13

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13 Dentist

Certain dental health care services are available for eligible children as part of the Early and Periodic Screening, Diagnosis, and Treatment up to age 21 as long as the child remains eligible for Medicaid **with the exception of SOBRA children** who cease to be eligible upon reaching their 19th birthday.

Dental services are any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individual.

As defined in the Rules of The Board of Dental Examiners of Alabama, Rule 270-X3.06, “Direct supervision is defined as supervision by a dentist who authorizes the intraoral procedure to be performed, is physically present in the dental facility, and available during the performance of the procedure, and takes full professional responsibility for the completed procedure”.

Any facility that utilizes unlicensed graduate dentists to treat Medicaid Recipients must meet the requirements set forth in Section 270-X-4.02 of the Dental Practice Act.

NOTE:

A dental consultant is available for clinical consultation regarding coverage for unusual services and may be contacted through the Dental Program Manager at (334) 242-5014. For claims processing questions please call HPE Provider Assistance Center at 1-800-688-7989.

The policy provisions for dental providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

NOTE:

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyrighted by the American Dental Association. All rights reserved. Applicable FARS/DFARS Apply.

13.1 Enrollment

HPE enrolls dental providers who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a Dental provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for dental-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Dental providers are assigned a provider type of 27 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (271)
- Oral and Maxillofacial Surgery (272)
- Endodontist (275)
- Pediatric Dentistry (276)
- Orthodontist (277)
- Periodontist (278)
- Mobile Provider (299)
- Anesthesiologist (311)

Oral Surgeons are assigned a provider type of 62, depending on the source of the licensure information sent to the HPE provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (272).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician and Chapter 5, Filing Claims. Dental procedures (current CDT procedure codes) should always be billed on the ADA dental claim form—Version ADA 2006.

Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state where care is provided. Each dental provider **must** enroll with a NPI that will follow them to each office location (a Service Location Provider Number will be assigned for each office location to assist in identifying where the service was provided). This also applies for reimbursement for preventive services and must be performed at a fixed physical office location. Each claim filed constitutes a contract with the Alabama Medicaid Agency. Dental providers are required to complete and sign a coding sheet (often referred to as a “super bill”) listing all procedure codes/ descriptions performed on each date of service for each Medicaid recipient. For audit purposes, these coding sheets are required to be maintained on file for a period of three (3) years from the date of service.

Dentists who perform anesthesia (general) or IV sedation services must submit a copy of their GA/IV certification to HPE with their provider enrollment application.

Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency, please refer to Chapter 2 - Becoming a Medicaid Provider. All program policies apply regardless of where care is provided.

Change of Ownership (CHOW) and Closures

Added: **Change of Ownership (CHOW) and Closures** section

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

Enrollment of Mobile Dental Clinics

A mobile dental facility or portable dental operation (Mobile Dental Clinic) is any self-contained facility in which dentistry or dental hygiene is practiced which may be moved, towed, or transported from one location to another.

Mobile Dental Clinics shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, Code of Federal Regulations and applicable Medicaid billing manuals.

In order to enroll as a Mobile Dental Clinic, an operator shall:

(a) obtain a certificate of registration issued by the Board of Dental Examiners (the Board); and
(b) complete an Alabama Medicaid Provider Enrollment application.

Mobile Dental Clinics shall comply with the following consent requirements:
(a) The operator of a Mobile Dental Clinic shall not perform services on a minor without the signed consent from the parent or guardian. The consent form shall be established by the Board.
(b) The consent form shall inquire whether the prospective patient has received dental care from a licensed dentist within one year and if so, the consent form shall request the name, address, and phone number of the dental home. If the information provided to the operator does not identify a dental home for the prospective patient, the operator shall contact the Alabama Medicaid Agency for assistance in identifying a dental home for Medicaid eligible patients. If this information is provided to the operator, the operator shall contact the designated dental home by phone, facsimile, or electronic mail and notify the dental home of the prospective patient's interest in receiving dental care from the operator. If the dental home confirms that an appointment for the prospective patient is scheduled with the dentist, the operator shall encourage the prospective patient or his or her guardian to seek care from the dental home.
(c) The consent form shall document that the patient, or legal guardian, understands the prospective patient has an option to receive dental care from either the Mobile Dental Clinic or his or her designated dental home if applicable.
(d) The consent form shall require the signature of a parent or legal guardian.

Each Mobile Dental Clinic shall maintain a written or electronic record detailing all of the following information for each location where services are performed:

(a) The street address of the service location.
(b) The dates of each session.
(c) The number of patients served.
(d) The types of dental services provided and the quantity of each service provided.
(e) Any other information requested by rule of the Board or Medicaid.

At the conclusion of each patient's visit to the Mobile Dental Clinic, the patient shall be provided with a patient information sheet which shall also be provided to any individual or entity to whom the patient has consented or authorized to receive or access the patient's records. The information sheet shall include at a minimum the following information:

(a) The name of the dentist or dental hygienist, or both, who performed the services.
(b) A description of the treatment rendered, including billing service codes and fees associated with treatment and tooth numbers when appropriate.
(c) If applicable, the name, address, and telephone number of any dentist to whom the patient was referred for follow-up care and the reason for such referral.
(d) The name, address, and telephone number, if applicable, of a parent or guardian of the patient.

Mobile Dental Clinics shall comply with the following requirements for Emergency Follow-up Care:

(a) The operator shall maintain a written procedure for emergency follow-up care for patients treated in a Mobile Dental Clinic, which includes arrangements for treatment and follow-up care by a qualified dentist in a dental facility that is permanently established within a 50-mile radius of where mobile services are provided.

(b) An operator who either is unable to identify a qualified dentist in the area or is unable to arrange for emergency follow-up care for patients otherwise shall be obligated to provide the necessary follow up via the Mobile Dental Clinic or the operator may choose to provide the follow-up care at his or her established dental practice location in the state or at any other established dental practice in the state which agrees to accept the patient.

(c) An operator who fails to arrange or provide follow-up care as required herein shall be considered to have abandoned the patient, and will subject the operator and any dentist or dental hygienist, or both, who fail to provide the referenced follow-up treatment to termination as a Medicaid provider.

The provider shall not charge Medicaid for services rendered on a no-charge basis to the general public.

A Mobile Dental Clinic that accepts or treats a patient but does not refer patients for follow-up treatment when such follow-up treatment is clearly necessary, shall be considered to have abandoned the patient and will subject the operator and any dentist or dental hygienist, or both, who fails to provide the referenced follow-up treatment to termination as a Medicaid provider.

Mobile Dental Clinics shall comply with the following requirements for sale or cessation of operation:

(a) In the event a Mobile Dental Clinic is to be sold, the current provider shall inform the Board and Medicaid, at least 10 days prior to the sale being completed and shall disclose the purchaser to the Board and Medicaid, via certified mail within 10 days after the date the sale is finalized.

(b) The provider shall notify the Board and Medicaid, at least 30 days prior to cessation of operation. Such notification shall include the final day of operation, and a copy of the notification shall be sent to all patients and shall include the manner and procedure by which patients may obtain their records or transfer those records to another dentist.

(c) It is the responsibility of the provider to take all necessary action to ensure that the patient records are available to the patient, a duly authorized representative of the patient, or a subsequent treating dentist. For purposes of this subsection, a patient shall mean any individual who has received any treatment or consultation of any kind within two years of the last date of operation of the Mobile Dental Clinic.

