Dental Procedures and Nomenclature

PURPOSE

The Dental Procedures and Nomenclature policy is one of many resources that dental providers can reference as participating providers with the ND Medicaid program and is designed to aid dentists in billing ND Medicaid.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled with ND Medicaid on the date of service. Servicing providers acting as a locum tenens provider must be enrolled with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System by dialing 1.877.328.7098.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled with ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The Procedure Code Look-up Tool can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates.

Refer to the Member Eligibility manual for additional information regarding eligibility including information regarding limited coverage categories.

DIAGNOSTIC

Frequency limitations on diagnostic services include two oral or periodontal evaluations per calendar year. The following diagnostic codes apply to the frequency limitations:

- Periodic oral evaluation (D0120);
- Oral evaluation for a member under 3 years of age and counseling with primary caregiver (D0145);
- Comprehensive oral evaluation – new or established member (D0150);
- Detailed and extensive oral evaluation – problem focused, by report (D0160); and
- Comprehensive periodontal evaluation – new or established member (D0180).

Detailed and extensive oral evaluation – problem focused, by report (D0160), requires documentation.

Comprehensive periodontal evaluation – new or established member (D0180) may not be billed in addition to a periodic oral evaluation (D0120) or a comprehensive oral evaluation – new or established member (D0150) on the same date of service. The billing of either evaluation must follow ADA guidelines. Should multiple evaluations be performed on the same date of service, clinical documentation must be available upon request. The documentation must support two separately identifiable office examinations.

When oral examinations exceed frequency limitations, a service authorization is required.

ND Medicaid covers one panoramic radiographic image every three years. A service authorization must be submitted when more than one panoramic radiographic image is needed within a three-year time frame. When services are being rendered by the same treating dentist or dental office, the service authorization must be received prior to the service being performed with documentation to support the medical necessity.

PREVENTIVE

Frequency limitations on preventive services include two prophylactic examinations, periodontal maintenance procedures, or scaling in presence of generalized moderate or severe gingival inflammation per calendar year. The following preventative codes apply to the frequency limitations:

- Prophylaxis – adult (D1110);
- Prophylaxis – child (D1120);

- Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth (D4346); and
- Periodontal maintenance (D4910).

The two per calendar year limitations may be a combination of codes. When frequency limitations have been met or exceeded, a service authorization is required.

When requesting authorization for frequent recalls (i.e., "frequency list") the member's specific medical condition, medication lists, and recall of visits is required. The medical condition(s) of the member must render him/her incapable of maintaining good oral hygiene. A service authorization will not be needed until the members' limits have been met or exceeded or the recall is greater than the standard Medicaid benefit.

Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth (D4346) and Periodontal Maintenance (D4910) will require probing depths when submitting for additional recall visits per calendar year.

Topical Fluoride Treatment
ND Medicaid allows the topical application of fluoride varnish when performed in the clinical office. For children through the age of 20 years old, ND Medicaid allows either treatment (D1206 or D1208) 3 times per calendar year. For adults age 21 and older, ND Medicaid allows either treatment (D1206 or D1208) 2 times per calendar year.
A service authorization is not necessary.

Please see the ND Medicaid Fluoride Varnish Guideline for more information.

Silver Diamine Fluoride
Silver diamine fluoride is allowed for children and adults and is allowed for primary and permanent teeth. There is a maximum of two (2) applications per tooth, per calendar year and a lifetime maximum of four (4) applications per tooth.

This service must be billed using code D1354. Service authorization is required for teeth requiring restoration within 6 months after application of Silver Diamine Fluoride (D2000-D2999) by the same treating dentist or dental office. Restoration must be medically necessary. Application of hydroxyapatite regeneration medicament (D2991) may not be billed on the same tooth/same day.

Signed informed consent is required.

RESTORATIVE

Crowns – Single Restoration Only

For members age 21 and older, ND Medicaid covers anterior crowns only. There must be a root canal on the tooth for consideration of a crown. Pre- and post-endodontic radiographs are required with submission of the service authorization to support medical necessity.

D2991 – Application of hydroxyapatite regeneration medicament – per tooth

This service is allowed twice per unrestored tooth per year. The entire tooth must be unrestored to bill D2991. This service may be performed for children and adults and may be performed on primary or permanent unrestored teeth. Additional treatments per year require a service authorization.

This service may not be billed with the following on the same tooth by the same dentist/dental office:

- Sealants (D1351);
- Sealant repair (D1353);
- Silver diamine fluoride (D1354);
- Cannot be done if lesions are already cavitated; and
- Cannot be billed on teeth that have had a previous restoration.

Service Authorization Requirements

Crowns for all recipients, except stainless steel crowns, require a service authorization. Prefabricated resin crowns (D2928 and D2932) require a service authorization for members age 21 and older and are only covered for anterior teeth. Radiographs, photos, and documentation must be submitted with the service authorization request.

