Dental Services
Provider Manual

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CHAPTER III. COVERAGE AND LIMITATIONS

A. General Letters

A record of past and current General Letters outlining the content changes to this chapter are available online at: https://hhs.iowa.gov/media/4368.

B. Dentists Eligible to Participate

Dentists licensed to practice in the state of Iowa are eligible to participate in the Medicaid program. Dentists in other states are also eligible to participate, providing they are duly licensed in that state.

C. Annual Benefit Maximum (ABM)

Every **adult** Medicaid member, age 21 and older, has a one-thousand-dollar ($1,000) ABM each State Fiscal Year (July 1-June 30). A member's ABM amount is updated when a claim is paid, rather than when the services are provided. Providers are encouraged to submit claims timely. For information reg1arding a member's ABM, call the Eligibility and Verification Information System (ELVS) line at 1-800-338-7752 or 515-323-9639 in the Des Moines Area. Providers may also view ABM information by accessing the ELVS web portal or https://hhs.iowa.gov/medicaid/provider-services/eligibility-verification-information-system

There are exclusions to an adult Medicaid member's $1,000 ABM.

These services include:

- Preventive and diagnostic services
- Anesthesia (when billed in conjunction with approved oral surgery procedures)
- The fabrication of dentures and removable partial dentures.
- Emergent dental services are not included in a member's ABM. Providers must identify when services are being provided as emergent for exclusion to the members ABM.

A comprehensive list of codes excluded from a member's ABM can be found on the Dental Wellness Plan webpage under Dental Provider Resources: Dental Wellness Plan Excluded Services - Annual Benefit Maximum(ABM) or https://hhs.iowa.gov/media/6824/download?inline

Emergent Services - For claims submitted to Iowa Medicaid for emergent services, the claim form must contain the following information:

- ICD-10 diagnosis code qualifier AB must be included in box 34.
- In box 34a, the ICD-10 diagnosis code in line A must reflect the reasoning for the emergency service.

Providers must document the emergent care in the recipients' dental record, but no additional information is required. This documentation shall include a diagnosis with signs and symptoms, description of the treatment provided, and post-operative instructions and prescriptions when applicable.

For more information on how to submit dental claims, the following link will take you to the billing manual instructions on the Iowa Medicaid website:
https://hhs.iowa.gov/medicaid/provider-services/claims-billing or
https://hhs.iowa.gov/media/232/download?inline=

D. Coverage of Dental Services

Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by Doctor of Medicine, osteopathy, dental surgery, or dental medicine and would be covered if furnished by Doctor of Medicine or osteopathy.

Services must be reasonable, necessary, and cost effective for the prevention, diagnosis, and treatment of dental disease or injuries, subject to the limits listed in the following sections.

Certain services require prior approval before starting the service (see Prior Approval). Payment will be made for other certain procedures based on documentation of medical necessity (see **Iowa Medicaid DWP CDT Codes Requiring Prior Authorization and Additional Documentation with the Claim – Comm 710**).
https://hhs.iowa.gov/media/6823/download?inline

1. Diagnostic Services

a. Oral Evaluations

A **comprehensive oral evaluation** is payable once per member, per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period. It is not payable in conjunction with emergency treatment visits, denture repairs, or similar appointments.

A **periodic oral evaluation** is a payable benefit once in a six-month period. The six-month period starts from the date of the examination.

A **limited oral evaluation** for an evaluation limited to a specific oral health problem is payable. Typically, members receiving this type of evaluation have been referred for a specific problem. These services require documentation on the claim form or attached to the claim form which specifies the medical and dental necessity of the visit.

Additional necessary diagnostic procedures, such as x-rays, should be reported separately. Definitive procedures required on the same date as the evaluation should also be reported separately.

A **limited re-evaluation** is payable when necessary to assess the status of a previously existing condition that is not postoperative. Examples include:

- A traumatic injury where no treatment was rendered, but the member needs follow-up monitoring.
- Evaluation for undiagnosed continuing pain.
- Soft tissue lesion requiring follow-up evaluation.

