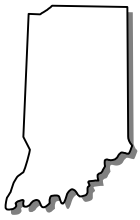
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200302 JANUARY 15, 2003

To: All Dentists and Dental Clinics

Subject: Implementation of the $600 Dental Cap

Overview

The Office of Medicaid Policy and Planning (OMPP) has coordinated efforts with the Dental Advisory Panel (DAP) to reduce dental expenditures by implementing a cap of $600 on dental services for adults. The DAP worked with the OMPP to identify codes and services that are included or excluded from the $600 cap. This bulletin notifies Indiana Health Coverage Programs (IHCP) providers of the changes in dental services under *405 IAC 5-14* regarding the dental cap implementation. Effective January 15, 2003, the IHCP will limit dental services to $600 per calendar year, per member. This cap applies only to members 21 years of age and older.

In addition to the implementation of a dental cap, this bulletin provides a 45-day notice that claims for *D4341 – Periodontal root planing and scaling* will require supporting documentation. Claims that do not include attachments with supporting documentation will deny.

Dental Cap

Effective January 15, 2003, a $600 cap on dental services per calendar year, per member, for members 21 years of age and older will be established. This includes members who will reach 21 years of age in 2003, and new members who are 21 years of age or older on the date the member is eligible for dental services. When a member reaches 21 years of age, services provided on or after that date any services provided are included in the $600 cap. For years 2004 and beyond, the calendar year for the $600 cap will start on January 1 and end on December 31. Dental services provided in a hospital will not apply to the cap. If the place of service is not indicated on the claim form, the service will be captured as delivered in a dental office.

Table 1 identifies codes for services included in the $600 dental cap when provided in a dentist's office.

Table 1 – Codes Included in the $600 Dental Cap

HCPCS Code	Description
D0120	Periodic oral evaluation
D0140	Limited oral evaluation - problem focused
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation - problem focused, by report

Table 1 – Codes Included in the $600 Dental Cap

HCPCS Code	Description
D0170	Re-evaluation-limited, problem focused (established patient; not post-operative visit)
D0210	Intraoral-complete series (including bitewings)
D0220	Intraoral-periapical-first film
D0230	Intraoral-periapical-each additional film
D0240	Intraoral-occlusal film
D0250	Extraoral-first film
D0260	Extraoral-each additional film
D0270	Bitewing-single film
D0272	Bitewings-two films
D0274	Bitewings-four films
D0290	Posterior-anterior or lateral skull and facial bone survey film
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0321	Other temporomandibular joint films, by report
D0322	Tomographic survey
D0330	Panoramic film
D0340	Cephalometric film
D1110	Prophylaxis-adult
D2110	Amalgam-one surface, primary
D2120	Amalgam-two surfaces, primary
D2130	Amalgam-three surfaces, primary
D2131	Amalgam-four or more surfaces, primary
D2140	Amalgam-one surface, permanent
D2150	Amalgam-two surfaces, permanent
D2160	Amalgam-three surfaces, permanent
D2161	Amalgam-four or more surfaces, permanent
D2330	Resin-based composite - one surface, anterior
D2331	Resin-based composite - two surfaces, anterior
D2332	Resin-based composite - three surfaces, anterior
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2336	Resin-based composite – crown, anterior-primary
D2380	Resin-based composite - one surface, posterior-primary
D2381	Resin-based composite - two surfaces, posterior-primary
D2382	Resin-based composite - three or more surfaces, posterior-primary

Table 1 – Codes Included in the $600 Dental Cap

HCPCS Code	Description
D2385	Resin-based composite - one surface, posterior-permanent
D2386	Resin-based composite - two surfaces, posterior-permanent
D2387	Resin-based composite - three or more surfaces, posterior-permanent
D2388	Resin-based composite - four or more surfaces, posterior permanent
D2910	Recement inlay
D2920	Recement crown
D2930	Prefabricated stainless steel crown-primary tooth
D2931	Prefabricated stainless steel crown-permanent tooth
D2940	Sedative filling
D2951	Pin retention-per tooth, in addition to restoration
D2970	Temporary (fractured tooth)
D2980	Crown repair, by report
D3110	Pulp cap-direct (excluding final restoration)
D3120	Pulp cap-indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament
D3230	Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)
D4210	Gingivectomy or gingivoplasty-per quadrant
D4211	Gingivectomy or gingivoplasty-per tooth
D4240	Gingival flap procedure, including root planing-per quadrant
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Upper partial-resin base (including any conventional clasps, rests and teeth)
D5212	Lower partial-resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps,rests and teeth)
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth-complete denture (each tooth)
D5610	Repair resin denture base
D5620	Repair cast framework

Table 1 – Codes Included in the $600 Dental Cap

HCPCS Code	Description
D5630	Repair or replace broken clasp
D5640	Replace broken teeth-per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline lower complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D9220	General anesthesia - first 30 minutes
D9221	General anesthesia - each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9248	Non-intravenous conscious sedation
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
D9610	Therapeutic drug injection, by report
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report

The dental cap applies only to the IHCP paid dental services provided in a dental office. Dental services for root planing and scaling, intravenous sedation provided in conjunction with oral surgeries, oral surgery, and osseous surgery are excluded from the dental cap.

