Dental Services
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of October 1, 2015 Published: February 25, 2016</td>
<td>New document</td>
<td>FSSA and HPE</td>
</tr>
<tr>
<td>1.1</td>
<td>Policies and procedures as of April 1, 2016 Published: July 28, 2016</td>
<td>Scheduled update</td>
<td>FSSA and HPE</td>
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<tr>
<td>1.2</td>
<td>Policies and procedures as of April 1, 2016 Published: August 9, 2016</td>
<td>Corrected the age requirements in the <em>Prophylaxis</em> section</td>
<td>FSSA and HPE</td>
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<td>1.3</td>
<td>Policies and procedures as of April 1, 2016 <em>(CoreMMIS updates as of February 13, 2017)</em> Published: March 21, 2017</td>
<td><em>CoreMMIS update</em></td>
<td>FSSA and HPE</td>
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<tr>
<td>2.0</td>
<td>Policies and procedures as of April 1, 2017 Published: August 1, 2017</td>
<td>Scheduled update</td>
<td>FSSA and DXC</td>
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| 3.0     | Policies and procedures as of April 1, 2018 Published: July 31, 2018 | Scheduled update:  
- Updated standard wording in the initial note box  
- Merged relevant information from the *Medical Policy Manual* into this module  
- Edited and reorganized text as needed for clarity  
- Expanded the *Introduction* section  
- Removed outdated information about Hoosier Healthwise dental services being carved out prior to January 1, 2017  
- In the *Package E Coverage for Emergency Dental Services* section, added a reference to the *Claim Submission and Processing* module for billing information  
- Clarified information in the *Prior Authorization for Dental Services* section and updated references to the *IHCP Prior Authorization Dental Request Form* | FSSA and DXC |
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<thead>
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<tr>
<td></td>
<td></td>
<td>• In the <em>Coverage, Limitations, and Billing for Specific Dental Services</em> section, replaced references to the <em>Dental Services Codes</em> document for CDT code age restrictions with a reference to the Professional Fee Schedule.</td>
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<td></td>
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<td>• Updated the <em>Dentures – Complete and Partial</em> section and its subsections, including:</td>
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<tr>
<td></td>
<td></td>
<td>├── Updated references to dentures as needed to clarify inclusion of complete, partial, or both</td>
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<td></td>
<td></td>
<td>└── Clarified PA documentation requirements for initial versus replacement dentures</td>
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<td></td>
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<td>└── Replaced the <em>Billing a Member for Noncovered Services</em> subsection with a general note under the <em>Billing and Reimbursement for Dental Services</em> section</td>
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<td>• Clarified billing information and updated the heading for the <em>Palliative Treatment of Facial Pain for Emergency Dental Services</em> section</td>
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<td>• Added coverage information to the <em>Extractions</em> section</td>
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<td>• Updated the <em>Fluoride Treatment (Topical)</em> section and its subsection as follows:</td>
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<tr>
<td></td>
<td></td>
<td>└── Added a table for coverage limitations</td>
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<tr>
<td></td>
<td></td>
<td>└── Added information about the types of topical fluoride treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>└── Removed details about the specific certified training courses required for coverage of physician-administered topical fluoride varnish</td>
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<td>• Added the <em>Frenulectomy (Frenectomy or Frenotomy)</em> section</td>
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<td>• Added the Maxillofacial Surgery section</td>
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<td>• Added a table for coverage limitations and added a note about State-operated group homes in the Oral Evaluations section</td>
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<tr>
<td></td>
<td></td>
<td>• Completely updated the Orthodontics section and its subsections to reflect current policies and procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added a table for coverage limitations in the Periodontal Maintenance section</td>
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<tr>
<td></td>
<td></td>
<td>• Added a table for coverage limitations in the Periodontal Root Planing and Scaling and Full-Mouth Debridement section</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added Periodontal Surgery section</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added a table for coverage limitations in the Prophylaxis section</td>
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<tr>
<td></td>
<td></td>
<td>• Added a table for coverage limitations in the Radiographs section, and added information about noncovered services</td>
</tr>
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<td></td>
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<td>• Updated the Restorations section and subsections</td>
</tr>
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<td></td>
<td></td>
<td>• Updated the Sedation for Dental Procedures (Dental Anesthesia) section</td>
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<tr>
<td></td>
<td></td>
<td>• Updated and renamed the Services Provided Outside the Dental Office section, and consolidated information from the former Billing for Dental Procedures at a Hospital or ASC section</td>
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<tr>
<td></td>
<td></td>
<td>• Added information to the Space Maintenance section</td>
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Introduction

Dental services are provided to Indiana Health Coverage Programs (IHCP) members as described in this module, subject to limitations established for certain benefit packages. Dental services include diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession. These services include treatment of the teeth and associated structures of the oral cavity, disease, injury, or impairment that may affect the oral or general health of the individual. Dental services may be provided by general dentistry practitioners or by dental specialists, such as endodontists, oral surgeons, orthodontists, pediatric dentists, and periodontists.

Dental providers must bill for services as a dental claim, using the appropriate Current Dental Terminology (CDT®) procedure codes, as described in the Billing and Reimbursement for Dental Services section.

This module also includes information about physician-administered fluoride varnish billed as a professional claim; see the Physician-Administered Topical Fluoride Varnish section.

See the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch module for information about EPSDT-related dental screening services.

Member Eligibility Verification and Benefit Limit Information

Providers must verify eligibility at the time a member makes an appointment and again on the day of the appointment, before rendering the service. Providers can verify member eligibility through the Eligibility Verification System (EVS) options:

- Provider Healthcare Portal at portal.indianamedicaid.com
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic transaction

These methods provide benefit plan enrollment information for members enrolled in a managed care program (such as HIP, Hoosier Care Connect, or Hoosier Healthwise) as well as for those enrolled in a fee-for-service program (such as Traditional Medicaid).
The EVS options also provide benefit limit information for fee-for-service members. For managed care members, providers must follow the MCE’s procedures for obtaining benefit limit information. To avoid claim denials for the explanation of benefits (EOB) codes in Table 1, providers should verify that a member has not exhausted benefit limits before rendering such services as fluoride treatment, oral evaluations, prophylaxis, periodontal maintenance, periodontal scaling and root planing, and full-mouth or panoramic x-rays. For more information about IHCP coverage of these and other detail services, see the **Coverage, Limitations, and Billing for Specific Dental Services** section for information about IHCP coverage and benefit limits for specific dental services.