An oral evaluation for children under three years of age and counseling with the primary caregiver is payable once every six months. It includes:

- Oral and physical health history.
- Evaluation of caries susceptibility.
- Development of an appropriate preventive oral health regimen.
- Communication and counseling with the parent, legal guardian, or primary caregiver.

A **comprehensive periodontal evaluation** is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the practice during the three years. It is not payable when provided with, or subsequent to, a comprehensive or periodic evaluation.

Screening of a patient is payable once every six months. It includes the initial assessment to evaluate a patient's oral health status and identify any potential dental issues commonly provided by a dental hygienist.

b. Diagnostic Imaging

A complete series of radiographic images, consisting of periapical films and posterior bitewing images, or a panographic radiograph with bitewings, is a covered benefit once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries, and diseases.

It is not payable for children under six years of age, unless medically necessary. Procedure code D0210 should be billed for a complete series of intraoral radiographs.

When radiographs taken on the same date of service exceed the reimbursement level for a complete series of radiographic images, the radiographs should be combined with D0210 instead of billing each periapical radiograph and bitewing radiographs individually.

A panographic X-ray with bitewings is considered the same as a complete series of radiographic images.

Children should receive only the minimum number of radiographs needed to detect anomalies, diseases, and to evaluate development. When a child has received recent radiographs in another dental office, efforts should be made to obtain those radiographs so that re-exposure of the child can be avoided.

Bitewing films are a covered benefit not more than once every 12 months.

Single periapical films are a covered benefit when medically necessary.

Intraoral and extraoral films are payable when necessary to diagnosis a condition.

Temporomandibular joint and cephalometric films are payable when necessary to diagnosis a condition.

Cone beam images are payable when medically necessary. Documentation of the medical necessity must be submitted with the claim. Examples include:

- Detection of tumors
- Positioning of severely impacted teeth
- Supernumerary teeth

Cone beam images for placement of dental implants are covered only when prior authorization approval for implants has been obtained.

c. Pulp Vitality Tests

Pulp vitality testing includes multiple teeth and contra lateral comparisons and is payable when necessary for diagnosis.

d. Casts

Diagnostic casts are payable for orthodontic cases, implants or when requested by Iowa Medicaid.

e. Caries Risk Assessment

Caries Risk Assessments (D0601, D0602, D0603) are payable one (1) time per 12-month period and is excluded from the ABM. Providers must clearly document the individual member's dental condition(s) that justifies the risk assessment classification submitted with the claim. Documentation must be maintained in the member's dental record.

2. Preventive Services

Services to prevent the occurrence or reoccurrence of oral disease are covered with frequency limitations.

a. Oral Prophylaxis

Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period, except for members who need more frequent care because of a physical or mental condition (including members receiving orthodontic treatment). This should not be billed more than once every ninety (90) days.

b. Fluoride

Topical application of fluoride (varnish, gel mouth rinse) is payable four times per year. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

Silver Diamine Fluoride (SDF)/ Application of caries arresting medicament – per tooth is payable per tooth.

- Limit of 4 teeth per date of service for dentists (this does not apply to Screening Centers, Maternal Health Centers, or Public Health Agencies providing I-Smile Silver Services).
- Allowed twice per year per tooth (no required number of days between applications)

- Restorations placed within 90 days of SDF are denied if completed by the same dentist.

However, a dentist that places a restoration after a different dentist has billed SDF will not be denied payment for the restoration

SDF applied by Screening Centers, Maternal Health, or Public Health providers will not cause any reduction of payment for a dentist placing a restoration within 3 months.

c. Pit and Fissure Sealants

Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on children through 18 years of age and for any person who has a physical or mental disability that impairs their ability to maintain adequate oral hygiene.

Replacement sealants are covered when medically necessary. Documentation in the member record must indicate that the sealant is totally or partially missing.

d. Space Management Services

Space management services are payable for persons 0 through 20 when:

- Premature loss of teeth would permit existing teeth to shift causing a handicapping malocclusion, or
- There is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if not corrected.
- Recementing of space maintainers is reimbursable to a provider who was not the original treating provider. Payment to another provider can only be made after 90 days of the initial placement. This service is limited to children 14 years of age and younger.