NOTE:

If you are already a Medicaid Provider, you do not have to re-enroll with Medicaid to be a Mobile Dental Provider. As a mobile dental provider you will need to submit a request to HPE Provider Enrollment, P.O. 241685, Montgomery, AL 36124, to add the mobile provider specialty (299) to your existing provider file along with a copy of your certification received from the Alabama Dental Board. **When filing claims for mobile dental services please indicate your place of service as 15.**

13.2 1st Look – The Oral Health Risk Assessment and Dental Varnishing Program

Medicaid covers the application of fluoride varnishes for children 6 months through 35 months of age who have a high caries risk based on the risk assessment by **Patient 1st medical providers or their clinical staff (RNs, PAs, Nurse Practitioners, LPNs) that have received the 1st Look Training.** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals**, a specialty indicator (274)** will be added to the provider file in order for the provider to receive reimbursement.

NOTE:

The trained Patient 1st provider does not include the nurse practitioner under his/her Patient 1st practice. An enrolled nurse practitioner that has been trained in the 1st Look program can bill for the 1st Look services provided.

Once training is completed, a list is sent to the Medicaid Agency for the new specialty to be added to the provider's file. The effective date of the specialty is the same as the date of certification.

Dental Home as defined by the American Dental Association – The ongoing relationship between who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

A list of Medicaid Dental Providers is available on the Medicaid website at: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.2.6_Locate_Participating_Dentist.aspx .

Patient 1st medical providers will be able to bill in accordance with Medicaid reimbursement policies for the oral assessment (D0145) and the applications of the fluoride varnish (D1206).

Procedure D0145 may be billed **once by the pediatric medical provider and once by the dental provider for children age 6 months through 35 months of age.** Records must document the content of anticipatory guidance counseling given to parents/caregivers, the results of the Caries Assessment Tool (CAT) and that a referral has been made to the Patient 1st Care Coordinators for all high-risk children. Documentation must also include where referral to a dental home has been made.

NOTE:

At least two high risk indicators must be present in the high risk category to classify a child as being high risk.

Procedure D1206 will be **limited to three per calendar year**, regardless of the provider and cannot exceed a maximum of six fluoride varnish applications **between 6 months through 35 months of age.** Once a recipient is referred to a dental home, D1206 (application of fluoride varnish) is no longer a covered service when performed by the 1st Look Medical Provider.

13.3 Patient Record

The patient record shall include the following:

1. Patient's full name, address and treatment date;
2. Patient's nearest relative or responsible party;
3. Current health history, including chief complaint, if applicable, and a listing of all current medications;
4. Diagnosis of condition
5. Specific treatment rendered and by whom; (e.g. Tooth #04 DO resin 1.8 cc of Lidocaine by Dr. Smith)
6. After each date of service, the Rendering Provider's **SIGNATURE** must be present after the written documentation of the service in the Patient's Operative Notes. Reimbursement for services **without** the Rendering Provider's SIGNATURE in the Patient's Operative Notes is subject to **recoupment**.
7. Signature electronic or written, or Provider's initials.
8. Name and strength of any medications prescribed, dispensed or administered along with the quantity, date provided and authorized refills;
9. Treatment plan;
10. Applicable radiographs; and
11. Informed consent.

13.4 Informed Consent

Informed consent shall be documented in the record for all patients for whom treatment is to be provided. The consent form should be procedure specific and include the following:

- Name and date of birth of patient;
- Name and relationship to the patient/legal basis on which the person is consenting on behalf of the patient;
- Description of the procedure in simple terms;
- Disclosure of known adverse risk(s) of the proposed treatment specific to that procedure;
- Professionally-recognized or evidence-based alternative treatment(s) to recommended therapy and risk(s);
- Place for custodial parent or legal guardian to indicate that all questions have been asked and adequately answered;
- Places for signatures of the custodial parent or legal guardian, dentist, and office staff member as a witness.

  Consistent violation of the informed consent requirement can result in further investigation and appropriate action.

13.5 Benefits and Limitations

Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program.

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of recipient's needs.
- The services cannot be experimental or investigational.
- The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Covered procedures are located in section 13.8.2

13.5.1 Orthodontic Services

Medicaid provides medically necessary orthodontic services for eligible and qualified recipients. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service at 1(800) 441-7607or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. All medically necessary orthodontic treatment must be prior authorized by Medicaid before services are provided.

Requests for orthodontic services must include the recommendations of the multidisciplinary team, photos and x-rays.

Criteria for coverage include the following diagnoses when medical necessity exists:

- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch
- Craniofacial anomalies included but not limited to
- Hemifacial microsomia
- Craniosynostosis syndromes
- Cleidocranial dysplasia
- Arthrogryposis
- Marfan's syndrome
- Apert's syndrome
- Crouzon's Syndrome
- Other syndromes by review

- Trauma, diseases, or dysplasias resulting in significant facial growth impact or jaw deformity.

NOTE:

Extractions for orthodontic purposes are not covered unless there is a Medicaid approved orthodontia case.

Specific **non-covered services** include the following diagnoses:

- Dento-facial Anomaly, NOS (not otherwise specified)
- Orofacial Anomaly, NOS
- Severe Malocclusion

NOTE:

Procedures billable only by Alabama Children's Rehabilitation Service providers:

D8080 – Comprehensive orthodontic treatment of the adolescent dentition

D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s))

D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dental or physician.

13.5.2 Non-Covered Services

The following dental services are non-covered except where noted. Non-covered dental services include but are not limited to the following:

- Procedures which are not necessary or do not meet accepted standards of dental practice based on scientific literature. This will be determined thru review of submitted radiographs and written documentation which must support the medical necessity of the service rendered.
- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis).
- Orthodontic treatment (Exception: medically necessary orthodontic services after evaluation by CRS and referral to the Alabama Medicaid Agency for prior authorization. See section 13.5.1 for additional information).
- Prosthetic treatment, such as fixed or removable bridgework (D6240 and D6750), or full or partial dentures (Exceptions require prior authorization: prosthesis for closure of a space created by the removal of a lesion or due to congenital defects (permanent tooth congenitally missing).
- Panoramic films on recipients under age 5.
- Dental transplants
- Dental implants

- Prosthetic implants
- Esthetic veneers
- Silicate restorations
- Pulp caps on primary teeth
- Pulpotomies on permanent teeth
- Space maintainers for premature loss of primary incisors or as “pedo bridges”
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainers for teeth A, J, K, T, M and R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L and S age eight years and older
- Bilateral space maintainer for teeth C and H
- Repair of a damaged space maintainer or replacement of a lost space maintainer
- D2940 for teeth A-T for recipients greater than 6 years of age and older
- D2951 for teeth A-T
- D3220 and D3230 for teeth N, O, P and Q
- D4355 for recipients under age 6
- D1120 for recipients less than 3 years of age
- Non-diagnostic radiographs
- Extraction of exfoliating primary teeth without a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the record
- Acrylic, plastic restorations (class III or V)
- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Porcelain/ceramic substrate crowns
- Permanent crowns, core buildups, and post & cores on recipients under the age of 15
- Adult Dental Care
- Temporomandibular joint disorder

Palliative (emergency) treatment (D9110) is not covered when billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures.

