Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: All Dental Providers and Federally-Qualified Health Clinics

Subject: Dental Claim Instructions

Overview

Claims research for the last quarter of calendar year 2000 revealed that Indiana Health Coverage Programs (IHCP) paid for 71,997 restorations. Of this number, 4,656 restorations or 6 percent of total restorations, were paid with more than one procedure code per tooth, for the same date of service, for the same member. For example, one provider billed codes D2150, Amalgam, two surfaces, twice, and D2160, Amalgam, three surfaces, once, for tooth number 12 (a total of seven surfaces).

In order to set policy to standardize reimbursement for these services, research included: (1) checking with other payers of dental services, (2) consulting with other IHCP-enrolled dentists, and (3) obtaining the policy from other state Medicaid agencies. Based on the results of the research and the claim analysis, dentists who are billing more than one procedure code per restoration are clearly in the minority. Therefore, effective December 17, 2001, dental claims received by EDS for dates of service December 17, 2001, and later will be processed according to the clarifications outlined in this bulletin. Claim submission guidelines are consistent with dental billing and reimbursement practices of Delta Dental, Metlife Dental, Aetna, and several Medicaid State Agencies, including California, Texas, Maryland, Georgia, Pennsylvania, Louisiana, and Arkansas.

In conjunction with adoption of this policy, system changes have been made that will facilitate editing for duplicate claim payments. Claims that have been paid in error, as duplicates, will be mass adjusted. Providers will receive a list of internal control numbers (ICNs) for claims to be adjusted prior to the mass adjustment processing.

Tooth Numbers for Procedure Codes

A tooth number is required for certain dental procedure codes. **Claims submitted on and after December 17, 2001, must include the appropriate tooth number as indicated in Table 1.1**. If the code has no tooth number or the tooth number is invalid, the claim detail will deny with one of the following explanation of benefits (EOBs):

- If the tooth number is missing, the claim detail will deny with *EOB 261 – Tooth Number Missing*.
- If a tooth number is not in the range of valid tooth number letters A through T, or tooth numbers 1 through 32, the claim detail will deny with *EOB 262 – Tooth Number Invalid*.
- If a procedure code requires a tooth number and the tooth number filed on the claim detail is not valid for the particular dental procedure, the claim detail will deny with *EOB 4211 – Tooth Number/Procedure Code Combination Invalid*.

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
D0220		Intraoral – periapical first film	A – T, 1 – 32
D0230		Intraoral – periapical each additional film	A – T, 1 – 32
D0460		Pulp vitality tests	1 – 32
D1351*	Covered for younger than age 21	Sealant – per tooth	2, 3, 4, 5, 7, 10, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31
D2110		Amalgam – one surface, primary	A – T
D2120		Amalgam – two surfaces, primary	A – T
D2130		Amalgam – three surfaces, primary	A – T
D2131		Amalgam – four or more surfaces, primary	A – T
D2140		Amalgam – one surface, permanent	1 – 32
D2150		Amalgam – two surfaces, permanent	1 – 32
D2160		Amalgam – three surfaces, permanent	1 – 32
D2161		Amalgam, four or more surfaces permanent	1 – 32

(Continued)

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
D2330		Resin-based composite – one surface	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D2331		Resin-based composite – two surfaces, anterior	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D2332		Resin-based composite– three surfaces, anterior	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D2335		Resin-based composite – four or more surfaces or involving incisal angle (anterior)	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D2336		Resin-based composite crown, anterior-primary	C, D, E, F, G, H, M, N, O, P, Q, and R
D2380		Resin-based composite – one surface, posterior - primary	A, B, I, J, K, L, S, and T
D2381		Resin-based composite – two surfaces, posterior - primary	A, B, I, J, K, L, S, and T
D2382		Resin-based composite – three or more surfaces, posterior - primary	A, B, I, J, K, L, S, and T
D2385		Resin-based composite – one surface, posterior - permanent	1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32
D2386		Resin-based composite – two surfaces, posterior - permanent	1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32
D2387		Resin-based composite – three surfaces, posterior - permanent	1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32
D2388		Resin-based composite – four or more surfaces, posterior - permanent	1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32
D2910		Recement inlay	1 – 32
D2920		Recement crown	1 – 32, A – T
D2930		Prefabricated stainless steel crown – primary tooth	A – T

(Continued)