**Table 1 – Dental Claim Denials Related to Benefit Limit Information Available on the EVS**

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>EOB Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>6209</td>
<td>Full-mouth or panorex x-rays limited to once every three years.</td>
</tr>
<tr>
<td>6211</td>
<td>Periodic or limited oral evaluations are limited to one every 6 months.</td>
</tr>
<tr>
<td>6212</td>
<td>Indiana Health Coverage Program benefits allow payment for one topical application of fluoride every six (6) months. Fluoride treatments are limited to recipients 0 through 20 years of age.</td>
</tr>
<tr>
<td>6221</td>
<td>Reimbursement limited to four treatments of periodontal root planing/scaling every two (2) years for non-institutionalized recipients between the ages of three (3) and twenty (20) years.</td>
</tr>
<tr>
<td>6222</td>
<td>Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.</td>
</tr>
<tr>
<td>6223</td>
<td>Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.</td>
</tr>
<tr>
<td>6226</td>
<td>Comprehensive/extensional oral evals are limited to one per lifetime per member per provider.</td>
</tr>
<tr>
<td>6232</td>
<td>Prophylaxis and periodontal maintenance is limited to one treatment every six months for institutionalized members.</td>
</tr>
<tr>
<td>6235</td>
<td>Prophylaxis and periodontal maintenance is limited to one treatment every 12 months for non-institutional members 21 years or older.</td>
</tr>
<tr>
<td>6310</td>
<td>Prophylaxis and periodontal maintenance limited to one treatment every six months for non-institutionalized members over age twelve months to twenty-one years.</td>
</tr>
</tbody>
</table>

**Note:** In general, denied services do not credit waiver liability. For example, a service that is not covered by Medicaid under Indiana Administrative Code 405 IAC 5, and therefore denied by the IHCP, does not credit waiver liability. However, a service that is denied because the member exceeds a benefit limitation, which cannot be overridden with an approved prior authorization, may credit waiver liability. See the **Member Eligibility and Benefit Coverage** module for more information about waiver liability. For waiver billing information, see the **Home and Community-Based Services Billing Guidelines** module.
Package E Coverage for Emergency Dental Services

The Package E benefit plan provides IHCP coverage for emergency services only. With the assistance of the Dental Advisory Panel (DAP), the IHCP created a table of the CDT codes that are allowed for reimbursement under Package E. These codes are listed in the Dental Procedure Codes Allowed for Package E Members table in Dental Services Codes on the Code Sets page at indianamedicaid.com. The listing of a code in this table does not eliminate the need for providers to document the emergency medical condition that required treatment.

The Omnibus Budget Reconciliation Act of 1990 (OBRA) defines an emergency medical condition as follows:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of an organ or part.

Radiographs are reimbursed under Package E only when the member presents with symptoms that warrant the diagnostic service.

For information about billing services for Package E members, see the Emergency Services Only (Package E) Billing section of the Claim Submission and Processing module.

Prior Authorization for Dental Services

The following dental services are subject to prior authorization (PA) for medical necessity:

- Periodontal surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Orthodontics
- Dentures (complete and partial) for members 21 years of age or older
- Repairs and relines of dentures (complete and partial) for members 21 years of age or older
- Frenulectomy (frenectomy or frenotomy)
- General anesthesia for members 21 years of age or older
- IV sedation for members 21 years of age or older

The IHCP returns PA requests to the provider if the requests are submitted for any other dental services. Prior authorization does not override a noncovered status on a dental code; therefore, a dental provider should not submit a PA request for a noncovered procedure code. The IHCP provides no reimbursement for ineligible members or for noncovered services. PA does not guarantee payment.

PA for FFS dental services may be requested through the Portal, as described in the Provider Healthcare Portal module, or by mail or fax using the appropriate PA request form, available on the Forms page at indianamedicaid.com. For orthodontic PA requests, use the IHCP Prior Authorization Request Form (universal PA form). For all other dental PA requests, use the IHCP Prior Authorization Dental Request Form. For general information about completing and submitting PA requests, see the Prior Authorization module.

Prior authorization of dental benefits for HIP, Hoosier Care Connect, and Hoosier Healthwise members is the responsibility of the MCEs and their contracted dental benefit managers. For fee-for-service members, contact Cooperative Managed Care Services (CMCS) with questions about dental PA. For MCE and CMCS contact information, see the IHCP Quick Reference Guide.
Billing and Reimbursement for Dental Services

The IHCP reimburses dental services using a combination of a maximum fee pricing methodology and manual pricing methodology. Providers must use CDT procedure codes to bill dental services and must submit dental claims on the American Dental Association 2006 Dental Claim Form (ADA 2006) or its electronic equivalent (the 837D transaction or Provider Healthcare Portal [Portal] dental claim). See the Claim Submission and Processing module for instructions for completing and submitting a dental claim. CDT codes and related reimbursement information are included in the Professional Fee Schedule at indianamedicaid.com.

For information about billing and reimbursement related to dental procedures performed in a hospital or ambulatory surgical center (ASC), see the Services Provided Outside the Dental Office section.

Note: If a member wants a service that is noncovered by the IHCP, such as a type of denture that does not meet coverage guidelines, IHCP providers can bill the member for the services within the guidelines described in the Charging Members for Noncovered Services section of the Provider Enrollment module.

Valid Tooth Numbers

The IHCP requires a tooth number on the dental claim service line associated with certain CDT procedure codes. See Dental Services Codes on the Code Sets page at indianamedicaid.com for a list of applicable codes. The IHCP accepts only one tooth number per service line.

Note: The IHCP recognizes the Universal/National System for tooth numbering as described in the CDT reference manual.

Tooth Surface Procedure Codes

For any claim detail billed using a procedure code that requires a tooth surface, as indicated in the CDT description of the code, providers must bill using the appropriate number of valid tooth surface codes. Table 2 provides valid tooth surface codes.

