INDIANA MEDICAID UPDATE

January 16, 1998

TO: **All Indiana Medicaid Enrolled Dentists**

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The purpose of this bulletin is two-fold: (1) to update all Indiana Medicaid-enrolled dentists regarding measures the OMPP has taken to date and is planning for the future to increase participation by dentists in the Indiana Medicaid program and (2) to provide clarification regarding covered services, rates, current policy, recent policy changes, and claims processing issues.

I. Office of Medicaid Policy and Planning (OMPP) Efforts to Increase Dental Participation

Participation by dentists in the Indiana Medicaid program has decreased from approximately 1700 dentists in 1993 to about 700 dentists in 1997. This has resulted in a dental access problem for Medicaid recipients. To increase participation by dentists in the Indiana Medicaid program OMPP believed it was critical to involve the Indiana dental community and to identify all issues involved in declining access. Thus, a Dental Advisory Panel was formed in June and all licensed Indiana dentists were surveyed in August and September.

We extend a huge THANK YOU to all dentists who responded to the survey. 1195 responses were received out of a total of 2721 mailed. The results of the survey indicated that low reimbursement, slow claims processing, missed appointments, and covered services issues have contributed to dentists withdrawing from the program and have kept new dentists from enrolling. We will provide you with the results of this survey under separate cover.

In response to issues raised by the Dental Advisory Panel, an interim inflationary increase of 11.12% was applied to all covered dental services effective 9-1-97 and prior authorization requirements were removed from all covered dental services 9-1-97. While researching several policy issues OMPP and the Dental Advisory Panel identified claims that were denied due to edits which did not correctly reflect the Indiana Administrative Code (IAC) for dental services at 405 IAC 5-14-1. These edits that were erroneously denying claims have been corrected. These edits and reprocessing projects are identified in this bulletin. This bulletin also provides criteria for services that previously required prior authorization and a copy of the Medicaid dental rule 405 IAC 5-14-1.

The Dental Advisory Panel last met on 12/12/97 and recommended additional rate increases for Medicaid dental services. Fiscal impact statements for these recommendations are now being obtained. The next meeting of the Dental Advisory panel will be on 1/30/98. The agenda includes continuation of the discussion regarding recommendations for handling missed appointments and recommendations for the dental survey for covered services. Providers will be notified when any further changes are made to the dental fee schedule, covered services or dental polices.

II. Clarification of Current Covered Services, Rates, Claims Processing and Policy Changes

1) Description of Chart

Providers should review the chart that is included in this bulletin. It provides the following information:

- A comprehensive list of all covered dental procedure codes. Health Care Financing Administration Common Procedure Coding System (HCPCS) codes are utilized rather than ADA codes. The HCPCS coding system differs from the ADA system in that the first character in the procedure is a "D" rather than a "0" (zero). Submitted ADA codes are automatically converted to the HCPCS codes by the Indiana AIM claims processing system, to comply with Federal requirements.

- The narrative description for all covered codes.

- Applicable coverage criteria for codes previously subject to prior approval.

- An indication as to whether the code is only covered for recipients who are under 21 years of age. All Medicaid recipients under age 21 are covered by the Early and Periodic Screening Diagnosis and Treatment Program (EPSDT), a Federal program that mandates Medicaid to provide all medically necessary services to recipients under twenty-one (21) years of age.

- Rate of reimbursement after the 11.12% inflationary increase effective 9/1/97

2) Removal of Prior Authorization for all Covered Dental Services

The Office of Medicaid Policy and Planning (OMPP) has taken action to remove prior approval for all dental services effective with dates of service on or after 9/1/97. Dental services, except for those rendered in an out-of-state non-designated area, will no longer be subject to prior authorization.

With the advice and cooperation of the Indiana Dental Advisory Panel, coverage criteria has been developed for dental codes that previously required prior authorization. Providers who bill for these services, **should not submit documentation with the claim**, but should maintain any supporting documentation within the patient's dental record. The medical necessity for all Medicaid dental services provided should be documented in the patient's dental record.

(For a listing of covered dental codes refer to page 16)

3) Limited Acceptance of Medicaid Patients

Providers may restrict the number of Medicaid patients they accept as long as their methods for doing so do not violate federal or state law. The following are some examples of allowable limitations: 1) Limiting acceptance of Medicaid patients to children only; 2) Limiting access to only those Medicaid patients who reside in group home settings, or to Medicaid recipients who reside in group home settings, or to Medicaid disability patients; 3) Limiting the number of Medicaid patients in the practice to a certain percentage of the overall practice population, and only accepting new Medicaid patients in the practice when the percentage falls below that level; 4) Limiting Medicaid patients in the practice to only accepting new Medicaid patients from a singular referral source (such as another dentist).

4) Importance of Verifying Recipient Eligibility

When should Medicaid eligibility be verified?

Eligibility should be verified at the time the appointment is made and on the day the service is rendered prior to the rendering the service.

How do I verify eligibility?

Eligibility can be verified by using one of the Eligibility Verification Systems (EVS) listed below. Eligibility verification is available 7 days a week during the hours of 5:00 AM to 1:00 AM.

- Automated Voice Response (AVR) uses a touch-tone telephone. Step-by-step instructions for using AVR are available in Section 2-4 of the Indiana Medical Assistance Programs Provider Manual. The AVR phone numbers are 1-800-738-6770, or Indianapolis local calls 317-692-0819.

- National Electronic Claim Submission (NECS) Dial-up software is an EDS proprietary product that can be used to verify eligibility and submit claims electronically by providers who have an IBM compatible computer. If you are interested in obtaining this software you may call Provider Assistance.

- OMNI Swipe Card Device is a small box that is available for eligibility verification by swiping the recipient's plastic card through the device. Eligibility verification can be viewed on line or a print-out of the eligibility can be made if a printer is available. The cost for the OMNI 380/128 is $391 and the printer P250 is an additional $258. If you are interested in obtaining the OMNI device, please call EDS at 1-800-526-9839.

It is important to listen to or read the entire message since there may be eligibility restrictions associated with the message. In particular, if the individual is in the Hoosier Healthwise Risk-Based Managed Care (RBMC) delivery system on the date services are being rendered, the Managed Care Organization (MCO) must be contacted prior to delivery of services. For

Hoosier Healthwise recipients, the message will identify the recipient's primary care provider (PMP), MCO delivery system, and the telephone numbers for the PMP and MCO.

5) What is the Hoosier Healthwise Program?

Hoosier Healthwise is the mandatory Indiana Medicaid managed care program for parents and children who receive Temporary Assistance for Needy Families (TANF) and for children and pregnant women at or just above the federal poverty limit. A recent addition to Hoosier Healthwise is a voluntary managed care program for persons with disabilities and chronic illnesses (MCPD) which is available only in Marion County.

There are two delivery systems in the mandatory Hoosier Healthwise program: Primary Care Case Management (PCCM) and Risk-Based Managed Care (RBMC). For purposes of the mandatory Hoosier Healthwise program, the State of Indiana is divided into three geographic regions. These regions are the Northern, Central and Southern regions.

The Primary Care Case Management (PCCM) delivery system is available state-wide across all regions. It is sometimes referred to as "Prime Step". It is a fee-for-service arrangement very similar to the traditional Medicaid program where providers submit claims to EDS for payment.

In Risk-Based Managed Care (RBMC), the State contracts with Managed Care Organizations (MCOs) in each region to provide Medicaid covered services, including dental services, to enrolled Medicaid recipients. The State of Indiana has contracted with Maxicare as the MCO in the Northern, Central and Southern regions. Maxicare has named its Medicaid MCO delivery system "MaxiHealth". The State of Indiana has also contracted with another MCO in the Central region, Managed Health Services (MHS). The MCOs are paid by the State of Indiana a capitation fee per member, per month, to provide all covered services to enrolled recipients. The MCOs in turn negotiate payment arrangements with their network of providers. Under certain circumstances, and for certain services, including dental, non-network providers may provide services to the MCOs enrollees. In these instances, the MCO's pay the non-network provider on a fee-for-service basis in accordance with Medicaid's fee schedule.

The managed care program for persons with disabilities and chronic illnesses (MCPD) is a voluntary program available only in Marion County. Managed Health Services (MHS) is the Managed Care Organization (MCO) the State has contracted with to administer the MCPD program. MHS has named its MCPD delivery system "

General information about dental services in Hoosier Healthwise

A Hoosier Healthwise recipient is enrolled in either the Primary Care Case Management (PCCM) or Risk-Based Managed Care (RBMC) delivery system, depending on which physician the recipient selects as his/her primary medical provider (PMP). If the recipient's physician is enrolled as a PMP in an MCO, the recipient will be enrolled in the same MCO. If the recipient's physician is enrolled as a PMP in PCCM, the recipient will be enrolled in PCCM.

The delivery system in which the recipient is enrolled determines from which providers the recipient accesses dental services.

In general, PMP authorization is not needed for recipients to access dental services. PMPs are responsible for rendering or authorizing most primary preventive health care. Most services need a PMP's authorization for the claim to be paid if the PMP does not render the service. This is called PMP authorization. Services rendered by dental providers are excluded from PMP authorization.

Dental services in PrimeStep (Primary Care Case Management - PCCM)

Medicaid recipients enrolled in the PrimeStep delivery system can obtain Medicaid covered dental services from any Medicaid enrolled dentist. No prior, or PMP, authorization is required. Dentists submit claims to EDS.