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
D2931		Prefabricated stainless steel crown – permanent tooth	1 – 32
D2932	Covered for younger than age 21	Prefabricated resin crown	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D2933	Covered for younger than age 21	Prefabricated stainless steel crown with resin window	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27, C, D, E, F, G, H, M, N, O, P, Q, and R
D3110		Pulp cap – direct (excluding final restoration)	1 – 32, A – T
D3120		Pulp cap – indirect (excluding final restoration)	1 – 32, A – T
D3220		Therapeutic pulpotomy (excluding final restoration)	1 – 32, A – T
D3230		Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)	C, D, E, F, G, H, M, N, O, P, Q, and R
D3240		Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	A, B, I, J, K, L, S, and T
D3310	Covered for younger than age 21	Endodontic therapy, anterior (excluding final restoration)	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27
D3320	Covered for younger than age 21	Endodontic therapy, bicuspid (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, and 29
D3330	Covered for younger than age 21	Endodontic therapy, molar (excluding final restoration)	1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32
D3346	Covered for younger than age 21	Retreatment of previous root canal therapy – anterior	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27
D3347	Covered for younger than age 21	Retreatment of previous root canal therapy – bicuspid	4, 5, 12, 13, 20, 21, 28, and 29

(Continued)

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
D3348	Covered for younger than age 21	Retreatment of previous root canal therapy – molar	1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32
D3410	Covered for younger than age 21	Apicoectomy/periradicular surgery – anterior	6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27
D3421	Covered for younger than age 21	Apicoectomy/periradicular surgery – bicuspid (first root)	4, 5, 12, 13, 20, 21, 28, and 29
D3425	Covered for younger than age 21	Apicoectomy/periradicular surgery – molar (first root)	1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, and 32
D3426	Covered for younger than age 21	Apicoectomy/periradicular surgery – (each additional root)	1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32
D3430	Covered for younger than age 21	Retrograde filling – per root	1 – 32
D4211		Gingivectomy or gingivoplasty – per tooth	1 – 32, A – T
D5520 (age 21 and older)	Requires prior authorization	Replace missing or broken teeth – complete denture (each tooth)	2-15, 18-31
D5640 (age 21 and older)	Requires prior authorization	Repairs to partial dentures, replace broken teeth – per tooth	2-15, 18-31
D5650 (age 21 and older)	Requires prior authorization	Add tooth to existing partial denture	2-15, 18-31
D7110		Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care), single tooth	1 – 32, A – T
D7120		Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care), each additional tooth	1 – 32, A – T

(Continued)

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
D7130		Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care), root removal – exposed roots	1 – 32, A – T
D7210		Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care): Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	1 – 32, A – T
D7220		Removal of impacted tooth – soft tissue	1 – 32, A – T
D7230		Removal of impacted tooth – partially bony	1 – 32, A – T
D7240		Removal of impacted tooth – completely bony	1 – 32, A – T
D7241		Removal of impacted tooth – completely bony, with unusual surgical complications	1 – 32, A – T
D7250		Surgical removal of residual tooth roots (cutting procedure)	1 – 32, A – T
D7270		Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	2-15, 18-31, A – T
D7281		Surgical exposure of impacted or unerupted tooth to aid eruption	1 – 32, A – T
D9911		Application of desensitizing resin for cervical and/or root surface, per tooth	1 – 32
Z5082	Covered for younger than age 21	Replace broken or missing teeth – complete denture (each tooth)	2-15, 18-31, A – T

(Continued)

Table 1.1 – Valid Tooth Numbers

Dental Code	Limitations	Description of Procedure	Valid Tooth Numbers
Z5090	Covered for younger than age 21	Replace broken teeth – per tooth	2-15, 18-31, A – T
Z5091	Covered for younger than age 21	Add tooth to existing partial denture	2-15, 18-31, A – T

Note: D1351, sealants, will only be covered for permanent molars and premolars effective **November 12, 2001**. *This is in accordance with* 405 IAC 5-14-5.

Tooth Surface Procedure Codes

Any claim detail billed using a procedure code that requires a tooth surface, as indicated in the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS) or *Current Dental Terminology Users Manual, Third Edition* (CDT-3) description of the code, must be billed using the appropriate number of valid tooth surface codes. Table 1.2 provides the valid tooth surface codes.

Table 1.2 – Valid Tooth Surface Codes

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

Note: The IHCP recognizes the Universal/National System for tooth numbering as described in the CDT-3 Users Manual.

Table 1.3 provides a current list of all procedure codes that require a tooth surface for billing, as well as the minimum number of tooth surface codes required for each procedure code.

