed once in a 12 month period.</p>
<b>D4910</b>	<p>Periodontal maintenance. This procedure is instituted following periodontal therapy (surgical and/or non-surgical periodontal therapies exclusive of <b>D4355</b>), and continues for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and/or polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Allowed once in a three month period. This code should only be used for participants who have completed active (surgical or non-surgical) periodontal therapy.</p>
<p><b>Removable Prosthodontics:</b> See <i>Section 3.2.7 Periodontics D4000 - D4999</i> for guidelines and limitations. Dentures include six months of routine post-delivery care following placement.</p>	
<b>D5110</b>	Complete denture, maxillary.
<b>D5120</b>	Complete denture, mandibular.
<b>D5130</b>	Immediate denture, maxillary.
<b>D5140</b>	Immediate denture, mandibular.
<b>D5211</b>	Maxillary partial denture, resin base. Includes any conventional clasps, rests, and teeth.
<b>D5212</b>	Mandibular partial denture, resin base. Includes any conventional clasps, rests, and teeth.
<b>D5410</b>	Adjust complete denture, maxillary.
<b>D5411</b>	Adjust complete denture, mandibular.
<b>D5421</b>	Adjust partial denture, maxillary.
<b>D5422</b>	Adjust partial denture, mandibular.
<b>Repairs to Complete Dentures</b>	
<b>D5510</b>	Repair broken complete denture base. Arch designation required.
<b>D5520</b>	Replace missing or broken teeth, complete denture (each tooth), tooth designation required.
<b>Repairs to Partial Dentures</b>	
<b>D5610</b>	Repair resin denture base. Arch designation required.
<b>D5620</b>	Repair cast framework. Arch designation required.

Dental Code	Description
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture. Involves clasp or abutment tooth.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
<b>Denture Relining:</b> No allowance on relines for the first six months following placement of denture, and then only once every two years. Relines done during the first six months following placement are included in complete/partial fee allowance.	
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).
D5740	Reline partial maxillary denture (chairside).
D5741	Reline partial mandibular denture (chairside).
D5750	Reline complete maxillary denture (laboratory).
D5751	Reline complete mandibular denture (laboratory).
D5760	Reline partial maxillary denture (laboratory).
D5761	Reline partial mandibular denture (laboratory).
D5899	Unspecified removable prosthodontic procedure, by report. Narrative required when authorizing. Use <b>D5899</b> to report, <i>Unable to deliver full or partial denture</i> , and include invoice listing lab and professional fees and the arch designation required. Prior authorization is required.
<b>Simple Extraction</b>	
D7111	Extraction, coronal remnants, deciduous tooth. Removal of soft tissue-retained coronal remnants. Tooth designation required.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal). Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary. Tooth designation required.
<b>Surgical Extractions</b>	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone, and closure. Tooth designation required.
D7220	Removal of impacted tooth, soft tissue. Occlusal surface of tooth covered by soft tissue. Requires mucoperiosteal flap elevation. Tooth designation required.
D7230	Removal of impacted tooth, partially bony. Part of crown covered by bone. Requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7240	Removal of impacted tooth, completely bony. Most or all of crown covered by bone. Requires mucoperiosteal flap elevation, bone removal, and may require segmentalization of tooth. Tooth designation required.
D7241	Removal of impacted tooth, completely bony, with unusual surgical complications. Most or all of crown covered by bone. Usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Allowed only when pathology is present. Tooth designation required.
D7250	Surgical removal of residual tooth roots (cutting procedure). Includes cutting of gingiva and bone, removal of tooth structure, and closure. Can be completed for the same tooth number as previously extracted without prior approval. Tooth designation required.
D7286	Biopsy of oral tissue, soft. For surgical removal of an architecturally intact specimen only. This code is not to be used at the same time as codes for apicoectomy/periradicular curettage.