13.6 Prior Authorization (PA) and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, periodontal maintenance procedures)
- Excision of hyperplastic tissue
- Inpatient and Outpatient hospitalizations for dental care for children 5 years and older.
- Inpatient and outpatient hospitalization and anesthesia charges for adults when hospitalization is required because (1) the individual's underlying medical condition and status is currently exacerbated by the dental condition, or (2) the dental condition is so severe that it has caused a medical condition (for example, acute infection has caused an increased white blood count, sepsis, or bacterial endocarditis in a susceptible patient)
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery
- Removal of completely bony impactions
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Diagnostic models (when requested by Medicaid)
- Oral/Facial Images (e.g., photographs or slides when requested by Medicaid)
- Therapeutic drug injection (by report)

NOTE:

Prior authorization does not guarantee eligibility. Providers are responsible for verifying eligibility prior to rendering services.

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

13.6.1 Obtaining Prior Authorization for Dental Services

Emergency Prior Authorizations

In an emergency situation where the delay for written request of prior authorization would endanger the health of the recipient, initiate prior authorization by contacting HPE/Dental PA Unit at (334) 215-4144, please be sure to include all the information listed below. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message will be accepted. The voice mail message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of dentist

- Phone number of dentist, including area code
- Nature of emergency
- Contact person, if other than dentist for follow-up

A paper or electronic PA request must be received by HPE within ten business days of the telephone call and or/voice message request. If the request is not received within ten business days of the telephone call, the authorization will be denied. The request must meet established guidelines and criteria.

Paper PA Request

Providers must use the Prior Review and Authorization Dental Request Form (form 343, revised 5/28/13) to request prior authorization for those procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth; D9420 (hospital or ambulatory surgical center call, etc.) as noted in section 13.6. All sections of this form must be completed. If the form is not completed in its entirety or if the PA request is submitted on any other form, the request will be denied. The completed form must be submitted with the required legible documentation. If the required documents are not received with the paper PA request, the PA will be denied. The form and required documentation should be forwarded to:

HPE Dental PA Unit
P.O. Box 244032
Montgomery, AL 36124-4032

or

301 Technacenter Drive
Montgomery, AL 36117

Electronic PA Requests

Providers may use Medicaid's web portal of PES software to submit an electronic PA for those procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth; D9420 (hospital or ambulatory surgical center call, etc.) When submitting an electronic request, select "Dental" if the service is being performed in the dental office. Select "Surgical" if the service is being performed in hospital setting**.**

Following submission of an Electronic PA request the legible documentation must be mailed to HPE/Dental PA Unit, P.O. Box 244032, Montgomery, AL 36124-4032 or 301 Technacenter Drive, Montgomery, AL 36117. The documents must have the PA number written legibly in the upper right hand corner of each page (e.g. clinical notes, radiographs, etc.) so that documentation can be matched to the electronic PA request.

PA requests will be held for up to 10 business days to allow sufficient time for providers to mail required supporting documents. If legible documents are not received in this time period, the PA will be denied. For reconsideration of the PA, a new **paper** PA request must be submitted with all the required documents attached.

Additional Instructions for Completing PA Request:

- For treatment in the dental office:

  When completing the Alabama Prior Review and Authorization Dental Request (Paper or Electronic), **ONLY** list those procedures that require prior authorization.

- For treatment in outpatient/inpatient hospital or nursing facility:

  When completing the Alabama Prior Review and Authorization Dental Request (Paper or Electronic), list **ALL** procedures planned even if they do not normally require prior authorization.

- Providers cannot charge or collect money from the recipient to schedule a service or guarantee patient compliance

Refer to Chapter 4, Section 4.4, Obtaining Prior Authorization, for instructions on obtaining prior authorization and completion of the form. PA request may be submitted via paper, web portal of PES**.**

Prior authorization requests take approximately two to three weeks for processing. Providers should call the Provider Assistance Center (PAC) at 1(800) 688-7989 to verify request is in the system if approval/denial is not received within this time frame.

NOTE:
For information on Administrative Reviews, see Chapter 7, Section 7.2.1. Prior authorization does not guarantee eligibility**.**

13.6.2 Criteria for Prior Authorization

This section discusses specific criteria for prior authorization for certain periodontal, preventive anesthetic and inpatient/outpatient procedures. There are additional dental procedures that require prior authorization as indicated in Section 13.8.2, Procedure Codes.

Documentation Necessary for Hospital Cases Requiring Dental Prior Authorization (For recipients age 5 or older)

Prior authorization for patients **5** years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization; the mere extent of caries or large quantity of teeth to be treated, or preference to provide all treatment in one appointment, or need for premedication, are not, by themselves, qualifying reasons for hospitalization.
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder (requires an additional report described in a. – k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. **On children under age 5, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting.**

If Criteria number 4 above (without a physical or mental disability) is cited as the justification for treatment in a hospital setting, it additionally requires a report of at least one active failed attempt to treat in the office. This report must include (if applicable):

a. recipient's behavior preoperatively
b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. recipient's behavior during the procedure
d. the use, amount, and type of local anesthetic agent
e. use and dosage of premedication, if attempted
f. use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. procedure(s) attempted
h. reason for failed attempt
i. start and end times of the procedure(s) attempted
j. name(s) of dental assistant(s) present in the treatment room
k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

If above criteria is met the provider should submit a Prior Authorization request (paper or electronic) listing the CDT code D9420. If the Prior Authorization is approved, the approval letter will generally reflect the approval of **only one procedure code** (usually the hospital code) and the other requested procedure codes will show as pending. The letter will also contain a statement to the effect: "Outpatient/Inpatient Hospital Approved; all other procedures **CONTINGENT UPON**: preoperative radiographs *(type will be specified)* being taken at the hospital and submitted with list of actual treatment procedures directly to: HPE Dental PA Unit for review of treatment meeting criteria."

After treatment is completed PA update consisting of radiographs and a claim documenting actual services rendered should be sent to:

HPE Dental PA Unit
P.O. Box 244032
Montgomery, AL 36124-4032

or

301 Technacenter Drive
Montgomery, AL 36117

Once the prior authorization is reviewed and updated, a letter will be sent to the provider indicating services approved. Upon receipt of the letter, the provider may file their claim for services approved by Medicaid.

Outpatient/ASC Admission (D9420, limited to 4 times per recipient per calendar year)

Prior authorization is not required for children under 5 years on date of service (dos), unless the planned procedure code itself requires a Prior Authorization (e.g. scaling and root planing D4341)

Adult Anesthesia and Facility Fees (D9420, limited to 4 times per recipient per calendar year)

- Coverage may be available for facility and anesthesia charges through the prior authorization process for medically compromised adults whose dental problems have exacerbated their underlying medical condition. This code covers Anesthesia and Facility fee only and does not cover any dental procedures.
- Criteria for coverage of adult anesthesia and facility fees include the following conditions:
- Uncontrolled diabetes
- Hemophilia
- Cardiovascular problems (for example, CHF, prosthetic heart valves, acute endocarditis)
- When an existing qualifying medical condition is presently exacerbated by the dental condition or when the dental condition is so severe that it has caused a medical condition (for example, acute dental infection has caused an increased white blood cell count, sepsis, or bacterial endocarditis in a susceptible patient)

Documentation by the patient's primary care physician must be included with the completed Alabama Prior Review and Authorization Dental request form, which confirms the medical compromise indicated.

Additional dental prior authorization criteria will be provided to all Medicaid dental providers, as they become available.

13.6.3 Referral Requirements

EPSDT Referral

Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Refer to Appendix A for EPSDT services.