Dental services in Risk-Based Managed Care (RBMC)

Medicaid recipients enrolled in the Risk-Based Managed care delivery system (with an MCO) must, in general, obtain services through any dentist who is a contracted provider in the MCO network, unless the MCO does not have contracted dental providers in the area. Check with the MCO in your area.

If a non-network dentist elects to provide services to a risk-based managed care enrollee, in order to ensure payment, the non-network dentist should notify the appropriate managed care entity prior to providing services. In general, this situation is most likely to arise if an enrollee is unable to schedule a timely appointment with a network dentist.

Verification and billing for dental services in Hoosier Healthwise

As is the case in the traditional fee-for-service Medicaid program, eligibility should be verified at the time an appointment is made and again on the day the service is rendered, prior to rendering the service. Eligibility can be verified through the Automated Voice Response System (AVR), the Electronic Verification System (EVS) and the National Electronic Claims Submission (NECS). These methods are the same whether the recipient is a Hoosier Healthwise member or enrolled in the traditional Medicaid program.

For dentists who have contracted with a network, provision of service and billing requirements have been communicated to you by that network. Non-network Medicaid dental providers should follow the following steps when verification is received that a recipient is enrolled in the RBMC delivery system:

FOR ALL DENTISTS NOT ENROLLED IN THE NETWORK FOR MAXIHEALTH.

If the recipient is enrolled in MaxiHealth, providers should call the appropriate number listed below to confirm services that may be provided and where the claim should be sent for payment:

Northern Region 1-800-336-8937

Central Region 1-800-401-6294

Southern Region 1-800-552-2043 until 2-1-98
1-800-401-6294 on and after 2-1-98

If the recipient is enrolled in MaxiHealth and resides in the Northern region, the recipient can be referred to the member services number, 1-800-336-8937 to schedule an appointment with a network dentist.

FOR ALL DENTIST NOT ENROLLED IN THE NETWORK FOR MANAGED HEALTH SERVICES (MHS) (Central Region Only)

If the recipient is enrolled in MHS in the Central Region, the provider should call 1-800-401-6294 to confirm services that may be provided and where the claim should be sent for payment:

If the recipient is enrolled in MHS and resides in the Central Region, the recipient can be referred to the same telephone number to schedule an appointment with a network dentist.

FOR ALL DENTISTS NOT ENROLLED IN THE NETWORK FOR MANAGED CARE FOR PERSONS WITH DISABILITIES AND CHRONIC ILLNESSES (MCPD) PROGRAM OR TEAM SELECT

If the recipient is enrolled in MCPD or Team Select (currently in Marion County only), the recipient should be advised to call 1-888-218-9014 or 317-630-7636 to select a dentist.

6) Service Limitations

This section discusses the more commonly used dental services and service limitations.

Prophylaxis

405 IAC 5-14-6(1) states prophylaxis is limited to one (1) unit every six (6) months for non-institutionalized recipients eighteen (18) months of age up to their twenty-first (21) birthday. However, Federal law requires that all medically necessary services be provided for children under age twenty-one (21) even if the service is not covered under the State Plan. Thus, Medicaid will cover prophylaxis for children under eighteen (18) months of age when the service is medically necessary. The next dental rule revision will incorporate this change. Regardless of the age of the recipient, institutionalized recipients may receive up to two (2) units every six (6) months. Prophylaxis is limited to one (1) unit every twelve (12) months for non-institutionalized recipients twenty-one (21) years of age and older.

Periodontal Root Planing and Scaling

Periodontal root planing and scaling for recipients over three (3) years of age and under twenty-one (21) years of age and for institutionalized recipients, is limited to four (4) units every two (2) years. For non-institutionalized recipients twenty-one (21) years of age and older, periodontal root planing and scaling is limited to four (4) units per lifetime. Service for all four (4) quadrants may be provided on the same day of service.

The following chart has been developed to facilitate Medicaid dental providers' understanding of the program's coverage policy for prophylaxis, periodontal root planing and scaling services, and evaluations:

Recipient	Prophylaxis	Periodontal Root Planing and Scaling*	Periodic or Limited Oral Evaluation
Non-institutionalized Children and young Adults	One (1) Unit Every Six (6) Months (For recipients up to 21 years of age)	Four (4) Units Every Two (2) Years (For ages 36 months to under 21 years)	One (1) every six (6) months, per recipient, any provider.
Non-institutionalized Recipients 21 Years of Age and Older	One (1) Unit Every Twelve (12) Months	Four (4) Units Per Adult Lifetime	One (1) every six (6) months, per recipient, any provider.
Institutionalized	Two (2) Units Every Six (6) Months	Four (4) Units every Two (2) Years	One (1) every six (6) months, per recipient, any provider.

Providers can avoid claim denials for Audit 6210 (Prophylaxis limited to 1 unit every 6 months), Audit 6211 - (Periodic or limited oral evaluation is limited to 1 every 6 months, per recipient), Audit 6212 - (Fluoride treatments limited to one every 6 months for recipients age birth through 20 years of age) and Audit 6209 - (Full mouth or panoramic x-rays limited to one every 3 years) **by verifying that a recipient has not received fluoride, periodic or limited exams, or prophylaxis within the previous six months, or full mouth or panoramic x-rays within the last three (3) years.** Verification can be made by writing to the EDS Provider Written Inquiry Unit, P.O. BOX 68420, Indianapolis, Indiana 46268-0420. A system modification has been requested to allow dental providers to access this information in the future through the Automated Voice Response (AVR) System. Providers will be notified when this information is available on AVR.

Comprehensive/Detailed and Extensive Oral Evaluations

Comprehensive (00150) or Detailed and Extensive Oral Evaluations (00160) are limited to (1) per lifetime, per recipient, per provider. Periodic (00120) or Limited (00140) Oral Evaluations will be limited to one (1) every (6) months, per recipient. The system has been updated so that codes 00150 and 00160 may be rendered regardless of the provision of a periodic exam by

another rendering provider. Previously claims were erroneously denied when claims from other providers were included in the utilization.

Topical Fluoride Treatment

Procedure codes 01204- (Topical application of fluoride (prophylaxis not included) - adult) and 01205- (Topical application of fluoride (including prophylaxis) - adult), remain non-covered. Dentists should utilize procedure codes 01201 and 01203 to bill these services for individuals up to age 21.

Prophylaxis

If an adult prophylaxis is provided, the code 01110 can be billed every (6) months for individuals ages 13 years of age up to 21 years of age and every 12 months once the individual turns 21 years of age. Code 01120 should be billed for child prophylaxis up to age 13.

Anesthesia

General Anesthesia, Intravenous (IV) Sedation, and Nitrous Oxide Analgesia

Medicaid reimbursement for general anesthesia provided in the dentist's office is available only for recipients under twenty-one (21) years of age. General anesthesia is covered for adults only if the procedure is performed in a hospital (in-patient or out-patient) or an ambulatory surgical center. Medicaid reimbursement for IV sedation and nitrous oxide analgesia will continue to be available to all recipients, regardless of age.

The criteria for coverage of general anesthesia services is as follows:

- Mental incapacitation such that the recipient's ability to cooperate with procedures is impaired, including mental retardation, 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 recipient's ability to cooperate with procedures.
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication.

Monitored Sedation for Children

Medicaid reimbursement for monitored sedation for children provided in the dentist's office is available for recipients under the age of 21. Monitored sedation is the administration of either

subcutaneous, intramuscular, intravenous or oral sedation, in combination with monitoring of the patient's vital signs. This service should be billed utilizing service code Z5155.

Radiographs

Either full mouth series radiographs or panorex x-rays are limited to one (1) set per recipient every three (3) years. Bitewing, intraoral, and extraoral radiographs are limited to one (1) set per recipient every twelve months. One (1) set is defined as a total of four (4) single films.

The audit that previously reduced reimbursement or denied claims when bitewing x-rays were billed on the same date of service that full-mouth or panoramic x-rays were billed has been suppressed effective 12-18-97. Providers can now bill bitewing x-rays on the same day as full-mouth or panoramic x-rays are billed. Reprocessing of these claims is discussed later in this bulletin.

Emergency Services

405 IAC 5-14-13 states "Palliative treatment of facial pain such as an abscess, incision, and drainage is limited to emergency treatment only." Code 00130 can be billed for the emergency exam. If the procedure done to provide palliative care has a corresponding ADA code, the code for the procedure should be billed and the code for palliative care should not be billed. For example, if an emergency incision and drainage of abscess - intraoral soft tissue procedure is performed, code 07510 should be billed with code 00130. Code 09110 should not be billed. However, if there is no corresponding code that describes the palliative procedure performed in an emergency, then code 09110 and code 00130 should be billed and the procedure should be documented in the patient's chart.

7) New Covered Service

Coverage of ADA Code 09440

OMPP has extended coverage to include the American Dental Association (ADA) code 09440, Office Visit After Regularly Scheduled Hours. The effective date on this was June 1, 1997. Due to a lack of qualified staff in many rural hospitals it is impossible for Medicaid recipients to receive treatment at the emergency room for dental emergencies. Therefore, dentists who agree to treat recipients after hours in their office for emergency services may bill the above code. Providers should bill their usual and customary charge for this service. The allowed amount will be the billed amount. Utilization for this service will be monitored on a post-payment basis.

Supranummery Teeth Extractions

Effective 1/5/98 the Indiana Medicaid program will utilize ADA procedure code D9999 to denote supranummery teeth extractions. An attachment (note of explanation) with the ADA claim form is required. The attachment should indicate the service(s) that were performed on

the supranummery teeth. Providers should use tooth number "A" for adults and tooth number

8) Claim Reminders

The following three EOBs were found to be among the most common reasons for claim denials.