Dental Code	Description
<b>Surgical Incision</b>	
<b>D7510</b>	Incision and drainage of abscess, intraoral soft tissue. Involves incision through mucosa, including periodontal origins.
<b>D7511</b>	Incision and drainage of abscess— intraoral soft tissue—complicated (includes drainage of multiple fascial spaces).
<b>D7521</b>	Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces).
<b>Repair of Traumatic Wounds:</b> Excludes closure of surgical incisions.	
<b>D7910</b>	Suture of recent small wounds up to five cm.
<b>Other Repair Procedures</b>	
<b>D7970</b>	Excision of hyperplastic tissue, per arch. Arch designation required.
<b>D7971</b>	Excision of pericoronal gingival. Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. Arch designation required.
<b>Unclassified Treatment</b>	
<b>D9110</b>	Palliative (emergency) treatment of dental pain, minor procedure (open and drain abscess, etc.). Open and drain is included in the fee for root canal when performed during the same sitting. This is typically reported on a per visit basis for emergency treatment of dental pain. Tooth or arch designation required. This code is not to be billed when no minor procedure is provided.
<b>Anesthesia</b>	
<b>D9220</b>	Deep sedation/general anesthesia, first 30 minutes. Not included as general anesthesia is tranquilization, nitrous oxide, or enteral or parenteral administration of analgesic, sedative, tranquilizing, or dissociative agents. 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 patient. Anesthesia services are considered completed when the patient 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.
<b>D9221</b>	Deep sedation/general anesthesia, each additional 15 minutes.
<b>D9230</b>	Analgesia, anxiolysis, inhalation of nitrous oxide. Allowed once per day.
<b>D9241</b>	Intravenous conscious sedation/analgesia, first 30 minutes. Provider certification required. 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 patient. Anesthesia services are considered completed when the patient 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.
<b>D9242</b>	Intravenous conscious sedation/analgesia, each additional 15 minutes. Provider certification required.
<b>D9248</b>	Non-intravenous conscious sedation. A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. Not covered on same day as D9220, D9230, or D9241. Provider certification required.
<b>Professional Consultation</b>	
<b>D9310</b>	Consultation— diagnostic service provided by dentist or physician other than requesting dentist or physician. A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the participant's medical record and communicated to the requesting dentist or physician.

Dental Code	Description
<b>Professional Visit</b>	
<b>D9410</b>	House/extended care facility call. Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed. Limited to once per day, per participant. To be used when participant's health restrictions require treatment at the house/extended care facility. If procedures are done in the hospital, use procedure code <b>D9420</b> .
<b>D9420</b>	Hospital call. May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. Limited to once per day, per participant. Not covered for routine preoperative and postoperative care. If the procedure are done in other than hospital or surgery center use procedure code <b>D9410</b> .
<b>D9440</b>	Office visit, after regularly scheduled hours.
<b>Miscellaneous Service</b>	
<b>D9920</b>	Behavior management. May be reported in addition to treatment provided when the participant is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill, and/or assistance to render treatment. Notation and justification must be written in the participant's record identifying the specific behavior problem and the technique used to manage it. Allowed once per participant, per day. Describe the highest level of behavior management technique used for the participant in the comments field of paper or electronic claim.
<b>D9930</b>	Treatment of complications (post surgical), unusual circumstances.

## 3.3 Denturist Policy Guidelines

### 3.3.1 Overview

Approved services are limited to those services allowed by Idaho code for Idaho licensed denturists. Claims may be submitted electronically or on an approved American Dental Association (ADA) claim form. See *Section 3.5 Claim Billing* for more information.

#### 3.3.1.1 Adult Denture Services Restrictions

See *Section 3.2.13 Adult Dental Services* for service limitations for Medicaid adult participants. A Medicaid participant is considered an adult as of the first month after the month of their twenty-first birthday.

### 3.3.2 Participant Eligibility

Eligibility must be verified with Medicaid Automated Voice Information System (MAVIS) before services are rendered.

**Note:** Only participants who are on the Medicaid Enhanced Plan are eligible for denturist services through Medicaid.

Contact MAVIS at:

**(208) 383-4310 in the Boise calling area**  
**(800) 685-3757 (toll free)**

Provider representatives are available Monday through Friday from 8 a.m. – 6 p.m. MT (excluding state holidays).

Participants who are eligible for the Medicaid Basic Plan, including pregnant women on the Pregnant Women (PW) Program, are covered for denture benefits through Idaho Smiles dental insurance. Contact Idaho Smiles customer service at **(800) 936-0978** for additional information and limitations.

**Qualified Medicare Beneficiary (QMB):** Participants who have only QMB are not eligible for dentures.

**Medicare-Medicaid Coordinated Plan (MMCP):** Participants who have denture benefits through their insurance carrier; contact the participant's insurance carrier for more information.