Removal of a fixed space maintainer is payable when performed by a dentist or practice that did not originally provide the appliance.

e. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care for Kids

Early and periodic screening, diagnosis, and treatment (EPSDT) (known in Iowa as the “Care for Kids” program) is covered for children under 21 years of age who are eligible for Medicaid.

The U.S. Department of Health and Human Services requires that the Medicaid program place special emphasis on early and periodic screening and diagnosis to ascertain physical and mental defects and provide treatment for conditions discovered.

The American Academy of Pediatric Dentistry's "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling and Oral Treatment for Infants, Children, and Adolescents" is applied. This information is available online at: http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

The I-Smile Dental Home program helps families with children to enable them to access early and regular dental care. Information about the I-Smile Program including contact information for local I-Smile Coordinators is available online at: https://hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health.

3. Restorative Services

Restorative services are payable when there is a fair to good prognosis for maintaining the tooth. Treatment of dental caries is covered in those areas that meet medical necessity.

Restoration of incipient or nonactive carious lesions is not a covered benefit. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic X-rays. Prophylactic fillings are not a Medicaid benefit.

Medicaid covers amalgam or composite resin filling material. Restorations are payable benefits for treatment of dental caries and are reimbursable only once in a two-year period.

a. Restorations

Any multi-surface restoration, regardless of the location should be combined and billed as follows:

- One, two, or more restorations on one surface of a tooth should be billed as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit on a maxillary molar, or mesial and distal occlusal pits of a lower bicuspid.
- Two separate one-surface restorations should be combined and billed as a two-surface restoration, i.e., an occlusal pit restoration and a buccal pit restoration should be billed as a two-surface restoration.

- Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove should be billed as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.
- More than four surfaces on an amalgam or composite restoration should be billed as a four-surface amalgam or composite.

Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia are included in the restorative fee and may not be billed separately.

- Pin retention is paid on a per-tooth basis and in addition to the final restoration.
- An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

b. Crowns

Stainless steel crowns are covered when a filling is not clinically appropriate. Examples include:

- Deciduous teeth when there is lack of sufficient tooth structure for a filling.
- Uncooperative members with a disability who need full coverage but cannot cooperate sufficiently for a full restoration.

There is no limit on the number of stainless-steel crowns that may be allowed in a 12-month period, as long as they are medically necessary.

Prefabricated porcelain/ceramic prefabricated stainless-steel crowns with resin window, or prefabricated esthetic coated stainless steel crowns are only covered on anterior primary teeth. Only one crown per primary tooth is allowed.

All **laboratory-fabricated crowns** utilizing non-precious materials shall be granted when:

- Coronal loss of tooth structure does not allow restoration with a composite or amalgam restoration, or
- There is evidence of recurring decay surrounding a large existing restoration, that cannot be repaired with another filling or
- The posterior tooth is fractured or has a broken cusp, or
- The posterior tooth has had endodontic treatment.

Crowns using noble or high noble metals are payable when the member meets the criteria for a crown and the member is allergic to all other restoration materials.

A replacement crown for the same tooth in less than 18 months due to failure of the crown is not covered and is the responsibility of the dentist who originally placed the crown.

*The billing date for any crown should be the date the crown is placed, not the preparation date.

Undelivered Crowns: If, after a three (3) month period, the member has not returned for the crown to be placed, Procedure code D2999 should be billed and submitted with the lab fee for reimbursement. Documentation included with the claim must include when the crown was fabricated, the procedure code for the type of crown and an explanation of the circumstances. The dentist must maintain the crown for a period of one year following the fabrication date.

c. Other Restorative Services

Restoration is not payable following a **sedative filling** in the same tooth, unless the sedative filling was placed more than 30 days previously.

Cast post and core, post and composite, or post and amalgam, in addition to a crown, are a covered benefit when the tooth is functional, and the integrity of the tooth would be jeopardized by no post support.