Edit 545 - Claim Past Filing Limit

When resubmitting claims that may be nearing or are past the one-year filing limit, please be sure to submit documentation to demonstrate the original timely submission of the claim. This will enable a waiver of the one-year filing limit, if needed, so that troublesome claims can be processed correctly. Specifics concerning acceptable documentation for waiver of the filing limit can be found in the Indiana Medical Assistance Programs Provider Manual, Section 10-12-1. In addition to prior EOP listings, copies of claims are also accepted by Medicaid as proof the services were billed timely. When a copy of a claim is submitted as proof of timely submission, a line should be drawn through the claim, and it should be submitted upside down.

Edit 2003- Recipient Ineligible for Medicaid on Dates of Service

Please be sure to verify eligibility of recipients prior to rendering services in order to avoid common claims denials for reasons such as: "Recipient enrolled in Risk-based Managed Care"; "Recipient not eligible for Medicaid on dates of service"; or "Recipient name and number do not match". An easy and effective method for confirming recipient eligibility is to call the Automated Voice Response (AVR) system, which can be reached at 1-800-738-6770 (or for local callers, 317-692-0819) from 5:00 a.m. to 1:00 a.m. (EST), seven days a week. It is important to be sure to listen to the entire message to obtain all pertinent eligibility information. Instruction on how to use AVR can be found starting on page 2-4-2 of the Indiana Medical Assistance Programs Provider Manual.

Edit 4013 - Procedure Code not Covered for Date of Service

Edit 4013 denies claims when a service is not covered by the Indiana Medicaid Program. Providers can avoid claim denials for Edit 4013 by verifying that the procedure code being billed is a covered service by the Indiana Medicaid Program.

For example, providers should note that procedure code 00110 - "Initial oral examination" was deleted from the Current Dental Terminology (CDT-2) code book in 1995. Providers should utilize one of the following procedure codes for clinical oral evaluations.

00120 - Periodic oral evaluation
00140 - Limited oral evaluation - problem focused
00150 - Comprehensive oral evaluation
00160 - Detailed and extensive oral evaluation - problem focused, by report

Additionally Code 04345, "Periodontal scaling for gingival inflammation" was deleted in 1996. Services should be billed under code 04355.

Note: All covered dental services are included in this bulletin. If there is a HCPCS Dental code which is not found in this listing it is a **non-covered** service for Indiana Medicaid.

Dental Code Z5154 - "Acid Etching"

Acid etching can be billed as a separate charge in conjunction with resin restoration and sealants.

Note: Infection control and sterilization of instruments are non-covered services under the Indiana Medicaid Program. All routine supplies and services should be included in the reimbursement amount of the procedure.

9) Mass Adjustment and Reprocessing

Interim Rate Increase Adjustment

All dental claims with dates of service on or after 9/1/97 which were processed before 9/15/97 will be mass adjusted to reflect the interim rate increases. Details regarding this adjustment will be published in a future banner page.

Medicaid providers who charged the Medicaid allowed amount will be contacted individually regarding adjustments.

Coverage of HCPCS Code O2951 Reprocessing

Dental procedure code 02951, "Pin retention, per tooth, in addition to restoration" was erroneously listed as a non-covered service in the Indiana AIM system. This was corrected, and claims denied with edit 4013 will be reprocessed. Details regarding this reprocessing will be published in a future banner page.

Edit 4021-"Procedure Code versus Program Indicator" Reprocessing

Claims for recipients under 21 years of age (EPSDT) have erroneously denied since implementation of the Indiana AIM System (8/1/95 - 10/14/97). These claims were systematically reprocessed and were reflected on the 12/16/97 remittance advice.

Denied Claims for Prior Authorization Reprocessing

All dental claims submitted which denied for lack of prior authorization on or after 9/1/97 will be systematically reprocessed. Details regarding this reprocessing will be published in a future banner page.

Dental Codes 00150 and 00160 Reprocessing

Claims for codes 00150 - (Comprehensive oral evaluation) and 00160 - (Detailed and extensive oral evaluation) were erroneously denied when claims from other providers were included in the utilization. These claims will be systematically reprocessed. Details regarding this reprocessing will be published in a future banner page.

Dental 00460, 00320 and 00321 Reprocessing

Dental code's 00460 - (Pulp vitality test), 00320 - (Temporomandibular arthrogram including injection) and 00321 - (Other temporomandibular joint films, by report) previously listed for EPSDT only are covered for all Medicaid recipients retroactive to 8/1/95. Denied claims billed with this code will be reprocessed. Details regarding this reprocessing will be published in a future banner page.

CPT Code 41899 Reprocessing

The Dental Advisory Panel brought to our attention that anesthesiologists were not being paid correctly for anesthesia services and hospitals were not being paid for CPT code 41899. The Reference File has been updated and anesthesia claims are being mass adjusted. Reprocessing for claims with CPT code 41899 which denied for EOB 499 will take place at a future date. Details regarding this reprocessing will be published in a future banner page.

Radiographs

As of 8-24-97 when the current rule was adopted, bitewing x-rays were allowed on the same day as full mouth or panoramic x-rays. Claims erroneously denied or incorrectly paid will be reprocessed or mass adjusted. Details regarding this reprocessing and mass adjustment will be published in a future banner page.

Claims for Pregnant Women with Limited Benefits Reprocessing

Claims denied with EOB 2005 for pregnant women with limited benefits for dates of service between 2/5/95 and 12/15/97 will be systematically reprocessed. Details regarding this reprocessing will be published in a future banner page. This edit was corrected 12-15-97 and will no longer deny dental services for pregnant women with limited benefits. If, in the judgment of the dentist, withholding the dental service(s) could affect the pregnancy, the service should be provided and documented in the patient's dental chart.

Providers, who have erroneously denied claims as listed above which have not been reprocessed, should contact Provider Assistance at 1-800-577-1278 or for local calls, 317-655-3240.

10) Billing of CPT Codes

As indicated on the attached chart CPT codes should be billed, rather than HCPCS codes. This change in billing will allow consistent reimbursement in accordance with the appropriate CPT code for the service rendered. These codes are for services which are generally provided in a non office setting by a dental specialist. The facility should bill on a UB-92 claim form. Oral surgeon services and anesthesiologist services should bill the CPT code on a HCFA 1500 claim form.

Providers should carefully review the chart and note that several HCPCS codes are scheduled to be deleted on 4/1/98. The decision to delete these codes was based on the assumption that these codes are provided in an outpatient or inpatient setting and should be billed with a Physicians' Current Procedure Terminology (CPT) code. If, after reviewing the list, you find a HCPCS code that is scheduled to be deleted that is used in a dental office setting, please contact provider assistance at 1-800-577-1278 or for local calls, 317-655-3240, and request that the code not be deleted. The decision to delete the code will be reconsidered. When there is a CPT code and an ADA code for the same procedure on a one-to-one correlation, the rate for the CPT code is also the rate for the ADA code. Manually priced codes are reimbursed at 90% of amount billed. If there are other questions about this bulletin, please call the above listed numbers.

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D0120	PERIODIC ORAL EXAMINATION			$15.25
	D0130	EMERGENCY ORAL EXAMINATION			$15.25
	D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED			$14.21
	D0150	COMPRESSIVE ORAL EVALUATION			$16.97
	D0160	DETAILED AND EXTENSIVE ORAL EVALUATION PROBLEM FOCUSED BY REPORT			$16.97
	D0210	INTRAORAL - COMPLETE SERIES (INCLUDING BITEWINGS)			$34.22
	D0220	INTRAORAL -PERIAPICAL-FIRST FILM			$6.17
	D0230	INTRAORAL -PERIAPICAL-EACH ADDITIONAL FILM			$5.27
	D0240	INTRAORAL -OCCLUSAL FILM			$7.91
	D0250	EXTRAORAL-FIRST FILM			$6.90
	D0260	EXTRAORAL - EACH ADDITIONAL FILM			$5.71
	D0270	BITEWING-SINGLE FILM			$7.00
	D0272	BITEWING-TWO FILMS			$16.78
	D0274	BITEWING - FOUR FILMS			$13.77
	D0290	POSTERIOR - ANTERIOR AND LATERAL SKULL AND FACIAL BONE SURVEY FILM			$20.12
	D0310	SIALOGRAPHY			$19.71

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
70332	D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	DOCUMENTATION OF MALFUNCTIONING OR POOR FUNCTIONING OF THE AREA INSIDE OR SURROUNDING TMJ JOINT		$76.71
70330 70328	D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	DOCUMENTATION OF RADIOGRAPH REPORT		$31.58 $20.40 D0321 - $38.58
	D0322	TOMOGRAPHIC SURVEY			$25.08
	D0330	PANORAMIC FILM			$32.29
	D0340	CEPHALOMETRIC FILM	COVERED SERVICE FOR CHILDREN AND ADOLESCENTS WITH CRANIOFACIAL ABNORMALITIES, GRADIENT MUST BE DOCUMENTED		$34.19
	D0460	PULP VITALITY TESTS			$8.42
	D1110	PROPHYLAXIS - ADULT			$24.62
	D1120	PROPHYLAXIS - CHILD		X	$22.09
	D1201	TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS) - CHILD		X	$32.23
	D1203	TOPICAL APPLICATION OF FLUORIDE (PROPHYLAXIS NOT INCLUDED) - CHILD		X	$16.17
	D1351	SEALANT - PER TOOTH			$15.99
	D1510	SPACE MAINTAINER - FIXED-UNILATERAL		X	$81.82
	D1515	SPACE MAINTAINER - FIXED-BILATERAL		X	$129.62
	D1520	SPACE MAINTAINER - REMOVABLE-UNILATERAL		X	$77.14