<table>
<thead>
<tr>
<th>Table 2 – Valid Tooth Surface Codes</th>
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</thead>
<tbody>
<tr>
<td>Anterior Teeth</td>
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<tr>
<td>-----------------</td>
</tr>
<tr>
<td>D (Distal)</td>
</tr>
<tr>
<td>F (Facial)</td>
</tr>
<tr>
<td>I (Incisal)</td>
</tr>
<tr>
<td>L (Lingual)</td>
</tr>
<tr>
<td>M (Mesial)</td>
</tr>
</tbody>
</table>

Table 3 provides a current list of all procedure codes that require a tooth surface for billing, as well as the minimum number of tooth surface codes required for each procedure code.
Table 3 – Current Procedure Codes Requiring a Tooth Surface Code

<table>
<thead>
<tr>
<th>Procedure codes that require one tooth surface code</th>
<th>Procedure codes that require two tooth surface codes</th>
<th>Procedure codes that require a minimum of three tooth surface codes</th>
<th>Procedure codes that require a minimum of four tooth surface codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2140</td>
<td>D2150</td>
<td>D2160</td>
<td>D2161</td>
</tr>
<tr>
<td>D2330</td>
<td>D2331</td>
<td>D2332</td>
<td>D2335*</td>
</tr>
<tr>
<td>D2391</td>
<td>D2392</td>
<td>D2393</td>
<td>D2394</td>
</tr>
</tbody>
</table>

* Providers must bill D2335 with four surfaces or with an I, indicating incisal angle. Providers must maintain appropriate supporting documentation in the dental or medical chart, because dental records are subject to postpayment review.

Coverage, Limits, and Billing for Specific Dental Services

This section provides coverage, limitations, and billing procedures for the more commonly used dental services. IHCP coverage for any particular service is subject to limitations established for certain benefit plans. For age restrictions attached to certain dental procedure codes, see the Professional Fee Schedule at indianamedicaid.com.

Behavior Management Services

The IHCP limits reimbursement of CDT code D9920 – Behavior management, by report to once per member, per date of service. Documentation supporting the medical necessity, type, and appropriateness of dental behavior management services must be retained in the member’s chart and is subject to postpayment review.

Dentures – Complete and Partial

The IHCP covers complete dentures (D5110 and D5120) and partial dentures for members of all ages, subject to medical necessity and (for members 21 years of age and older) prior authorization. See the Covered Partial Denture Types section for covered codes for partial dentures. The IHCP covers immediate dentures (D5130 and D5140) only for members 21 years of age and older. The IHCP does not reimburse an additional amount for immediate dentures beyond the current denture allowance.

The IHCP waives the 60-day waiting period between the date of the last extraction and the date of the initial impression. The IHCP does not reimburse for additional charges related to furnishing the dentures before the 60-day waiting period. Providers can hold the patient responsible for these additional charges if the provider gives the patient advance notice and documents this in the record as described previously.

The IHCP provides reimbursement for dentures once every 6 years, if medically necessary; however, providers must obtain PA for members 21 years old and older. Though PA is not required for members under age 21, medical necessity should be included in the patient chart.

The IHCP can require the member to use the most cost-effective treatment instead of the specifically requested treatment, as long as the cost-effective procedures meet the medically necessary needs of the member.

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The provider must bill the IHCP according to when the services are rendered. The IHCP requires that provider records be maintained in accordance with 405 IAC 1-5-1. Per 405 IAC 1-5-1(b)(4), the medical record must contain the date when the service was rendered. In addition, according to 405 IAC 1-1-4, denial of claim payment can occur if the services claimed are not documented in accordance with 405 IAC 1-5-1.
Prior Authorization for Medical Necessity

The IHCP requires PA for dentures for members 21 years of age and older; requests are reviewed for medical necessity. The IHCP considers eight posterior teeth in occlusion – four maxillary and four mandibular teeth in functional contact with each other – to be adequate for functional purposes. The IHCP does not approve requests for partial dentures that replace only anterior teeth. The IHCP considers anterior tooth replacement purely an aesthetic or cosmetic concern and not medically necessary.

A service is “medically necessary” when it meets the definition of “medically reasonable and necessary service” as defined in 405 IAC 5-2-17. The IHCP determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the patient. When submitting the PA request (either via the Portal or using the IHCP Prior Authorization Dental Request Form), the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the patient and the need for the request. The request should include any information about bone or tissue changes due to shrinkage, recent tooth loss, weight loss, bone loss in the upper or lower jaw, recent sickness or disease, or changes due to physiological aging. If the member’s primary source of nutrition is parenteral or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request. If the prosthesis is 6 years old or older, dentists should indicate on the PA request whether the useful life of the existing prosthesis can be extended by a repair or a reline. Dentists must also include their office telephone number on the PA request, in case the PA analyst has questions.

Note: Prior authorization is not required for members younger than 21 years of age; however, the provider must maintain documentation to support the medical necessity of the services and type of denture or partial provided. Providers are responsible for maintaining supporting documentation within the member’s medical record for members of all ages.

The dental provider must submit documentation supporting the need for a new denture (full or partial), including the following:

- The member is edentulous and unable to masticate properly (fewer than eight posterior teeth are in occlusion).
  - If a member has been edentulous for 3 or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time. The documentation must include a favorable prognosis, an analysis of the oral tissue status (such as muscle tone, ridge height, and muscle attachments), and justification of the reason the patient has been without a prosthesis.
  - If the provider’s request indicates that the member has not worn an existing prosthesis for 3 or more years and the provider documents no mitigating circumstances warranting the authorization of a new prosthesis, the IHCP denies the PA request.

- The member is physically and psychologically able to wear and maintain the prosthesis.

For replacement dentures, the provider must submit documentation that the existing prosthesis requires replacement due to one of the following reasons:

- The existing prosthesis is 6 years old or older, beyond repair, and cannot be relined.
- The base is ill-fitting, the teeth are worn, and the prosthesis cannot be relined.
- There is severe loss of vertical dimension, and the prosthesis cannot be relined.
- The prosthesis has been lost, destroyed, or stolen. (Providers must submit an explanation of the circumstances; otherwise, the IHCP denies the request.)
**Covered Partial Denture Types**

The following types of partial dentures are covered for all ages by the IHCP:

- **Resin partial dentures** (D5211 and D5212) are covered; prior authorization is required for members 21 years of age and older.

