Dental Services

Provider Manual

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CHAPTER III. COVERAGE AND LIMITATIONS

A. DENTISTS ELIGIBLE TO PARTICIPATE

All 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.

Dentists with a specialized practice, such as oral and maxillofacial surgery, must provide documentation of their specialized credentials in order to bill for procedures using Current Procedural Terminology (CPT) codes.

NOTE: Payment will not be made to a dental laboratory unless it is under the supervision of a dentist.

B. 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 doctors of medicine, osteopathy, dental surgery, or dental medicine and would be covered if furnished by doctors 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 Appendix A. Dental Procedures that Require Prior Authorization).

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** (D0145) 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.

b. Diagnostic Imaging

A complete series of radiographic images, consisting of a minimum of 14 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.

Supplemental bitewing films are a covered benefit not more than once every 12 months. Single periapical films are a covered benefit when necessary.

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

A posterior-anterior or lateral skull and facial bone film is 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 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 the IME.

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). Paper claims should be billed with “DISABLED” entered in the “Remarks” section of the claim form. Electronic claims should be billed with “DIS” in the appropriate segment.

b. Fluoride

Topical application of fluoride (gel, mouth rinse) is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

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 persons who have 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 do not require prior authorization. They are payable 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.

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

e. Care for Kids

Early and periodic screening, diagnosis, and treatment (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 provides assistance to families with children to enable them to access early and regular dental care. Information about the I-Smile program and the I-Smile oral health coordinators is available online at: http://www.ismiledentalhome.iowa.gov/

Local I-Smile oral health coordinators can be found online at: http://www.idph.iowa.gov/ohds/oral-health-center/coordinator

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 require immediate attention.

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 dentoenamel 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, and inhaled 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 would not be clinically appropriate. Examples include:

- Deciduous teeth when there is lack of sufficient tooth structure for a filling
- Hypoplastic permanent molars in young children
- 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 stainless steel crowns with a resin window are covered for anterior teeth only.

Esthetic coated stainless steel crowns are covered only on primary anterior teeth numbers C through H and M through R. One crown per each primary anterior tooth is allowed. Prior authorization is not required.

All **laboratory-fabricated crowns** utilizing non-precious materials require prior authorization. Approval 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, or
- The tooth is fractured or has a broken cusp, or
- The tooth has had endodontic treatment.

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

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. If, after a reasonable time, the member has not returned for the crown to be placed, partial reimbursement for the crown can be allowed. Procedure code D2999 should be billed. 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, should be billed using procedure code D2950, not other restoration procedures.

Crown repair is payable. For pricing purposes, documentation of the repair must be submitted with the claim.

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 treatments do not require prior approval.

Root canal retreatment requires prior approval and 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 clinical findings and do not require prior approval. 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, débrided, 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 and does not require prior approval. 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 planing, gingivoplasty, osseous surgery, osseous allograft, pedicle soft tissue graft, free soft tissue graft, and maintenance therapy are covered periodontic benefits when prior approval has been received. A request for approval must be accompanied by:

- A periodontal treatment plan,
- A completed copy of a periodontic probe chart that exhibits pocket depths,
- A periodontal history, and
- Radiographs.

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

- The periodontal probe chart evidences active periodontal disease,
- Interproximal and subgingival calculus is evident in X-rays, or
- You justify and document that curettage, scaling, or root planing is required in addition to routine prophylaxis.

Periodontal maintenance therapy requires prior approval and includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling.

This procedure may be approved once per three-month interval after periodontal scaling and root planing and periodontal surgical procedures have been provided as long as periodontal charting shows evidence of active periodontal disease (pocket depths of 4 mm or greater, inflammation or bleeding on probing).

If pocket depths have returned to 3 mm or less, and there are no signs of active periodontal disease, quarterly prophylaxis should be provided instead.

Periodontal surgical procedures, including gingivectomy, osseous surgery, and osseous allograft, will be approved after:

- Periodontal scaling and root planing 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 or demonstrate gingival hyperplasia resulting from drug therapy.

Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval and written narrative describing medical necessity.

Tissue regeneration procedures are payable when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good prognosis. Prior authorization is required.

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

- At least one year has lapsed since periodontal scaling and root planing 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.

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 when the denture is provided to establish masticatory function. Six months post-delivery care is included with the reimbursement for the denture.

c. Removable Partial Dentures

Removable partial dentures require prior authorization. Approval 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 require prior approval and are limited to members whose medical or mental condition precludes the use of a removable partial denture.

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 requires prior authorization and is limited to once per prosthesis in a five-year period. Approval shall be granted once per denture per arch when the denture is lost, broken beyond repair, stolen or 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, reimbursement can be allowed for the laboratory fabrication costs.

Procedure code D5899 or D5999, 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 requires prior authorization. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are on good condition.

