PROVIDER MANUAL FOR

DENTAL SERVICES

NORTH Dakota Be Legendary.

Health & Human Services

Published By:

Division of Medical Services
North Dakota Department of Health & Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505-0250

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SUMMARY OF CHANGES

The July 2024 ND Medicaid dental manual updates contain various changes that are detailed below. While dental providers should review changes that are specific to their specialty, all enrolled Medicaid providers are responsible to understand and comply with program requirements contained in the General Provider Policies such as Provider Enrollment, Provider Information, and noncovered Medicaid services. These chapters are contained on the Provider Guidelines, Manuals and Policies web page found here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota.

1. Dental Screenings and Assessments limitations updated
2. Code D6100 added to manual
3. Dental Valid Values
4. Services requiring authorization
5. Orthodontic Transfer Manual Additions
6. Root Canal Treatment – Medical Necessity Addition

KEY CONTACTS

Hours for key contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Central Time).

Provider Enrollment

(701) 277-6999
(701) 433-5956 (fax)

Send written inquiries to:
Noridian Healthcare Solutions
Attn: ND Medicaid Provider Enrollment
PO Box 6055
Fargo, ND 58108-6055

or e-mail inquiries to:
NDMedicaidEnrollment @noridian.com

Call Center

For questions about member eligibility, payments, denials or general claims questions:
(701) 328-7098
(877) 328-7098

or e-mail inquiries to:
mmisinfo@nd.gov

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 755- 2604
(701) 328-2347

Send written inquiries to:

Third Party Liability Unit
Medical Services
ND Dept. of Health & Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250

or e-mail inquiries to:
medicaidtpl@nd.gov

Coordinated Services Program

Inquiries regarding coordinated services program recipients:

(800) 755-2604
(701) 328-2346

or e-mail inquiries to:
medicaidCSP@nd.gov

Surveillance/Utilization Review

To report suspected ND Medicaid provider fraud and abuse:

(701) 328-4024
(800) 755-2604

Send written inquiries to:

Fraud and Abuse
Surveillance/Utilization Review
Medical Services
ND Dept. of Health & Human Services
Dept 325
600 E Boulevard Ave
Bismarck ND 58505-0250

Or e-mail inquiries to:

medicaidfraud@nd.gov

Service Authorization

For questions and inquiries:

dhsserviceauth@nd.gov

SHS Inquiries and to obtain forms

Special Health Services
ND Dept. of Health & Human Services
600 E Boulevard Ave Dept 401
Bismarck ND 58505-0200
(701) 328-2436

INTRODUCTION

This billing manual is one of many resources that providers will reference as participants in the Medicaid program. The combined information is designed to aid providers in billing the North Dakota Medicaid and Special Health Services (SHS) programs. Included are general items of interest to providers, specific claim form billing instructions and procedures to follow when voiding and replacing a claim.

When filing claims with the ND Medicaid program, the provider agrees to accept ND Medicaid payment as payment in full. The provider CANNOT BILL the recipient for any part of the bill unless the remittance advice indicates a recipient liability applies to the services, or it is a non-covered service.

Please contact the Medical Services office with questions. Addresses and telephone numbers are listed in the Key Contacts section of this manual.

Any disputes or questions on claims should be directed to the ND Medicaid call center at 701-328-7098.

THIRD PARTY LIABILITY (TPL)

Please refer to the General Provider Policies.

The manual can be found here:
Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

PROVIDER ENROLLMENT

Eligible providers may not bill for services under a supervising or peer provider's NPI. All eligible providers must enroll and bill with their own NPI. All dental providers that are treating ND Medicaid members are required to enroll.

Provider Enrollment Information can be found here: Provider Enrollment Information | Health and Human Services North Dakota or within the General Provider Policies located here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota.

Advanced Dental Therapists outside of North Dakota

ND Medicaid does not enroll nor reimburse services rendered by Advanced Dental Therapists (ADT). When the Advanced Dental Therapist is dually licensed as a hygienist, ND Medicaid will consider services within the scope of hygiene only upon license verification within the state services are rendered.

SERVICES TO AN INDIVIDUAL WITH A DEVELOPMENTAL DISABILITY

Individuals with a developmental disability (DD) may require an extra amount of time and a greater number of personnel to provide routine dental care. The Department may provide additional compensation to dentists who treat individuals who require extra care; therefore, providers will receive the standard fee for the dental services provided plus an additional payment for the extra time needed.

The policy does require providers to document the extra time and extra staff required to provide services to DD recipients. The provider is required to bill with procedure code D9920 and enter the usual and customary charge associated with the services provided to the DD recipient. Procedure Code D9920 does require a service authorization (SA) effective October 1, 2015. If approved, The Department will pay the extra charge based on the established fee schedule. Procedure code D9920 is expected to be billed in addition to other services rendered on the same date of service.

When the dentist provides a service to an individual with a developmental disability who requires extra time, the dental provider must submit the Request for Extra Time Individuals with Developmental Disabilities form (SFN 64). The form must be signed by the DD provider, guardian, or caregiver. The form must be completed in its entirety.

The DD services are only reimbursed when performed in an office setting. ND Medicaid does not recognize any other service locations for this recipient population. This service is not payable in conjunction with dental case management.

Any additional questions regarding this policy may be addressed by contacting the ND Medicaid call center at (701) 328-7098.

ANESTHESIA GUIDELINES

North Dakota Medicaid will reimburse procedure codes:

- D9222 deep sedation/general anesthesia – first 15 minutes
- D9223 deep sedation/general anesthesia – each 15-minute increment
- D9239 intravenous moderate (conscious) sedation/analgesia – first 15 minutes
- D9243 intravenous moderate (conscious) sedation/analgesia – each 15-minute increment
- D9223 and D9243 are allowed up to eight units and must all be billed on one line.

Documentation in the anesthesia record must support the start and stop times for units billed.

North Dakota Medicaid does not reimburse for code D9248 (Non-intravenous conscious 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.

This policy does not apply to recipients with a developmental disability who have been approved for D9920 – behavior management.

TELEDENTISTRY

Teledentistry services must be reported in addition to other procedures delivered to the patient on the date of service.

Synchronous teledentistry (D9995) is delivery of patient care and education where there is live, two-way interaction between the patient and at least one dental, medical, or health caregiver at one physical location and an overseeing supervising or consulting dentist or dental provider at another location.

Asynchronous (store-and-forward) teledentistry (D9996) is the transmission of recorded health information (i.e., radiographs, photographs, digital impressions) through a HIPAA-compliant electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

Teledentistry code D9995 or D9996 is required when billing ND Medicaid. Service authorization is not required.

Patient records must include the CDT© Code(s) that reflect the teledentistry encounter. The claim submission must include all applicable CDT© codes. ND Medicaid will reimburse CDT© code D9995 or D9996 once per date of service. Claim submissions must be billed using place of service (POS)/place of treatment codes:

02 Teledentistry provided in a location other than the patient's home.
10 Telehealth provided in patient's home.

Claims with any other place of service will be denied. Covered Services

D0120 periodic oral evaluation – established patient D0140 limited oral evaluation – problem focused
D0145 oral evaluation for a patient under three years of age and counseling with primary caregiver
D0170 re-evaluation – limited, problem focused (established patient, not post-operative visit)
D0171 re-evaluation – post-operative visit D0190 screening of a patient
D0191 assessment of a patient

**Image Capture Only Radiographs, if obtained via teledentistry, cannot be repeated in office

Non-Covered Services

- Examinations via online/email/electronic communication
- Patient contact with dentist who provides the consultation using *audio means only (no visual component)*
- Virtual check-in

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Revenue code 0780 should only be reported along with Q3014 when the FQHC is the originating site. When providing teledentistry services to patients located in their homes or another facility, FQHCs and RHCs should continue to bill the revenue code listed below along with the CDT© code for the service rendered appended with modifier GT or 95.