### 3.3.3 Prior Authorization (PA)

**Undelivered Dentures:** Laboratory and professional fees may be paid under procedure code **D5899**, with prior authorization, for an undelivered partial or complete denture if the participant meets one of the following conditions:

- The participant has decided not to complete the partial or complete denture.
- The participant returned the denture(s) within 90 days of delivery because they were dissatisfied with the denture(s).
- The participant has left the state.
- The participant cannot be located.
- The participant is deceased.

You must obtain a prior authorization before you can bill procedure code **D5899**. See *Section 3.4 Prior Authorization* for instructions on submitting a Request for Prior Authorization. If approved, bill procedure code **D5899** using a separate line for each arch and include the prior authorization number on your claim.

Dentists and denturists who have already received payment for dentures but were unable to deliver the dentures must refund the entire Medicaid payment, and then request prior authorization for **D5899**. Failure to follow this process with undelivered dentures is considered accepting payment for services not rendered.

### 3.3.4 Reimbursement

Denturists will be reimbursed for procedures on a fee-for-service basis. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount.

### 3.3.5 Service Limitations

Complete and partial denture adjustments and relines are considered part of the initial denture construction service for the first six months. After six months, denture reline is allowed once every two years.

Only one upper and one lower partial or full denture is covered in a five calendar year period. Complete dentures, placed immediately, must be of structure and quality to be considered the final prosthesis. Transitional or interim treatment dentures are not covered. No additional reimbursement is allowed for denture insertions.

If complete dentures are inserted during a month when the participant is not eligible, but other work, including laboratory work, is completed during an eligible period, the claim for the dentures is allowed. Use the impression date, not the seating date, as the service date.

Adult participants have restricted benefits. See *Section 3.2.13 Adult Dental Services* for more information.

### 3.3.6 Procedure Codes

The following codes are valid denturist procedure codes:

Dental Code	Description
D5110	Complete denture, maxillary.
D5120	Complete denture, mandibular.
D5130	Immediate denture, maxillary.
D5140	Immediate denture, mandibular.
D5410	Adjust complete denture, maxillary.
D5411	Adjust complete denture, mandibular.
D5421	Adjust partial denture, maxillary.
D5422	Adjust partial denture, mandibular.
D5510	Repair broken complete denture base. Arch designation required.
D5520	Replace missing or broken teeth, complete denture (each tooth), Six teeth maximum. Tooth designation required.
D5610	Repair resin denture base. Arch designation required.
D5620	Repair cast framework. Arch designation required.
D5630	Repair or replace broken clasp. Arch designation required.
D5640	Replace broken teeth, per tooth. Tooth designation required.
D5650	Add tooth to existing partial denture. Does not involve clasp or abutment tooth. Tooth designation required.
D5660	Add clasp to existing partial denture, not requiring the altering, oral tissue, or natural teeth. Tooth designation required.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).
D5730	Reline complete maxillary denture (chairside).
D5731	Reline complete mandibular denture (chairside).

Dental Code	Description
<b>D5740</b>	Reline partial maxillary denture (chairside).
<b>D5741</b>	Reline partial mandibular denture (chairside).
<b>D5750</b>	Reline complete maxillary denture (laboratory).
<b>D5751</b>	Reline complete mandibular denture (laboratory).
<b>D5760</b>	Reline partial maxillary denture (laboratory).
<b>D5761</b>	Reline partial mandibular denture (laboratory).
<b>D5899</b>	Unable to deliver full denture. Arch designation required. Include invoice listing lab and professional fees and the arch designation. See <i>Section 3.3.3 Prior Authorization</i> , and <i>Section 3.4 Prior Authorization</i> , for more information. PA is required.

## 3.4 Prior Authorization (PA)

### 3.4.1 How to Request Dental Prior Authorization

All procedures that require prior authorization must be approved prior to the service being rendered. Prior authorization requires submission of the appropriate dental prior authorization form and diagnostics. Verbal authorizations will not be given. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility.

**Note:** Any questions regarding the prior authorization procedure or prior authorization requirements should be addressed to the Medicaid Dental Unit at: **(208) 364-1839**.