Medicaid does support the recommendations of The American Academy of Pediatric Dentistry which recommend children be enrolled and under the care of a dentist by age one.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Dental	M D O	Dentists & Federally Qualified Health Centers (Claim Type D only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontia treatment of adolescent dentition), D8680 (Orthodontic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for observation services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for **DENTAL** procedures.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st to determine whether your services require a referral from the Primary Medical Provider (PMP).

Case Management Care Coordination

Alabama's Patient 1st program requires that Medicaid recipients understand the importance of dental care and how to use the dental health care system. Now, professional case managers in the patient's county of residence can complement the dental services of your practice by working with patients you identify as needing additional assistance.

Referrals should be limited to "special cases" only. These include but are not limited to children with special needs who require follow-up care, children needing assistance with referral for specialty care, and missed appointments for children lost to follow-up during treatments such as root canals.

If you have a child that meets the "special cases" criteria, then refer this patient to the targeted case manager in the patient's county of residence for further screening, support, counseling, monitoring and education. For a list of managers in your area, call the Dental Program at (334) 242-5014 or visit the Alabama Medicaid Agency's website at www.medicaid.alabama.gov.

13.7 Cost Sharing (Copayment)

Dental Providers cannot charge Medicaid Recipients, since copayment does not apply to services provided by dental providers.

13.8 Completing the Claim Form

Effective June 1, 2008, all Medicaid dental providers must use the 2006 version of the American Dental Association Dental claim form. If you experience problems with HPE processing your forms, contact HPE for resolution, 1-800-688-7989. Refer to Chapter 5, Filing Claims, Section 5.5, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental Form.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Dental providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

13.8.1 Time Limit for Filing Claims

Medicaid requires all claims for Dental providers **to be filed within one year of the date of service**. Refer to Chapter 5, Filing Claims, Filing Limits, Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

13.8.2 Procedure Codes

Use the code numbers and procedure descriptions as they appear in this section when filling out the ADA dental form. The listing of a procedure in this section does not imply unlimited coverage. **Certain procedures require prior authorization as noted in the PA Required column.**

Diagnostic Clinical Oral Examinations

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0120	Periodic oral examination is an evaluation a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This examination is limited to once every six months (per calendar month) for eligible Medicaid recipients. A full six month period between oral exams is not required. For example, if a recipient received an oral exam on January 15, 2002, he or she is eligible for another exam any time in July 2002 (the sixth month). Cannot be billed within 6 months of D0150 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No
D0140	Limited oral evaluation – problem focused (emergency treatment) A limited oral examination is an evaluation or re-evaluation limited to specific health problems. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same day. Typically, recipients receiving this type of evaluation have been referred for a specific problem or are presented with dental emergencies, such as acute infection. Providers using this procedure code must report the tooth number or area (please refer to page 41 for specific instructions) of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record where the specific problem is suspected. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to one per recipient per provider/provider group per calendar year.	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver : This code is intended to be for the first visit to a dental and/or *medical office for a patient under three years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling with the child's parent or guardian. This code will only be allowed once per recipient lifetime (only exception is the 1st Look Program). Cannot be billed on the same date of service as procedure codes D0120 (periodic exam); D0140 (limited oral evaluation) or D0150 (comprehensive oral evaluation). Under the 1st Look Program: D0145 will be billable once by a pediatric medical provider and once by a dental provider for children ages 6 months through 35 months.	No
D0150	A comprehensive oral examination used by a general dentist or specialist when evaluating a recipient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. This procedure is limited to once per recipient's lifetime per provider or provider group. Cannot be billed within 6 months of D0120 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No

Radiographs

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated.

A full series consisting of at least 14 periapical and bitewing films OR a panoramic film are permitted every three years if professional judgment dictates. Effective July 1, 2003, panoramic films are limited to age 5 and above. A full series (D0210) uses the panoramic film (D0330) *once every three years* benefit and vice versa.

If **medically necessary**, posterior bitewing and single anterior films may be taken every six months as part of an examination and, subject to the annual limits. **Documentation must support medical necessity**. All periapical films are limited to a maximum of **five** per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).

In order to be reimbursed, **all films must be of diagnostic quality suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type, date taken, recipient's name, and name of dentist.**

Radiographs of non-diagnostic quality are not chargeable to Medicaid or the recipient.

When billing Intraoral - Periapical, first film (D0220), and Periapical, each additional film (D0230) a tooth number/letter is required in tooth number column on electronic or paper claim.

Any combination of periapical films with or without bitewings taken on the same date of service which exceed the maximum allowed, must be billed as a Complete Intraoral Series (D0210). D0330 uses the benefit of D0210.

Periapical and occlusal films **must have a valid indication** documented in the record (e.g. aid in diagnosing an emergency, endodontic obturation evaluation, etc.) **Routine use of periapical radiographs(s)** at periodic/comprehensive evaluations or treatment appointments without valid documented indications **are not allowable**.

Radiology Guidelines (guidelines do not override benefit limits)

A. Radiographic Examination of the New Patient

Child-Primary Dentition: Posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

Child-Transitional Dentition: Individualized periapical/occlusal examination with posterior bitewings OR a panoramic X-ray and posterior bitewings, for a new patient with a transitional dentition.

Adolescent – Permanent Dentition Prior to the eruption of the third molars.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high-risk factors for caries

   a. Child – Primary and Transitional Dentition: Posterior bitewings performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent: Posterior bitewings performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

2. Patients with no clinical caries and no other high risk factors for caries

   a. Child-Primary Dentition: Posterior bitewings performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts who show no clinical caries and are not at increased risk for the development of caries.

   b. Adolescent: Posterior bitewings performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition and Adolescent: Individualized radiographic survey consisted of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

   Child- Primary Dentition: Prior to the eruption of the first permanent tooth, no radiographs should be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

   Child – Transitional Dentition: Individualized periapical/occlusal series OR a panoramic x-ray to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

   Adolescent: Age 16-19 year of age recall patient, a single set of periapicals of the wisdom teeth or a panoramic radiograph.

Requests to Override the Panoramic Film Limitation

An override of the 3-year limitation on panoramic films will be considered **only** under the following exceptional circumstances:

a. The provider finds clinical or radiographic evidence of **new** oral disease or a **new** problem that cannot be evaluated adequately using any other type of radiograph, or

b. The recipient's previous provider is unable or unwilling to provide a copy of the previous panoramic film that is of diagnostic quality. (Such cases may result in recoupment of Medicaid's payment for the previous film.)

To request a panoramic override, the provider must submit the following:

a. A properly completed 2006 ADA claim form,

b. Copies of the current and previous panoramic films as well as any other radiographs that support the override request, and

c. A cover letter that clearly describes the circumstances of the case.