Revenue Code 512: Dental Clinic.

One dental encounter is allowed per day. The encounter must be a face-to-face encounter to qualify for payment. Asynchronous teledentistry performed as a stand-alone service does not qualify for an encounter payment. At least one covered service must be performed as a face-to-face service to qualify for the dental encounter payment.

This policy may be viewed in its entirety here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

DENTAL SCREENING AND ASSESSMENT

Dental screening and assessments are allowed for children and

adults. These services are to be billed under code:

- D0190 – screening of a patient
- D0191 – assessment of a patient

These services may be done at the time of a well child visit/Health Tracks screening, in a school setting, via teledentistry, or in addition to other dental services (i.e., fluoride varnish or prophylaxis).

Dental screening and assessment services are not allowed when billed in conjunction with dental oral evaluation codes: D0120-D0180. Dental Screening and Assessment services are considered inclusive when performed in conjunction with any dental exam or evaluation on the same date of service.

Medicaid will allow either service two times per calendar year for children and adults.

- Only the following professionals may perform the procedure:
    a. Dentists
    b. Registered Dental Hygienist or Registered Dental Assistant under the direct or general supervision of a licensed dentist (claim must be submitted under the enrolled practitioner's NPI).
    c. Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) under the direct supervision of a physician, family nurse practitioner, or physician assistant (claim must be submitted under the enrolled practitioner's NPI)
        a. RNs that complete these services must bill utilizing code T1002. This service must be billed electronically on a professional claim form (CMS-1500).
        b. LPNs that complete these services must bill utilizing code T1003. This service must be billed electronically on a professional claim form (CMS-1500).

DENTAL CASE MANAGEMENT

Dental Case Management is a program that is designed for members with mental, physical and/or behavioral health care needs who are unable to schedule and/or coordinate complex treatment plans involving one or more medical or dental providers.

Dental Case Management may involve addressing appointment compliance barriers, care coordination, motivational interviewing, patient education, and addressing special healthcare needs.

Dental Case Management may be performed by the following:

- Dentists
- Registered Dental Hygienist or Registered Dental Assistant under the direct or general supervision of a licensed dentist (claim must be submitted under the enrolled practitioner's NPI)

Dental case management services may be:

- Performed in addition to other dental services (i.e., fluoride varnish, prophylaxis, interpreter services). The intent of Dental Case Management is to provide other dental services on the same day.
- Billed in addition to an oral evaluation, however, does not take the place of the oral evaluation.

ND Medicaid allows a limit of two dental case management services per calendar year (D9991-D9994, D9997). Additional services may be submitted via a service authorization request with documentation to support the previous dental case management services provided. The complexity of the patient treatment plan and health care needs will be taken into consideration for the timeframe of services.

ND Medicaid will not allow dental case management in conjunction with behavior management, code D9920.

Documentation Requirements

The following must be documented within the medical/dental record to support the services billed:

- The name of the individual
- The date of the dental case management service
- The name of the individual providing the dental case management service
- Documentation must have a valid signature and signature date
- Efforts made to assist patient with appointments and appointment planning, barriers to treatment and compliance issues, treatment planning, referrals, oral health decision making, and care coordination.

- D9991 requires name of the individual at the Human Service Zone that assisted in transportation efforts with the dental office and patient. A copy of the taxi voucher or authorization should be kept on file in the patient dental record.
- D9992 requires the names and documentation across all providers involved in the coordinated care of the patient. This service must involve multiple providers.
- D9993 and D9994 must include documentation to support the medical necessity for the oral health outcomes and literacy specific to the patient centered approach. These two codes cannot be used for education and counseling alone. Motivational Interviewing must include a one to one, face-to-face patient centered counseling session used to identify negative behaviors and improve positive oral health outcomes.
- D9997 must include documentation that supports the patient's special health care need and any patient special treatment considerations. The patient specific medical/mental health condition must be documented. ND Medicaid will not allow behavior management (D9920) in addition to this service.

Non-Covered Services

- Oral hygiene instructions which would otherwise be billed using code D1330.
- Missed appointments.
- Smoking Cessation/Tobacco Counseling which would otherwise be billed using code D1320.
- Nutritional Counseling which would otherwise be billed using code D1310.
- Counseling for Substance Use Disorder which would otherwise be billed using code D1321.

FQHC and Encounter Based Dental Clinics

- Encounter-based dental clinics and FQHC's must bill Dental Case Management in addition to another qualifying service to receive reimbursement for the encounter.

This policy may be viewed in its entirety here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

HOUSE/EXTENDED CARE FACILITY CALL

This service must be billed with code D9410. This Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. This code must be billed in addition to a ND Medicaid reimbursable service.

This service is reimbursed once per member, per day. Service authorization is required for members thru the age of 5 years old. ND Medicaid will not allow this procedure for Head Start physicals.

This service is non-covered when performed in the dental office.

This service is not allowed when billed in conjunction with denture preparatory services, denture impressions, denture adjustments, denture cleanings, or any other denture or partial denture related services that fall under codes D5000-D5999 as these are considered inclusive to the cost of the denture or partial denture service.

ND Medicaid will require documentation when D9410 is billed in conjunction with one of the following codes and no other covered procedure: D0120, D0140, D0145, D0150, D0160, D0170, D0171, and D0180. ND Medicaid will allow code D9410 when billed in conjunction with an evaluation and a reimbursable service. When services billed are denied for limits met/exceeded, this service is non-payable.

SILVER DIAMINE FLUORIDE

This service is to be billed using code D1354.

D1354- Interim caries arresting medicament application-per tooth
*Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

This service is allowed for children and adults. This service is allowed for primary and permanent teeth.

Signed informed consent is required an example for use can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4778976/figure/F4/

There is a maximum of two (2) applications per tooth, per calendar year and a lifetime maximum of four (4) applications per tooth.

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.

PREVENTATIVE RESIN RESTORATION

Preventative Resin Restoration in a moderate to high caries risk patient – permanent tooth is to be billed using code D1352.

Code D1352 is a conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.

This service is reimbursed for members through the age of 20 years old. A service authorization is not required.

This service must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth.

This service must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year.

VALID VALUES

Claims and Service Authorization

The following valid values are required on service authorizations and claims for payment.

Areas of the Oral Cavity	
00	Designates the whole of the oral cavity
01	Designates the maxillary area
02	Designates the mandibular area
10	Designates the upper right quadrant
20	Designates the upper left quadrant
30	Designates the lower left quadrant
40	Designates the lower right quadrant
03	Designates the upper right sextant
04	Designates the upper anterior sextant
03	Designates the upper left sextant
06	Designates the lower left sextant
07	Designates the lower anterior sextant
08	Designates the lower right sextant

Tooth Surface
I
F
O
L
B
M
D

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Supernumerary #	51	52	53	54	55	56	57	58	56	60	61	62	63	64	65	66
Tooth #	32	31	30	29	28	27	26	25	24	23	22	24	20	19	18	17
Supernumerary #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67
Tooth #	A	B	C	D	E	F	G	H	I	J						
Supernumerary #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS						
Tooth #	T	S	R	Q	P	O	N	M	L	K						
Supernumerary #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS						

DENTAL SERVICE AUTHORIZATION (SA)

A service authorization (SA) must be obtained for procedures for ND Medicaid eligible recipients before services are started. The Department will refuse payment for any covered service or procedure for which a SA is required but not obtained. Retro service authorizations may be submitted for consideration up to 90 days from the date of service. The dental office must demonstrate good cause for the failure to secure the required service authorization request prior to the date services were rendered. The submission of a retro authorization request does not guarantee the approval of the service authorization or payment of the claim.