Core build-ups, including pins (when required), should be billed using procedure code D2950, no other restoration procedures.

Crown repair is payable. For pricing purposes, documentation of the repair must be submitted with the claim. The repair cannot exceed the cost of a new crown.

Unspecified restorative procedures require documentation of medical necessity submitted with the claim and may not be payable.

4. Endodontic Treatment

Root canal treatments on permanent anterior and posterior teeth are a covered benefit when there is a presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a non-vital tooth.

Root canal retreatment may be allowed when:

- The conventional treatment has been completed,
- A reasonable time (approximately one year) has elapsed, and
- The failure has been demonstrated with a radiograph and narrative history.

Vital pulpotomies are an allowable benefit. Cement bases, pulp capping, and insulating liners are considered part of the restoration and must not be billed separately.

Covered **surgical endodontic treatment** includes an apicoectomy performed either as a separate surgical procedure or in conjunction with an endodontic procedure, an apical curettage, a root resection, or excision of hyperplastic tissue.

Payment shall be approved when nonsurgical treatment has been attempted, a reasonable time (approximately one year) has elapsed, and treatment failure has been demonstrated. Surgical endodontic procedures may be indicated when:

- Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided, or obturated due to calcifications, blockages, broken instruments, severe curvatures, open-ended canals, and dilacerated roots.
- Problems resulted from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.

Retrograde filling and root amputation may be billed in addition to apicoectomy.

5. Periodontal Services

Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is a covered service. It is payable once in a 24-month period. Full-mouth debridement is not payable on the same date of services as other prophylactic or preventive procedures.

Periodontal scaling and root planning, gingivoplasty, osseous surgery, osseous allograft, pedicle soft tissue graft, free soft tissue graft, and maintenance therapy are covered periodontic benefits and must include documentation of the following:

- A periodontal treatment plan,
- A completed copy of a periodontal probing chart that exhibits 4mm pocket depths (or greater), along with the evidence of bone loss collected within the past year, and
- Radiographs.

Payment for periodontal scaling and root planning will be approved when:

- The periodontal probe chart evidence 4mm pocketing
- Interproximal and subgingival calculus is evident in X-rays, or
- Evidence of bone loss

Scaling in the presence of generalized moderate or severe gingival inflammation is also a covered benefit.

Periodontal maintenance therapy includes the removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planning where indicated, and polishing the teeth.

This procedure may be approved once per three-month interval after periodontal scaling and root planning and periodontal surgical procedures have been provided as long as periodontal charting shows evidence of active periodontal disease

Periodontal surgical procedures, including gingivectomy, osseous surgery, and osseous allograft, are covered benefits and may include documentation of the following:

- Periodontal scaling and root planning has been provided,
- A re-evaluation examination has been completed, and
- The member has demonstrated reasonable oral hygiene, unless the member is unable to demonstrate reasonable oral hygiene because of physical or mental disability

Pedicle soft tissue graft and free soft tissue graft are covered benefits with written narrative describing medical necessity once per year.

Tissue regeneration procedures are payable when:

- Radiographs show evidence of recession in relation to the muco-gingival junction
- The bone level indicates the tooth has a fair to good prognosis

Localized delivery of antimicrobial agents is limited to once per site every twelve months. Approval requires that:

- At least one year has lapsed since periodontal scaling and root planning has been completed, and
- The member has maintained regular periodontal maintenance, and
- Pocket depths remain at a moderate to severe depth with bleeding on probing.

Crown Lengthening is allowed in a healthy periodontal environment when there is inadequate tooth structure exposed to the oral cavity to retain a dental restoration. Crown lengthening will not be considered when performed in conjunction with any periodontal procedure that indicates unhealthy periodontal tissues in the same quadrant.

An x-ray must be submitted with the prior authorization demonstrating less than 3mm of sound natural tooth structure between the restorative margin and the alveolar crest. If the x-ray does not make the need for crown lengthening evident, additional narrative will be requested documenting the need for treatment. Prior to final restoration of a tooth, a minimum of six weeks must be allowed for healing of bone and soft tissue following clinical crown lengthening.

