



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Dental Services

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## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: August 9, 2016	Corrected the age requirements in the <a href="#">Prophylaxis</a> section	FSSA and HPE
1.3	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: March 21, 2017	CoreMMIS update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: August 1, 2017	Scheduled update: <ul style="list-style-type: none"> <li>• Edited and reorganized information as needed for clarity</li> <li>• Changed HPE and Hewlett Packard Enterprise to DXC</li> <li>• Updated Hoosier Healthwise information in the <a href="#">Dental Services for Managed Care Members</a> section</li> <li>• Added Portal in billing instructions in the <a href="#">Billing for Dental Procedures at a Hospital or ASC</a> section</li> <li>• Updated the following in the <a href="#">Member Eligibility Verification and Benefit Limit Information</a> section: <ul style="list-style-type: none"> <li>– Added 270/271 electronic transaction to EVS options and provided Portal link and IVR telephone number</li> <li>– Clarified that EVS benefit limit information is for FFS members only and removed specific limits listed</li> <li>– Added additional EOBs to Table 1</li> </ul> </li> </ul>	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>• Updated the <a href="#">Prior Authorization for Dental Services</a> section</li> <li>• Clarified prior authorization requirements in the <a href="#">Dentures and Partials</a> section</li> <li>• Changed acrylic to resin partial dentures in the <a href="#">Covered Partial Denture Types</a> section</li> <li>• Added note about HIP to the <a href="#">Periodontal Maintenance</a> section</li> <li>• Clarified information in the <a href="#">Radiographs</a> section and added D0240</li> <li>• Added the <a href="#">Space Maintainers</a> section</li> <li>• Updated the <a href="#">Topical Fluoride Treatment</a> section</li> </ul>	

# Table of Contents

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Introduction.....	1
Dental Services for Managed Care Members.....	1
Billing for Dental Procedures at a Hospital or ASC.....	1
Package E Billing for Emergency Dental Services .....	2
Member Eligibility Verification and Benefit Limit Information.....	2
Valid Tooth Numbers.....	3
Tooth Surface Procedure Codes .....	3
Prior Authorization for Dental Services .....	4
Dental Service Coverage, Limitations, and Billing.....	5
Dental Behavior Management Services .....	5
Dental Extractions.....	5
Dentures and Partials .....	5
Emergency Dental Services .....	8
Anesthesia, Analgesia, and Sedation for Dental Procedures.....	8
Services Provided in Hospital Setting.....	9
Multiple Restorations Reimbursement.....	10
Oral Evaluations .....	11
Orthodontics.....	11
Periodontal Maintenance .....	14
Periodontal Root Planing and Scaling and Full-Mouth Debridement.....	14
Prophylaxis .....	15
Radiographs .....	15
Sealants .....	16
Space Maintainers.....	16
Supernumerary Tooth Extractions .....	16
Topical Fluoride Treatment .....	17



*Note:* For policy information regarding coverage of dental services, see the [Medical Policy Manual](#) at indianamedicaid.com.

## Introduction

The Indiana Health Coverage Programs (IHCP) reimburses dental services using a combination of a maximum fee pricing methodology and manual pricing methodology. Providers must use Current Dental Terminology (CDT<sup>®1</sup>) 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 dental claim). See the [Claim Submission and Processing](#) module for detailed instructions for completing the *ADA 2006*. CDT codes are included in the [Professional Fee Schedule](#) at indianamedicaid.com.

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

## Dental Services for Managed Care Members

Management of dental benefits and dental claim processing for Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members are the responsibility of the managed care entities (MCEs) and their contracted dental benefit managers. See the [IHCP Quick Reference Guide](#) for contact information.

Before January 1, 2017, for Hoosier Healthwise members, dental services performed by dental specialists and billed on the *ADA 2006* or electronic equivalent using CDT procedure codes were carved-out services, excluded from the responsibility of the Hoosier Healthwise managed care entity (MCE). For dates of service on or after January 1, 2017, dental providers are required to file dental claims with, and obtain any required prior authorization for dental services from, the dental benefit manager for the MCE in which the Hoosier Healthwise member is enrolled.