For members under age 21, crowns may be prior approved without endodontic therapy based on medical necessity.

Core Buildups and Post Core services do not require a service authorization, however, require appropriate documentation and must be medically necessary.

ND Medicaid requires a service authorization when restoration is needed on a supernumerary tooth. Radiographs and documentation are required with the authorization request. Medicaid will only consider approval of the request when the supernumerary tooth is functional.

Restorative Non-Covered Services
Non-covered services include:

- Temporary crowns; and
- Permanent crowns on primary teeth.

Overlapping services are not permitted.

ENDODONTICS

Endodontic therapy includes primary teeth without succedaneous teeth and permanent teeth. Pulpectomy is part of root canal therapy. This includes all appointments necessary to complete treatment and intra-operative radiographs. This does not include diagnostic evaluation and necessary radiographs/diagnostic images.

ND Medicaid allows root canal treatment or retreatment of a previous root canal on anterior teeth only for adults age 21 and older. Root canal treatment or retreatment of a previous root canal is allowed on anterior, premolar, and molar teeth for members through the age of 20 years old.

Root canal treatment must be medically necessary and the most cost-effective treatment option for the member. Supporting documentation is required and may be requested for cases where multiple procedures are performed on the same date of service.

Service Authorization Requirements
No service authorization is required for root canal treatment or retreatment of a previous root canal.

Apicoectomy is not intended for routine treatment but will be reviewed on a case-by-case basis, where such apicoectomies will result in greater cost effectiveness. A service authorization is required for apicoectomy procedures.

PERIODONTICS

Non-Surgical Periodontal Service
Periodontal scaling and root planing, four or more teeth, per quadrant or one to three teeth, per quadrant (D4342) is allowed once per quadrant every two years for adults age 21 and older. The per quadrant limitation applies to either procedure. Service authorization is required prior to rendering the service should the limitation per quadrant be met or exceeded within the two-year timeframe.

When scaling and root planing is performed (D4341 or D4342), the following must be available upon request:

- Periodontal charting. The charting must support the number of teeth per quadrant procedure, and the charts must be reflective of the dates the services were rendered and be no more than one year old.
- Documentation and hygiene treatment plan supporting the service rendered.

If a service authorization is needed for non-surgical periodontal services (D4341, D4342, D4346 or D4910) the following is required:

- Periodontal charts:
  - Depth chart must be no more than 1 year old; and
  - Depth chart must include the member's name and must be dated.
- Photos and/or radiographs must be sent with documentation of the members' most recent office visit when periodontal charting is not available;
- The medical record must reflect a probing depth of 5mm or greater to be considered medically necessary. The Clinical Attachment Level (CAL) will be taken into consideration with radiographs to support the dental necessity; and
- Teeth planned for extraction within 90 days of the treatment for scaling and root planing must not be included in the treatment plan. The appropriate procedure code should be requested initially.

Full mouth debridement cannot be billed in addition to a comprehensive periodontal evaluation (D0180) on the same date of service. Full mouth debridement does not require a service authorization.

Prophylaxis, periodontal maintenance and anesthesia is included in the above codes and cannot be billed separately.

D4346 requires periodontal charting be submitted with the authorization when frequency limitations have been met or exceeded. This procedure will not be allowed if the member previously had scaling and root planing. Maintenance visits include prophylactic (D1110) visits only. Please see A Guide to Reporting D4346 for more information.

When a procedure is performed in an outpatient hospital due to member disability, and the periodontal charts are not available, radiographs and supportive documentation are required to support the procedure.

PROSTHODONTICS (COMPLETE AND PARTIALS)

Immediate and Complete Dentures

An immediate denture is defined as a complete, final prosthesis inserted on the same day, immediately following the removal of natural teeth. Immediate dentures (D5130 and D5140) have a lifetime limit and cannot be billed as a replacement denture.
Medicaid allows one upper denture (D5110 or D5130) every 5 years with no service authorization.

Medicaid allows one lower denture (D5120 or D5140) every 5 years with no service authorization. Early replacement will require a service authorization.

A service authorization is required when the complete denture replaces a partial denture, and the partial denture is less than 5 years old. Medicaid allows one prosthesis per 5 years.

There is a 5-year limitation on all dentures. All dentures must be billed no earlier than the date of final impression.

Service Authorization Requirements

There is a 5-year limitation on all immediate and complete dentures. Early replacement of dentures requires a service authorization. If a denture approval has not been granted, the authorization will be denied and will be the provider's responsibility.

All service authorization requests must include the age of the current denture and the reason for early replacement. Radiographs are required with the authorization submission.