Unspecified removable prosthodontic, procedure code D5899, should be billed for new dentures where such things as a soft reline or denture cutters are required.

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 require prior authorization. Approval may be granted when the member cannot use a conventional prosthetic due to:

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

8. Oral Appliance for Obstructive Sleep Apnea

Prior approval is required for an oral appliance for treatment of obstructive sleep apnea. The device must be custom fabricated by a dentist. Approval shall be granted when:

- Prescribed by a MD, DO, nurse practitioner, clinical nurse specialist, or physician's assistant working within their scope of practice, and
- The results of a sleep study test show that:
  - The apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or
  - The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
    - Hypertension, ischemic heart disease, or history of stroke; or
    - If the AHI greater than 30 or the RDI greater than 30 and either of the following conditions applies:
      - The member is not able to tolerate a positive airway pressure (PAP) device, or
      - The treating physician determines that the use of a PAP device is contraindicated.

Claims must first be submitted to Medicare for members who are eligible for Medicare and Medicaid.

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 doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. These services will be reimbursed in a manner consistent with the physician's reimbursement policy.

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 covered for adults 21 years of age and older, except for an occlusal orthotic appliance.

Orthodontic procedures require prior approval.

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.

Interceptive 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.

Comprehensive orthodontic treatment approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

A request for prior approval must be accompanied by:

- An interpreted cephalometric radiograph and either a full series of radiographs or panography film.
- Study models trimmed so that the models simulate centric occlusion of the member when the models are placed on their heels.
- A written plan of treatment.

A one-time lump sum payment is allowed for dentists who have signed form 470-3174, *Addendum to Dental Provider Agreement for Orthodontia*. To access the form online, click here.

If the treatment is not completed by the dentist or dental practice that received the lump sum payment, form 470-3744, *Provider Inquiry*, should be submitted with documentation describing the services provided. To access the form online, click here.

Refer to Chapter IV. *Billing Iowa Medicaid*, for a sample of the form and instructions for completing it. To access the manual online, click here.

An occlusal orthotic device that includes splints may be allowed for both children and adults with severe temporomandibular joint dysfunction due to structure problems with the joint and surrounding musculature.

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. Examples include treatment of soft tissue infections or 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.

Application of a **desensitizing medicament** is payable on a per visit basis for tooth or root sensitivity. It is not payable when bases, liners, or adhesives are to be used under a restoration. The medicament used must be documented 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 with the use of a pulse oximeter and precordial stethoscope. The provider must have a current conscious sedation permit.

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

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

An occlusal guard for treatment of severe bruxism and other occlusal factors requires prior authorization. Approval shall be granted when photographs support evidence of significant loss of tooth enamel or tooth chipping, or the medical documentation supports headaches or jaw pain.

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. Claims must be submitted in a paper claim format.

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."

12. Prior Approval

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

See Appendix A. Dental Procedures that Require Prior Authorization.

a. Process for Obtaining Prior Approval

Dentists must submit form 470-0829, *Request for Prior Authorization*, to the IME Medical Services Unit to request prior approval. Refer to Chapter IV. *Billing Iowa Medicaid*, for a sample of the form and instructions for completing it. To access the manual online, click here.

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

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

If the IME 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 Appendix B. Dental Procedures that Require Documentation with the Claim.

C. 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 here. Providers who do not have Internet access can obtain a copy of the provider-specific fee schedule upon request from the IME.

D. 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.

Important Information Regarding ICD-10

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). Please note that the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for dental services are billed using the Dental Claim Form published by the American Dental Association.

To view a sample of the Dental Claim Form online, click here.

To view billing instructions for the Dental Claim Form online, click here.

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. To access the manual online, click here.

Appendix A.
Dental Procedures that Require Prior Authorization

Code	Description
D2710	Crown, resin (laboratory)
D2712	Crown, resin based composite
D2720	Crown, resin with high noble metal
D2721	Crown, plastic with predominantly base metal
D2740	Crown, porcelain/ceramic substance
D2750	Crown, porcelain fused to high noble metal
D2751	Crown, porcelain fused to predominantly
D2752	Crown, porcelain fused to noble metal
D2781	Crown, 3/4 cast predominately base metal
D2790	Crown, full cast high noble metal
D2791	Crown, full cast predominantly base metal
D2792	Crown, full cast noble metal
D3346	Retreatment of previous root canal therapy
D3347	Retreatment of previous root canal therapy
D3348	Retreatment of previous root canal therapy
D3999	Unspecified endodontic procedure
D4210	Gingivectomy or gingivoplasty, per quadrant
D4211	Gingivectomy or gingivoplasty, per tooth
D4212	Gingivectomy or gingivoplasty to allow access
D4240	Gingival flap procedure
D4241	Gingival flap procedure including root planing
D4260	Osseous surgery, including flap entry and close
D4261	Osseous surgery 1-3 teeth per quadrant
D4263	Bone replacement graft, first site in quadrant
D4264	Bone replacement graft, each additional site
D4265	Biologic materials to aid in soft and osseous tissue
D4266	Guided tissue regeneration, resorbable barrier
D4267	Guided tissue regeneration, non-resorbable
D4270	Pedicle soft tissue grafts
D4273	Subepithelial connective tissue graft, per tooth