Prior authorization of Medicaid dental procedures does not guarantee payment. The participant's Medicaid eligibility must be verified by the provider before the authorized service is rendered.

Prior authorization forms for general dentistry and orthodontics are included in the *Appendix D; Forms*. They can be duplicated as needed. The forms must be filled out completely.

Attach or include any pertinent information to substantiate the request for PA, such as x-rays, models, and narratives when appropriate. A Medicaid dental consultant reviews the requested procedure(s) with documentation and returns the approvals or denials via a 'Notice of Decision for Medical Assistance Benefits' letter. If the request for prior authorization is denied, a dental consultant's explanation will be included.

When billing for services that require prior authorization, the prior authorization number is required to be on the claim form. Be sure to inform all associated providers of the prior authorization number.

Approved authorizations are valid for one year from the date of Medicaid authorization, unless otherwise indicated on the prior authorization approval letter. Participants must be Medicaid eligible on the date of service or the prior authorization is void.

See *Section 2.3.2 Medicaid Prior Authorizations, General Billing Information*, or more information on electronically billing services that require prior authorization.

Send prior authorization requests to:

**Division of Medicaid**  
**Attn: Dental Unit**  
**PO Box 83720**  
**Boise, ID 83720-0036**  
**(208) 364-1839**

#### 3.4.1.1 Submit In Writing for Prior Authorization (PA) Changes

If changes are required on a prior authorization, such as a procedure that was done outside of the Start and Stop dates, or another procedure was provided rather than the procedure that was initially authorized, submit in writing to the address above requesting the change. Include the participant's name, Medicaid identification number, prior authorization number, tooth number(s) or quadrant designations, if applicable, and what needs to be changed.

#### 3.4.1.2 Prior Authorization (PA) Code List

For descriptions and limitations for the codes listed below, see *Section 3.2.3 Children Dental Services* through *Section 3.2.11 Adjunctive General Services D9000 – D9999*, and *Section 3.2.13 Adult Dental Services*.

##### Children's Dental Services:

D0999	D3999	D5952	D6999	D8210
D2710	D4999	D5953	D7999	D8220
D2721	D5899	D5954	D8010	D8670

D2750	D5931	D5955	D8020	D8060
D2751	D5932	D5958	D8030	D6080
D2752	D5933	D5959	D8040	D8999
D2790	D5934	D5960	D8070	D9952
D2791	D5935	D5982	D8080	D9999
D2792	D5936	D5988	D8090	D7671
D3351	D5951	D5999	D5820	D5821
D6090	D6040	D6100	D1555	D6050
D6199	D7760	D3353	D3352	D6055
D7670	D8050			

**Adult Dental Services:**

D5899

## 3.5 Claim Form Billing

### 3.5.1 Which Claim Form to Use

Claims received more than one year after the date of service (365 days) are not covered.

Idaho Medicaid encourages the use of ADA 1999 claim form. Processing of other ADA forms will take longer and cause a delay in reimbursement. Idaho Medicaid does not currently accept the ADA 2002, 2003 or 2006 claim form.

See *Section 2 General Billing Information* for more information on electronic billing.

#### 3.5.1.1 General Billing Instructions

**Prior Authorization Number:** Paper claims may have only one prior authorization number.

**National Oral Cavity Designation (Quadrant) Codes:** Idaho Medicaid accepts the National Oral Cavity Designation Codes (quadrant codes) on electronic and paper dental claims. Idaho Medicaid does not accept the sextant codes.

**Multiple Tooth Designations per Detail:** Although HIPAA allows multiple tooth designations per detail, Idaho Medicaid can only accept one tooth designation and unit per detail.

**Oral Surgeons:** When billing for extractions, use the correct CDT procedure code and the ADA 1999 claim form or electronic HIPAA 837 Transaction. Use your Medicaid dental provider number.

**Place-of-Service (POS) Codes:** The following POS codes are allowed for dental providers. Not all of the POS (except for 11 Office) listed are available for every procedure. Please verify with MAVIS prior to rendering services outside of the provider office.