These requests should be mailed to:

Alabama Medicaid Agency
Dental Program
P.O. Box 5624
Montgomery, AL 36103-5624

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0210	Intraoral – Complete series, including bitewings, consists of 14 periapicals and bitewings. Limit once every 3 years. A complete series uses the benefit of a panoramic film. Any combination of D0220, D0230, D0240, D0272, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210 must be billed as D0210	No
D0220	Intraoral – Periapical, first film. Not allowed on the same date of service as D0210. All periapical films are limited to a maximum of five per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).	No
D0230	Intraoral – Periapical, each additional film This film is taken **after** the initial film (D0220) Not allowed on the same date of service as D0210	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0240	Intraoral – Occlusal film Requires tooth number. Should not be reimbursed when a periapical film is the appropriate service (D0220 or D0230**). If billed where periapical is more appropriate, reimbursement will be subject to recoupment** **This code is not to be billed when periapicals are billed (D0220 and D0230) for the same area of the mouth as the occlusal film.** **This procedure is for the maxillary (teeth C-H) and mandibular (teeth N-R) areas only. This code is not to be utilized for single teeth.**	No
D0250	Extraoral – first film	No
D0260	Extraoral – each additional film	No
D0272	Bitewings – two films Limit 1 every six months Not allowed on same the date of service as D0274	No
D0274	Bitewings - four films Limit 1 every six months Effective July 1, 2003, procedure restricted to age 13 or older. Not allowed on same the date of service as D0272	No
D0330	Panoramic film Cannot be billed in addition to D0210. A panoramic film uses the benefit of a complete series (D0210) Limited to once per recipient every three years (calendar year), Effective July 1, 2003 procedure restricted to age 5 or older)	No
D0350	Oral/facial images (traditional photos and intraoral camera images) *Oral/facial images are authorized only when required by Medicaid*	Yes

Tests and Laboratory Examinations

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D0470	Diagnostic casts, per model. Models must be trimmed and able to be articulated and must include bases. *Diagnostic casts are authorized only when required by Medicaid.*	Yes

Preventive Services

Dental prophylaxis includes scaling and/or polishing utilizing a dental prophy cup. Providers should not bill for a “tooth brush prophy”. When billing for prophylaxis and fluoride treatment provided on the same date of service for a recipient, use D1110 and D1208 for recipients over the age of 12 and D1120 and D1208 for children up to and including 12 years of age.

Topical Fluoride Treatment (Office Procedure) D1203, D1204 & D1206

Prescription strength fluoride product designed solely for use in the dental/medical office, delivered to the dentition under the direct supervision of a dental professional or an approved medical professional under the 1st Look Program. Fluoride must be applied separately from prophylaxis paste.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D1110	Prophylaxis - **Recipient (13 years of age and older)** Limited once every 6 months. (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as: D4341, D4355, or D4910	No
D1120	Prophylaxis - **Recipient (covered for age 3 up to and including 12 years of age)** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as D4341, D4355, or D4910	No
D1208	Topical application of fluoride (excluding prophylaxis) **Recipient (up to and including 0-20 years of age)** **Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or “swish”.** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)).	No

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
	Not allowed on the same date of service as: D1206	
D1206	Topical Fluoride Varnish, Therapeutic Evaluation for High Risk Caries In order to bill this code the patient must have documented evidence of moderate to high risk caries. This procedure can only be billed once annually beginning age 3**.** Not allowed on the same date of service as D1208 (topical application of fluoride – child) **NOTE:** For the 1st Look Program: D1206 will be limited to 3 per calendar year, regardless of the provider (medical or dental) not to exceed 6 fluoride varnish applications for children ages 6 months through 35 months.	No
D1351	Sealant, per tooth **Only covered for teeth: 02,03,14,15,18,19,30,31, on children aged 5 through 13 years)** For procedure D1351, teeth to be sealed must be free of caries and restorations. Surface sealed must be noted on the dental claim form. Reimbursement for restorations placed for previously sealed surface by the same provider within a 12 month period will be reduced by the amount of the reimbursement for the sealant. Limit one per tooth per lifetime	No

NOTE:

Multiple visits needed to accomplish an exam, prophy; fluoride and sealants must have documented medical necessity in order for Medicaid payment to be allowable. Payment will be subject to recoupment if documentation does not support the medical necessity for multiple visits to accomplish an exam, prophy; fluoride and sealants.

It is considered fraudulent practice for a provider to intentionally schedule multiple appointments for no medical reason in order to maximize their reimbursement.

Space Maintainers

Effective July 1, 2003, space maintainers are covered on the following missing teeth ONLY:

1. Premature loss of second primary molar (A,J,K,T)
2. Premature loss of first primary molar (B,I,L,S) except in mixed dentition with normal class I occlusion
3. Premature loss of primary canines (C,H,M,R)

Space maintainers are NON-COVERED in the following instances:

- Repair of a damaged space maintainer or the replacement of a lost space maintainer
- For premature loss of primary incisor teeth or as "pedo bridges"

- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- More than once per recipient's lifetime for a given space(tooth) to be maintained
- Space maintainers for the loss of permanent teeth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainer for teeth A, J, K, T, M, R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L, S after age 8
- Bilateral space maintainer for teeth C and H
- Repair of a damaged space maintainer or replacement of a lost space maintainer

NOTE:

Contraindications to Space Maintainers According to the American Academy of Pediatric Dentistry:

A space maintainer is usually not necessary if there is a sufficient amount of space present to allow for eruption of permanent tooth/teeth.

A space maintainer may not be recommended if severe crowding exists, such that space maintenance is of minimal effect and subsequent orthodontic intervention is indicated.

A space maintainer may not be necessary if the succedaneous tooth will be erupting soon.

Space maintainers, when indicated, should be placed as soon as possible after early primary tooth loss, but no later than 180 days after extraction or loss. On the 181st day, the space maintainer procedure will deny. The claim or prior authorization form must indicate the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. The first two space maintainer procedure codes billed regardless of tooth (i.e. two per mouth) do not require prior authorization, but must meet coverage requirements. Prior authorization with justification is required for the billing of each additional space maintainer procedure code after the first two.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1510	Space maintainer- fixed, unilateral	Yes (See above)
D1515	Space maintainer- fixed, bilateral	Yes (See above)
D1520	Space maintainer – removable, unilateral	Yes (See above)
D1525	Space maintainer- removable, bilateral	Yes (See above)
D1550	Re-cement space maintainer (re-cementing is limited to two times for a given space maintainer (tooth)	Yes (See above)

Restorative Services

Fee for restorative service includes: all adhesives including amalgam or resin bonding agents, lining or base, restoration, and local anesthesia or analgesia, if necessary. **Amalgam or resin restorations are not covered on a tooth receiving any of the following procedures:** stainless steel crowns (D2930, D2931), resin crowns (D2932), core buildups (D2950), post & cores (D2952, D2953, D2954, D2957), or crowns (D2750, D2751, D2752, or D2792).

Amalgam or resin codes (D2140 – D2394) **may not be billed** in substitution for a core buildup (D2950). Primary tooth restorations are not allowed when normal exfoliation is imminent. Effective July 1, 2005 restorations (D2140 – D2394) **on primary teeth are not covered unless there is greater than one-third of the original root length remaining.**

Amalgam Restorations (Including Polishing)

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2140	Amalgam – one surface, primary or permanent	No
D2150	Amalgam – two surfaces, primary or permanent	No
D2160	Amalgam – three surfaces, primary or permanent	No
D2161	Amalgam – four or more surfaces, primary or permanent	No

Composite Restorations

Resins are not allowed for preventive procedures or cosmetic purposes (e.g. diastema closure, discolored teeth, correction of developmental anomaly, etc.). **Resins are used to restore a carious lesion into the dentin or a deeply eroded area into the dentin**. Reimbursement for enamel only resins may be subject to recoupment when used as a non-preventative measure. Resins must be visible on radiographs with evidence of tooth preparation.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2330	Resin – one surface, anterior	No
D2331	Resin – two surfaces, anterior	No
D2332	Resin – three surfaces, anterior	No
D2335	Resin – four or more surfaces or involving incisal (anterior) angle	No
D2391	Resin - one surface, posterior	No
D2392	Resin - two surfaces, posterior	No
D2393	Resin - three surfaces, posterior	No
D2394	Resin - four or more surfaces, posterior	No

NOTE:

For procedure codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394, the reimbursement determinations are based on the total number of different surfaces restored, not to exceed the total number of surfaces characteristic of that tooth, and no surface shall be billed twice. Reimbursement is not based on the total number of restorations placed. For example if a buccal, occlusal and lingual resin restoration were placed in a posterior tooth, the correct billing would be BOL D2393 and **not** D2391 times 3.