## Billing for Dental Procedures at a Hospital or ASC

Dental services provided to members in an inpatient, outpatient, or 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 Provider Healthcare Portal institutional claim).
- Dental **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 oral surgery, 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 Provider Healthcare Portal professional claim).

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## Package E Billing for Emergency Dental Services

With the assistance of the Dental Advisory Panel (DAP), the IHCP created a table of the CDT codes that are allowed for reimbursement of emergency services provided to Package E members. 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 must be billed only when the member presents with symptoms that warrant the diagnostic service.

For more information about billing emergency dental services, see the [Emergency Dental Services](#) section of this document.

## 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 eligibility verification and 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. Providers should verify that a member has not exhausted benefit limits before rendering services such as fluoride treatment, oral evaluations, prophylaxis, periodontal maintenance, periodontal scaling and root planing, and full-mouth or panoramic x-rays. By checking a member's benefit limit information before rendering services, providers can avoid claim denials for the explanation of benefits (EOB) codes in Table 1.



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

EOB Code	EOB Message
6209	Full-mouth or panorex x-rays limited to once every three years.
6211	Periodic or limited oral evaluations are limited to one every 6 months.
6212	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.
6221	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.
6222	Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.
6223	Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.
6226	Comprehensive/extensive oral evals are limited to one per lifetime per member per provider.
6232	Prophylaxis and periodontal maintenance is limited to one treatment every six months for institutionalized members.
6235	Prophylaxis and periodontal maintenance is limited to one treatment every 12 months for non-institutional members 21 years or older.
6310	Prophylaxis and periodontal maintenance limited to one treatment every six months for non-institutionalized members over age twelve months to twenty-one years.

*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.*

## Valid Tooth Numbers

The IHCP requires a tooth number on the claim form 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 2 – Valid Tooth Surface Codes

Anterior Teeth		Posterior Teeth	
D	(Distal)	B	(Buccal)
F	(Facial)	D	(Distal)
I	(Incisal)	L	(Lingual)
L	(Lingual)	M	(Mesial)
M	(Mesial)	O	(Occlusal)

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

Procedure codes that require <i>one</i> tooth surface code	Procedure codes that require <i>two</i> tooth surface codes	Procedure codes that require a minimum of <i>three</i> tooth surface codes	Procedure codes that require a minimum of <i>four</i> tooth surface codes
D2140	D2150	D2160	D2161
D2330	D2331	D2332	D2335*
D2391	D2392	D2393	D2394
* Providers must bill D2335 with four surfaces or with an <b>I</b> , indicating incisal angle. Providers must maintain appropriate supporting documentation in the dental or medical chart, because dental records are subject to postpayment review.			

## 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 (covered only for members younger than 21 years of age)
- Dentures and partials for members 21 years of age and older
- Repairs and relines of dentures and partials for members 21 years of age and older
- Frenulectomy (frenectomy or frenotomy)
- General anesthesia for members 21 years of age or older (covered only if the procedure is performed in an inpatient or outpatient hospital setting or in an ambulatory surgical center)
- IV sedation for members 21 years of age or older (when provided in a dental office, covered only for oral surgery services)

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 Provider Healthcare Portal, as described in the [Provider Healthcare Portal](#) module, or by mail or fax using the *Indiana Prior Review and Authorization*

Dental Request form, available on the [Forms](#) page at indianamedicaid.com. For information about completing and submitting this form, see the [Prior Authorization](#) module.

*Note: Prior authorization of dental benefits for HIP, Hoosier Care Connect, and (effective January 1, 2017) Hoosier Healthwise members is the responsibility of the managed care entities (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](#).*

## Dental Service Coverage, Limitations, and Billing

This section provides coverage, limitations, and billing procedures for the more commonly used dental services. For age restrictions on certain dental procedure codes see *Dental Services Codes* on the [Code Sets](#) page at indianamedicaid.com.

### Dental Behavior Management Services

The IHCP limits reimbursement of CDT code D9920 – *Behavior management, by report* to once per member, per DOS. 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.

### Dental Extractions

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.

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.

### Dentures and Partialials

The IHCP covers procedure codes D5110 and D5120 for complete dentures for members of all ages, subject to medical necessity and (for members 21 years of age and older) prior authorization. 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 and partials once every six 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.