Table 1.3 – Current Procedure Codes Requiring a Tooth Surface

Procedure codes that require *one* tooth surface code	**Procedure codes that require *two* tooth surface codes**	**Procedure codes that require a minimum of *three* tooth surface codes**	**Procedure codes that require a minimum of *four* tooth surface codes**
D2110	D2120	D2130	D2131
D2140	D2150	D2160	D2161
D2330	D2331	D2332	D2335*
D2380	D2381	D2382	D2388
D2385	D2386	D2387	

D2335 is to be billed with either four surfaces or with an **I, indicating incisal angle. Appropriate supporting documentation must be maintained in the dental or medical chart because dental records are subject to post-payment review.*

A claim detail billed using a procedure code that requires a tooth surface will deny if at least the minimum number of valid tooth surface codes is not present. The following two explanation of benefits (EOBs) explain claims denied for tooth surface discrepancies:

- *EOB 266 – The number of valid tooth surface codes present does not meet the minimum number required for the procedure code billed. Refer to the HCPCS or CDT-3 procedure code description for the minimum number required.*
- *EOB 263 – One or more of the tooth surface codes billed is invalid. The minimum number of valid tooth surface codes has not been met. Valid tooth surface codes are B, D, F, I, L, M, or O. Please verify and resubmit.*

Multiple Restorations Reimbursement

Only one restoration code is reimbursed per tooth for restorations using the same material performed on the same date by the same dentist for the same member.

> For example, only one of the appropriate procedure codes (D2110, D2120, D2130, or D2131) for an amalgam restoration of primary tooth letter **K** is reimbursed when performed on the same date by the same dentist.

In the example, if codes D2110, D2120, D2130, or D2131 are billed for the same tooth number, the system pays the first line item. The

second code causes the system to suspend the claim as a possible duplicate. The second and all subsequent restoration codes for the same material for the same tooth are denied as duplicates with the *EOB 5011, Possible Duplicate – Only one restoration code, per tooth, per day, per dentist will be reimbursed.* If the claim denies for EOB 5011, an adjustment must be submitted for the paid detail line with one restoration code per tooth that identifies the number of unique surfaces restored. Please refer to Table 1.3.

Multiple restorations on the same tooth, using the same material on the same surface of a tooth, without involvement of a second surface, on the same date and by the same dentist, will be processed as a single surface restoration. Multiple restorations involving only one surface will be reimbursed as a single surface restoration.

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

For the dentist to be reimbursed for each **surface** restored, the code identifying the total number of unique surfaces must be used. Each surface may only be counted once when selecting the code identifying the total number of unique surfaces. Reimbursement never exceeds the maximum fee for a four or more surface restoration when the same material is used.

> If a two surface amalgam restoration (D2150) is billed for surfaces **D** and **O** on tooth number **14**, and another two surface amalgam restoration (D2150) is billed for surfaces **M** and **O** on tooth number **14**, the claim is not reimbursed as billed. The second D2150 submission is considered an exact duplicate claim and will deny with *EOB 5010, Exact Duplicate - Only one restoration code, per tooth, per day, per dentist will be reimbursed.*

If the claim in the example above is to be reimbursed for all surfaces restored, the claim will need to be adjusted. The original claim should be refunded and the dentist should submit an adjustment billing the three surface amalgam restoration code D2160 with the **MOD** surfaces. The claim is reimbursed at the *lower of* the submitted charge or the maximum fee for a three surface amalgam restoration (D2160).

Multiple restorations on the same tooth, using different materials, which involve the same surface without involvement of a second surface, on the same date and by the same dentist, are processed as a single surface restoration for *each material*. **Situations requiring**

multiple restorations using different materials on the same tooth should be rare and may be reviewed for medical necessity because of the use of the different materials.

For example, for tooth number **30**, a one surface amalgam restoration (D2140) billed for the **B** surface and a one surface resin-based composite restoration (D2385) billed for the **B** surface, is reimbursed once for D2140 and once for D2385.

Both anterior and posterior resin restorations are covered by the IHCP. However, as stated in bulletin *E95-41*, published June 29, 1995, posterior resin restorations are reimbursed at the same rate as amalgam restorations.

Additionally, claim details billed with non-covered procedure codes will deny with *EOB 4021, Procedure code not covered for the dates of service for the Program billed. Please verify and resubmit.* Non-covered procedure codes may also deny with *EOB 3001, Dates of service are not on the PA database.*

*Note: Prior authorization (PA) does not guarantee payment. Prior authorization **does not override** a non-covered status on a dental code; therefore, a dental provider should **not** submit a PA request for a non-covered procedure code. Currently, PA for dental services is only required for services related to dentures and partials for individuals age 21 and older. PA requests received for any other dental services are returned to the provider. There is no reimbursement for ineligible members or for non-covered services.*

D9230 – Analgesia, Anxiolysis, Inhalation of Nitrous Oxide

Effective December 17, 2001, D9230 will be reimbursed once per day, for the same dentist, on the same date of service, and for the same member. These billing instructions are consistent with CDT-3 guidelines and American Dental Association (ADA) policy.

Additional Information

If there are questions about the information contained in this bulletin, please contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1276.