Code	Description
D4275	Soft tissue allograft
D4276	Combined connective tissue/pedical graft, per tooth
D4277	Free soft tissue graft, 1st tooth or edentulous tooth position in graft
D4278	Free soft tissue graft, procedure (including donor site surgery)
D4341	Periodontal scaling and root planing – four or more teeth per quadrant
D4342	Periodontal scaling and root planing 1-3
D4381	Localized delivery of antimicrobial agents
D4910	Preventive periodontal procedures
D4999	Unspecified periodontal procedure
D5211	Maxillary partial denture-resin base
D5212	Mandibular partial denture-resin base
D5213	Maxillary partial denture, cast metal framework with resin denture bases
D5214	Mandibular partial denture, cast metal framework with resin denture bases
D5225	Maxillary partial denture flexible base
D5226	Mandibular partial flexible base
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5861	Over denture partial
D5862	Precision attachment - overdenture
D5899	Unspecified removable prosthodontic procedure
D5992	Adjust maxillary prosthetic appliance
D6010	Endosteal (osseous) implant
D6012	Surgical placement interim implant body
D6040	Surgical placement eposteal implant
D6050	Transosteal implant
D6053	Removable denture complete edentulous arch
D6054	Removable denture partially edentulous arch
D6055	Connect bar-implant support or abutment
D6056	Prefabricated abutment
D6057	Custom abutment - includes placement
D6058	Abutment support porcelain/ceramic crown
D6059	Abutment support porcelain fused metal
D6060	Abutment support porcelain fused metal

Code	Description
D6061	Abutment supported noble metal crown
D6062	Abutment supported cast metal crown
D6063	Abutment supported cast metal crown
D6064	Abutment supported cast metal crown
D6065	Implant support porcelain/ceramic crown
D6066	Implant support porcelain fused to metal
D6067	Implant supported metal crown
D6068	Abutment support retainer porcelain/ceramic
D6069	Abutment support retainer porcelain fused
D6070	Abutment support retainer porcelain fused
D6071	Abutment support retainer porcelain fused
D6072	Abutment supported retainer for cast
D6073	Abutment supported retainer for cast
D6074	Abutment supported retainer for cast
D6075	Implant support retainer for ceramic FPD
D6076	Implant support retainer porcelain fused
D6077	Implant support retainer cast metal FPD
D6078	Fixed overdenture completely edentulous
D6079	Fixed overdenture partially edentulous
D6080	Implant maintenance procedures
D6090	Repair implant supported prosthesis, by report
D6091	Replacement attach for implant/abutment
D6092	Recement implant/abutment support crown
D6093	Recement implant/abutment support fixed
D6094	Abutment supported crown titanium
D6095	Repair implant abutment, by report
D6100	Implant removal, by report
D6101	Debridement of periimplant defect and surface
D6102	Debridement and osseous contouring of periimplant
D6190	Radiograph/surgical implant index
D6194	Abutment supported retainer crown titanium
D6199	Unspecified implant procedure, by report
D6205	Pontic-indirect resin based composite
D6210	Pontic, cast high noble metal
D6211	Pontic, cast predominantly base metal
D6212	Pontic, cast noble metal

Code	Description
D6240	Pontic, porcelain fused to high noble metal
D6241	Pontic, porcelain fused to predominantly
D6242	Pontic, porcelain fused to noble metal
D6245	Pontic, porcelain/ceramic
D6250	Pontic, resin with high noble metal
D6251	Pontic resin with predominantly base metal
D6252	Pontic resin with noble metal
D6545	Cast metal retainer, resin banded fixed
D6710	Crown-indirect resin based composite
D6720	Crown, resin with high noble metal
D6721	Crown, resin with predominantly base metal
D6722	Crown, resin with noble metal
D6750	Crown, porcelain fused to high noble metal
D6751	Crown, porcelain fused to predominately
D6752	Crown, porcelain fused to noble metal
D6780	Three fourth cast gold crown
D6790	Crown, full cast high noble metal
D6791	Crown, full cast predominantly base metal
D6792	Crown, full cast noble metal
D6940	Stress breaker
D6950	Precision attachment
D6980	Fixed partial denture repair
D6999	Unspecified fixed prosthodontic procedure
D8060	Interceptive orthodontic treatment
D8070	Ortho treat of transitional dentition
D8080	Comprehensive orthodontic treatment/adolescent dentition
D8090	Comp ortho treatment of adult dentition
D8210	Removable appliance therapy to control harmful habits
D8220	Fixed appliance therapy to control harmful habits
D8680	Orthodontic retention
D8690	Orthodontic treatment (alternative billing to a contract fee)
D8692	Replacement of lost/broken retainer
D8999	Unspecified orthodontic procedure
D9940	Occlusal guard