To verify service authorization requirements for dental procedures, please utilize the Procedure Code Look-up Tool.

1. All SA submissions must use appropriate codes, procedures, and usual and customary fees.

2. Web based service authorizations are required. ND Medicaid will provide training and support when needed for authorization submissions. Should web based service authorizations be unable to be sent, please notify The Department by email at dhsserviceauth@nd.gov .

3. All supporting documentation must be attached to the SA electronically**. All submissions without required documentation will be denied and must be resubmitted with required documentation.**

4. No payment for dental services which require a service authorization will be made unless a dental SA is on file with the Department **PRIOR** to the date the service is started showing that the treatment plan was approved for the codes and procedures submitted on the claim.

5. Once the authorization is submitted, the Department's dental consultant will review the plan and either approve or deny the services listed on the request. Services submitted that do not require service authorization will be voided from the authorization request. Services are reviewed and approved with the date of service of the review. When services are planned for a specific date of service, this must be noted on the request.

6. Approval of the SA is only for the dental treatment plan. THIS APPROVAL DOES NOT GUARANTEE PAYMENT OR ENSURE THE ELIGIBILITY OF THE INDIVIDUAL AT THE TIME DENTAL PROCEDURES ARE COMPLETED. Payment will be based on the fee schedule on the date of service.

7. The North Dakota Department of Health & Human Services reserves final authority to approve or deny any submitted dental treatment plan.

8. Reconsideration requests for a denied SA must be submitted with additional supporting documentation. Failure to do so will result in denial of the authorization request. Reconsideration requests must be submitted through the web portal. Reconsideration requests must be separately identifiable with unique, additional supporting documentation submitted with each request. Duplicate requests will not be accepted.

9. Extensions or revisions to previously approved SA's must be faxed to 701-328-0350 or emailed to dhsserviceauth@nd.gov. When the authorization has expired and is more than 90 days past the expiration of the request, the authorization must be resubmitted in its entirety.

10. When requesting retro authorization for services, the requested begin and end dates must be the date the service was rendered. No date span will be accepted. If a date span is requested, the authorization will be denied. The dental office must demonstrate good cause for the failure to secure the required service authorization request prior to the date services were rendered.

11. Service authorization requests for services that apply to frequency limitations must be submitted with documentation. Documentation required must include the patient specific medical condition, probing depths, and the recall of visits. If approved, these authorizations will be approved for a minimum of five years and must be re-authorized by the dental office if allowed to expire. The authorization is only required if the recall of visits necessary is more than the allowed Medicaid limitations. Authorizations will not be considered for those patients that currently have a dental treatment plan with Medicaid's current allowed limitations.

12. Services that do not require prior approval should not be submitted. These requests will be voided or returned to the provider when received. When a web-based authorization is voided, no authorization letter is generated.

ORTHODONTIC PROCEDURES

The Department does not reimburse limited or comprehensive orthodontic treatment unless referred by ND Health Tracks, EPSDT or the referring dentist.

Dentists that complete the Health Tracks screening must bill ND Medicaid utilizing code D8660. The orthodontia screening may be billed in conjunction with other covered services when performed at the same visit. The full Health Tracks Orthodontia Screening Policy can be viewed here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota .

Orthodontists must submit a service authorization request for limited or comprehensive orthodontia services. The service authorization must be submitted with the Health Tracks screening from the referring screener/dentist and the orthodontist that will be rendering treatment. It is recommended that orthodontia services be billed at the time brackets are placed.

The Department has defined treatment options for orthodontia services to clarify those options and reimbursement for those services by ND Medicaid. They are as follows:

(1) Limited orthodontic treatment under the ND Medicaid program will include only treatment of anterior or posterior crossbite and minor treatment for tooth guidance in the transitional or adolescent dentition. Limited treatment is not part of the comprehensive treatment plan. Treatment typically begins at age 6 or older. This service requires a service authorization and must be billed under code D8020 or D8030.

(2) Comprehensive orthodontic treatment includes treatment of transitional or adolescent dentition; requires 20 or more points on an evaluation; and is begun when a child is approximately 10 years old or older but no older than 20 years of age. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. Treatment requires a service authorization and must be billed under code D8090.

- Radiographs, Photos, and a Cephalometric film along with a narrative description of the malocclusion are required for review. Without images, the service authorization may be denied for additional information.
- Maxillary and mandibular retainers are included in the reimbursement.
- Replacement of lost/broken maxillary or mandibular retainers are allowed once per lifetime, with service authorization for those under age 21.
- Code D8670 is included in D8090.

As with all services, the child must be eligible at the beginning of each treatment or service.

PROVIDERS MUST USE THE MALOCCLUSION INDEX TO EVALUATE THE NEED FOR ORTHODONTIC TREATMENT OF ND MEDICAID RECIPIENTS.

The Health Tracks Comprehensive Orthodontic Screening form (SFN 61) is available online at http://www.nd.gov/eforms.

The SFN 61 form must be completed in its entirety when submitting for service authorization. When the SFN 61 form is missing any form requirement, the authorization will be denied, and the request must be resubmitted. The form must be signed in ink, by the screener/dentist, dated the date the orthodontia screening took place, and the Medicaid ID number must match the member's name. ND Medicaid will not accept a stamped signature. The signed screening form must be current and no older than one year from the date the service authorization request is received by ND Medicaid. ND Medicaid will accept an electronic version of the SFN 61 form when the attachment of the electronic report/form version includes the same criteria as the SFN form.

The Orthodontic Screening Guide can be found online at: OrthoTrainingManual20130822.pdf (nd.gov)

ORTHODONTIC TRANSFERS

A service authorization is required for all orthodontic transfer cases. Codes D8070 and D8080 may only be authorized when the member is in the middle of treatment. Medicaid will reimburse at the fee schedule amount when D8070 or D8080 is submitted for payment.

North Dakota Medicaid will prorate the payment if another orthodontist becomes involved with the service due to the member relocating in-state or out-of-state while treatment is in progress. This process may include recouping (from the current treating dental office) a prorated percentage representing the uncompleted treatment of the original payment made to the current treating office. This process allows partial payment to be available to be made to the secondary orthodontist.

A current Service Authorization must also be in place for the member's orthodontic treatment. Payment will be prorated based upon the number of months of orthodontic treatment remaining. A new Health Tracks screening form is not required for orthodontic transfers. The documentation submitted from the dental office will determine the prorated payment as it is based upon the treatment recommendations and months of remaining treatment.

ORTHODONTIC TRANSFER CALCULATION

The prorated calculation is based off the current fee schedule amount for comprehensive orthodontia (D8090) on the date of service the claim was billed.

The below calculation and fees are an **example only**. Each orthodontic transfer is unique, and the fees are determined from the documentation submitted with the authorization request.