Crowns, Single Restorations Only

Medicaid covers crowns, post & cores, and core buildups **only** following root canal therapy (D3310, D3320, D3330) which must qualify for Medicaid coverage. Effective July 1, 2003, crowns (**excluding stainless steel or resin crowns**), core buildups and post & cores are limited to the permanent teeth on eligible recipients age 15 years or older following root canal therapy. Limited to one per tooth per lifetime. Crowns, post & cores, and buildups on 3rd molars are not covered, with the exception noted below:

NOTE:

Exception: when the second molar is missing and the third molar has moved into the second molar's space and is functioning tooth, the provider must submit a radiograph with a prior authorization request for consideration of payment.

Effective April 1, 2006, permanent, stainless steel or resin crowns are limited to 6 per date of service individually or in combination when performed in an office setting. These procedure codes include D2750, D2751, D2752, D2792, D2930, D2931, and D2932.

Amalgam or resin restorations or sedative fillings are not authorized on teeth being crown. Codes D2940, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394 are non-covered services for a tooth eligible for a crown (D2750-D2792). Codes D2950, D2951, D2952, D2953, D2954 and D2957 are covered services for a tooth eligible for a crown (D2750-D2792).

***No prior authorization is required for crowns, core buildups, or post & cores. If no root canal is in Medicaid's history, send a diagnostic postoperative periapical x-ray after crown is seated showing completed root canal and crown (bitewings are not acceptable) with completed claim form directly to: Alabama Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36103-5624.**

Effective January 1, 2005 reimbursement fees for crown (D2750 – D2792) procedures include any: crown follow up appointments, pre and post radiographs, equilibration, or recementation within 6 months of insertion.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2750	Crown – porcelain fused to high noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2751	Crown – porcelain fused to predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2752	Crown – porcelain fused to noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2791	Crown – full cast predominantly base metal	No*
D2792	Crown – full cast noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*

NOTE:

Providers will be reimbursed for only one code per tooth per lifetime for procedures D2750, D2751, D2160, D2752 and D2792.

Incomplete Procedures

Effective July 1, 2003 for multiple appointment procedures, payment will be made to the provider that started the procedure. **Documentation that several attempts were made to complete the procedure** (i.e. phone calls, certified letters) must be supported in the medical record. If no documentation can be provided to support multiple attempts were made to complete the procedure, the starting provider will not be reimbursed. **Billing should only occur after documentation of failed attempts is complete.** If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered.

Other Restorative Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2920	Re-cement crown - Limit 2 per lifetime per tooth None allowed within the first six months of placement	No
D2930	Prefabricated stainless steel crown, primary tooth The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) When the failure of other restorative materials is likely with interproximal caries extended beyond line angles Following pulpotomy or Pulpectomy For restoring a primary tooth being used as an abutment for a space maintainer, or For restoring fractured teeth when the tooth cannot be restored with other restorative materials. Limited to once per tooth per lifetime	No
D2931	Prefabricated stainless steel crown, permanent tooth.	No
D2932	Prefabricated resin crown are authorized on primary or permanent teeth. **Allowable on anterior teeth only.**	No
D2940	Sedative fillings - temporary restoration intended to relieve pain. Not to be used as liners or bases under restorations. Not allowable with: amalgam or resin restoration, endodontically treated teeth, core buildups, posts and cores, done on same tooth, same DOS.	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
	Non-covered for teeth A-T age 6 and older. Limit one per tooth.	
D2950	Core buildup, including any pins. Covered for permanent teeth that have had endodontic treatment. Not covered on primary teeth. **Limited to age 15 or older** Not allowable on the same tooth with: • Amalgam or resins (D2140 – D2394) • Posts & Cores (D2952, D2953, D2954, D2957) Sedative (temporary) fillings (D2940) Pins (D2951)	No
D2951	Pin retention – per tooth in addition to restoration. Not allowable with D2950	No
D2952	Post and core in addition to crown, indirectly fabricated Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2953	Each additional indirectly fabricated post – same tooth - (maximum of 2) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2954	Prefabricated post and core in addition to crown - (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2957	Each additional prefabricated post – same tooth – (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No

Effective April 1, 2006, core buildups (D2950) and post and cores (D2952, D2954) are limited to 6 per date of service individually or in combination when performed in an office setting.

Effective July 1, 2003, the following codes require at a **minimum a diagnostic pre-treatment periapical radiograph** be taken and maintained on file: D2750, D2751, D2752, D2792, D2952, D2953, D2954, and D2957.

Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. "So-called Posts" made in the office solely by flowing or compacting materials into the canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered. In order to qualify for coverage, posts must be fitted and cemented within the prepared root canal, and be attached to the core in order to retain the core. Posts which do not meet criteria for coverage will not be covered as core buildups. Core buildups and posts & cores are only covered on teeth which are receiving crowns and are limited to once per eligible tooth per lifetime.

Endodontics

Pulp Capping

Bases, liners, and sedative fillings do not qualify as pulp caps. Pulp caps without a protective restoration are not covered. There must be radiographic evidence of deep caries.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3110	Pulp cap, Direct (excluding final restoration) Covered for permanent teeth only. Pulp cap must cover a documented exposed pulp. **Limit one per tooth**	No
D3120	Pulp cap, Indirect (excluding final restoration) Covered for permanent teeth only. Effective January 1, 2005, indirect pulp caps are only covered for documented treatment of **deep** carious lesions near the dental pulp with a protective dressing over the remaining carious dentin to prevent operative pulp exposure. Radiographs must support the indication of deep caries. **Limit one per tooth per lifetime.**	No

Pulpotomy/Pulpectomy

Only the single most appropriate endodontic code should be billed. It is not appropriate to bill pulpotomy/pulpectomy (D3220) and pulpal therapy on primary teeth (D3230 or D3240) for the same tooth. D3220 must not be billed with D3310, D3320, D3330 or D3332 for the same tooth, as these four codes already include a pulpotomy or pulpectomy. **Pulpotomies are not covered for permanent teeth effective July 1, 2003.**

Effective April 1, 2006, the following limitations apply for endodontic procedures when performed in an office setting. Pulpotomies (D3220) and Pulpal Therapy (D3230, D3240) are limited to 6 per date of service individually or in combination.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3220	Therapeutic pulpotomy **Covered for primary teeth only, excluding final restoration**	No

Primary Endodontics

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

D3230 and D3240 would be covered **ONLY** when all of the following documented indications exist: the primary tooth is restorable and must be saved until the permanent tooth erupts, **the pulp is non-vital** with no radiographic signs of internal or external root resorption, is present. **These procedures requiring a complete pulpectomy, require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file.** POST-TREATMENT PERIAPICAL FILMS MUST BE TAKEN ON THE SAME DATE THE PULPECTOMY WAS COMPLETED. Radiographs are included as part of the procedure (D3230 & D3240) and are not billable to Medicaid or the recipient. These radiographs must show successful filling of canals with a resorbable filling material without gross overextension or underfilling. Follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Endodontics on Permanent Teeth

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canals(s), progress radiographs, including a root canal fill radiograph and follow-up care. Endodontics on third molars is not a covered procedure. Effective April 1, 2006, Root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination when performed in an office setting. Molar root canals (D3330) are limited to 2 per date of service in an office setting. One molar root canal can be performed with 3 anterior or premolar root canal procedures in an office setting.