6. Prosthetics

a. Dentures

Complete and partial dentures are payable once in a five-year period. The date of service for the denture is the date the denture was placed. Reimbursement includes six months fitting and follow-up.

b. Complete Dentures

An immediate or a first-time complete denture is a covered benefit. Six months post-delivery care is included with the reimbursement for the denture.

c. Removable Partial Dentures

Removable partial dentures shall be granted for replacement of a missing **anterior** tooth when radiographs demonstrate adequate space for replacement of a missing anterior tooth.

Approval for a removable partial denture replacing **posterior** teeth shall be granted when:

- The member has fewer than eight posterior teeth in occlusion, or
- The member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.

When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved.

d. Fixed Partial Dentures

Fixed partial dentures are limited to members whose medical or mental condition precludes the use of a removable partial denture. A fixed partial denture may also be covered when a member has an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

Approval for fixed partial dentures replacing only posterior teeth is limited to members who have:

- Fewer than eight posterior teeth in occlusion, or
- A full denture in one arch and a partial denture replacing posterior teeth are required in the opposing arch to balance occlusion.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials.

e. Replacement Dentures

Replacement of complete dentures, removable partial dentures, and fixed partial dentures is limited to once per prosthesis in a five-year period. The five frequency starts over with the delivery date of the replacement denture and another replacement is not allowable from the original denture fabrication date.

Approval shall be granted once per denture per arch when the denture no longer fits due to growth or changes in the jaw structure and a replacement is required to prevent significant dental problems. Approval shall also be granted for more than one denture replacement per arch in less than five years for members who have a medical condition that necessitates thorough mastication.

Replacement of a complete or partial denture in less than five years due to resorption is not covered.

f. Undelivered Dentures

When a denture has been fabricated, but the member does not return for the denture or complete the follow-up after three (3) months, reimbursement can be allowed for the laboratory fabrication costs.

Procedure code D5899, unspecified prosthetic procedure should be billed. A copy of the invoice and documentation of the situation must be included as attachments with the claim.

The dentist must maintain the undelivered denture for a period of two years.

g. Other Denture Services

Chairside relines are a benefit only once per denture every 12 months, beginning 6 months after the denture was placed.

Laboratory processed relines are a benefit only once per prosthesis every 12 months, beginning 6 months after the denture was placed.

Tissue conditioning is a benefit twice per prosthesis in a 12-month period, beginning 6 months after the denture was placed.

Two **repairs** per prosthesis in a 12-month period are a covered benefit, beginning 6 months after the denture was placed.

Adjustments to a complete or removable partial denture are payable when medically necessary **after** six months' post-delivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better.

Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

Rebase of a complete or partial denture shall be granted when the acrylic of the denture is cracked or has had numerous repairs, and the teeth are on good condition.

7. Maxillofacial Prosthetics

a. Obturator

An **obturator** for surgically excised palatal tissue is covered.

b. Definitive Obturator Prosthesis

A **definitive obturator prosthesis** for naso-alveolar molding for infants with a cleft palate is covered when provided by a dentist with a specialty in orthodontics. Reimbursement for the device includes the custom fabrication and placement. The date of service for the device is the date the device was placed.

Modifications and adjustments for obturators are covered when medically necessary.

c. Implants

Dental implants and related services may be granted only when the member cannot use a conventional prosthetic due to:

- Missing significant oral structures after cancer, traumatic injuries, etc., or
- Developmental defects such as cleft palate.

8. Oral Appliance for Obstructive Sleep Apnea

An oral device or appliance that is custom fabricated by a dentist and used to reduce upper airway collapsibility is covered when the member has a diagnosis of obstructive sleep apnea. This is a benefit through a member's *medical insurance* even though the device must be custom fabricated by a dentist. Dental providers are allowed to enroll in Iowa Medicaid as a Durable Medical Equipment (DME) provider to be reimbursed from the members medical plan administrator. Please see corresponding criteria for approval in the DME Provider Manual.