Comprehensive orthodontic fee - $4000.00
Brackets (no specific code) - $750.00
Consultation - $100.00 (D0160)
Removal - $200.00 (D8680)
Retainer upper - $150.00 (D8703)
Retainer lower - $150.00 (D8704)

***totals $1350.00,

$4000.00 - $1350.00 = $2650.00

$2650.00/24 (based on 24-month treatment plan) = $110.42 per month for adjustments.

FEDERALLY QUALIFIED HEALTHCARE FACILITIES

ND Medicaid covers services provided by Federally Qualified Health Centers (FQHC) that are enrolled with Medicare and enrolled with ND Medicaid.

Dental services are reimbursed an all-inclusive rate for each dental encounter. The dental encounter includes covered services and supplies.

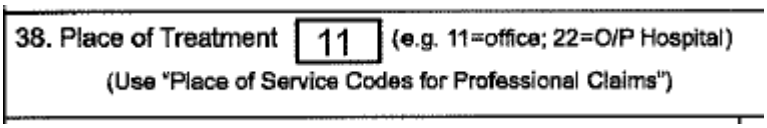
Services provided at a Federally Qualified Health Centers (FQHC) are subject to the same service authorization requirements and limitations.

Supervision rules apply to hygiene services per the supervising dentist's diagnosis and treatment plan per NDCC 43-20-03. An encounter is billable when hygiene only services are performed in accordance with the supervising dentist's diagnosis and treatment plan. These services must be billed under the supervising dentists NPI.

The full billing guidelines for FQHCs can be found in the General Information for Providers Manual here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

PLACE OF SERVICE CODES

ND Medicaid follows the standard place of service code set currently maintained by CMS as the code set used for describing the site of service. Place of service codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. On the ADA dental claim form (or electronic equivalent), this would be Box 38 - place of treatment:



The CMS Place of Service code set can be found in its entirety here: Place of Service Code Set | CMS

Dental codes that are specifically driven by place of service are:

****list is not all-inclusive****

D9410	house/extended care facility call	**not office based
D9420	hospital or ambulatory surgical center call	**not office based
D9995	teledentistry, synchronous; real-time encounter	
D9996	teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	

Common Place of Service Codes used by dental offices:

****list is not all-inclusive****

02	Telehealth Provided Other than in Patient's Home
03	School
10	Telehealth Provided in Patient's Home
11	Office
15	Mobile Unit
22	On Campus- Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility

GENERAL TIPS FOR BILLING

1. Bill only the usual and customary charges for each service.

2. It is important that all pertinent blocks on the claim form be completed. Omission of data may result in claim rejection, delays or return of the claim.

3. Ensure that all information on a claim form is **LEGIBLE**.

4. All monetary amounts must be entered without dollar signs, decimal points, or spaces. The amounts must be shown as dollars and cents. EX: Twenty dollars would be shown as 2000.

5. Strive for accuracy. Careful erasing is acceptable. Correction tapes can be used. Do not overlap information from one column to another. DO NOT USE RED PEN, INK OR HIGHLIGHTERS.

6. All dates entered should be entered as MMDDCCYY (month, day, year). EX: January 1, 2010, should be shown as 01012010. Do not use hyphens, dashes, or spaces between segments.

7. ND Medicaid must receive a provider's original Medicaid primary claim submission within one hundred eighty (180) days from the date of service. ND Medicaid's full timely filing policy may be viewed here: https://www.hhs.nd.gov/sites/www/files/documents/medicaid-policies/timely-filing-policy.pdf

8. For unspecified services use code D9999 and attach a report.

9. PLEASE CHECK BLOCK 1, DENTIST'S STATEMENT OF ACTUAL SERVICES TO DIFFERENTIATE THE BILLING FORM FROM THE PRETREATMENT ESTIMATE FORM.

10. Insurance payments must be deducted from the total charges billed in the appropriate block and an Explanation of Benefits (EOB) must be sent with the claim or claim will be denied.

11. If billing for a service that was service authorized, the authorization number approved for that claim must be on the form, or the claim will be denied.

12. When a paper claim spans to two forms, the claim forms must be labeled as **Page 1 of 2** and **Page 2 of 2 ,** etc. **Continued** must be written on page 1 in the **Total Fee** field. Combine the amount from page 1 & 2 and enter in the **Total Fee** field on page 2.

GENERAL TIPS FOR VOIDING AND REPLACING A CLAIM

ADA - Dental Claim Form Instructions April 2017

Replacing a Claim

A claim replacement may be submitted to modify a previously paid claim. Timely filing limits apply. To submit a claim replacement, complete the claim form fields below:

- Field 35: Enter the Resubmission Code of 7 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
- If replacing a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

Voiding a Claim

Voiding a claim reverses a previously processed Medicaid claim. Timely filing limits apply. To submit a claim void, complete the claim form fields below:

- Field 35: Enter the Resubmission Code of 8 and then enter the claim's Transaction Control Number (TCN) or Internal Control Number (ICN).
  - If voiding a claim processed in the ND Health Enterprise MMIS, enter the 17-digit TCN for the previously processed claim.

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

The North Dakota Medicaid Automated Voice Response System (AVRS) permits enrolled providers to readily access detailed information on a variety of topics using a touch-tone telephone. AVRS options available include:

- ∇ Member Inquiry
- ∇ Payment Inquiry
- ∇ Service Authorization Inquiry
- ∇ Claims Status

AVRS Access Telephone Numbers (available 24/7)
Toll Free: 877-328-7098
Local: 701-328-7098

Providers are granted access to the Automated Voice Response System (AVRS) by entering the new ND Health Enterprise MMIS issued 7-digit provider Medicaid ID number. A six-digit PIN number is also required for verification and access to secure information. One PIN number is assigned to each Medicaid ID number.

Touch Tone Phone Entry	Function
*****	Repeat the options
9 (nine)	Return to main menu
0 (zero)	Transfer to Provider Call Center (M-F 8am – 5pm CT) –or- Leave voicemail message (after hours, holidays, and weekends)

Callers may choose to exit the AVR system at any point to speak with a Provider Call Center customer service representative. The call center is available during regular business hours from 8am to 5pm Central Time, Monday through Friday, and observes the same holidays as the State of North Dakota. Providers may also elect to leave a voicemail message at any time when the call center is not available. Except during heavy call times, provider voice mail messages will be responded to in the order received on the following business day during regular business hours.

AVRS Options	Secondary Selections
Option 1: **Member** **Inquiry**	Callers may select any of the following options: ▪ Eligibility/Recipient Liability ▪ Primary Care Provider (PCP) ▪ Coordinated Services Program (CSP) enrollment ▪ Third Party Liability (TPL) ▪ Vision ▪ Dental ▪ Service Authorizations
Option 2: **Payment**	Remittance Advice payment information is available for the specific time frame entered.
Option 3: **Claims Status**	Claim information is available based upon the Member ID number entered, including: ▪ TCN (Transaction Control Number) ▪ Billed Amount ▪ Claim Submit Date ▪ Date(s) of Service ▪ Claim Status (paid, denied, suspended) ▪ Paid Amount (if applicable)
Option 4: **Service Authorization** **Inquiry**	Service Authorization information is available based upon the Member ID number entered, including: ▪ Service Authorization (SA) Number ▪ Date(s) of Service ▪ Authorization Status

FEES

Fee schedules can be accessed by clicking on the following link: Medicaid Provider Fee Schedules | Health and Human Services North Dakota

Providers should be aware that inclusion or exclusion of a procedure code, supply, product, or service does not imply Medicaid coverage, reimbursement, or lack thereof.