## Prior Authorization for Medical Necessity

The IHCP requires PA to review requests for medical necessity for members 21 years of age and older. 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 Provider Healthcare Portal or using the *Indiana Prior Review and 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 six 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.

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 or partial, including the following:

- The member is edentulous and unable to masticate properly.
  - Fewer than eight posterior teeth are in occlusion (that is, fewer than four maxillary teeth and four mandibular teeth are in functional contact with each other).

*Note: Requests for partial dentures that replace anterior teeth only are not approved. Anterior tooth replacement is considered purely an aesthetic or cosmetic concern and not medically necessary.*

- If a member has been edentulous for three 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 three 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.

- The existing prosthesis requires replacement due to one of the following reasons:
  - The existing prosthesis is six 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 by the IHCP:

- Resin partial dentures (D5211 and D5212) are covered when medically necessary based on PA criteria.
- 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.

## Billing a Member for Noncovered Services

If a member wants a service that is noncovered by the IHCP, such as dentures or a partial that does not meet the covered guidelines, IHCP providers can bill the member for the services.

The following guidelines must be met for IHCP providers to hold a member responsible for payment:

- The service rendered must be determined to be noncovered by the IHCP or a covered service for which the member has exceeded the program limitations for the particular service.
- The member must understand before receiving the service that the service is not covered by the IHCP and that the member is responsible for the charges associated with the service.
- The provider must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP will not cover the service.

The member should sign a waiver form to acknowledge and indicate the understanding that he or she is financially responsible for all services agreed to and that reimbursement is not available from the IHCP.

Providers can bill the member using the usual and customary charge for any services provided that are not covered by the IHCP. For more information, see the *Charging Members for Noncovered Services* section in the [Provider Enrollment](#) module.

## Date of Service Definition

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.

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

The IHCP covers laboratory relines, chairside relines, repairs to dentures, and repairs to partial dentures only when the reline or repair extends the useful life of a medically necessary denture or partial that is six 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 dentures and partials. 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**

## ***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*.

Field 2 on the *ADA 2006 Dental Claim Form* dental claim form must be used to specify if the services performed were for emergency care. Providers must include the word “emergency” in this field for emergency care rendered to Package E members. All services are subject to postpayment review, and documentation must support medical necessity for the services performed.

## ***Anesthesia, Analgesia, and Sedation for Dental Procedures***

The following sections provide information about general anesthesia, analgesia (including nitrous oxide), intravenous (IV) sedation, and monitored sedation for children related to dental procedures.

## 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. When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead the appropriate CPT/HCPCS code must be billed on the *CMS-1500* claim form, 837P transaction, or Provider Healthcare 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 three 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.

## Analgesia – Nitrous Oxide

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

## IV 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.

## 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 in Hospital Setting

Per 405 IAC 5-14-14, covered services provided outside the dental office will be reimbursed at the fee 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. D9420 – *Hospital or ambulatory surgical center call* is not covered.

## **Multiple Restorations Reimbursement**

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.

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.

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).

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.

The IHCP covers anterior and posterior resin restorations. However, the IHCP reimburses for posterior resin restorations at the same rate as amalgam restorations.



## Oral Evaluations

The IHCP limits procedure codes D0150 – *Comprehensive oral evaluation – New or established patient* and D0160 – *Detailed and extensive oral evaluation – Problem focused, by report* to two visits per member, per year. The two-unit limitation applies to any combination of these two codes billed per year, per member.

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 six months, per member, any provider.

The IHCP does not subject procedure code D0140 – *Limited oral evaluation – Problem focused* to service 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. 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.

## Orthodontics

The IHCP covers orthodontic procedures only for members younger than 21 years old. The Family and Social Services Administration (FSSA) requires PA for all orthodontic services. When submitting orthodontic prior authorization requests by mail or fax, providers must use the *IHCP Medical Prior Authorization Form*, **not** the *IHCP Prior Authorization Dental Request Form*. Providers can access the *IHCP Medical Prior Authorization Form* through the [Forms](#) page at indianamedicaid.com. For authorization requests submitted through the Provider Healthcare Portal, select **Orthodontics** as the service type to ensure proper processing.