- **Cast-metal partial dentures** (D5213 and D5214) are covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast-metal partial must be documented in the member’s medical record for all members requiring the partials, and the PA request for members 21 years and older must include specific reasons for the request.

- **Flexible-base partial dentures** (D5225 and D5226) are covered only for members with documented allergic reaction to other denture materials or for members with a facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial. The need for a flexible-base partial must be documented in the member’s medical record for all members, and the PA request for members 21 years of age and older must include specific reasons for the request.

- **Removable unilateral partial denture – one piece cast metal** (D5281) is covered; prior authorization is required for members 21 years of age and older.

**Repairs, Relines, and Rebases of Dentures**

The IHCP covers laboratory relines, chairside relines, repairs to dentures, and repairs to complete or partial dentures only when the reline or repair extends the useful life of a medically necessary denture that is 6 or more years old. The IHCP does not cover rebases (D5710–D5721).

Providers must obtain PA for members 21 years of age and older for relines and repairs to complete or partial dentures. To be approved, the provider should indicate on the PA request that the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis. Providers must use the following codes for claims and PA requests for relines and repairs:

- Repairs to dentures – D5510 and D5520
- Repairs to partial dentures – D5610–D5660
- Chairside relines – D5730-D5741 (PA is not required)
- Laboratory relines – D5750–D5761

PA is not required for members younger than 21 years of age; however, documentation to support medical necessity must be maintained by the provider in the medical record.

For research of a member’s FFS claim history to determine the age of a denture, contact the Written Correspondence Unit by sending secure correspondence as described in the Provider Healthcare Portal module or by mailing the inquiry to the following address:

**DXC Written Correspondence**
P.O. Box 7263
Indianapolis, IN 46207-7263
Extractions

The IHCP covers extraction of teeth when the procedure is medically necessary and the diagnosis supports the extraction.

The IHCP allows only one tooth number per service line for dental extractions. A provider submitting a claim for D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) must indicate the tooth number for each tooth extracted on a separate service line in field 27 on the ADA 2006 claim form or in the equivalent field of the electronic dental claim.

The IHCP pays 100% of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction. For multiple extractions within the same quadrant on the same date of service, the IHCP pays 90% of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

CDT code D7111 – Extraction coronal remnants – deciduous tooth will also cut back to 90% of the allowed amount when billed with multiple units or with D7140.

Fluoride Treatment (Topical)

According to 405 IAC 5-14-4, reimbursement is available for one topical application of fluoride every 6 months for members from first tooth eruption up to 21 years of age. Topical applications are not covered for members 21 years of age or older.

Table 4 summarizes these reimbursement limitations for topical fluoride treatment age restrictions.

<table>
<thead>
<tr>
<th>Age</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>From first tooth eruption up until 21st birthday</td>
<td>One application every 6 months (two units per calendar year)</td>
</tr>
<tr>
<td>21 years of age or older</td>
<td>No coverage for fluoride</td>
</tr>
</tbody>
</table>

Topical fluoride includes varnish, gel, or foam. Procedure code D1208 – Topical application of fluoride – excluding varnish is billed for members 0–20 years of age.

The IHCP reimburses for procedure code D1206 – Topical application of fluoride varnish for members 1–20 years of age who have a moderate to high risk of dental caries.

Physician-Administered Topical Fluoride Varnish

The IHCP covers physician-administered topical fluoride varnish for members from the time of first tooth eruption until the age of 4. Coverage requires the service be provided by or under the supervision of a physician. The IHCP recognizes the following provider types as eligible to render the service:

- Physicians
- Physician assistants
- Advanced practice nurses

Before performing and billing for this service, eligible providers are required to complete a certified training course.

Physician-administered topical fluoride varnish should be billed using Current Procedural Terminology (CPT®) code 99188 – Application of topical fluoride varnish by a physician or other qualified health care

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professional. Reimbursement is available for one physician-administered topical application of fluoride every 6 months per member. Billing for CPT code 99188 will not affect dental benefit limits.

**Frenulectomy (Frenectomy or Frenotomy)**

A frenulectomy (frenectomy or frenotomy) (D7960) in the dental setting is a covered IHCP service. There is a restriction of two units per date of service.

Prior authorization is required for a frenulectomy. Medical necessity must be established, which may include breast-feeding issues, ankyloglossia (tongue-tie), tissue pull, or diastema.

**Maxillofacial Surgery**

Prior authorization is required for maxillofacial surgery. IHCP providers may be required, based on the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as ambulatory surgical center, hospital, or clinic.

**Oral Evaluations**

The IHCP limits reimbursement of procedure codes D0150 – *Comprehensive oral evaluation – New or established patient* and D0160 – *Detailed and extensive oral evaluation – Problem focused, by report* to one unit of either D0150 or D0160 per provider per member lifetime. In addition, members are limited to a total of two units per year for any combination of these two codes.

The IHCP limits procedure code D0145 – *Oral evaluation for a patient under three years of age and counseling with primary caregiver* to one per year, per member, any provider.

The IHCP limits procedure code D0120 – *Periodic oral evaluation – Established patient* to one every 6 months, per member, any provider.

The IHCP does not subject procedure code D0140 – *Limited oral evaluation – Problem focused* to unit limitations; however, providers should use the code as defined in CDT. This type of evaluation is for patients who have been referred for a specific problem, such as dental emergencies, trauma, acute infections, conditions requiring immediate medical attention, and so forth. Providers should not use D0140 for periodic oral evaluations or other types of evaluations.