GENERAL PRINCIPLES OF DENTAL RECORD DOCUMENTATION

1. The dental record must be complete and legible.
2. The dental record must include:
    a. Patient name and demographic information
    b. Medical and dental history, including medication prescription history
    c. Progress and treatment notes
    d. Diagnostic records and radiographs
    e. Treatment plan
    f. Patient complaints and resolutions
3. The information in the dental record must be dated, signed, and handwritten in ink by the healthcare professional rendering the service. It may also be computer generated. Stamped signatures will only be accepted per CMS guidelines. If the dental office maintains a signature log, ND Medicaid will accept an attestation from the dental office and team members in that office if an audit is performed, and the signature is in question.
4. Appropriate health risk factors must be identified.
5. The patient's progress, response to and changes in treatment, and revision of diagnosis must be documented.
6. The information contained in the dental record should not contain many abbreviations.
7. The identifying practitioner must be clearly noted in the dental record.
8. The treating dentist is ultimately responsible for the patient chart. However, when the assistant, hygienist, or other staff member documents/scribes on behalf of the treating dentist; the treating dentist must sign, initial or attest and date acknowledging the completeness of the entry.
9. The CPT©, CDT©, and ICD-10-CM codes reported on the CMS-1500 Claim Form, ADA Dental Claim Form, or UB-04 Claim Form must be supported by the documentation in the dental record.
10. Any services rendered in the outpatient hospital or ambulatory surgical center must be supported by an operative report showing medical necessity of the services performed.
11. Any services rendered in the office setting with the use of IV sedation or General Anesthesia must maintain an anesthesia record and this must be available to the Department upon request.
    a. Sedation provided by an ND Medicaid enrolled CRNA need to be submitted on a CMS 1500 form and follow the guidelines as outlined by ND Medicaid.

ND MEDICAID PROVIDER SIGNATURE REQUIREMENTS

Documentation submitted to ND Medicaid must be signed by the ND Medicaid enrolled provider performing the service. All medical record entries must be legible and complete, dated, and timed, and authenticated in written or electronic format by the person responsible for providing or evaluating the service provided. It may also be computer generated. Stamped signatures will only be accepted per CMS guidelines. If the dental office maintains a signature log, ND Medicaid will accept an attestation from the dental office and team members in that office if an audit is performed, and the signature is in question. For a signature to be valid, the following criteria are used:

- Services that are provided/ordered must be authenticated by the author
- Signatures shall be handwritten or an electronic signature
- Signatures are legible
- Rubber Stamps for signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that he/she has reviewed the document.
- Medical record entries completed by a scribe must be authenticated by the treating physician's/non-physician's (NPP's) signature and date.

Electronic signatures in medical records will be **accepted** in the following format (examples, not limited to):

- ‘Approved by’ with provider’s name
- ‘Authorized by’ with provider’s name
- ‘Chart 'Accepted By' with provider's name
- ‘Closed by - with date/time’ with provider’s name
- ‘Completed by’ with provider’s name
- ‘Confirmed by’ with provider’s name
- ‘Data entered by’ with provider’s name
- ‘Digitalized signature: Handwritten and scanned into computer
- 'Electronically signed by' with provider's name
- ‘Electronically verified by’ with provider’s name
- ‘Finalized by’ with provider’s name
- ‘Generated by’ followed by a signature and treating physician credentials
- 'Released by' with provider's name
- 'Reviewed by' with provider's name
- ‘Sealed by’ with provider’s name
- ‘Seized by’ with provider’s name
- ‘Signed before import by’ with provider’s name
- 'Signed by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- 'This is an electronically verified report by John Smith, M.D.'
- ‘Validated by’ with provider’s name
- 'Verified by' with provider's name

Unacceptable Signatures are:

- 'Signed but not read' is not acceptable

If there is no signature appended to medical record documentation, claims will be denied for no signature.
Source: CMS Medical Documentation Signature Requirements
https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements

Documentation Guidelines for Amended Medical Records

ND Medicaid follows CMS guidelines regarding medical recording amendments. These can be found here: Documentation Guidelines for Amended Records - JE Part B - Noridian (noridianmedicare.com) .

Valid documentation signatures and amendments to medical records are required. Documentation manipulation will not be tolerated.

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record, bears the **current date** of that entry and is **signed** by

the person making the addition or change.

An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin.
Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

CDT© CODE ON DENTAL PROCEDURES AND NOMENCLATURE

CATEGORY OF SERVICE		CODE SERIES
I.	Diagnostic	D0100-D0999
II.	Preventive	D1000-D1999
III.	Restorative	D2000-D2999
IV.	Endodontics	D3000-D3999
V.	Periodontics	D4000-D4999
VI.	Prosthodontics, removable	D5000-D5899
VII.	Maxillofacial Prosthetics	D5900-D5999
VIII.	Oral and Maxillofacial Surgery	D7000-D7999
XI.	Orthodontics	D8000-D8999
XII.	Adjunctive General Services	D9000-D9999

PROCEDURES WITH TIME LIMITATIONS

D0120, D0145, D0150, D0160 & D0180	Child	2 per calendar year
D0120, D0150, D0160 & D0180	Adult	2 per calendar year
D0190-D0191	Child, Adult Screening, Assessment	2 per calendar year
D0210	Intraoral – comprehensive series of radiographic images	1 per calendar year
D0330, D0701	panoramic radiographic image - child	Once per 5 years
D0330, D0701	panoramic radiographic imagine - adult	Once per 5 years
D1110 & D4910	prophylaxis - adult	2 per calendar year
D1110, D1120 & D4910	prophylaxis - child	2 per calendar year
D1206, D1208	topical fluoride treatment – child (office procedure)	three times per calendar year under 21
D1206, D1208	topical fluoride treatment - adult (office procedure)	two times per calendar year
D1354	Interim caries arresting medicament application – per tooth	Two times per year Lifetime maximum of four per tooth
D5110 & D5120	replacement dentures	Once per 7 years
D5130	immediate denture - maxillary	Lifetime of limit of 1
D5140	immediate denture – mandibular	Lifetime of limit of 1
D5211-D5286	partial dentures	Once per 7 years
D5410-D5421	Denture and partial denture adjustments	2 per calendar year
D5730-D5761, D5765	reline procedures	1 per year
D5820 & D5821	Interim partial dentures (flippers)	Once per 7 years

D9991, D9992, D9993, D9994, and D9997	Dental Case Management	2 per calendar year

The following procedures are limited as to the frequency they are paid for by the North Dakota Medicaid program. Requests for exception will be reviewed on a case-by-case basis and additional services may be granted based on medical necessity.

Providers must submit a service authorization request prior to treatment and indicate the medical reason.

DIAGNOSTIC

Providers must bill usual and customary charges.

I. D0100 – D0999 DIAGNOSTIC

When oral examinations exceed frequency limitations, a service authorization is required. **Frequency limitations include two exams per calendar year**. Exams D0120, D0145, D0150, D0160, and D0180 apply to the frequency limitations. Exam D0160 requires documentation.

ND Medicaid covers one panoramic radiographic image (D0330 and D0701) every five years. A service authorization must be submitted if more than one panoramic radiographic image is needed within a five-year time frame. When services are being rendered by the same treating dentist or dental office, the service authorization should be received prior to the panoramic being performed with documentation to support the medical necessity.