The patient must be diagnosed by a member of a recognized craniofacial anomalies team, such as the American Cleft Palate-Craniofacial Association. A licensed practitioner who minimally accepts routine craniofacial patients for orthodontic services, such as patients with cleft lip and palate, must treat the member. Braces are a primary example of the type of procedure code that is not covered as a reimbursed service through the IHCP unless the member meets these requirements:

- Has a recognized diagnosis, such as a craniofacial abnormality, cleft lip and palate, or a malocclusion diagnosis
- Has been diagnosed through a prior authorization from a recognized craniofacial anomalies team member or a member of the American Cleft Palate-Craniofacial Association

The IHCP covers orthodontic services for patients with documentation of one or more of the diagnoses for craniofacial anomaly and malocclusion. Cleft palate and craniofacial specialists helped develop the criteria. The diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. The provider must submit a step-wise treatment plan with the treatment phase and length of treatment specified. The PA lasts for the time period of the length of treatment specified. The IHCP expects that most patients who meet the criteria require comprehensive orthodontic treatment. CMCS reviews prior authorization requests for limited or interceptive orthodontic treatment (procedure codes D8010 through D8060) on a case-by-case basis. PA requests for removable or fixed appliance therapy (procedure codes D8210 or D8220) must show that the patient meets the criteria and has a harmful habit in need of correction. The IHCP denies prior authorization requests for any member who does not meet the criteria.

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 seven 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."

The IHCP does not cover 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 most patients who meet the criteria for orthodontic services to require comprehensive orthodontic treatment, which providers must bill using procedure codes D8070, D8080, or D8090, as listed in the CDT reference manual. The IHCP considers appliances and retainers as included in the fee for the comprehensive treatment, and providers cannot separately bill for them when rendering comprehensive treatment. The IHCP advises practitioners to carefully consider the appropriate amount to bill for the service and advises them to bill their *usual and customary charge* for the service rendered.

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 upon the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.

Current coverage criteria for dental orthodontic procedure codes (covered codes that fall within the range D8010–D8999) are as follows.

The IHCP does not approve orthodontic procedures except in cases of craniofacial deformity or cleft palate. (Patients in Category I and Category II do not require additional information to be submitted for approval of PA requests.)

- Category I: The following diagnoses and conditions are appropriate for orthodontic services:
  - Cleft Lip and Palate and Facial Clefts
  - Oculoauriculovertebral Dysplasia

- Mandibulofacial Dysostosis (Treacher Collins Syndrome)
- Pierre Robin
- Cleidocranial Dysplasia
- Frontonasal Malformation
- Crouzon Syndrome
- Apert Syndrome
- Pfeiffer’s Syndrome
- Ectodermal Dysplasia
- Hemifacial Microsomia
- Amniotic Band Syndrome
- Neurofibromatosis of the Facial Region
- Holoprosencephaly
- Gorlin Syndrome
- Beckwith-Wiedmann Syndrome
- Klippel-Feil
- Category II: The following conditions when accompanied by moderate to severe malocclusions are appropriate for orthodontic services:
  - Fetal Alcohol Syndrome
  - Encephalocele
  - Down Syndrome
  - Werdnig-Hoffman Disease
  - Spina Bifida
  - Developmental disturbances related to oncology radiation
  - Cerebral Palsy
  - Achondroplasia
  - Osteogenesis Imperfecta
  - Arthrogryposis of the Temporomandibular Joint (Congenital Contractures)
  - Ankylosis of the Mandibular Condyles
  - VATER Association
  - Hemimandibular Hypertrophy
  - Condylar Hyperplasia
  - Condylar Hypoplasia
  - Arcofacial Dysostosis
  - Rieger Syndrome
- Category III: For patients in Category III, Severe Atypical Craniofacial Skeletal Pattern, accompanied by moderate to severe malocclusion, the following listed documentation must be submitted for approval of prior authorization requests:
  - Patients in this category will likely have a secondary diagnosis of a maxillary or mandibular skeletal problem, such as maxillary vertical hyperplasia, mandibular hypoplasia, maxillary excess, vertical maxillary deficiency, and so forth.
  - Documentation is by special report and must include frontal and lateral photographs of the face and of the occlusion, a panoramic film, and a lateral cephalometric film (with tracing). For Category III patients with vertical skeletal problems (as noted in the [last guideline](#) of the following list), the practitioner must enclose a posterior-anterior cephalometric film.