Table 5 summarizes these reimbursement limitations for oral evaluation codes.
Table 5 – Oral Evaluation Limitations

<table>
<thead>
<tr>
<th>Dental Code</th>
<th>Code Description</th>
<th>Unit Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral evaluation – Established patient</td>
<td>One every 6 months, per member, any provider</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral evaluation – Problem focused</td>
<td>None</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral evaluation for a patient under three years of age and counseling with primary</td>
<td>One per year, per member, any provider</td>
</tr>
<tr>
<td></td>
<td>caregiver</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral evaluation – New or established patient</td>
<td>One per lifetime, per member, per provider*</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral evaluation – Problem focused, by report</td>
<td>One per lifetime, per member, per provider*</td>
</tr>
</tbody>
</table>

*Note: The IHCP allows members up to two units per year for any combination of procedure codes D0150 and D0160, but the two units cannot be from the same provider. A particular provider can bill either D0150 or D0160 only one time per member per lifetime.

Dental evaluations are closely monitored by the IHCP and are subject to recoupment. Documentation in the dental and medical records must support that the provider rendered the oral evaluation in compliance with the procedure definition for the dental code being used.

Note: Oral exams and routine cleanings for residents of State-operated group homes are included in the per diem rate when performed at the group home.

Orthodontics

The IHCP covers orthodontic procedures only for Members 20 years old and younger and only for cases of craniofacial deformities, whether congenital or acquired.

The IHCP allows for phased orthodontic treatment that incorporates both an interceptive phase and a comprehensive phase, with specific objectives at various stages of dentofacial development. For example, the use of an expander, partial fixed appliances, and a headgear may be stage one of a two-stage treatment. In this situation, placement of full-arch fixed appliances generally will be stage two of a two-stage phased treatment plan.

The IHCP covers the following orthodontic treatments:

- **Limited orthodontic treatment** is defined as 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 treatment. The IHCP does not accept limited orthodontic treatment as part of a multiphased treatment plan. Limited orthodontic treatment codes are as follows:
  - D8010 – Limited orthodontic treatment of the primary dentition
  - D8020 – Limited orthodontic treatment of the transitional dentition
  - D8030 – Limited orthodontic treatment of the adolescent dentition
  - D8040 – Limited orthodontic treatment of the adult dentition

- **Interceptive orthodontic treatment** is defined as treatment for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. It can be considered an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition. An example might be use of a palatal expander to correct a damaging one-sided crossbite. Interceptive orthodontic treatment codes are as follows:
Dental Services

– D8050 – Interceptive orthodontic treatment of the primary dentition
– D8060 – Interceptive orthodontic treatment of the transitional dentition

• Comprehensive orthodontic treatment is defined as treatment of a dentition as a whole. Treatment usually, but not always, uses fixed orthodontic appliances or braces. Comprehensive treatment includes appliances, retainers, and repair or replacement of retainers; these may not be separately billed if comprehensive treatment is rendered. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development. Comprehensive orthodontic treatment codes are as follows:
  – D8070 – Comprehensive orthodontic treatment of the transitional dentition
  – D8080 – Comprehensive orthodontic treatment of the adolescent dentition
  – D8090 – Comprehensive orthodontic treatment of the adult dentition

Prior Authorization Requirements

PA is required for all orthodontic services. When submitting a PA request for orthodontic services by mail or fax, providers must use the Indiana Health Coverage Programs Prior Authorization Request Form (universal PA form), available on the Forms page at indianamedicaid.com. The dental PA request form should not be used for submitting orthodontic PA requests. For authorization requests submitted through the Provider Healthcare Portal, select Orthodontics as the service type to ensure proper processing.

PA requests for limited, interceptive, or comprehensive orthodontic treatment are reviewed on a case-by-case basis. A PA request for removable or fixed-appliance therapy must show that the patient meets the criteria outlined in this policy and has a harmful habit in need of correction.

Phased Orthodontic Treatment

The IHCP accepts PA requests for phased orthodontic treatment. The provider must submit a step-by-step treatment plan with the treatment phase and length of treatment specified. One PA is issued per phase of treatment, and the PA lasts for the length of the treatment specified.

The IHCP will reimburse for a maximum of two phases of orthodontic treatment: one interceptive phase and one comprehensive phase. When requesting multiple phases of orthodontic treatment, providers should use the following guidance:

• Phase 1 – Request the most appropriate interceptive orthodontic code (D8050 or D8060).
• Phase 2 – Request the most appropriate comprehensive orthodontic code (D8070, D8080, or D8090).

All requests for PA must include detail on time frames and the expectations of both phases of treatment.

The IHCP does not accept limited orthodontic treatment codes (D8010, D8020, D8030, and D8040) as part of the treatment plan for phased orthodontic treatment. By definition, limited orthodontic treatment has a specific, limited objective and is not part of a multiphased treatment approach.

Medical Necessity Requirements for Orthodontic PA

Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony that includes, but is not limited to:

• Overjet equal to or greater than 9 mm
• Reverse overjet equal to or greater than 3.5 mm
• Posterior crossbite with no functional occlusal contact
• Lateral or anterior open bite equal to or greater than 4 mm
• Impinging overbite with either palatal trauma or mandibular anterior gingival trauma
• One or more impacted teeth with eruption that is impeded (excluding third molars)
• Defects of cleft lip and palate or other craniofacial anomalies or trauma
• Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)

The member’s diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Diagnostic records required to establish medical necessity include:

• Panoramic radiograph
• Cephalometric radiograph
• Intraoral and extraoral photos

Members with malocclusions associated with a craniofacial anomaly must be diagnosed by a member of a craniofacial anomalies team recognized and endorsed by the American Cleft Palate-Craniofacial Association (ACPA), presumably an orthodontist, and treated by an orthodontist who may or may not be a member of a recognized craniofacial anomalies team.

Members with malocclusions not associated with a craniofacial anomaly may be diagnosed and treated by any orthodontist, whether a member of a recognized craniofacial anomalies team or not. The treating provider is not required to be associated with a recognized craniofacial anomalies team.