The following codes are covered only on permanent teeth and require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D3310, D3320, D3330, D3351, D3410, and D3430. Endodontics (D3310 – D3430) are **only** covered when there are documented tests performed (electrical pulp tests, thermal, percussion, palpation) in the record consistent with radiographic findings and symptoms which support a documented pulpal pathology diagnosis of an irreversible nature on a specific restorable tooth and one of the following procedures are indicated: D3310, D3320, or D3330. When reviewing a radiograph, canals must be filled at approximately 1mm or less from the apex of the root and have no voids in material. There should be a sealing material between the root canal filling material and restorative material.

Intentional endodontics performed for reasons other than documented irreversible pulpal pathology of a specific restorable tooth, such as, but not limited to: prosthetics, bleaching, orthodontics, non-covered periodontal or oral surgery procedures, pain of undetermined origin, preference of the recipient or provider, etc. are not covered and are subject to recoupment.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3310	Anterior, excluding final restoration (age 6 or older)	No
D3320	Bicuspid, excluding final restoration (age 9 or older)	No
D3330	Molar, excluding final restoration (age 6 or older)	No
D3332	Incomplete endodontic therapy on permanent teeth due to the tooth becoming inoperable or unrestorable due to a fracture or removal of gross decay must be submitted for an administrative review prior to payment.	No
D3351	Apexification, per treatment visit **(nonvital permanent teeth only)** This procedure is only covered after apical closure is obtained and demonstrated with a postoperative periapical radiograph maintained in the record. This postoperative film must be taken after apexification is completed but before canal obturation is performed. Usually several treatments are required. Treatment performed in less than 180 days after apexification with Calcium Hydroxide is not covered. When using Mineral Trioxide Aggregate (MTA) for apexification, the 180 days does not apply.	No

Periapical Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3410	Apicoectomy - Anterior, per tooth - Limit 1 per tooth per lifetime	Yes
D3430	Retrograde filling - **Limit 1 per tooth per lifetime** Covered only in conjunction with D3410 on anterior teeth	Yes

D3230, D3240, D3310, D3320, D3330, D3410 and D3430: **require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file**. In addition, follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Prior Authorization requests for D3410 and D3430 require a postoperative endodontic periapical film with the history and examination findings to include: symptoms, periodontal probings, palpation, percussion, mobility, presence of swelling or sinus tract, etc. and an **explanation of why re-treatment is not being considered.**

Periodontics

Periodontics requires prior authorization. Prior authorization for periodontal therapy codes, D4341 or D4910 requires the following:

- Complete periodontal charting (including probing depths) and free gingival margins in relation to Cementoenamel Junctions(CEJs)
- Posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs to be submitted with the prior authorization request

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D4341	Periodontal scaling and root planning, per quadrant Prior authorization for scaling and root planning requires documentation of pocket depths as follows: • Patients **over** 12 years old must have a generalized pocket depth **greater than 4 mm**, with demonstrable radiographic evidence of generalized periodontitis. (This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque from these surfaces.) • For patients **under** 12 years old, this procedure is ordinarily not indicated unless some unusual circumstance requires a more in-depth review and documentation (for example, familial juvenile periodontitis.) • This procedure will not be authorized for treatment of pseudopockets. • This procedure requires that radiographs (posterior bitewings and anterior periapicals or bitewings) and complete periodontal charting (including probing depths, free gingival margins in relation to CEJs, etc.) be provided with the request. A limit of no more than **two quadrants** of scaling and root planning will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases. This procedure not allowed for same quadrant, same date of service with: D1110, D1120, D1201, D1205, D4355, or D4910.	Yes
D4355	Full mouth debridement Covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs (bitewings, periapicals) be sent with the request. Clinical photographs/images may be required upon request. This procedure is not allowed on the same date of service or within 6 months of scaling and root planning. If prior approved, this procedure must be performed before a comprehensive evaluation is done. This procedure is not allowed on same date of service or within 6 months of: D1110, D1120, D4341, or D4910. Difficult prophylaxis should be reported as a “routine” dental prophy (D1120, D1110).	Yes
D4910	Periodontal maintenance procedures Prior authorization for Periodontal/Special Maintenance	Yes

Procedure Code	Description of Procedure	Prior Authorization Required
	following active therapy (D4341) requires the following information: • A clinical description of the service • Procedure recommendations • X-rays • Complete periodontal charting (probing depths, free gingival margins in relation to CEJs) • Current CDT procedure code • The number of units or visits This procedure is not allowed on same date of service with: D1110, D1120, D4341 or D4355	

Oral Surgery

Extractions

Extractions include local anesthesia, (infiltration **and/or** nerve block), aveoloplasty, suturing if needed and routine postoperative care. Extractions of exfoliating primary teeth will not be covered unless there is a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the dental record.

Procedure Code	Description of Procedure	Prior Authorization Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

NOTE:

Payment for extraction is for the complete removal of tooth (clinical crown and roots). Partial extraction of a tooth is subject to recoupment.

Surgical Extractions

Effective July 1, 2003, surgical extractions include and require documentation of local anesthesia, alveoloplasty, mucoperiosteal flap elevation, osseous removal, sectioning and removal of tooth structure, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241. D7241 requires a report by tooth number of **actual unusual surgical complication(s)**. The following codes are only covered for permanent teeth: D7210, D7220, D7230, D7240, D7241, and D7250. **Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs.** To be reimbursed, providers must send a diagnostic x-ray of primary tooth, report and completed claim form directly to: Alabama Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Extractions due to crowding to facilitate orthodontics are not covered unless the orthodontics is covered meeting Medicaid criteria.

Procedure Code	Description of Procedure	Prior Authorization Required
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
	tooth. Requires documentation of cutting of both gingival and bone, removal of tooth structure, and closure. **Covered for permanent teeth only**	
D7220	Removal of impacted tooth – soft tissue occlusal surface must be covered by soft tissue, requires documentation of mucoperiosteal flap elevation. **Covered for permanent teeth only.**	No
D7230	Removal of impacted tooth – partially bony a portion of the crown must be covered by bone, requires documentation of mucoperiosteal flap elevation and bone removal. **Covered for permanent teeth only.**	No
D7240	Removal of impacted tooth – completely bony **most or all of the crown must be covered by bone,** requires documentation of mucoperiosteal flap and bone removal. **Covered for permanent teeth only.**	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal. Covered for **actual** complications only by report. **Covered for permanent teeth only.**	Yes
D7250	Surgical removal of residual tooth roots must require documentation of cutting of both soft tissue and bone and removal of tooth structure. Not covered if a portion or all of crown is present. **Covered for permanent teeth only.**	No

Procedures: D7210, D7220, D7230, D7240, D7250 requirements listed above (i.e. flap, bone removal, sectioning, etc.) must be documented in the dental record to be covered.