The following list presents guidelines for defining moderate to severe malocclusion as a medical problem for Categories II and III:

- Cleft lip and palate and other craniofacial anomalies with a severe functional compromise of the occlusion
- Hypodontia or malalignment (one tooth or more per quadrant) precluding routine restorative dentistry
- Overjet greater than 6 millimeters (mm)
- Reverse overjet (underbite) less than 1 mm
- Anterior or posterior crossbite with greater than 2 mm discrepancy
- Lateral or anterior openbite greater than 4 mm
- Severe overbite with gingival or palatal trauma
- Impaction or impeded eruption of teeth (other than third molars)
- Dysplasia of the vertical dimension of occlusion, lower facial height (LFH) greater than 59% or less than 52%
- Facial skeletal vertical asymmetry greater than two standard deviations (SDs) from the norm for menton-zygoma (left or right) or gonion-zygoma (left or right)

## ***Periodontal Maintenance***

The IHCP covers HCPCS code D4910 – *Periodontal maintenance*. Coverage applies to all IHCP programs except for the Healthy Indiana Plan (HIP), subject to limitations established for certain benefit packages. The coverage is provided with the following restrictions:

- 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* has been billed. There must be at least six months between the first DOS for D4341 or D4342, and the first DOS for periodontal maintenance.
- Coverage is limited to once every six months for members 3 through 20 years of age or for institutionalized members.
- Coverage is limited to once every 12 months for members 21 years of age and older.
- Providers are not allowed to bill for HCPCS code D1120 – *Prophylaxis, child* or D1110 – *Prophylaxis, adult* for members receiving periodontal maintenance. For members under age 21 and for institutionalized members, there must be at least six months between a DOS billed for periodontal maintenance and a DOS billed for prophylaxis. For noninstitutionalized members age 21 and older, there must be 12 months between a DOS billed for periodontal maintenance and a DOS billed for prophylaxis.

*Note: Providers need to contact the HIP member's MCE to see what services are covered for HIP members.*

## ***Periodontal Root Planing and Scaling and Full-Mouth Debridement***

The IHCP limits periodontal root planing and scaling for members over 3 years old and under 21 years old (or for institutionalized members) to four units every two 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.

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 three years per member
- Limited to one unit per date of service

*Note: When prophylaxis and periodontal root planing and scaling or full-mouth debridement are provided on the same date of service, reimbursement of prophylaxis is included in the reimbursement for root planing and scaling or full-mouth debridement.*

## **Prophylaxis**

The IHCP limits prophylaxis for members as follows:

- One unit every six months for noninstitutionalized members 12 months of age up to their 21<sup>st</sup> birthday
- One unit every 12 months for noninstitutionalized members 21 years of age or older
- One unit every six months for institutionalized members, regardless of age

Members under 12 months of age are not eligible for prophylaxis service unless medical necessity can be established.

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

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

## **Radiographs**

The IHCP limits reimbursement of a full-mouth series or Panorex to one set per member every three 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 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.*

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.*

The IHCP limits reimbursement of procedure code D0240 – *Intraoral – Occlusal radiographic image* to two units per member per day.

## Sealants

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. 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. Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services. Benefit limitation information is available on the eligibility verification system.

## Space Maintainers

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 4 – Supernumerary Tooth Designations for Permanent Dentition

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

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

## 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 5 – Supernumerary Tooth Designations for Primary Dentition

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

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

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

## Topical Fluoride Treatment

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

Procedure code D1208 – *Topical application of fluoride – excluding varnish* is billed for members age 0–20. 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

Effective for dates of service on or after January 1, 2017, 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 the certified training course, *Protecting All Children’s Teeth (PACT): A Pediatric Oral Health Training Program*, available at the *Children’s Oral Health* page at aap.org. (From the web page, choose “Begin Module” to begin the training).

Physician-administered topical fluoride varnish should be billed using Current Procedural Terminology (CPT<sup>®2</sup>) code 99188 – *Application of topical fluoride varnish by a physician or other qualified health care professional*. Reimbursement is available for one physician-administered topical application of fluoride every six months per member. Billing for CPT code 99188 will not affect dental benefit limits.

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