Billing and Reimbursement

The IHCP does not reimburse for the following procedure codes; these services are included in the reimbursement for orthodontic treatment and are not separately reimbursed:

• D8660 – Pre-orthodontic treatment examination to monitor growth and development
• D8670 – Periodic orthodontic treatment visit
• D8680 – Orthodontic retention (Removal of appliances, construction and placement of retainer(s))
• D8681 – Removable orthodontic retainer adjustment
• D8690 – Orthodontic Treatment (Alternative billing to a contract fee)
• D8691 – Repair of orthodontic appliance
• D8692 – Replacement of lost or broken retainer
• D8693 – Re-cement or re-bond fixed retainer
• D8694 – Repair of fixed retainers, includes reattachment
• D8999 – Unspecified orthodontic procedure, by report

The IHCP expects patients to continue treatment with the same practitioner for the period of treatment time that is prior authorized. In the unlikely event that the patient must discontinue treatment with one practitioner and begin treatment with another practitioner, the practitioner continuing the treatment must submit a new PA request. The first practitioner must refund part of the reimbursement to the IHCP. Generally, one-third of the reimbursement is for the evaluation and treatment plan, and two-thirds of the reimbursement is for the actual treatment. Based on the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.
Patient Records Requirements

Providers must maintain documentation for orthodontic services in the patient’s dental or medical record, as required by 405 IAC 1-5-1. This rule states, “Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. All providers participating in the Indiana Medicaid program shall maintain, for a period of 7 years from the date Medicaid services are provided, such medical and/or other records, including x-rays, as are necessary to fully disclose and document the extent of the services. A copy of the claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records which are independent of claims for reimbursement.”

Palliative Treatment of Facial Pain for Emergency Dental Services

405 IAC 5-14-13 limits palliative treatment of facial pain, such as an abscess, incision, and drainage, to emergency treatment only. Providers can bill procedure code D0140 for the emergency exam. If the procedure for the palliative care has a corresponding ADA code, providers should bill that code for the procedure.

For example, if a provider performs an emergency incision and drainage of an abscess or intraoral soft tissue procedure, the provider should bill code D7510 with code D0140. The IHCP does not cover procedure code D9110 – Palliative (emergency) treatment of dental pain – Minor procedure.

To specify that the services performed were for emergency care, providers must write the word “Emergency” in field 2 of the ADA 2006 Dental Claim Form dental claim form or select the Emergency box in the Claim Information panel in Step 1 of the Portal dental claim submission. All services are subject to postpayment review, and documentation must support medical necessity for the services performed.

Periodontal Maintenance

The IHCP covers HCPCS code D4910 – Periodontal maintenance for members over 3 years of age. For members over 3 years old and under 21 years old, and for all institutionalized members, coverage is limited once every 6 months. For noninstitutionalized members 21 years old and older, coverage is limited to once every 12 months.

Table 6 summarizes these reimbursement limitations for periodontal maintenance.

<table>
<thead>
<tr>
<th>Age</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 3 years old</td>
<td>No coverage for periodontal maintenance</td>
</tr>
<tr>
<td>At least 3 years old but under 21 years old</td>
<td>Once every 6 months per member</td>
</tr>
<tr>
<td>21 years and older</td>
<td>Once every 12 months per month</td>
</tr>
</tbody>
</table>

Note: Institutionalized members may receive periodontal maintenance once every 6 months, regardless of age.

For reimbursement of D4910, at least one unit of either D4341 – Periodontal scaling and root planing – four or more teeth per quadrant or D4342 – Periodontal scaling and root planing – one to three teeth per quadrant must have been billed. There must be at least 6 months between the first date of service for D4341 or D4342, and the first date of service for periodontal maintenance.
Periodontal Root Planing and Scaling and Full-Mouth Debridement

The IHCP covers periodontal root planing and scaling for members over 3 years old. For members over 3 years old and under 21 years old, and for all institutionalized members, coverage is limited to four units every 2 years. For noninstitutionalized members 21 years old and older, the IHCP limits periodontal root planing and scaling to four units per lifetime. Providers can perform the service for all four quadrants on the same date of service.

Table 7 summarizes these reimbursement limitations for root planing and scaling services.

<table>
<thead>
<tr>
<th>Age</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 3 years old</td>
<td>No coverage for root planing and scaling</td>
</tr>
<tr>
<td>At least 3 years old but under 21 years old</td>
<td>Four units every 2 years</td>
</tr>
<tr>
<td>21 years and older</td>
<td>Four units per lifetime</td>
</tr>
</tbody>
</table>

*Note: Institutionalized members may receive four quadrants of periodontal root planing and scaling every 2 years, regardless of age.*

When IHCP providers submit claims for D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant* or D4342 – *Periodontal scaling and root planing – one to three teeth per quadrant*, they must submit supporting documentation (periodontal charting) as the medical necessity of providing this service. Documentation must show that the member has periodontal disease by showing pocket markings or evidence of attachment loss and showing that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or microorganisms. The date of the root planing and scaling must be written on the periodontal chart next to the quadrant. The IHCP does not require radiographs documenting the periodontal disease with the claim submission, but radiographs must be part of the dental record and maintained in the dentist’s office. When billing the claim for D4341 or D4342, do not list the quadrants on the claim.

Full-mouth debridement is intended for patients with excessive plaque or calculus that inhibits the dental professional’s ability to perform comprehensive oral evaluations. It is only indicated in situations when the patient has not had a dental visit for several years. The IHCP limits coverage of full-mouth debridement services (D4355 – *Full mouth debridement to enable comprehensive evaluation and diagnosis*) as follows:

- Limited to once per 3 years per member
- Limited to one unit per date of service

*Note: When prophylaxis is provided on the same date as periodontal root planing and scaling or full-mouth debridment, reimbursement of prophylaxis is included in the reimbursement for root planing and scaling or full-mouth debridment.*
**Periodontal Surgery**

Periodontal surgery is a covered IHCP service for cases of drug-induced periodontal hyperplasia. Documentation in the patient’s record must substantiate that the service was provided for drug-induced periodontal hyperplasia.

**Prophylaxis**

The IHCP covers prophylaxis for members over 12 months of age. For members from 12 months of age to their 21st birthday, and for institutionalized members of all ages, coverage is limited to once every 6 months. For noninstitutionalized members 21 years old and older, coverage is limited to once every 12 months. Members under 12 months of age are not eligible for prophylaxis unless medical necessity can be established.

Table 8 summarizes these reimbursement limitations for prophylaxis.