Clinical Oral Examinations			
Code	**Description**	**SA**	**Requirements/Policy**
D0120	periodic oral evaluation – established patient		SA considered when limit is met/exceeded; documentation is required to support medical necessity
D0140	limited oral evaluation – problem focused		
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver		SA considered when limit is met/exceeded; documentation is required to support medical necessity
D0150	comprehensive oral evaluation - new or established patient		SA considered when limit is met/exceeded; documentation is required to support medical necessity

D0160	detailed and extensive oral evaluation – problem focused, by report		SA considered when limit is met/exceeded; documentation is required to support medical necessity
D0170	re-evaluation – limited, problem focused (established patient; not post- operative visit)		
D0171	re-evaluation – post-operative office visit		
D0180	comprehensive periodontal evaluation – new or established patient		SA considered when limit is met/exceeded; documentation is required to support medical necessity
D0190	Screening of a patient		limit is shared with D0191, two per calendar year
D0191	Assessment of a patient		limit is shared with D0190, two per calendar year
Radiographs		**SA**	**Requirements/Policy**
D0210	intraoral – comprehensive series of radiographic images		SA considered when limit is met/exceeded
D0220	intraoral – periapical first radiographic image		tooth number required
D0230	intraoral – periapical each additional radiographic image (max of 5)		tooth number required
D0240	intraoral – occlusal radiographic image		maximum of two allowed when billed
D0270	bitewing – single radiographic image		
D0272	bitewings – two radiographic images		
D0273	bitewings – three radiographic images		
D0274	bitewings – four radiographic images		
D0322	tomographic survey		
D0330	panoramic radiographic image – 1 every 5 years		SA considered when limit is met/exceeded; documentation is required to support medical necessity including the date of the last panoramic image
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis.		allowed for members thru the age of 20 years old only
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw		
D0365	cone beam CT capture and interpretation with field view of one full dental arch - mandible		
D0366	cone beam CT capture and interpretation with field view of one full dental arch – maxilla, with or without cranium		
D0367	cone beam CT capture and interpretation with field view of both jaws; with or without cranium		

D0368	cone beam CT capture and interpretation for TMJ series including two or more exposures		
D0369	maxillofacial MRI capture and interpretation	Y	Documentation to support medical necessity
D0383	cone beam CT image capture with field of view of both jaws, with or without cranium	Y	allowed for members thru the age of 20 years old only; documentation required to support medical necessity
D0391	intraoral – complete series of radiographic images – image capture only		Teledentistry only - if obtained cannot be repeated in the office
Tests and Laboratory Examinations		**SA**	**Requirements/Policy**
D0460	pulp vitality tests	Y	radiographs with documentation to support medical necessity are required
D0470	diagnostic casts	Y	documentation to support medical necessity
D0604	antigen testing for a public health related pathogen, including coronavirus		
D0605	antibody testing for a public health related pathogen, including coronavirus		
D0701	panoramic radiographic image – image capture only – limit 1 every 5 years		Teledentistry only - if obtained cannot be repeated in the office
D0702	2-D cephalometric radiographic image -image capture only		Teledentistry only - if obtained cannot be repeated in the office
D0704	3-D photographic image – image capture only		Teledentistry only - if obtained cannot be repeated in the office
D0706	intraoral – occlusal radiographic image – image capture only		Teledentistry only - if obtained cannot be repeated in the office
D0707	intraoral – periapical radiographic image – image capture only		Teledentistry only - if obtained cannot be repeated in the office
D0708	intraoral – bitewing radiographic image – image capture only		Teledentistry only - if obtained cannot be repeated in the office
D0709	intraoral – complete series of radiographic images – image capture only		Teledentistry only - if obtained cannot be repeated in the office

II. D1000 – D1999 PREVENTIVE DENTAL PROPHYLAXIS

When dental prophylaxis exceeds frequency limitations, a service authorization is required. **Frequency limitations include two prophy's or periodontal maintenance procedures per calendar year**. Codes D1110, D1120, and D4910 apply to the frequency limitations. The per calendar year limitation may be a combination of codes.

When requesting authorization for frequent recalls (i.e., "frequency list") the patient specific medical condition, medication lists, and recall of visits is required.

* This service will not be allowed to be billed for individuals with upper and lower dentures. Any active request will be end dated upon approval for upper and lower dentures.

Topical Fluoride Treatment – Codes D1206 and D1208

ND Medicaid allows the topical application of fluoride or fluoride varnish when performed in the dental office. For children thru the age of 20 years old, Medicaid allows either treatment (D1206 or D1208) 3 times per calendar year.

For Medicaid adults ages 21 and older, Medicaid allows either treatment (D1206 or D1208) 2 times per calendar year.

A service authorization is not necessary.

The ND Medicaid Fluoride Varnish policy can be viewed in its entirety here: Provider Guidelines, Manuals and Policies | Health and Human Services North Dakota

Dental Prophylaxis			
Code	**Description**	**SA**	**Requirements/Policy**
D1110	prophylaxis – adult		SA considered when limit is met/exceeded
D1120	prophylaxis – child		SA considered when limit is met/exceeded; allowed for members thru the age of 20 years old only
Topical Fluoride Treatment			
Code	**Description**	**SA**	**Requirements/Policy**
D1206	topical application of fluoride varnish		limit is shared with D1208 - limit allowance is 3 per calendar year for members thru the age of 20 and 2 per calendar year for members ages 21 and older
D1208	topical application of fluoride – excluding varnish		limit is shared with D1206 - limit allowance is 3 per calendar year for members thru the age of 20 and 2 per calendar year for members ages 21 and older

Other Preventive Services			
Code	**Description**	**SA**	**Requirements/Policy**
D1351	sealant – per tooth		allowed for members thru the age of 20 years old only
D1352	preventative resin restoration in a moderate to high caries risk patient – permanent tooth		allowed for members thru the age of 20 years old only; allowed for non-restored permanent teeth that have not had a sealant placed within one year
D1353	sealant repair – per tooth		allowed for members thru the age of 20 years old only
D1354	application of caries arresting medicament – per tooth		Maximum of two applications per tooth, per calendar year; Lifetime maximum of 4 applications per tooth; service authorization required for teeth requiring restoration (D2000-D2999) within 6 months of application by same treating dental office
D1355	caries preventive medicament application – per tooth		
Space Maintenance (Passive Appliances)			
Code	**Description**	**SA**	**Requirements/Policy**
D1510	space maintainer – fixed, unilateral - per quadrant		allow for members thru the age of 20 years old only
D1516	space maintainer – fixed – bilateral, maxillary		allow for members thru the age of 20 years old only
D1517	space maintainer – fixed – bilateral, mandibular		allow for members thru the age of 20 years old only
D1520	space maintainer – removable unilateral – per quadrant		allow for members thru the age of 20 years old only
D1526	space maintainer – removable – bilateral, maxillary		allow for members thru the age of 20 years old only
D1527	space maintainer – removable – bilateral, mandibular		allow for members thru the age of 20 years old only
D1551	re-cement or re-bond bilateral space maintainer - maxillary		allow for members thru the age of 20 years old only
D1552	re-cement or re-bond bilateral space maintainer - mandibular		allow for members thru the age of 20 years old only
D1553	re-cement or re-bond unilateral space maintainer – per quadrant		allow for members thru the age of 20 years old only
D1556	removal of fixed unilateral space maintainer – per quadrant		allow for members thru the age of 20 years old only
D1557	removal of fixed bilateral space maintainer – maxillary		allow for members thru the age of 20 years old only
D1558	removal of fixed bilateral space maintainer – mandibular		allow for members thru the age of 20 years old only

D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant		allow for members thru the age of 20 years old only

III. D2000 - D2999 RESTORATIVE

* Overlapping surfaces are not allowed

CROWNS-SINGLE RESTORATION ONLY

Crowns for all recipients, except stainless steel crowns, require a service authorization.