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D1525	SPACE MAINTAINER - REMOVABLE-BILATERAL		X	$144.17
	D1550	RECEMENTATION OF SPACE MAINTAINER		X	$17.79
	D2110	AMALGAM-ONE SURFACE, PRIMARY		X	$25.77
	D2120	AMALGAM-TWO SURFACES, PRIMARY		X	$31.64
	D2130	AMALGAM-THREE SURFACES, PRIMARY		X	$37.03
	D2131	AMALGAM-FOUR OR MORE SURFACES, PRIMARY		X	$41.82
	D2140	AMALGAM-ONE SURFACE, PERMANENT			$26.53
	D2150	AMALGAM - TWO SURFACES, PERMANENT			$32.88
	D2160	AMALGAM - THREE SURFACES, PERMANENT			$39.59
	D2161	AMALGAM - FOUR OR MORE SURFACES, PERMANENT			$46.46
	D2210	SILICATE CEMENT-PER RESTORATION			$17.57
	D2330	RESIN-ONE SURFACE, ANTERIOR			$29.55
	D2331	RESIN-TWO SURFACES, ANTERIOR			$37.26
	D2332	RESIN-THREE SURFACES, ANTERIOR			$41.65
	D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)			$56.75
	D2336	COMPOSITE RESIN CROWN-ANTERIOR-PRIMARY		X	$79.82

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D2380	RESIN-ONE SURFACE, POSTERIOR-PRIMARY		X	$25.76
	D2381	RESIN-TWO SURFACES, POSTERIOR PRIMARY		X	$31.64
	D2382	RESIN-THREE OR MORE SURFACES, POSTERIOR PRIMARY		X	$37.03
	D2385	RESIN-ONE SURFACE, POSTERIOR-PERMANENT			$26.53
	D2386	RESIN-TWO SURFACES, POSTERIOR-PERMANENT			$32.89
	D2387	RESIN-THREE OR MORE SURFACES, POSTERIOR-PERMANENT			$39.59
	D2650	INLAY-COMPOSITE/RESIN - ONE SURFACE (LABORATORY PROCESSED)			MANUAL
	D2651	INLAY-COMPOSITE/RESIN - TWO SURFACES (LABORATORY PROCESSED)			MANUAL
	D2652	INLAY-COMPOSITE/RESIN - THREE OR MORE SURFACES (LABORATORY PROCESSED)			MANUAL
	D2910	RECEMENT INLAYS			$21.85
	D2920	RECEMENT CROWN			$19.60
	D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH		X	$63.99
	D2931	PREFABRICATED STAINLESS STEEL CROWN- PERMANENT TOOTH			$73.15

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D2932	PREFABRICATED RESIN CROWN	DOCUMENTATION OF DECAY AND/OR FRACTURE OF ANTERIOR TEETH (NUMBER 6-11 AND 22-27)	X	$114.56
	D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW		X	$63.24
	D2940	SEDATIVE FILLING			$16.83
	D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION			$11.13
	D2970	TEMPORARY CROWN (FRACTURED TOOTH)			$58.03
	D2980	CROWN REPAIR, BY REPORT			MANUAL
	D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	INCOMPLETE ROOT FORMATION		$11.46
	D3120	PULP CAP-INDIRECT (EXCLUDING FINAL RESTORATION)	INCOMPLETE ROOT FORMATION		$9.36
	D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	INCOMPLETE ROOT FORMATION		$40.28
	D3230	PULPAL THERAPY ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	INFECTED PULP	X	$37.21
	D3240	PULPAL THERAPY POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	INFECTED PULP	X	$37.21

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	DOCUMENTATION OF MEDICAL NECESSITY I.E., INFECTION, TRAUMA	X	$132.74
	D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	DOCUMENTATION OF MEDICAL NECESSITY, I.E., INFECTION, TRAUMA	X	$158.25
	D3330	MOLAR (EXCLUDING FINAL RESTORATION)	DOCUMENTATION OF MEDICAL NECESSITY I.E., INFECTION, TRAUMA	X	$204.17
	D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH.	X	MANUAL
	D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH.	X	MANUAL
	D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH.	X	MANUAL
	D3351	APEXIFICATION/RECALCIFICATION- INITIAL VISIT	INCOMPLETE ROOT FORMATION	X	$94.04
	D3352	APEXIFICATION/RECALCIFICATION- INTERIM MEDICATION REPLACEMENT	INCOMPLETE ROOT FORMATION	X	$31.66
	D3353	APEXIFICATION-RECALCIFICATION- FINAL VISIT	ROOT FORMATION COMPLETE	X	$44.33

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D3410	APICOECTOMY/PERIRADIC-ULAR SURGERY-ANTERIOR	DOCUMENTATION OF ROOT CANAL FAILURE OR FISTULA TRACT	X	$121.86
	D3421	APICOECTOMY/PERIRADIC-ULAR SURGERY-BICUSPID (FIRST ROOT)	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH	X	MANUAL
	D3425	APICOECTOMY/PERIRADIC-ULAR SURGERY-MOLAR (FIRST ROOT)	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH	X	MANUAL
	D3426	APICOECTOMY/PERIRADIC-ULAR SURGERY-(EACH ADDITIONAL ROOT)	DOCUMENTATION OF RECURRENT INFECTION, PAIN, SWELLING, DOCUMENTATION OF RADIOGRAPH	X	MANUAL
	D3430	RETROGRADE FILLING-PER TOOTH	DOCUMENTATION OF ROOT CANAL FAILURE OR FISTULA TRACT	X	$44.33
	D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	NON-COVERED EFFECTIVE 4-1-98	X	$587.63
	D4210	GINGIVECTOMY OR GINGIVOPLASTY-PER QUADRANT	DRUG-INDUCED PERIODONTAL DISEASE WHICH CAN LEAD TO HYPERPLASIA, DOCUMENTATION OF PAST OR PRESENT USE OF MEDICATION. PERIODONTAL CHARTING.		$306.99

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D4211	GINGIVECTOMY OR GINGIVOPLASTY-PER TOOTH	DRUG-INDUCED PERIODONTAL DISEASE WHICH CAN LEAD TO HYPERPLASIA, DOCUMENTATION OF PAST OR PRESENT USE OF MEDICATION. PERIODONTAL CHARTING.		$86.41
	D4220	GINGIVAL CURETTAGE, SURGICAL, PER QUADRANT, BY REPORT	DOCUMENTATION OF MEDICAL NECESSITY AND MEDICATIONS RECIPIENT CURRENTLY TAKING	X	$80.49
	D4240	GINGIVAL FLAP PROCEDURE INCLUDING ROOT PLANING-PER QUADRANT			MANUAL
	D4250	MUCOGINGIVAL SURGERY-PER QUADRANT	DRUG-INDUCED PERIODONTAL DISEASE WHICH CAN LEAD TO HYPERPLASIA, DOCUMENTATION OF PAST OR PRESENT USE OF MEDICATION. PERIODONTAL CHARTING.	X	$332.44
	D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)-PER QUADRANT			MANUAL
	D4341	PERIODONTAL SCALING AND ROOT PLANING, PER QUADRANT			$43.60

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D4345	PERIODONTAL SCALING FOR GINGIVAL INFLAMMATION (CODE DELETED 1/1/96, UTILIZE D4355)		X	$32.21
	D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS			$32.21
	D4920	UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST	DOCUMENTATION FOR MEDICAL NECESSITY, (EXAMPLE: DRY SOCKET)		MANUAL
	D5110	COMPLETE UPPER	COVERED FOR CHILDREN AND ADOLESCENT WITH ONE OF THE FOLLOWING, EDENTULOUS, INFECTION, TRAUMA, GENETICS, OR OTHER DOCUMENTED MEDICAL NECESSITY.	X	$271.51
	D5120	COMPLETE LOWER	COVERED FOR CHILDREN AND ADOLESCENT WITH ONE OF THE FOLLOWING, EDENTULOUS, INFECTION, TRAUMA, GENETICS, OR OTHER DOCUMENTED MEDICAL NECESSITY.	X	$273.78
	D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE	COVERED FOR CHILDREN AND ADOLESCENT WITH ONE OF THE FOLLOWING, EDENTULOUS, INFECTION, TRAUMA, GENETICS, OR OTHER DOCUMENTED MEDICAL NECESSITY.	X	$200.82