<table>
<thead>
<tr>
<th>Age</th>
<th>Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12 months</td>
<td>No coverage for prophylaxis service unless medical necessity can be established</td>
</tr>
<tr>
<td>12 months up until 21st birthday</td>
<td>One every 6 months (two units per calendar year)</td>
</tr>
<tr>
<td>21 years of age or older</td>
<td>One every 12 months (one unit per calendar year)</td>
</tr>
</tbody>
</table>

*Note: Institutionalized members may receive up to one unit of prophylaxis every 6 months, regardless of age.*

If an adult prophylaxis is supplied, the provider can bill CDT code D1110 – *Prophylaxis, adult* for members 12 years old and up. Providers use code D1120 – *Prophylaxis, child* to bill for child prophylaxis for members under age 12.

Providers are not allowed to bill for prophylaxis (D1120 or D1110) for members receiving periodontal maintenance. For members under age 21 and for institutionalized members, there must be at least 6 months between a date of service for periodontal maintenance and a date of service for prophylaxis. For noninstitutionalized members age 21 and older, there must be 12 months between a date of service for periodontal maintenance and a date of service for prophylaxis.

*Note: For residents of a nursing home or a group home, the IHCP will pay for prophylaxis only once every 6 months. Oral exams and routine cleanings for residents of State-operated group homes are included in the per diem rate when performed at the group home.*

**Radiographs**

The IHCP limits reimbursement of a full-mouth series or panoramic x-rays to one set per member every 3 years. Bitewing radiographs are limited to one set per member every 12 months. The IHCP defines one set of bitewings as four horizontal films or seven to eight vertical films.

*IAC 5-14-3(3) limits intraoral films to one first film (D0220) and seven additional films (D0230) per member every 12 months. Claims billing more than one first film in a 12-month period will be denied with EOB 6243 – *D0220 is limited to one film every twelve months*. Claims billing more than seven additional films in a 12-month period will be denied with EOB 6231 – *D0230 Intraoral-periapical–each additional film is limited to seven films per twelve months.*
Table 9 summarizes these reimbursement limitations for radiograph services.

<table>
<thead>
<tr>
<th>Age</th>
<th>Unit Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full mouth radiographs/panoramic x-rays</td>
<td>One set per member every 3 years</td>
</tr>
<tr>
<td>Bitewing radiographs</td>
<td>One set (four horizontal films or seven to eight vertical films) per member every 12 months</td>
</tr>
<tr>
<td>Intraoral radiographs</td>
<td>One first film and seven additional films per member every 12 months</td>
</tr>
</tbody>
</table>

The IHCP covers procedure code D0340 – 2D cephalometric image – acquisition, measurement and analysis only for orthodontic services and limits it to provider specialty 273 – Orthodontists.

Temporomandibular joint (TMJ) arthrograms, other temporomandibular films, tomographic surveys, and cephalometric films are not covered in a dental office.

The IHCP limits reimbursement of procedure code D0240 – Intraoral – Occlusal radiographic image to two units per member per day. Each occlusal film provides a more extensive view of the maxilla and mandible and reveals the entire arch of teeth in either the upper or lower jaw.

**Restorations**

Treatment of dental caries with amalgam restorations, resin-based composite restorations, or stainless-steel crowns is a covered IHCP service. The use of pit sealants on permanent molars and premolars only is a covered service for members under 21 years of age; there is a limit of one treatment per tooth, per lifetime.

The IHCP covers anterior and posterior resin restorations. However, the IHCP reimburses for posterior resin restorations at the same rate as amalgam restorations. IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant (see the Sealants section). Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

*Note:* Margination of restorations and occlusal adjustments are not separately reimbursed.

The IHCP reimburses for only one restoration code per tooth for restorations using the same material, performed on the same date by the same dentist for the same member.

For example, the IHCP reimburses for only one of the appropriate procedure codes (D2140, D2150, D2160, or D2161) for an amalgam restoration of primary tooth letter K when performed on the same date by the same dentist. In the example, if the provider bills codes D2140, D2150, D2160, or D2161 for the same tooth number, the IHCP pays the first line item. The second code causes the claim to suspend as a possible duplicate. The IHCP denies the second and all subsequent restoration codes for the same material for the same tooth as duplicates, with the EOB 5000 or 5001 – This is a duplicate of another claim. If the IHCP denies the claim for EOB 5000 or 5001, the provider must submit an adjustment for the paid detail line with one restoration code per tooth that identifies the number of unique surfaces restored.
Multiple Restorations on the Same Surface

For multiple restorations on the same tooth, using the same material on the same surface of a tooth, without involvement of a second surface, on the same date and by the same dentist, the IHCP processes the restorations as a single-surface restoration. The IHCP reimburses for multiple restorations involving only one surface as a single-surface restoration.

For example, for a one-surface amalgam restoration (D2140) billed multiple times for tooth number 14 for the same surface O, the IHCP reimburses once at the lower of the submitted charge or the maximum fee allowable for that procedure.

Multiple Restorations on Different Surfaces of the Same Tooth

For the IHCP to reimburse the dentist for each surface restored, the dentist must use the code identifying the total number of unique surfaces. Providers can count each surface only once when selecting the code identifying the total number of unique surfaces. Reimbursement can never exceed the maximum fee for a restoration of four or more surfaces when providers use the same material.

If providers bill a two-surface amalgam restoration (D2150) D and O on tooth number 14, and bill another two-surface amalgam restoration (D2150) for surfaces M and O on tooth number 14, the IHCP cannot reimburse the claim as billed. The IHCP considers the second D2150 submission to be an exact duplicate claim and denies with code EOB 5010 – Exact Duplicate – Only one restoration code, per tooth, per day, per dentist will be reimbursed.

For the IHCP to reimburse the claim in the previous example for all surfaces restored, the provider must adjust the claim. The provider should refund the original claim, and the dentist should submit an adjustment billing the three-surface amalgam restoration code D2160 with the MOD surfaces. The IHCP reimburses the claim at the lower of the submitted charge or the maximum fee for a three-surface amalgam restoration (D2160).

Multiple Restorations Using Different Materials

For multiple restorations on the same tooth, using different materials, which involve the same surface without involvement of a second surface, on the same date by the same dentist, the IHCP processes the restorations as a single surface restoration for each material. Providers should rarely experience situations requiring multiple restorations using different materials on the same tooth, and the IHCP may review such claims for medical necessity because of the use of the different materials.