When a complete denture replaces a partial denture the service authorization must include the tooth numbers to be extracted. The partial denture must be at least 5 years old. Radiographs will be required, and the authorization must be in place prior to extractions taking place.

Once the denture has been reimbursed, payment will not be made for restorative procedures on teeth that will be extracted.

Partial Dentures

Medicaid requires a service authorization for all partial dentures. Medicaid allows partial dentures once every 5 years.

Partial denture coverage includes the following:

- When posterior teeth only are necessary for the partial denture Medicaid will allow with 6 teeth or more, less the 3rd molars (teeth 1,16, 17, 32);
- Medicaid will allow a partial denture with a combination of anterior and posterior teeth; and
- Medicaid will allow a partial denture with anterior teeth only.

Radiographs must be submitted to support the tooth numbers included in the partial denture and when the partial denture is a replacement, the age of the existing partial denture and reason for replacement is required.

Additional documentation may be required upon request.

Service Authorization Requirements
All partial dentures require a service authorization. When submitting a service authorization for partial dentures, radiographs are required. The authorization must also indicate the teeth included in the partial denture. When the partial denture is a replacement, the age of the current partial denture and the reason for replacement must be included on the service authorization.

Interim Partial Dentures/Prosthesis
Interim partial dentures will be considered when the prosthetic includes 1-3 teeth. If the prosthesis includes posterior teeth only or a combination of anterior teeth and posterior teeth – a different dental code may be considered.

An interim partial denture (flipper) is covered once every 5 years.

Service Authorization Requirements
Interim partial dentures require a service authorization. The service authorization must indicate the teeth included in the interim prosthesis and radiographs must be submitted with the request. When the interim prosthesis is a replacement, the age of the current prosthesis and the reason for replacement must be included on the service authorization.

Non-Covered Services
Interim complete dentures (D5810-D5811) are non-covered by ND Medicaid.
Early Replacement Lost Dentures or Partial Dentures
If a member over age 21 loses their denture or partial denture prior to the 5-year

limitation, ND Medicaid will not cover a replacement. Exceptions to this may be granted to developmentally disabled (DD) members if documentation on the service authorization justifies the exception. These exceptions will be decided on a case-by-case basis.

Dentures/partials will not be covered when lost or stolen in a long-term care facility pursuant to 42 CFR 483.25. If the recipient is under full care of the facility due to physical or mental conditions, the facility is responsible for the cost of replacement. The member, caregiver, or family member may not be billed for any lost denture in the long-term care facility.

Dentures/partial dentures lost in the hospital are the responsibility of the hospital to replace. The facility must provide the requested documentation to the dental office for the authorization submission when requested. The member, caregiver, or family member may not be billed for any lost denture in the hospital. Medicaid will allow replacement if it has been 5 or more years since the member received a new denture/partial denture. Special consideration for early replacement (less than 5 years) is given on a case-by-case basis.

Stolen
If a member's dentures are stolen, a service authorization must be submitted with a copy of the police report and the age of the dentures at the time they were stolen.

Damage
If a member's dentures are damaged, a service authorization must be submitted including documentation on why the denture is not repairable. The service authorization must also include photos of the unrepairable denture and the age of the dentures at the time they were damaged.

If a member's dentures are damaged by unnatural means (i.e., fire, flood, motor vehicle accident, natural disaster, domestic dispute), a service authorization must be sent with a copy of the medical records or emergency responders report to support the event. A copy of the no-fault carrier insurance explanation of benefits (EOB) is required along with the age of the current denture or partial denture.

Encounter Based Clinics
An encounter is defined as a visit related to a complete or partial denture service. A denture/partial denture visit such as an impression, placement, reline, or an adjustment

qualifies as an encounter. One year post placement, subsequent encounters will be allowed with prior approval for denture related services.

There is a maximum of 5 encounters per arch per complete/partial denture for the initial placement when all 5 encounters are medically necessary. Extension of the approved service authorization includes the maximum 5 encounters per arch/per complete/partial denture, not 5 additional encounters.

Service Authorization Requirements
A service authorization is required for all partial dentures. A service authorization is required for all early replacements and complete dentures replacing partial dentures within the 5-year timeframe. Documentation and all procedure codes must be submitted with the service authorization request.

Non-Covered Services
ND Medicaid does not cover denture/partial denture cleanings.

Implant Services – Dental Implants
Dental implants are a non-covered ND Medicaid service.
Implant supported removable dentures, and partial dentures will be considered for coverage when documentation supports medical necessity, and the dental implants are existing.

A service authorization is required with radiographs to support medical necessity. ND Medicaid will not reimburse the cost of the dental implants, locator parts, or the bone grafting specifically for the dental implants as these are a non-covered service. Should dental implants require removal, ND Medicaid will not cover the cost of replacement.