Table 2 identifies those codes for services that are excluded from the dental cap.

Table 2 – Codes Not Included in the $600 Dental Cap

HCPCS Code	Description
D4260	Osseous surgery (including flap entry and closure) - per quadrant
D4341	Periodontal scaling and root planing, per quadrant
D7110	Single tooth
D7120	Each additional tooth
D7130	Root removal-exposed roots
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth and removal of bone and/or section of tooth
D7220	Removal of impacted tooth-soft tissue
D7230	Removal of impacted tooth-partially bony

Table 2 – Codes Not Included in the $600 Dental Cap

HCPCS Code	Description
D7240	Removal of impacted tooth-completely bony
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oral antral fistula closure
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7310	Alveoloplasty in conjunction with extractions - per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7430	Excision of benign tumor-lesion diameter up to 1.25 cm
D7431	Excision of benign tumor-lesion diameter greater than 1.25 cm
D7440	Excision of malignant tumor-lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor-lesion diameter greater than 1.25 cm
D7450	Removal of odontogenic cyst or tumor-lesion diameter up t0 1.25 cm
D7451	Removal of odontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	Removal of nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7471	Removal of exostosis - per site
D7510	Incision and drainage of abscess-intraoral soft tissue
D7520	Incision and drainage of abscess-extraoral soft tissue
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla-open reduction (teeth immobilized if present)
D7620	Maxilla-closed reduction (teeth immobilized if present)
D7630	Mandible-open reduction (teeth immobilized if present)
D7640	Mandible-closed reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch-open reduction
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus - stabilization of teeth, closed reduction splinting
D7680	Facial bones-complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla-open reduction
D7720	Maxilla-closed reduction
D7730	Mandible-open reduction
D7740	Mandible-closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7760	Malar and/or zygomatic arch-closed reduction

Table 2 – Codes Not Included in the $600 Dental Cap

HCPCS Code	Description
D7770	Alveolus-stabilization of teeth, open reduction splinting
D7780	Facial bones-complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture-up to 5 cm
D7912	Complicated suture-greater than 5 cm
D7940	Osteoplasty - for orthognathic deformities
D7980	Sialolithotomy
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7999	Unspecified oral surgery procedure, by report
D9241	Intravenous sedation / analgesia - first 30 minutes
D9242	Intravenous sedation / analgesia - each additional 15 minutes

Dental services that are included in the dental cap are considered noncovered when the dental cap is reached for that calendar year. If additional dental services are needed beyond the $600 of dental services covered under the dental cap for that calendar year, providers can hold members responsible for the additional payment. The following guidelines must be met for the IHCP providers to hold a member responsible for payment.

- The service rendered must be determined to be noncovered by the IHCP.
- The member has exceeded the program limitations for a particular service.
- The member must understand before receiving the service that the service is not covered under 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.

In summary, a provider can bill a member only when the above criteria are fully met. A generic consent form is not acceptable unless it identifies the specific procedure being performed, and the member signs the consent before receiving the service. If written statements are used, the statement must *not* contain language such as, "If an IHCP service is not covered..."

Note: A written statement is not required, but to bill the member it is necessary to demonstrate the member was informed that the service is not covered and the member voluntarily chose to receive the service knowing the IHCP would not cover it.

Providers must verify member eligibility prior to delivering services. The Eligibility Verification System (EVS) for the automated voice-response system (AVR) and Web interChange will confirm if a member has reached the dental cap. Audit *6236 – Dental services are limited to $600 per member 21 years of age and older* identifies whether a member has met his or her cap. To inquire about eligibility via AVR, providers must use the billing number for the dental office.

To verify how much of the dental cap has been paid, providers can call Customer Assistance Unit at (317) 655-3240 in the Indianapolis area or 1-800-577-1278. Dentists should remember the information provided by Customer Assistance only reflects services paid up to the point in time of the call. The IHCP does not reserve services for a provider or guarantee payment of services.

D4341 - Periodontal Scaling and Root Planing

Effective 45 days from the publication date of this bulletin, IHCP providers submitting claims for *D4341 – Periodontal scaling and root planing*, must submit supporting documentation as to the medical necessity of providing this service. Claims submitted for dates of service on or after March 1, 2003, that do not include supporting documentation for periodontal scaling and root planing will deny. Dentists should be aware that D4341 is limited to four quadrants per lifetime for members 21 years of age and older who are not institutionalized. Institutionalized members are restricted to four quadrants every two years.

Further Information

Direct questions about the $600 dental cap to Health Care Excel at (317) 347-4500. Refer any questions about the amount a member has used toward the dental cap to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.