For example, for tooth number 30, if the provider bills a one-surface amalgam restoration (D2140) for the B surface and bills a one-surface resin-based composite restoration (D2391) for the B surface, the IHCP reimburses once for D2140 and once for D2391.

Sealants

Pursuant to 405 IAC 5-14-5, the IHCP covers sealants for molars and premolars for members less than 21 years old, and limited to one per tooth, per member, per lifetime. The IHCP does not cover sealants for members 21 years old and older. Benefit limitation information is available on the eligibility verification system.

The American Dental Association Current Dental Terminology is the current coding reference for dental providers. The ADA distinguishes a sealant from a preventative resin restoration as follows:

“If the care is limited to the enamel, it is still considered a sealant. If the decay penetrates the dentin, then this is considered a restorative procedure.”
IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant. Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

**Sedation for Dental Procedures (Dental Anesthesia)**

The following sections provide information about IHCP coverage of the following types of sedation for dental procedures:

- General anesthesia
- Inhalation of nitrous oxide
- Intravenous (IV) moderate (conscious) sedation
- Nonintra venous conscious sedation (monitored sedation for children)

The IHCP restricts reimbursement for dental anesthesia to **one type of sedation per member per date of service**. For example, general anesthesia may not be billed and reimbursed for the same date of service as inhalation of nitrous oxide, intravenous conscious sedation, or nonintra venous conscious sedation.

**General Anesthesia for Dental Procedures**

The IHCP reimburses for general anesthesia provided in the dentist’s office only for members younger than 21 years old.

The IHCP covers general anesthesia for members 21 years old and older only if the procedure is performed in an inpatient or outpatient hospital setting, or in an ambulatory surgical center (ASC). When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on the professional claim (CMS-1500 claim form, 837P transaction, or Portal professional claim). Prior authorization is required for general anesthesia for members 21 years of age or older.

Documentation for general anesthesia for adults or children should include why the individual cannot receive necessary dental services unless the provider administers general anesthesia. The provider must retain documentation in the member’s file for at least 3 years.

The criteria for coverage of general anesthesia for dental services are as follows:

- Mental incapacitation (such that the member’s ability to cooperate with procedures is impaired), including intellectual disability, organic brain disease, and behavioral problems associated with uncooperative but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member’s ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication

For more information about anesthesia, see the [Anesthesia Services](#) module.
Nitrous Oxide

The IHCP covers nitrous oxide analgesia only for members younger than 21 years old.

Intravenous (IV) Conscious Sedation

The IHCP provides medical reimbursement for intravenous sedation in a dental office when provided for oral surgery services only.

Prior authorization is required for IV sedation for members 21 years of age or older.

Nonintravenous Conscious Sedation (Monitored Sedation for Children)

The IHCP reimburses for monitored sedation for children, provided in the dentist’s office, for members younger than 21 years old. Monitored sedation is the administration of subcutaneous, intramuscular, or oral sedation, in combination with monitoring the patient’s vital signs.

Providers should bill this service using service code D9248 – Non-intravenous conscious sedation. The IHCP does not cover nonintravenous conscious sedation for members aged 21 years or older.

Services Provided Outside the Dental Office

Per 405 IAC 5-14-14, the IHCP reimburses covered services provided outside the dental office at the amount allowed for the same service provided in the office.

The IHCP considers reimbursement of dental services provided in the hospital or surgery center to be included in the reimbursement for services actually provided (for example, surgical procedures). It is not appropriate for providers to bill the IHCP or the IHCP member (or member’s family) an additional charge for covered dental services provided in the hospital or surgery center setting.

Dental services provided to members in an inpatient hospital, outpatient hospital, or ambulatory surgical center (ASC) setting (after obtaining authorization) must be billed as follows:

- Dental-related facility charges must be billed on a UB-04 claim form or electronic equivalent (837I transaction or Portal institutional claim).
- Dental-related services provided in an inpatient, outpatient, or ASC setting can be billed with CDT codes on the ADA 2006 dental claim form or electronic equivalent.
- All other associated professional services, such as radiology and anesthesia, as well as ancillary services related to the dental services, must be billed on the CMS-1500 claim form or electronic equivalent (837P transaction or Portal professional claim).

Space Maintenance

Space maintenance in children with deciduous molar teeth is a covered IHCP service. Space maintenance for children under 3 years of age requires PA. Space maintenance for missing permanent teeth requires PA. Adjustment to space maintainers, bands, and all other appliances included in the reimbursement for the service and may not be billed separately. All requests for PA will be reviewed on a case-by-case basis.

For all bridge devices and space maintainers, providers must indicate the tooth number for the tooth to which the device or appliance is cemented (the abutment tooth) on the ADA 2006 claim form or its electronic equivalent.
**Supernumerary Tooth Extractions**

The IHCP has adopted the ADA tooth designations for supernumerary tooth services.

**Permanent Dentition**

Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar.

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Super” #</td>
<td>51</td>
<td>52</td>
<td>53</td>
<td>54</td>
<td>55</td>
<td>56</td>
<td>57</td>
<td>58</td>
<td>59</td>
<td>60</td>
<td>61</td>
<td>62</td>
<td>63</td>
<td>64</td>
<td>65</td>
<td>66</td>
</tr>
</tbody>
</table>

**Primary Dentition**

Supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (supernumerary “AS” is adjacent to “A”).

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Super” #</td>
<td>AS</td>
<td>BS</td>
<td>CS</td>
<td>DS</td>
<td>ES</td>
<td>FS</td>
<td>GS</td>
<td>HS</td>
<td>IS</td>
<td>JS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>T</th>
<th>S</th>
<th>R</th>
<th>Q</th>
<th>P</th>
<th>O</th>
<th>N</th>
<th>M</th>
<th>L</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Super” #</td>
<td>TS</td>
<td>SS</td>
<td>RS</td>
<td>QS</td>
<td>PS</td>
<td>OS</td>
<td>NS</td>
<td>MS</td>
<td>LS</td>
<td>KS</td>
</tr>
</tbody>
</table>

The supernumerary tooth services will be billed using the appropriate CDT procedure code with the appropriate tooth number combination, and no attachment is required.