- 11 Office
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room
- 24 Ambulatory Surgical Center
- 31 Skilled Nursing Center
- 32 Nursing Facility
- 54 Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR)
- 71 Public Health Clinic

### 3.5.2 Electronic Claims

#### 3.5.2.1 Guidelines for Electronic Claims

**Provider Number:** In compliance with HIPAA and the National Provider Identifier (NPI) initiative, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

**Detail Lines:** Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Dental transactions.

**Modifiers:** Although HIPAA allows up to four modifiers, Idaho Medicaid does not accept modifiers for dental services.

**Prior Authorization Number:** Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Dental transaction. A prior authorization number is accepted at the header, at each detail, or both. The prior authorization number must be on the claim or the claim will be denied.

### **3.5.2.2 Guidelines for Paper Claim Forms**

Idaho Medicaid encourages the use of ADA 1999 claim form. Processing of other ADA forms will take longer and cause a delay in reimbursement. Idaho Medicaid does not currently accept the ADA 2002, 2003, or 2006 claim form. The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format.
- A maximum of eight line items, per claim can be accepted. If the number of services performed exceeds eight lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed.
- Only one prior authorization number is allowed for paper claims.
- Idaho Medicaid does not allow modifiers for dental claims.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

See *Section 3.5.1.2 ADA Claim Form* for more specific instructions on how to complete the form.

### **3.5.2.3 Where to Mail the Paper Claim Form**

Send completed claim forms to:

**EDS  
Dental Claims  
PO Box 23  
Boise, ID 83707**

### **3.5.2.4 American Dental Association (ADA) 1999 (2000) Dental Claim Form**

These numbered fields correspond to the ADA 1999 (2000) Dental claim form and indicate those fields that must be completed for Medicaid submission.

A sample ADA 1999 (2000) dental claim form with all fields numbered is at the end of this section. Remember that EDS denies incomplete claims, so make every effort to provide valid, complete information as specified on the claim form.

<b>Field</b>	<b>Field Name</b>	<b>Directions</b>
<b>2</b>	Medicaid Claim/ Prior Authorization #/ EPSDT	Check the box marked, Medicaid Claim. If applicable, enter the prior authorization number.
<b>8</b>	Patient Name (Last, First, Middle)	Enter the participant's name exactly as it is spelled on the participant's eligibility verification response. Enter last name, first name, middle initial, in that order.
<b>13</b>	Patient ID #	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the participant's MAID card.

Field	Field Name	Directions
42	Name of Billing Dentist or Dental Entity	Enter your name exactly as it appears on the provider master file at EDS.
44	Provider ID #	Enter your complete 9-digit Idaho Medicaid provider number.
49	Place of treatment	Mark an X in the appropriate box.
56	Is treatment result of occupational illness or injury?	Mark an X in the appropriate box. If yes, enter a brief description and dates.
57	Is treatment result of: auto accident? other accident? neither?	Mark an X in the appropriate box. If yes, enter a brief description and dates.
59	Examination and treatment plans – List teeth in order Date (MM?DD/YYYY)	Enter the date the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2004 becomes 11242004.
59	Examination and treatment plans – List teeth in order Tooth	Complete this item using the tooth number, arch designation, or quadrant codes listed in <i>Section 3.2.2 Descriptive Codes</i> .
59	Examination and treatment plans – List teeth in order Surface	Enter up to 5 tooth surface codes.
59	Examination and treatment plans – List teeth in order Procedure Code	Enter the appropriate dental code from the <i>Current Dental Terminology (CDT)</i> reference manual.
59	Examination and treatment plans – List teeth in order Qty	Enter the quantity or number of units of the service provided. Enter the number of x-rays in this field.
59	Examination and treatment plans – List teeth in order Description	Provide a narrative description specifying services provided.
59	Examination and treatment plans – List teeth in order Fee	Enter your usual and customary fee for each service provided.
59	Admin. Use Only	Use this field to enter the performing provider number, if applicable. This field is used for the Medicaid performing provider number when a group provider number is used in field 44. The performing provider's number must be indicated on each detail line.
60	Total Fee	Add the charges for all detail lines. Enter the total amount in this field.
60	Payment by other plan	Enter any amount paid by other liable parties or health insurance payments. Attach documentation from an insurance company showing payment or denial to the claim.
62	Signed (Treating Dentist)/ License # (not required)/ Date (MM/DD/YYYY)	The provider or his agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a Statement of Certification must be on file at EDS before the claim can be processed. See <i>Section 1.2 Services for Providers</i> , for more information.