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE	COVERED FOR CHILDREN AND ADOLESCENT WITH ONE OF THE FOLLOWING, EDENTULOUS, INFECTION, TRAUMA, GENETICS, OR OTHER DOCUMENTED MEDICAL NECESSITY.	X	$239.57
	D5410	ADJUST COMPLETE DENTURE- MAXILLARY	COVERED FOR CHILDREN AND ADOLESCENT FOR PAIN, IRRITATION, OR POOR FITTING	X	$15.30
	D5411	ADJUST COMPLETE DENTURE- MANDIBULAR	COVERED FOR CHILDREN AND ADOLESCENT FOR PAIN, IRRITATION, OR POOR FITTING	X	$15.22
	D5421	ADJUST PARTIAL DENTURE - MAXILLARY	COVERED FOR CHILDREN AND ADOLESCENT FOR PAIN, IRRITATION, OR POOR FITTING	X	$19.94
	D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	COVERED FOR CHILDREN AND ADOLESCENT FOR PAIN, IRRITATION, OR POOR FITTING	X	$15.16
	D5510	REPAIR BROKEN COMPLETE DENTURE BASE	COVERED FOR CHILDREN AND ADOLESCENT WITH DOCUMENTATION OF BREAK IN DENTURE BASE	X	$33.88
	D5520	REPLACE MISSING OR BROKEN TEETH (COMPLETE DENTURE)-EACH TOOTH	COVERED FOR CHILDREN AND ADOLESCENT WITH DOCUMENTATION OF MEDICAL NECESSITY FOR REPLACING	X	$28.93

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D5610	REPAIR RESIN SADDLE OR BASE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$29.50
	D5620	REPAIR CAST FRAMEWORK	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$35.98
	D5630	REPAIR OR REPLACE BROKEN CLASP	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$22.22
	D5640	REPLACE BROKEN TEETH-PER TOOTH	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$39.93
	D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$38.86
	D5660	ADD CLASP TO EXISTING PARTIAL	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$45.10
	D5710	REBASE COMPLETE MAXILLARY DENTURE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$107.16
	D5711	REBASE COMPLETE MANDIBULAR DENTURE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$88.30
	D5720	REBASE MAXILLARY PARTIAL DENTURE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$180.14
	D5721	REBASE MANDIBULAR PARTIAL DENTURE	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$85.20
	D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$52.32

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$55.81
	D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$49.37
	D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$61.81
	D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$79.89
	D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$80.45
	D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$78.16
	D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$79.05
21088	D5911 (THIS SPECIFIC CODE D5911 WILL BE NON-COVERED EFFECTIVE 4-1-98)	FACIAL MOULAGE (SECTIONAL)	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21088	D5912 (THIS SPECIFIC CODE D5912 WILL BE NON-COVERED EFFECTIVE 4-1-98)	FACIAL MOULAGE (COMPLETE)	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
21087	D5913 (THIS SPECIFIC CODE D5913 WILL BE NON-COVERED EFFECTIVE 4-1-98)	NASAL PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
21086	D5914 (THIS SPECIFIC CODE D5914 WILL BE NON-COVERED EFFECTIVE 4-1-98)	AURICULAR PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,496.59
21077	D5915 (THIS SPECIFIC CODE D5915 WILL BE NON-COVERED EFFECTIVE 4-1-98)	ORBITAL PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$2,026.48

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21077	D5916 (THIS SPECIFIC CODE D5916 WILL BE NON-COVERED EFFECTIVE 4-1-98)	ORBITAL PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$2,026.48
21088	D5919 (THIS SPECIFIC CODE D5919 WILL BE NON-COVERED EFFECTIVE 4-1-98)	FACIAL PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
	D5922	NASAL SEPTAL PROSTHESIS	NON COVERED EFFECTIVE 4-1-98		MANUAL
21077	D5923 (THIS SPECIFIC CODE D5923 WILL BE NON-COVERED EFFECTIVE 4-11-98)	ORBITAL PROSTHESIS, INTERIM	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$2,026.48
21089	D5924 (THIS SPECIFIC CODE D5924 WILL BE NON-COVERED EFFECTIVE 4-1-98)	CRANIAL PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
	D5925	FACIAL AUGMENTATION IMPLANT PROSTHESIS	NON COVERED EFFECTIVE 4-1-98		MANUAL

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21087	D5926 (THIS SPECIFIC CODE D5926 WILL BE NON-COVERED EFFECTIVE 4-1-98)	NASAL PROSTHESIS, REPLACEMENT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,496.59
21086	D5927 (THIS SPECIFIC CODE D5927 WILL BE NON-COVERED EFFECTIVE 4-1-98)	AURICULAR PROSTHESIS, REPLACEMENT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,496.59
21077	D5928 (THIS SPECIFIC CODE D5928 WILL BE NON-COVERED EFFECTIVE 4-1-98)	ORBITAL PROSTHESIS, REPLACEMENT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$2,026.48
21088	D5929 (THIS SPECIFIC CODE D5929 WILL BE NON-COVERED EFFECTIVE 4-1-98)	FACIAL PROSTHESIS, REPLACEMENT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21076	D5931 (THIS SPECIFIC CODE D5931 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OBTURATOR PROSTHESIS SURGICAL	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$805.73
21080	D5932 (THIS SPECIFIC CODE D5932 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OBTURATOR PROSTHESIS DEFINITIVE	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,507.46
21076	D5933 (THIS SPECIFIC CODE D5933 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OBTURATOR PROSTHESIS, MODIFICATION	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$805.73
21081	D5934 (THIS SPECIFIC CODE D5934 WILL BE NON-COVERED EFFECTIVE 4-1-98)	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,373.66

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21081	D5935 (THIS SPECIFIC CODE D5935 WILL BE NON-COVERED EFFECTIVE 4-1-98)	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,373.66
21079	D5936 (THIS SPECIFIC CODE D5936 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OBTURATOR PROSTHESIS, INTERIM	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,341.81
21089	D5937 (THIS SPECIFIC CODE D5937 WILL BE NON-COVERED EFFECTIVE 4-1-98)	TRIMUS APPLIANCE (NOT FOR TEMPOROMANDIBULAR TREATMENT)	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
	D5951	FEEDING AID	SYNONYMOUS TERMINOLOGY: FEEDING PROSTHESIS, DOCUMENTATION OF CLEFT ABNORMALITY, MAINTAINS RIGHT AND LEFT MAXILLARY SEGMENTS IN THEIR ORIENTATION UNTIL SURGERY IS PERFORMED TO REPAIR THE CLEFT	X	$364.11

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D5952	SPEECH AID PROSTHESIS, PEDIATRIC	DOCUMENTATION OF MEDICAL NECESSITY AND DIAGNOSIS, CRANIOFACIAL ABNORMALITY INVOLVING MOUTH AND/OR ORAL CAVITY	X	MANUAL
	D5953	SPEECH AID PROSTHESIS, ADULT	DOCUMENTATION OF MEDICAL NECESSITY, DIAGNOSIS VERSUS COSMETIC RECONSTRUCTION		MANUAL
21082	D5954 (THIS SPECIFIC CODE D5954 WILL BE NON-COVERED EFFECTIVE 4-1-98)	PALATAL AUGMENTATION PROSTHESIS	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL:
21083	D5955 (THIS SPECIFIC CODE D5955 WILL BE NON-COVERED EFFECTIVE 4-1-98)	PALATAL LIFT PROSTHESIS, DEFINITIVE	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,159.22
21083	D5958 (THIS SPECIFIC CODE D5958 WILL BE NON-COVERED EFFECTIVE 4-1-98)	PALATAL LIFT PROSTHESIS, INTERIM	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,159.22

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21083	D5959 (THIS SPECIFIC CODE D5959 WILL BE NON-COVERED EFFECTIVE 4-1-98)	PALATAL LIFT PROSTHESIS, MODIFICATION	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,159.22
21083	D5960 (THIS SPECIFIC CODE D5960 WILL BE NON-COVERED EFFECTIVE 4-1-98)	SPEECH AID PROSTHESIS, MODIFICATION	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		$1,159.22
21089	D5982 (THIS SPECIFIC CODE D5982 WILL BE NON-COVERED EFFECTIVE 4-1-98)	SURGICAL STENT	COVERED FOR JUVENILE PERIDONTOSIS AND/OR TRAUMA. DOCUMENTATION OF MEDICAL NECESSITY INCLUDING OPERATIVE REPORT, RADIOGRAPH, AND PULP DEPTHS.	X	MANUAL
21089	D5983 (THIS SPECIFIC CODE D5983 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADIATION SHIELD	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21089	D5984 (THIS SPECIFIC CODE D5984 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADIATION SHIELD	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
21089	D5985 (THIS SPECIFIC CODE D5985 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADIATION CONE	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
	D5986	FLUORIDE GEL CARRIER	XEROSTOMIA SECONDARY TO RADIATION OR OTHER SYSTEMIC DISEASE		MANUAL
21089	D5987 (THIS SPECIFIC CODE D5987 WILL BE NON-COVERED EFFECTIVE 4-1-98)	COMMISSURE SPLINT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
21089	D5988 (THIS SPECIFIC CODE D5988 WILL BE NON-COVERED EFFECTIVE 4-1-98)	SURGICAL SPLINT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21089	D5999 (THIS SPECIFIC CODE D5999 WILL BE NON-COVERED EFFECTIVE 4-1-98)	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY, I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, AND/OR ABNORMALITY CAUSED BY SURGICAL INTERVENTION.		MANUAL
	D6040	SURGICAL PLACEMENT: EPOSTEAL IMPLANT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D6050	SURGICAL PLACEMENT: TRANSOSSEOUS IMPLANT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D6090	REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
41806	D6100 (THIS SPECIFIC CODE D6100 WILL BE NON-COVERED EFFECTIVE 4-1-98)	IMPLANT REMOVAL, BY REPORT	PRESENCE OF SYMPTOMATIC FOREIGN BODY		$120.06
	D6199	UNSPECIFIED IMPLANT PROCEDURE, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D6930	RECEMENT FIXED PARTIAL DENTURE		X	$22.69
	D6980	BRIDGE REPAIR, BY REPORT	COVERED FOR CHILDREN AND ADOLESCENT, DESCRIPTION OF PROCEDURE	X	$23.11
	D7110	SINGLE TOOTH			$27.34
	D7120	EACH ADDITIONAL TOOTH			$25.18
	D7130	ROOT REMOVAL-EXPOSED ROOTS			$41.42