Appendix B. Dental Procedures that Require Documentation with the Claim

Code	Description
D0210	Complete series less than 5 years from last
D0330	Panorex less than 5 years from last one
D0363	Cone beam - three dimensional image
D0364	Cone beam less than one whole jaw
D0365	Cone beam full mandible arch
D0366	Cone beam full maxilla arch
D0367	Cone beam both jaws
D0368	Cone beam TMJ series
D0380	Cone beam image capture limited
D0381	Cone beam image capture mandible
D0382	Cone beam image capture maxilla
D0383	Cone beam image capture both jaws
D0384	Cone beam image capture for TMJ series
D2980	Crown repair
D2999	Unspecified restorative procedure
D3332	Incomplete endodontic therapy; inoperable
D5899	Unspecified removable prosthetic
D5992	Adjust maxillofacial prosthetic appliance
D5999	Unspecified maxillofacial prosthesis
D7241	Removal impacted tooth completely bony w/unusual surgical complications
D7283	Place device to facilitate eruption tooth
D7490	Radical resection of mandible/bone graft
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue
D7980	Sialolithotomy
D7982	Sialodochoplasty
D7991	Coronoidectomy
D7999	Unspecified oral surgery procedure
D9110	Palliative treatment
D9910	Apply desensitizing medicaments
D9999	Unspecified adjunctive procedure

Code	Description
	Diagnostic
D0470	Diagnostic casts
	Restorations
D2710	Crown resin (laboratory)
D2720	Crown, resin with high noble metal
D2721	Crown, plastic with predominantly base metal
D2740	Crown, porcelain/ceramic substance
D2750	Crown, porcelain fused to high noble metal
D2751	Crown, porcelain fused to predominantly
D2752	Crown, porcelain fused to noble metal
D2781	Crown, 3/4 cast predominantly base metal
D2790	Crown, full cast high noble metal
D2791	Crown, full cast predominantly base metal
D2792	Crown, full cast noble metal
D2910	Recement inlays
D2920	Recement crowns
D2930	Prefabricated stainless steel crown, primary tooth
D2931	Prefabricated stainless steel crown, permanent tooth
D2932	Prefabricated resin crown
D2940	Sedative filling
D2951	Pin retention, per tooth, in addition to restoration
D2952	Cast post and core in addition to crown
D2954	Prefabricated post and core in addition to crown
D2970	Temporary crown (fractured tooth)
D2980	Crown repair
D2999	Unspecified restorative procedure
	Endodontics
D3220	Vital pulpotomy, excluding final restoration
D3320	Root canal therapy-bicuspid (excludes final restoration)
D3330	Root canal therapy-molar (excludes final restoration)
D3340	Root canal therapy, four canals
D3351	Apexification/recalcification, initial visit
D3352	Apexification/recalcification, interim
D3353	Apexification/recalcification, final visit, with root canal therapy

Code	Description
D3410	Apicoectomy-separate surgical, bicuspid
D3421	Apicoectomy/periradicular surgery, bicuspids
D3425	Apicoectomy/periradicular surgery, molar
D3426	Apicoectomy/periradicular surgery, each additional root
D3430	Retrograde filling, per root including apical surgery
D3450	Root amputation, per root
D3999	Unspecified endodontic procedure
	Periodontics
D4210	Gingivectomy or gingivoplasty, per quadrant
D4211	Gingivectomy or gingivoplasty, per tooth
D4260	Osseous surgery, including flap entry and closure
D4263	Bone replacement graft, first site in quadrant
D4264	Bone replacement graft, each additional site
D4270	Pedicle soft tissue grafts
D4271	Free soft tissue grafts (including donor site)
D4341	Periodontal scaling and root planing, per quadrant
D4355	Full mouth debridement
D4910	Preventive periodontal procedures
D4920	Unscheduled dressing change, by nontreating dentist
D4999	Unspecified periodontal procedure
	Orthodontia
D8210	Removable appliance therapy to control harmful habits
D8220	Fixed appliance therapy to control harmful habits
D8549	Maxillary fixed lingual appliance with attachments
D8550	Maxillary fixed lingual appliance with attachments
D8551	Construct and place mandibular appliance
D8552	3-month active treatment maxillary arch
D8553	3-month active treatment mandibular arch
D8557	Appliance without clasps-no teeth
D8558	Anterior ortho wire (labial) 2 clasps
D8559	Chrome wire clasps, each additional
D8999	Unspecified orthodontia procedure