Prosthodontic Limitations
Adjustments to dentures and partial dentures have a limit of two per calendar year for the life of the denture/partial denture. A service authorization is not needed unless limits have been met or exceeded.

Repairs to complete or partial dentures require a service authorization when more than 4 teeth per year are replaced. If replacing all teeth in the denture or partial denture or converting the partial denture to a full complete denture, a service authorization is required. This will be subject to the 5-year limitation.

Denture or partial denture rebase procedures require a service authorization. When a denture is rebased, a complete denture would not be approved for 5 years from the rebase date of service.

Denture or partial denture relines are allowed one year after denture/partial denture placement and allowed once per year. A service authorization is required if needed early or more frequently. A service authorization is required after more than 3 relines are needed. Exceptions on time limitations may be granted based on medical necessity. The medical reason must be indicated on the service authorization.

Prosthodontics - Fixed
These require a service authorization for recipients under the age of 21 and are non-covered for adults ages 21 and over.

ORAL AND MAXILLOFACIAL SURGERY DENTAL EXTRACTIONS

ND Medicaid considers a tooth extraction once per lifetime per tooth procedure. All extractions billed to ND Medicaid must be medically necessary. Extraction of asymptomatic teeth is not covered.

Dental extractions that are attempted but are unable to be completed must be billed under dental code D7999 with a tooth number and dental record documentation that explains why the tooth extraction was not completed. This procedure requires a service authorization, and a retro authorization will be considered per ND Medicaid's service authorization policy.

Anesthesia
ND Medicaid will reimburse deep sedation/general anesthesia (D9222, D9223) or intravenous moderate (conscious) sedation (D9239, D9243). Documentation in the anesthesia record must support the start and stop times for units billed. Medicaid will allow the first 15 minutes of anesthesia time and up to 8 additional units of anesthesia time. North Dakota Medicaid does not reimburse for non-intravenous sedation.

CRNA services and medication must be billed on a CMS-1500 claim form and will be edited by National Correct Coding Initiative (NCCI) edits. Any services supplied by a CRNA must be supplied by a CRNA enrolled with ND Medicaid. Documentation in the anesthesia record must support the start and stop times for units billed including:

- Moderate sedation services provided by a CRNA:
    - 99155 – Members younger than 5 years old and

  - 99156 - Members 5 years and older.
    - One unit is billed for every 15 minutes of intraservice time.
- Each additional 15 minutes of time, bill 99156 one unit per 15 minutes.

Specific guidelines for time- based billing may be found here: provider-requirements.pdf

ORTHODONTICS – UNDER 21 ONLY
Orthodontic treatment requires a service authorization and is only allowed/reimbursed for recipients under the age of 21. Please see the Orthodontics policy for more information.

ADJUNCTIVE GENERAL SERVICES
Palliative Treatment
Palliative treatment of dental pain is reimbursed on a "per visit" basis. Procedures performed on the same date of service may be billed in addition to this service. Palliative Treatment does not include an evaluation. The evaluation should be billed separately when performed in addition to the other services performed.

ND Medicaid does not reimburse palliative treatment for routine treatment such as prophylaxis or sealants. Palliative treatment may not be billed for denture "steps." Palliative treatment does not require a service authorization. Examples of palliative treatment would be smoothing a sharp edge on a broken tooth or incising an abscess.

Fixed Partial Denture Sectioning
ND Medicaid requires a service authorization for fixed partial denture sectioning. Radiographs are required in addition to the service authorization request.

Occlusal Guards
ND Medicaid will allow one occlusal guard per calendar year. A service authorization is not required unless the limit has been met/exceeded.

Sleep Apnea Appliances
ND Medicaid requires a service authorization for consideration of a sleep apnea appliance along with documentation to support medical necessity. The documentation must include compliance with continuous positive airway pressure (CPAP)/level positive airway pressure (BIPAP) and current sleep study results.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

All documentation must be signed with the provider's full signature. Initials will not be accepted by ND Medicaid.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

Orthodontic EPSDT policy
Service Authorization policy
Provider Requirements policy
Teledentistry policy

FREQUENTLY ASKED QUESTIONS

Q: What is the number of cleanings Medicaid will allow per year?
A: Medicaid allows 2 cleanings per calendar year and up to 4 cleanings per calendar year with a service authorization.

Q: Does Medicaid pay for store and forward?
A: Medicaid reimburses Synchronous (D9995) and Asynchronous (D9996) teledentistry in addition to the service performed.

CONTACT

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POLICY UPDATES

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Section	Updates
Documentation	Full signature required
Restorative	Application of hydroxyapatite regeneration medicament guidelines
Periodontics	Policy updates
Prosthodontics	Policy Updates
FAQ	Added Common questions