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH			$54.26
	D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE			$61.55
	D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY			$87.17
	D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY			$116.62
	D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS			$168.96
	D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)			$43.10
30580	D7260	OROANTRAL FISTULA CLOSURE REPAIR FISTULA; OROMAXILLARY	PATENT OROANTRAL FISTULA PRESENT FOR GREATER THAN TWO (2) WEEKS.		$355.87
	D7270	TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS			$73.12
	D7281	SURGICAL EXPOSURE OF IMPACTED OR UNERUPTED TOOTH TO AID ERUPTION			$43.52
	D7285	BIOPSY OF ORAL TISSUE - HARD			$82.32

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7286	BIOPSY OF ORAL TISSUE - SOFT			$74.80
	D7291	TRANSSEPTAL FIBEROTOMY, BY REPORT	TO STABILIZE DENTITION AFTER ORTHODONTICS.	X	MANUAL
	D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT			$60.03
	D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT			$57.62
	D7340	VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)	DOCUMENTATION OF MEDICAL NECESSITY, PROCEDURE AND MEDICAL DIAGNOSIS	X	$158.31
	D7350	VESTIBULOPLASTY-RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE RE-ATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)	DOCUMENTATION OF MEDICAL NECESSITY, MEDICAL DIAGNOSIS AND DESCRIPTION OF PROCEDURE	X	$110.81

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
40525,40527405308,4081641120,4113041135,4114041145,4115041153,4115541825,4182641827,4183042120,42140	D7410 (THIS SPECIFIC CODE D7410 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADICAL EXCISION-LESION DIAMETER UP TO 1.25 CM	DOCUMENTATION OF BENIGN TUMOR AND/OR NEOPLASM		$76.77-$1,503.34 PRICE SPECIFIC TO APPROPRIATE CPT CODE
40525,40527405308,4081641120,4113041135,4114041145,4115041153,4115541825,4182641827,4183042120,42140	D7420 (THIS SPECIFIC CODE D7420 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADICAL EXCISION-LESION DIAMETER GREATER THAN 1.25 CM	DOCUMENTATION OF BENIGN TUMOR AND/OR NEOPLASM		$76.77-$1,503.34 REIMBURSEMENT SPECIFIC TO APPROPRIATE CPT CODE
40500,40510405208,4081040812,4081441110,4111241113,4111441115,4111641825,4182641827,4183042104,4210642107	D7430	EXCISION OF BENIGN TUMOR-LESION DIAMETER UP TO 1.25 CM	DOCUMENTATION OF BENIGN TUMOR AND/OR NEOPLASM		$68.04-$401.65 REIMBURSEMENT SPECIFIC TO APPROPRIATE CPT CODE D7430 - $81.91

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
40500,40510405 20,40810408 12,4081441110, 4111241113,41 11441115,4111 641825,418264 1827,41830421 04,4210642107	D7431	EXCISION OF BENIGN TUMOR-LESION DIAMETER GREATER THAN 1.25 CM	DOCUMENTATION OF BENIGN TUMOR AND/OR NEOPLASM		$68.04-$401.65 REIMBURSEMENT SPECIFIC TO APPROPRIATE CPT CODE D7431 - $186.80
	D7440	EXCISION OF MALIGNANT TUMOR, LESION DIAMETER UP TO 1.25 CM			$151.97
	D7441	EXCISION OF MALIGNANT TUMOR, LESION DIAMETER GREATER THAN 1.25 CM			$170.97
	D7450	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CCM			$85.86
	D7451	REMOVAL OF ODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM			$177.21
	D7460	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER UP TO 1.25 CM			$80.90
	D7461	REMOVAL OF NONODONTOGENIC CYST OR TUMOR - LESION DIAMETER GREATER THAN 1.25 CM			$178.57
41850 42160	D7465	DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHODS, BY REPORT	DOCUMENTATION OF BENIGN TUMOR AND/OR NEOPLASM, AND/OR DYSPLASIA		41850 -MANUAL 42160 - $92.12 D7465 - $92.12

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7470	REMOVAL OF EXOSTOSIS - MAXILLA OR MANDIBLE			$116.79
21025 21026	D7480 (THIS SPECIFIC CODE D7480 WILL BE NON-COVERED EFFECTIVE 4-1-98)	PARTIAL OSTECTOMY (GUTTERING OR SAUCERIZATION)	OSTEOMYELITIS, MANDIBLE AND/OR MAXILLA		21025- $256.81 21026 - $214.62
21044 21045	D7490 (THIS SPECIFIC CODE D7490 WILL BE NON-COVERED EFFECTIVE 4-1-98)	RADICAL RESECTION OF MANDIBLE WITH BONE GRAFT	MALIGNANT TUMOR OR NEOPLASM		21044- $580.67 21045 - $814.01
	D7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE			$33.90
	D7520	INCISION AND DRAINAGE OF ABSCESS - EXTRAORAL SOFT TISSUE			$37.62
41805	D7530 (THIS SPECIFIC CODE D7530 WILL BE NON-COVERED EFFECTIVE 4-1-98)	REMOVAL OF FOREIGN BODY, SKIN, OR SUBCUTANEOUS AEROLAR TISSUE	PRESENCE OF SYMPTOMATIC FOREIGN BODY		$56.83
41806	D7540 (THIS SPECIFIC CODE D7540 WILL BE NON-COVERED EFFECTIVE 4-1-98)	REMOVAL OF REACTION-PRODUCING FOREIGN BODIES-MUSCULOSKELETAL SYSTEM	PRESENCE OF SYMPTOMATIC FOREIGN BODY		$120.06

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7550	SEQUESTRECTOMY FOR OSTEOMYELITIS			$26.37
	D7560	MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY			MANUAL
	D7610	MAXILLA-OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)			MANUAL
	D7620	MAXILLA-CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)			$189.97
	D7630	MANDIBLE-OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)			MANUAL
	D7640	MANDIBLE-CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)			$816.86
	D7650	MALAR AND/OR ZYGOMATIC ARCH- OPEN REDUCTION			MANUAL
	D7660	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION			$84.96
	D7670	ALVEOLUS-STABILIZATION OF TEETH, OPEN REDUCTION SPLINTING			$52.31
	D7680	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES			MANUAL
	D7710	MAXILLA-OPEN REDUCTION			$28.87
	D7720	MAXILLA-CLOSED REDUCTION			$31.92

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7730	MANDIBLE-OPEN REDUCTION			$986.31
	D7740	MANDIBLE-CLOSED REDUCTION			$1,899.68
	D7750	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION			MANUAL
	D7760	MALAR AND/OR ZYGOMATIC ARCH-CLOSED REDUCTION			MANUAL
	D7770	ALVEOLUS-STABILIZATION OF TEETH, OPEN REDUCTION SPLINTING			MANUAL
	D7780	FACIAL BONES-COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES			MANUAL
	D7810	OPEN REDUCTION OF DISLOCATION			$22.80
	D7820	CLOSED REDUCTION OF DISLOCATION			$131.08
	D7830	MANIPULATION UNDER ANESTHESIA			MANUAL
21050	D7840 (THIS SPECIFIC CODE D7840 WILL BE NON-COVERED EFFECTIVE 4-1-98)	CONDYLECTOMY	TUMOR, BONY ANKLOSIS OR SEVERE DEGENERATION OF THE TMJ		$624.39
21060	D7850 (THIS SPECIFIC CODE D7850 WILL BE NON-COVERED EFFECTIVE 4-1-98)	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	INTERNAL DERANGEMENT OF TMJ WITH HYPOMOBILITY AND/OR PAIN. DOCUMENTATION OF FAILURE OF APPROPRIATE NON-SURGICAL THERAPY. RADIOGRAPHS NECESSARY.		$590.88

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21240 21242 21243	D7860 (THIS SPECIFIC CODE D7860 WILL BE NON-COVERED EFFECTIVE 4-1-98)	ARTHROTOMY	TUMOR, BONY ANKYLOSIS OR INTERNAL DERANGEMENT OF TMJ WITH HYPOMOBILITY AND/OR PAIN. FAILURE OF APPROPRIATE NON-SURGICAL THERAPY. RADIOGRAPHS NECESSARY.		21240 - $951.56 21242 - $964.83 21243 - $940.13
20605	D7870 (THIS SPECIFIC CODE D7870 WILL BE NON-COVERED EFFECTIVE 4-1-98)	ARTHROCENTESIS	INTERNAL DERANGEMENT OF TMJ WITH HYPOMOBILITY AND/OR PAIN. DOCUMENTATION OF FAILURE OF APPROPRIATE NON-SURGICAL THERAPY. RADIOGRAPHS NECESSARY.		$31.99
	D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	MYOFASCIAL PAIN, BRUXISM OR INTERNAL DERANGEMENT OF THE TMJ DOCUMENTED BY HISTORY, PHYSICAL EXAM, AND APPROPRIATE RADIOGRAPHS, INCLUDES ADJUSTMENTS FOR TWO MONTHS.		$244.28
	D7899	UNSPECIFIED TMD THERAPY, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM			$32.28
	D7911	COMPLICATED SUTURE - UP TO 5 CM			$68.80
	D7912	COMPLICATED SUTURE - OVER 5 CM			$302.42