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

For adults, ND Medicaid covers anterior crowns only and 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.

D2950, D2952 and D2954, if needed, do not require a service authorization, however, must be documented and medically necessary.

ND Medicaid does not cover temporary crowns.

ND Medicaid does not cover permanent crowns on primary teeth.

ND Medicaid will require a service authorization when a restoration is needed on a supernumerary tooth. Radiographs and documentation will be required to be submitted with the authorization request. Medicaid will only consider approval of the request if the supernumerary tooth is functional.

Amalgam Restorations (Including Polishing)			
Code	**Description**	**SA**	**Requirements/Policy**
D2140	amalgam – one surface, primary or permanent		authorization required if performed within 6 months of SDF placement, see SDF policy
D2150	amalgam – two surfaces, primary or permanent		authorization required if performed within 6 months of SDF placement, see SDF policy
D2160	amalgam – three surfaces, primary or permanent		authorization required if performed within 6 months of SDF placement, see SDF policy

D2161	amalgam – four or more surfaces, primary or permanent		authorization required if performed within 6 months of SDF placement, see SDF policy

Resin–Based Composite Restorations – Direct			
Code	**Description**	**SA**	**Requirements/Policy**
D2330	resin-based composite – one surface, anterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2331	resin-based composite – two surfaces, anterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2332	resin-based composite – three surfaces, anterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2335	resin-based composite – four or more surfaces or involving incisal angle (anterior)		authorization required if performed within 6 months of SDF placement, see SDF policy
D2390	resin-based composite crown, anterior		allowed for members thru the age of 20 years old only; authorization required if performed within 6 months of SDF placement, see SDF policy
D2391	resin-based composite – one surface, posterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2392	resin-based composite – two surfaces, posterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2393	resin-based composite – three surfaces, posterior		authorization required if performed within 6 months of SDF placement, see SDF policy
D2394	resin-based composite – four or more surfaces, posterior		authorization required if performed within 6 months of SDF placement, see SDF policy
Crowns – Single Restorations Only **Radiographs and SA required on all crowns except stainless steel. When crowns are being performed on the same day as a root canal treatment, authorization may be submitted after the completed procedure with proper complete documentation and supporting radiographs.**			
Code	**Description**	**SA**	**Requirements/Policy**
D2710	crown – resin-based composite (indirect)	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2720	crown – resin with high noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only

D2721	crown – resin with predominantly base metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2722	crown – resin with noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2740	crown – porcelain/ceramic	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2750	crown – porcelain fused to high noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2751	crown – porcelain fused to predominantly base metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2752	crown – porcelain fused to noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2780	crown – ¾ cast high noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2790	crown – full cast high noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2791	crown – full cast predominantly base metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
D2792	crown – full cast noble metal	Y	pre and post endodontic radiographs required; anterior crowns allowed for ages 21 and older only
**** No permanent crowns for primary teeth ****			
Other Restorative Services			
Code	**Description**	**SA**	**Requirements/Policy**
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		
D2920	re-cement or re-bond crown		
D2921	reattachment of tooth fragment, incisal edge or cusp		allowed for members thru the age of 20 years old only
D2928	prefabricated porcelain/ceramic crown – permanent tooth	Y	pre- and post- endodontic radiographs required
D2930	prefabricated stainless steel crown – primary tooth		

D2931	prefabricated stainless steel crown – permanent tooth		
D2932	prefabricated resin crown		allowed for members thru the age of 20 years old only
D2933	prefabricated stainless steel crown with resin window		
D2934	prefabricated esthetic coated stainless steel crown – primary tooth		allowed for members thru the age of 20 years old only
D2940	protective restoration		
D2950	core buildup, including any pins when required		
D2951	pin retention – per tooth, in addition to restoration (5 per tooth)		
D2952	post and core in addition to crown, indirectly fabricated		
D2954	prefabricated post and core in addition to crown		
D2955	post removal		

IV. D3000 - D3999 ENDODONTICS

Pulp Capping			
Code	**Description**	**SA**	**Requirements/Policy**
D3110	pulp cap – direct (excluding final restoration)		allowed for members thru the age of 20 years old only
Pulpotomy			
Code	**Description**	**SA**	**Requirements/Policy**
D3220	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament		allowed for members thru the age of 20 years old only
D3221	pulpal debridement, primary and permanent teeth		allowed for members thru the age of 20 years old only
Endodontic Therapy on Primary Teeth			
Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.			
Code	**Description**	**SA**	**Requirements/Policy**
D3230	pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)		allowed for members thru the age of 20 years old only
D3240	pulpal therapy (resorbable filing) – posterior, primary tooth (excluding final restoration)		allowed for members thru the age of 20 years old only

Endodontic Therapy (Including Treatment Plan, Clinical Procedures, and Follow-Up Care) Root canal therapy must be medically necessary and the most cost-effective treatment option for the patient. Supporting documentation may be required for cases where multiple procedures are performed on the same date of service.			
Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy.			
Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.			
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.			
Code	**Description**	**SA**	**Requirements/Policy**
D3310	endodontic therapy, anterior tooth (excluding final restoration)		
D3320	endodontic therapy, premolar tooth (excluding final restoration)		allowed for members thru the age of 20 years old only
D3330	endodontic therapy, molar tooth (excluding final restoration)		allowed for members thru the age of 20 years old only
D3331	treatment of root canal obstruction; non-surgical access	Y	allowed for members thru the age of 20 years old, radiographs required
D3333	internal root repair of perforation defects	Y	Radiographs required
D3346	retreatment of previous root canal therapy – anterior		
D3347	retreatment of previous root canal therapy – premolar		allowed for members thru the age of 20 years old only
D3348	retreatment of previous root canal therapy – molar		allowed for members thru the age of 20 years old only
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)		allowed for members thru the age of 20 years old only
D3352	apexification/recalcification – interim medication replacement		allowed for members thru the age of 20 years old only
D3353	apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)		allowed for members thru the age of 20 years old only
D3410	apicoectomy – anterior	Y	allowed for members thru the age of 20 years old only; radiographs required
D3430	retrograde filling – per root	Y	allowed for members thru the age of 20 years old only; radiographs required

V. D4000 - D4999 PERIODONTICS

NON-SURGICAL PERIODONTAL SERVICE

Periodontal scaling and root planning, four or more teeth, per quadrant (D4341) or one to three teeth, per quadrant (D4342) requires service authorization for adults ages 21 and older.

Periodontal maintenance (D4910) applies to frequency limitations and requires a service authorization when the recipient's frequency limitations have been met or exceeded. **Frequency limitations include two prophy's or periodontal maintenance procedures per calendar year**. Codes D1110, D1120, and D4910 apply to the frequency limitations. The two per calendar year limitation may be a combination of codes.

Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth (D4346) requires a service authorization for adults ages 21 and older. This procedure requires a service authorization is not eligible for the "frequency list".