9. Oral Surgery

Medically necessary oral surgery services furnished by dentists are a covered benefit to the extent that these services may be performed under state law either by a Doctor of Medicine, Osteopathy, dental surgery or dental medicine.

The following surgical procedures are also payable when performed by a dentist:

- Surgical and nonsurgical extractions.
- Soft tissue impaction that requires an incision of overlying soft tissue and the removal of the tooth (upper or lower).
- Complete and partial bony impaction that requires an incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth (upper or lower).
- Root recovery (surgical removal of residual root).
- Oral antral fistula closure (or antral root recovery).
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.
- Surgical exposure of impacted or unerupted tooth to aid eruption.

Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately. Payment may be made for postoperative care where:

- Need is shown to be beyond normal follow-up care, or
- Another dentist performed the original service.

Bill this service as a limited oral evaluation under procedure code 00140 if other treatment procedures are not billed for that visit.

10. Orthodontics

Orthodontic services are not a covered benefit for adults 21 years of age and older.

Providers must refer to the Iowa Medicaid Dental Wellness Plan, Dental Wellness Plan Kids and Hawki Orthodontic Administrative Guide for complete details on orthodontic coverage, located here: Iowa Medicaid Dental Wellness Plan, Dental Wellness Plan Kids and Hawki Orthodontic Administrative or Guidehttps://hhs.iowa.gov/media/10611/

Limited orthodontic treatment will be approved when it is cost-effective to lessen the severity of a malformation to such that extensive treatment is not required. Treatment includes retainers.

Comprehensive orthodontic treatment approval is limited to members under 21 years of age and shall be granted when the member meets medical necessity by one of the Automatic Qualifying Conditions established by Iowa Medicaid and are as follows:

- Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology
- Overjet: 9 mm of more
- Reverse Overjet: 3.5 mm or more
- Anterior and/or Posterior crossbite of three or more teeth per arch
- Lateral or anterior open bite of 2 mm or more on at least four teeth per arch
- Impinging overbite with evidence of occlusal contact into the opposing soft tissue
- Impaction where eruption is impeded but extraction is not indicated(excluding third molars)
- Two or more congenitally missing teeth of at least one tooth per quadrant(excluding third molars)
- Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars)

Minor orthodontic treatment to control harmful habits will be approved when it is cost-effective to lessen the severity of a malformation to such that extensive treatment is not required.

Other Orthodontic Services

One set of post-treatment replacement retainers (for orthodontic purposes) is covered.

11. Adjunctive General Services

a. Emergency Treatment

Minor **palliative treatment of dental pain** is covered in emergency situations when there is no other specific procedure code that defines the treatment. An example would be smoothing a fractured tooth.

The code may be billed in addition to a limited oral evaluation, radiographs, or other diagnostic procedures. It should not be billed on the same date of service as other treatment procedures on the same tooth, nor for other multi-visit treatments such as endodontics or orthodontics. Documentation of a description of the treatment must be included with the claim.

b. Anesthesia

General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when:

- The extensiveness of the procedure indicates it, or
- A concomitant disease or impairment warrants its use.

Non-intravenous conscious sedation is the use of oral medications that require monitoring of vital signs.

Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use for dental procedures. The member file must clearly document the reason for use.

Administration of anesthesia is subjected to rounding rules. For codes that use a 15-minute definition, providers shall round 1 to 7 minutes down to zero units and round 8 to 14 minutes up to one unit, 15-22 minutes down to 1 unit, 23-30 up to 2 units and so on.

c. Professional Consultation

A **professional consultation** is allowed when requested by another practitioner or appropriate source for the evaluation or management of a specific problem. The consultation includes an oral evaluation, which is not separately payable. Only one consultation per member per condition is allowed.

Specific diagnostic or therapeutic services may be billed separately.

d. Professional Visits

House calls, nursing home, extended care facility, and hospice visits are payable when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

When more than one Medicaid member is seen during the same visit, payment will be made for only one visit to the location.

A **hospital or ambulatory surgical center visit** is payable when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office. Payment is allowed once per member per day, in addition to other dental services provided.