Other Surgical Procedures Applied To Teeth

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus. This fee includes any composite or bonding attachment to evulsed or displaced tooth and adjacent teeth as well as any brackets, wire or line used.	No
D7280	Surgical exposure of impacted or unerupted tooth to aid eruption	No
D7285	Biopsy of oral tissue, hard (bone, tooth)	No
D7286	Biopsy of oral tissue, soft (all others)	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	**Description of Procedure**	*Prior Authorization Required*
D7410	Excision of benign lesion up to 1.25 cm	No
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7451	Removal of odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No
D7460	Removal of non-odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7461	Removal of non-odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue. Requires documentation of incision through mucosa, area of incision, presence of any purulence from the abscess, use of any drain or sutures. Not allowed in same site as a surgical tooth extraction. Incisions through the gingival sulcus are not covered.	No
D7520	Incision and drainage of abscess, extraoral soft tissue. Requires documentation of incision through skin and area of incision, type of drain (if any) and sutures (if closed)	No

Treatment of Fractures - Simple

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7610	Maxilla - open reduction (teeth immobilized if present)	No
D7620	Maxilla - closed reduction (teeth immobilized if present)	No
D7630	Mandible - open reduction (teeth immobilized if present)	No
D7640	Mandible - closed reduction (teeth immobilized if present)	No

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7820	Closed reduction of dislocation	No

Other Repair Procedures

Excision of hyperplastic tissue (D7970) requires:

- Medical documentation, that the hyperplasia is drug-induced
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7911	Complicated suture, up to 5 cm. **Excludes** closure of surgical incision reconstruction requiring delicate handling of tissue and wide undermining for meticulous closure.	No
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	No
D7970	Excision of hyperplastic tissue; per arch (covered for drug-induced cases only)	Yes
D7971	Excision of pericoronal gingival. Covered for partially erupted or impacted teeth only. Use for operculectomy. Not allowed for crown lengthening or gingivectomy.	No

Orthodontics

Orthodontic services require prior authorization. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. See Section 13.5.1 of this chapter entitled *Orthodontic Services* for more details.

Adjunctive General Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D9110	Palliative (emergency) treatment of minor dental pain. This procedure requires documentation in the record of: symptoms, findings, tests (if performed), radiographs if taken, diagnosis, and description of emergency treatment. Cannot be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. This is a specific code and must not be used to bill for any procedure that has its own unique code, even if the most appropriate code is not covered. Always bill the most appropriate and current CDT code **Limit one per visit.**	No

Procedures

The following procedures are limited to one per visit when not covered by separately listed procedures.

Anesthesia

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9220	General anesthesia **Requires current state board GA permit**	No
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide or similar analgesia is authorized for payment in special cases such as intellectual disability, a fearful, extremely nervous/anxious or obstreperous patient, or an extremely uncooperative patient. Effective April 1, 2004, documentation of medical necessity, written informed consent, and nitrous oxide dosage (% nitrous oxide/oxygen and/or flow rate, duration of the procedure, post treatment oxygenation procedure and condition of the patient upon discharge), **must be** in the medical record. The provider or recipient's desire to use this procedure, by itself, does not qualify it as medically necessary.	No
D9241	Intravenous sedation/analgesia **Requires current state board IV or GA permit**	No

Drugs

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9610	Therapeutic parental drug, single administration, by report billable only when no definitive treatment rendered in same visit	Yes
D9612	Therapeutic parenteral drugs, two or more administrations, different medications billable only when no definitive treatment rendered in same visit	Yes

Added: billable only when no definitive treatment rendered in same visit

Periodicity Schedule

NOTE:

The periodicity schedule below is only a guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. Please refer to policy and procedures within "Chapter 13 Dental" governing reimbursement for dental procedures.

ALABAMA MEDICAID'S EPSDT PERIODICITY SCHEDULE

	Infancy							Early Childhood						Middle Childhood						Adolescence									
AGE	Newborn[1]	3-5 days[2]	By 1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	18 Mo	24 Mo	30 Mo	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
Clinical oral examination[1,2]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assess oral growth and development[3]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caries-risk assessment[4]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Radiographic assessment[5]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prophylaxis and topical fluoride treatment[4,5]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	O	O	O	O	O
Fluoride supplementation[6,7]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Anticipatory guidance/counseling[8]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oral hygiene counseling[9]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dietary counseling[10]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Injury prevention counseling[11]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for nonnutritive habits[12]						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for speech/language development[13]						←→			X	X	X	X	X	X	X														
Alcohol and drug use assessment[13]																X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for intraoral/perioral piercing																X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and treatment of developing malocclusion						←→			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment for pita and fissure sealants[14]								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and/or removal of third molars																						X	X	X	X	X	X	X	X
Transition to adult dental care																					←→								

NOTES:

X To be performed
O Perform when necessary
←→ Perform within indicated timeframe

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2 Includes assessment of pathology and injuries.
3 By clinical examination.
4 Must be repeated regularly and frequently to maximize effectiveness.
5 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6 Consider when systemic fluoride exposure is suboptimal.
7 Up to at least 16 years of age.
8 Appropriate discussion and counseling should be an integral part of each visit.
9 Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.
10 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11 Initially play objects, pacifiers, car seats; then learning to walk, sports and routine playing.
12 At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13 Referral to a Pediatrician, if necessary.
14 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Tooth Numbers and Letters

- Enter the tooth number or letter for the appropriate tooth. Use the letters and/or numbers shown on the dental chart. Additional tooth designations are listed below. Insert these in the “Tooth # or Letter” block on the claim when indicated.
- Tooth Numbers should include for Permanent dentition: 01 through 32
- Tooth Numbers should include for Primary dentition: A through T
- Supernumerary are as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) would have 50 added to its tooth number. Therefore if a patient had an extra tooth number 30 it would be coded as tooth number '80' (30 + 50 = 80). Valid numbers would be 51 through 82.

A supernumerary tooth for Primary Dentition (Tooth numbers “A” through “T”) would place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it would be coded 'AS'. Valid letters would be ‘AS’ through ‘TS’.

The following codes may be used in conjunction with those listed on the claim form:

Code	***Designation***	***Code***	***Designation***
00	Full mouth	30	Lower Left Quadrant
01	Upper Arch	40	Lower Right Quadrant
02	Lower Arch		
10	Upper Right Quadrant	L	Left
20	Upper Left Quadrant	R	Right

Surface

Please bill the single most appropriate surface involved using the following abbreviations:

Code	***Designation***	***Code***	***Designation***
B	Buccal; Labial	L	Lingual
D	Distal	M	Mesial
I	Incisal	O	Occlusal
F	Facial; Labial		

When more than one surface on the same tooth is affected, use the following combinations:

2 Surfaces			***3 Surfaces***				***4 Surfaces***		***5 Surfaces***	
MO	IF	ML	MOD	IFL	BOL	MID	MODB	MIFL	*MODBL*	*MODFL*
DB	IL	OB	MOB	MIL	DOB	MIF	MODL	DIFL	*MIDBL*	*MIDFL*
MB	DI	DO	MOL	DIL	DOL	DIF	MOBL	MIDL		
DL	MI	OL	MBD	MLD			MIDF			

13.8.3 Place of Service Codes

The following place of service codes apply when filing claims for dental services:

Place of Service Codes	Place of Service
11	Dental office
15	Mobile Clinic
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes other than 11 and 15 require prior authorization before delivery of the service, unless recipient is less than 5 years old.

13.8.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy claim form must be submitted.

Refer to Chapter 5 Filing Claims, Section 5.8, Required Attachments, for more information on attachments

13.9 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
ADA Dental Claim Form Instructions	Chapter 5
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Dental Prior Authorization Form	Chapter 5
Medical Necessity/Medical Necessary Care	Chapter 7