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7920	SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION, AND TYPE OF GRAFT)			MANUAL
	D7940	OSTEOPLASTY - FOR ORTHOGNATHIC DEFORMITIES			$5.32
	D7941	OSTEOTOMY-RAMUS, CLOSED	NON-COVERED EFFECTIVE 4-1-98		MANUAL
21193 21195 21196	D7942 (THIS SPECIFIC CODE D7942 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OSTEOTOMY-RAMUS, OPEN	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		21193 - $804.01 21195 - $805.91 21196 - $888.50
21194	D7943 (THIS SPECIFIC CODE D7943 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OSTEOTOMY-RAMUS, OPEN WITH BONE GRAFT	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		$931.59
21198	D7944 (THIS SPECIFIC CODE D7944 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OSTEOTOMY-SEGMENTED OR SUBAPICAL-PER SEXTANT OR QUADRANT	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		$792.64

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21198	D7945 (THIS SPECIFIC CODE D7945 WILL BE NON-COVERED EFFECTIVE 4-1-98)	OSTEOTOMY-BODY OF MANDIBLE	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		$792.64
21141 21145	D7946 (THIS SPECIFIC CODE D7946 WILL BE NON-COVERED EFFECTIVE 4-1-98)	LEFORT I (MAXILLA-TOTAL)	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		21141-$870.49 21145- $936.89
21142 21143 21146 21147	D7947 (THIS SPECIFIC CODE D7947 WILL BE NON-COVERED EFFECTIVE 4-1-98)	LEFORT I (MAXILLA-SEGMENTED)	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		21142 - $902.83 21143 - $938.55 21146 - $969.51 21147 - $1,005.77
21150	D7948 (THIS SPECIFIC CODE D7948 WILL BE NON-COVERED EFFECTIVE 4-1-98)	LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONE FOR MIDFACE HYPOPLASIA OR RETRUSION)- WITHOUT BONE GRAFT	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		$1,194.41

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
21151 21159	D7949 (THIS SPECIFIC CODE D7949 WILL BE NON-COVERED EFFECTIVE 4-1-98)	LEFORT II OR LEFORT III-WITH BONE GRAFT	TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, OR SIGNIFICANT DISCREPANCY IN JAW RELATIONSHIP.		21151-$1,337.73 21159- $2,006.03
	D7950	OSSEOUS, OSTEOPERIOSTEAL OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES-AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
MULTIPLE CPTS	D7955 (THIS SPECIFIC CODE D7955 WILL BE NON-COVERED EFFECTIVE 4-1-98)	REPAIR OF MAXILLOFACIAL SOFT AND HARD TISSUE DEFECT	DOCUMENTATION OF TREATMENT PLAN AND MEDICAL NECESSITY I.E., TRAUMA, CRANIOFACIAL ABNORMALITY, ABNORMALITY CAUSED BY SURGICAL INTERVENTION, TO AUGMENT OR REPAIR THE DEFECT AND RESTORE ANATOMIC STRUCTURE TO REQUIRED FORM AND FUNCTION		REIMBURSEMENT SPECIFIC TO CPT CODE
	D7960	FRENULECTOMY (FRENECTOMY OR FRENOTOMY) - SEPARATE PROCEDURE			$127.36
	D7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH		X	$62.43

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D7971	EXCISION OF PERICORONAL GINGIVA	DOCUMENTATION OF MEDICAL NECESSITY, INCLUDING OPERATIVE REPORT AND DIAGNOSIS	X	$66.18
	D7980	SIALOLITHOTOMY			MANUAL
42408,42410 42415,42420 42425,42426 42440,42450	D7981 (THIS SPECIFIC CODE D7981 WILL BE NON-COVERED EFFECTIVE 4-1-98)	EXCISION OF SALIVARY GLAND, BY REPORT	BENIGN OR MALIGNANT TUMOR, CHRONIC SIALADENITIS.		$215.58 -$1,243.05 REIMBURSEMENT SPECIFIC TO DPT CODE
	D7982	SIALODOCHOPLASTY			MANUAL
	D7983	CLOSURE OF SALIVARY FISTULA			MANUAL
	D7990	EMERGENCY TRACHEOTOMY			MANUAL
21070	D7991 (THIS SPECIFIC CODE D7991 WILL BE NON-COVERED EFFECTIVE 4-1-98)	CORONOIDECTOMY	BENIGN OR MALIGNANT TUMOR, TRISMUS.		$407.94
	D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	NON-COVERED EFFECTIVE 4-1-98		MANUAL
	D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE	X	$111.10

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE	X	$111.10
	D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OF CLEFT PALATE	X	$111.10
	D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	ORTHODONTIC TREATMENT IS LIMITED TO EPSDT INDIVIDUALS	X	$111.10
	D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE	X	$191.90
	D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION		X	$353.50
	D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE	X	$707.00

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE	X	$909.00
	D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	NO ORTHODONTIC PROCEDURES WILL BE APPROVED EXCEPT IN CASES OF CRANIOFACIAL DEFORMITY OR CLEFT PALATE. COVERED UP TO AGE 21	X	$1,111.00
	D8210	REMOVABLE APPLIANCE THERAPY		X	$336.70
	D8220	FIXED APPLIANCE THERAPY		X	$165.50
	D8680	ORTHODONTIC RETENTION		X	$151.50
	D8999	UNSPECIFIED ORTHODONTIC PROCEDURE	NON-COVERED EFFECTIVE 4-1-98	X	$31.63
	D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN - MINOR PROCEDURE			$19.75

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	DOCUMENTATION AS TO WHY THE RECIPIENT CANNOT RECEIVE NECESSARY DENTAL SERVICES UNLESS GENERAL ANESTHESIA IS ADMINISTERED, I.E., A RECIPIENT MAY BE UNABLE TO COOPERATE WITH THE DENTIST DUE TO MENTAL/PHYSICAL DISABILITIES , DOCUMENTATION OF ANY OTHER MEDICAL NECESSITY OR UNCOOPERATIVE CHILDREN.		$21.63
	D9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	DOCUMENTATION AS TO WHY THE RECIPIENT CANNOT RECEIVE NECESSARY DENTAL SERVICES UNLESS GENERAL ANESTHESIA IS ADMINISTERED, I.E., A RECIPIENT MAY BE UNABLE TO COOPERATE WITH THE DENTIST DUE TO MENTAL/PHYSICAL DISABILITIES, DOCUMENTATION OF ANY OTHER MEDICAL NECESSITY OR UNCOOPERATIVE CHILDREN.		$10.22
	D9230	ANALGESIA			$7.79

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D9240	INTRAVENOUS SEDATION	PHYSICAL OR MENTAL HANDICAP, OR MORE THAN ONE IMPACTED TOOTH REQUIRING REMOVAL, OR MORE THAN 10 ROUTINE EXTRACTIONS, OR SURGICAL MANAGEMENT OF PATHOLOGY AND FACIAL FRACTURES.		$41.94
	D9310	CONSULTATION (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN)	DOCUMENTATION OF MEDICAL NECESSITY FOR CONSULTATION		$20.19
	D9420	HOSPITAL CALL			$23.93
	D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS			MANUAL
	D9610	THERAPEUTIC DRUG INJECTION, BY REPORT			$22.92
	D9630	OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT			MANUAL
	D9920	BEHAVIOR MANAGEMENT, BY REPORT		X	$16.31
	D9930	TREATMENT OF COMPLICATIONS (POST SURGICAL) - UNUSUAL CIRCUMSTANCES, BY REPORT			$17.30

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	D9940	OCCLUSAL GUARDS, BY REPORT	REMOVABLE DENTAL APPLIANCES WHICH ARE DESIGNED TO MINIMIZE THE EFFECTS OF BRUXISM (CLENCHING AND GRINDING) AND OTHER OCCLUSAL FACTORS	X	$85.33
	D9951	OCCLUSAL ADJUSTMENT-LIMITED	MAY ALSO BE KNOWN AS EQUILIBRATION; RESHAPING THE OCCLUSAL SURFACES OF TEETH BY GRINDING TO CREATE HARMONIOUS CONTACT RELATIONSHIPS BETWEEN THE UPPER AND LOWER TEETH. PRESENTLY INCLUDES DISCING, ODONTOPLASTY, ENAMELPLASTY	X	$6.33
	D9952	OCCLUSAL ADJUSTMENT - COMPLETE	DESIGNED TO ACHIEVE FUNCTIONAL RELATIONSHIPS AND MASTICATORY EFFICIENCY IN CONJUNCTION WITH RESTORATIVE TREATMENT, ORTHODONTICS, ORTHOGNATHIC SURGERY, OR JAW TRAUMA WHEN INDICATED. SEDATION MAY BE NECESSARY..	X	$158.31
	D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT			$15.25
	Z2950	BASE FILLING FOR RESTORATIONS			$1.11

Medicaid Covered ADA HCPCS Codes, Rates, and PA Requirements					
CPT CODE	ADA PROCEDURE CODE	DESCRIPTION	CRITERIA	EPSDT	ADA AND/OR CPT REIMBURSEMENT RATE
	Z5154	ACID ETCH FOR RESTORATIONS			$11.15
	Z5155	ADMINISTRATION OF SUBCUTANEOUS, INTRAMUSCULAR, INTRAVENOUS OR ORAL SEDATION WITH MONITORING BY REPORT (FOR CHILDREN)	DOCUMENTATION AS TO WHY THE RECIPIENT CANNOT RECEIVE NECESSARY DENTAL SERVICES UNLESS MONITORED SEDATION IS ADMINISTERED, I.E., A RECIPIENT MAY BE UNABLE TO COOPERATE WITH THE DENTIST DUE TO MENTAL/PHYSICAL DISABILITIES, DOCUMENTATION OF ANY OTHER MEDICAL NECESSITY OR UNCOOPERATIVE CHILDREN.	X	MANUAL