Payment will be made for an **office visit after regularly scheduled office hours** in emergencies under procedure code D9440. The office visit will be paid in addition to treatment procedures.

e. Prescription Drugs

Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. Payment will not be made for writing prescriptions.

f. Miscellaneous Services

For adjunctive procedures not specified below, documentation of medical necessity must be submitted with the claim.

(1) Occlusal Guard

A hard occlusal guard for treatment of severe bruxism and other occlusal factors is a covered benefit. Approval shall be granted when photographs and/or radiograph supports evidence of significant loss of tooth enamel or tooth chipping Medical documentation that supports headaches or jaw pain must also be accompanied by photographs and/or radiographs.

Replacements due to loss, theft or damage are limited to once every 12 months.

(2) Interpretation Services

Payment is allowed to the dentist for the cost of interpretation services when necessary.

Sign language or oral interpretive services should be billed using T1013 in field 29 on the ADA claim form. Field 30 should include the number of 15-minute units and a statement of whether sign language or oral interpretation was provided.

Telephone interpretation services should be billed using T1013 in field 29 on the ADA claim form. “UC” for telephone interpretation should be entered in field 30 along with the number of 15-minute units.

Example: 45 minutes equals three 15-minute units. “3” would be entered in field 30 along the either “sign,” “oral,” or “telephone.”

g. Teledentistry Services

All Iowa Medicaid recipients are eligible to receive services via synchronous and asynchronous teledentistry. Below lists the Current Dental Terminology (CDT) codes that may be billed with synchronous and/or asynchronous teledentistry.

D9995 Teledentistry - synchronous; real-time encounter: Only allowed with D0140 limited oral evaluation – problem focused. Requires place of service 02 (Telehealth) indicated.

D9996 Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review: The following services are billable when provided via asynchronous teledentistry: D0120, D0140, D0145, D0150, D0180, D0210, D0220, D0230, D0240, D0270, D0272, D0274, D0330. Requires place of service 02 (Telehealth) indicated.

All services provided via teledentistry must adhere to the Iowa Administrative Code 650 – Chapter 272, which establishes parameters for the practice of teledentistry in Iowa.

This includes ensuring the teledentistry network and electronic dental records comply with Health Insurance Portability and Accountability Act (HIPAA) requirements and federal standards for system security.

Any dental professional treating Medicaid, Dental Wellness Plan (DWP), or Healthy and Well Kids in Iowa (Hawki) members must be licensed to practice dentistry in Iowa and must use standard of care when providing services via teledentistry. The asynchronous teledentistry method used must be of sufficient visual clarity to be functionally equivalent to a face-to-face encounter.

12. Prior Approval

Under the Medicaid program, "prior approval" indicates approval of the selective program benefits.

See Dental Procedures that Require Prior Authorization or Additional Documentation with the Claim – Comm 710 or https://hhs.iowa.gov/media/6823/download?inline

a. Process for Obtaining Prior Approval

Dentists must submit form **470-0829, Request for Prior Authorization** to Iowa Medicaid to request prior approval. Refer to Chapter IV. Billing Iowa Medicaid for a sample of the form and instructions for completing it.

Fax or email completed form to:

(515) 725-0938 or paservices@hhs.iowa.gov

It is essential that you complete all items on the **Request for Prior Authorization** and give full and complete information. Iowa Medicaid will return incomplete forms and forms in which information is not clearly presented.

Providers must check member eligibility prior to rendering any services to a member. Regardless of the date on the Prior Authorization, if the member loses or changes coverage at the time the service is received, reimbursement cannot be made to the provider.

The Iowa Medicaid dentist consultant will enter the decision in item 28 on form 470-0829 and return the form to you.

If Iowa Medicaid denies a request for prior approval, you may resubmit it for reconsideration if you can provide additional information that might have a bearing on the decision.

Services for cosmetic purposes or member preference are not considered justification for granting prior approval.

A **Request for Prior Authorization** should not be submitted for unusual or exceptional situations not covered under the regular policy.

b. Documentation of Medical Necessity

Under the Medicaid program, the documentation submitted with the claim is the same type of documentation that physicians are required to submit to verify medical necessity. Procedures must be medically necessary to be payable. In dental services, this is usually called “by report.”

Documentation of medical necessity is different from prior approval. The documentation of medical necessity is submitted after the treatment has been provided. The information is included on or attached to the dental claim form.

The documentation of medical necessity includes a brief narrative of the history of the condition for which the diagnostic and treatment services have been provided. This history must include information on any treatments that have been provided and the results of these treatments. If surgical procedures are provided, an operative report must also be submitted.

In lieu of submitting required documentation with claims for the listed procedures, prior approval may be requested in advance of providing the procedure.

See: **Dental Procedures that Require Prior Authorization or Additional Documentation with the Claim – Comm 710** or https://hhs.iowa.gov/media/6823/download?inline

E. Basis of Payment

Basis of payment for services is a fee schedule. The fee schedule amount is a maximum payment amount, not an automatic payment. Reimbursement will be the lower of the customary charge and the fee schedule amount.

To view the fee schedule for Dental Services online, click Fee Schedule #04 - Dentist or https://secureapp.dhs.state.ia.us/medicaidfeesched/X04.xml. Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from Iowa Medicaid.

F. Dental Procedure Codes and Nomenclature

Claims submitted without a procedure code will be denied.

While every effort is made to use procedure numbers to describe services, there are certain instances where an existing procedure code number does not aptly describe a necessary procedure or treatment.

When the need for an unspecified treatment or procedure does arise, the procedure requires prior authorization if it is a periodontal, endodontic, prosthetic, or orthodontic procedure.

Documentation of the procedure's medical necessity is required if it is a diagnostic, restorative, or oral surgery procedure. Unspecified procedures may not be payable. Medicaid reserves the right to determine the fee payable for all unlisted procedures.

G. Billing Policies and Claim Form Instructions

Claims for dental services are billed using at minimum the 2012 American Dental Association(ADA) Dental Claim Form.

To view a sample of the Dental Claim Form online, click ADA - Dental Claim Form or https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/2019adadentalclaim-form_2019may.pdf

To view billing instructions for the Dental Claim Form online, click Instructions for completing the ADA 2012 Claim Form or https://hhs.iowa.gov/media/232/download?inline= Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading your Iowa Medicaid Remittance Advice statement.

Federally Qualified Health Center (FQHC) and Indian Health Service (IHS) Billing:

FQHC and IHS entities will be reimbursed for covered dental services provided in the FQHC/IHS facility using encounter rate methodology with the rates as determined by Iowa Medicaid. FQHC and IHS providers must bill D9999 on the first line of the claim form or the claim will deny. For encounter-based reimbursement situations, dental services should not be separated or performed on different dates of service solely to enhance reimbursement. If no restorative or other treatment services are necessary, all preventive and diagnostic services must be performed on a single date of service.

If restorative or other treatment services are necessary, preventive and diagnostic services may be performed on the same date of service as the restorative or other treatment services. Unless contraindicated, all restorative and treatment services per quadrant must be performed on the same date of service. If there are circumstances that would not allow restorative treatment in this manner, the contraindication(s) must be documented in the patient's dental record.

H. Waiver of Administrative Rule

A Waiver of Administrative Rule is an individual request made by a member, or a provider on behalf of the member (with the appropriate signed release), to waive an administrative rule based on the member's unique circumstance(s).

A Waiver of Administrative Rul may be granted in individual cases and granted by the Department's Director after all consideration of all relevant factors including:

- The need of the person or entity directly affected by the exception. Waivers will be granted only in cases of extreme need.
- Whether there are exceptional circumstances justifying a waiver to the general rule applicable in otherwise similar circumstances.
- Whether granting the waiver would result in net savings to the state or promote efficiency in the administration of programs or service delivery. Net savings or efficiency will make a waiver more likely.

For services, assistance, or grants, waivers are typically not granted unless all other possible sources have been exhausted.