Rule 14. Dental Services

405 IAC 5-14-1 Policy

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. Medicaid reimbursement is available only for those dental services listed in section 2 of this rule subject to the limitations set out in this rule. The dental portion of the Indiana Medicaid program places top priority on prevention, relief of pain, elimination of infection, and pathology. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-1)*

405 IAC 5-14-2 Covered services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. The following are covered dental services under the Indiana Medicaid program:
(1) Evaluations.
(2) Radiographs.
(3) Prophylaxis.
(4) Topical fluoride.
(5) Sealant.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Pin retention.
(13) Pulpcap.
(14) Therapeutic pulpotomy.
(15) Extractions.
(16) Oral biopsies.
(17) Alveoplasty.
(18) Excision of lesions.
(19) Excision of benign tumor greater than one and twenty-five hundredths (1.25) centimeters.
(20) Odontogenic cyst removal.
(21) Nonodontogenic cyst removal.
(22) Incise and drain abscess.
(23) Sequestrectomy osteomyelitis.
(24) Fracture simple stabilize.
(25) Compound fracture of the mandible.
(26) Compound fracture of the maxilla.
(27) Repair of wounds.
(28) Suturing.
(29) Osteoplasty - for orthognathic deformity.
(30) Emergency treatment dental pain.
(31) Analgesia.

(32) Therapeutic drug injection.
(33) Drugs and medicaments.
(34) Treatment of complications postsurgery.
(35) Periodontal surgery limited to drug-induced periodontal hyperplasia.
(36) Other dental services as medically necessary to treat recipients eligible for the EPSDT program.
(37) Confirmatory consultations.
(38) Periodontal root planing and scaling.
(39) General anesthesia.
(40) Intravenous (IV) sedation.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2)

405 IAC 5-14-3 Diagnostic services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. Medicaid reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs, and emergency treatments with the following limitations:
(1) Either full mouth series radiographs or panorex is limited to one (1) set per recipient every three (3) years.
(2) Bitewing, intraoral, and extraoral radiographs are limited to one (1) set per recipient every twelve (12) months. One (1) set is defined as a total of four (4) single films.
(3) A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider.
(4) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient, any provider.
(5) Mouth gum cultures and sensitivity tests are not covered.
(6) Oral hygiene instructions are reimbursed in the Medicaid payment allowance for diagnostic services and may not be billed separately to Medicaid.
(7) Payment for the writing of prescriptions is included in the reimbursement for diagnostic services and may not be billed separately to Medicaid.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-3)

405 IAC 5-14-4 Topical fluoride
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Reimbursement is available for one (1) topical application of fluoride every six (6) months per recipient only for patients who are eighteen (18) months of age or older but who are younger than nineteen (19) years of age. Topical applications of fluoride are not covered for recipients nineteen (19) years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-4)*

405 IAC 5-14-5 Treatment of dental caries
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. Treatment of dental caries with amalgam, composites, or resin restorations or stainless steel crowns is covered. The use of pit sealants on permanent molars and premolars only is a covered service for recipients under twenty-one (21) years of age. There is a limit of one (1)

treatment per tooth, per lifetime. Margination of restorations and occlusal adjustments are not covered. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-5)*

405 IAC 5-14-6 Prophylaxis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Prophylaxis is a covered service in accordance with the following limitations:
(1) One (1) unit every six (6) months for noninstitutionalized recipients over eighteen (18) months of age up to their twenty-first birthday.
(2) One (1) unit every twelve (12) months for noninstitutionalized recipients twenty-one (21) years of age and older.
(3) Institutionalized recipients may receive up to two (2) units every six (6) months.
(4) Prophylaxis is not covered for recipients under eighteen (18) months of age.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-6)

405 IAC 5-14-7 Periodontal root planing and scaling

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 7. Periodontal root planing and scaling for recipients over three (3) years of age and under twenty-one (21) years of age, or for institutionalized recipients, is limited to four (4) units every two (2) years. For noninstitutionalized recipients twenty-one (21) years of age and older, periodontal root planing and scaling is limited to four (4) units per lifetime. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-7)*

405 IAC 5-14-8 Extractions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. Medicaid reimbursement is available for extraction of teeth. Extraction of teeth must be medically necessary, and the diagnosis must support extraction. If multiple extractions are performed on the same date of service, the maximum allowable payment for additional teeth will be reduced by ten percent (10%) of the maximum allowable for the first tooth. Payment for preoperative and postoperative care is included in the allowance for the operative procedure and may not be billed separately to Medicaid. Payment for placement of sutures or tissue trim, or both, in simple extractions is included in the reimbursement fee for the extractions and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-8)*

405 IAC 5-14-9 Space maintenance

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 9. Medicaid reimbursement is available for space maintenance in children with deciduous molar teeth subject to the following restrictions:
(1) Space maintenance for children under three (3) years of age requires prior authorization by the office. Space maintenance for missing permanent teeth requires prior authorization by the office.
(2) Adjustment to space maintainers, bands, and all other appliances is included in the reimbursement for the service and may not be billed separately to Medicaid.

(3) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-9)

405 IAC 5-14-10 Pulpcap

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. Medicaid reimbursement is available for only one (1) pulp cap or one (1) base fill per tooth per recipient. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-10)*

405 IAC 5-14-11 Analgesia

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. Nitrous oxide analgesia and preanesthetic medication are covered services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-11)*

405 IAC 5-14-12 Infection control

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. Infection control is not a covered service. All routine supplies and services should be included in the reimbursement amount for the procedure. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-12)*

405 IAC 5-14-13 Emergency treatment of dental pain

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 13. Palliative treatment of facial pain, such as abscess, incision, and drainage, is limited to emergency treatment only. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-13)*

405 IAC 5-14-14 Office visits

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. Payment for office visits is not covered. Reimbursement is available only for covered services actually performed. Covered services provided outside the office will be reimbursed at the fee allowed for the same service provided in the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-14)*

405 IAC 5-14-15 General anesthesia and intravenous sedation

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 15. (a) Medicaid reimbursement is available for general anesthesia. General anesthesia for recipients twenty-one (21) years of age and older may only be provided in a hospital (inpatient or outpatient) or ambulatory surgical center. Prior authorization is required and shall include consideration of the following:

(1) Specific reasons why such services are needed, including specific justification if such services are to be provided on an outpatient basis.

(2) Documentation that the recipient cannot receive necessary dental services unless general anesthesia is administered. For example, a recipient may be unable to cooperate with the dentist due to physical or mental disability.

(b) Medicaid reimbursement is available for intravenous sedation when prior authorized. Prior authorization requests must include specific reasons why such services are needed, including specific justification if such services are to be provided on an outpatient basis. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-15)*

405 IAC 5-14-16 Periodontics; surgical

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 16. Periodontic surgery is a covered service only for cases of drug-induced periodontal hyperplasia. This service requires prior authorization. Requests for surgical periodontics will be evaluated and decided on an individual basis. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-16)*

405 IAC 5-14-17 Oral surgery

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 17. No oral surgical procedures shall be approved, other than those listed in this rule, except in extreme cases of facial trauma, pathology, or deformity. All oral surgery in the categories described in this rule require prior authorization by the office. Placement of sutures or tissue trim, or both, in a simple extraction does not constitute a surgical extraction. Multiple simple extractions with placement of sutures or tissue trim, or both, performed in either office or hospital shall not be reimbursed as surgical extractions. Payment of preoperative and postoperative care is included in the reimbursement for the operative procedure and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-17)*

405 IAC 5-14-18 Hospital admissions for covered dental services or procedures

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 18. Admission of a recipient to a hospital for the purpose of performing any elective dental service, or any elective dental service performed on an inpatient basis, requires prior authorization by the office. Authorization will be given only for those recipients with problems that require special or additional care to that care routinely provided in a dentist's office. In cases of life-threatening emergencies, retroactive prior authorization must be obtained within forty-eight (48) hours of the hospital admission. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-18)*

405 IAC 5-14-19 Prior authorization for early and periodic screening, diagnostic, and treatment covered services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 19. Prior authorization must be obtained for services not listed in section 2 of this rule but which are medically necessary to treat recipients eligible for the EPSDT. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-19)*

405 IAC 5-14-20 Dental services provided in a state-owned ICF/MR

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 20. Dental services that can be provided in a state owned ICF/MR shall be included in the per diem rate and do not require prior authorization. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization according to the following:

(1) Dental services prior authorized by the contractor must be billed to the Medicaid program directly by the outside dental provider.

(2) Prior authorization shall not be given for dental services provided off-site that are included within the per diem rate.

(3) Documentation on the Medicaid dental prior review and authorization request must substantiate:

(A) the medical necessity of the dental service; and

(B) an explanation of why the service cannot be rendered at the facility.

(4) The office will review criteria for prior authorization set forth in this rule for the specific dental service requested.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-20)

405 IAC 5-14-21 Maxillofacial surgery

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 21. Medicaid providers shall be required, based upon 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 an ambulatory surgical treatment center, a hospital, or a clinic. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-21)*