When submitting a service authorization 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.
  - Patient name and date of probing/chart must be legible on the chart.
- Photos and/or radiographs must be sent with documentation of the patient's 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.
- Teeth planned for extraction within 90 days of the treatment for scaling and root planning must not be included in the SRP treatment plan. The appropriate code should be requested initially.

Full mouth debridement (D4355) cannot be billed in addition to D0180 on the same date of service. Full mouth debridement does not require a service authorization.

Prophylaxis and Periodontal Maintenance (D1110, D1120, and D4910) is included in the above codes and cannot be billed separately.

Local anesthesia (D9210-D9215) is included in the above codes and cannot be billed separately.

Probing depths will not be required when patient has been approved for behavior management and services are being performed in the outpatient hospital due to patient disability.

When the procedure is performed in the outpatient hospital due to patient disability, the periodontal charts will be needed on a yearly basis to determine medical necessity for the scaling and root planning.

Code	Description	SA	Requirements/Policy
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	Y	Photos with documentation to support medical necessity required with the authorization
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	Y	Photos with documentation to support medical necessity required with the authorization
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Y	allowed for members thru the age of 20 years old only; Photos with documentation to support medical necessity with the authorization
D4249	clinical crown lengthening – hard tissue	Y	Radiographs and/or photos with documentation to support medical necessity
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	Y	Radiographs required
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	Y	Radiographs required
D4341	periodontal scaling and root planning – four or more contiguous teeth per quadrant	Y	Authorization required for 21 and older only; probing depths are required
D4342	periodontal scaling and root planning – one to three teeth per quadrant	Y	Authorization required for 21 and older only; probing depths are required
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Y	Authorization required for 21 and older only; probing depths are required
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit		

Other Periodontal Services			
Code	**Description**	**SA**	**Requirements/Policy**
D4910	periodontal maintenance		SA considered when limit is met/exceeded; probing depths are required to support medical necessity

VI. D5000 - D5899 PROSTHODONTICS, REMOVABLE

PROSTHODONTICS (complete and partials) – Early Replacement Lost

If an adult (ages 21 and over) loses his or her denture prior to the 7-year limitation, Medicaid will not cover another pair. Exceptions to this may be granted to DD patients if documentation on the SA justifies the exception. ND Medicaid does grant exceptions based on documentation review and medical necessity on a case-by-case basis.

Long Term Care Facilities must follow 42 CFR § 483.55 for Medicaid recipients who lose their dentures in the nursing home. Dental offices must submit documentation to support the early replacement for the lost denture. Each nursing home must have a replacement policy in place for lost dentures in the nursing home. ND Medicaid will consider these on a case-by-case basis. The nursing home must provide the needed 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 nursing home.

Dentures lost in the outpatient/inpatient hospital are the responsibility of the hospital to replace. ND Medicaid will consider these on a case-by-case basis. Dental offices must submit documentation to support the early replacement of the lost denture. The facility must provide the needed 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.

Stolen

A SA must include a copy of the police report. The age of the current denture or partial denture is required.

Breaks

A SA must indicate why the denture was not repairable. Must include photos of the unrepairable denture with the authorization request. The age of the current denture or partial denture is required.

Dentures destroyed 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 EOB is required. The age of the current denture or partial denture is required.

*All dentures must be billed no earlier than the date of final impression.

Encounter Based Clinics

Service authorization is required for all complete and partial dentures. Documentation and all procedure codes must be submitted with the service authorization request. The authorization will be allowed for a one-year timeframe.

There is a maximum of 5 encounters per arch per complete/partial denture for the initial placement when all 5 encounters are medically necessary.

An encounter is defined as a visit related to the complete denture/partial denture service such as an impression, placement reline, adjustment, etc. One year post placement, subsequent encounters will be allowed with prior approval for denture related services (relines, adjustments, etc.).

ND Medicaid does not cover denture/partial denture cleanings – codes D9932-D9935.

Immediate and Complete Dentures

All dentures require a service authorization. Immediate dentures (codes D5130 and D5140) have a lifetime limit and therefore cannot be billed as a replacement denture. ND Medicaid considers immediate dentures a final denture. An immediate denture is defined as a complete, final prosthesis inserted on the same day, immediately following the removal of natural teeth. There is a 7-year limitation on all dentures.

When submitting a service authorization for immediate and initial dentures, radiographs are required.

When dentures being placed are replacement dentures, a service authorization is required. ALL service authorizations for replacement dentures must indicate the age of the current denture and the reason for replacement.

Prior to a referral to oral surgery or extractions taking place, an approval for the denture must be in place as extractions must be medically necessary. If a denture approval has not been granted, the authorization will be denied and will be provider responsibility.

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 7 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

All partial dentures require a service authorization. There is a 7-year limitation on replacement of partial dentures. When submitting an SA for partial dentures, radiographs are required. The authorization must also indicate the teeth included in the partial denture.

Replacement of partial dentures must indicate the age of the partial denture and the reason for replacement. This must be indicated on the authorization request, or it will be denied.

ND Medicaid does not cover missing posterior teeth. For partial dentures to be considered for coverage, the partial denture must include at least one anterior tooth. ND Medicaid will consider a partial denture when ALL posterior teeth are missing, and the member is also in a full denture. This will require a service authorization.

INTERIM PROSTHESIS

An interim partial denture (flippers) is covered once every 7 years. These require a service authorization and must include at least one anterior tooth. The authorization must indicate the teeth included in the interim prosthesis and radiographs must be submitted with the service authorization request. When the interim prosthesis is a replacement, the age of the current prosthesis and the reason for replacement must be included on the authorization request.

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

Interim complete dentures (D5810-D5811) are non-covered by ND Medicaid.

PROSTHODONTICS, FIXED

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

Complete Dentures (Including Routine Post Delivery Care) There is a 7-year time limitation to replace dentures. All dentures require SA. ALL requests received for replacement dentures must indicate the age of the current denture and the reason for replacement on the SA. Service authorization must be submitted with radiographs.			
Code	**Description**	**SA**	**Requirements/Policy**
D5110	complete denture – maxillary	Y	Radiographs required – if replacement the age of the current denture and reason for replacement is required

D5120	complete denture – mandibular	Y	Radiographs required – if replacement the age of the current denture and reason for replacement is required
D5130	immediate denture – maxillary; lifetime limit of 1	Y	Radiographs required – if replacement the age of the current denture and reason for replacement is required
D5140	immediate denture – mandibular; lifetime limit of 1	Y	Radiographs required – if replacement the age of the current denture and reason for replacement is required

Partial Dentures (Including Routine Post Delivery Care)			
There is a 7-year time limitation on replacement partial dentures. Replacement of partial dentures before the 7-year time limit requires service authorization. ALL requests received for replacement partial dentures must indicate the age of the current partial denture and the reason for replacement. We do not cover missing posterior teeth. For adults, partial dentures must include at least one anterior tooth. Service authorizations received must include radiographs and the tooth numbers included in the partial denture.			
Code	**Description**	**SA**	**Requirements/Policy**
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5213	maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required

D5214	mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5225	maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5226	mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required

D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests, and teeth)	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5282	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5283	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5284	removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5286	removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required

Adjustments to Dentures – limit of two per calendar year for the life of the denture/partial denture			
Code	**Description**	**SA**	**Requirements/Policy**
D5410	adjust complete denture – maxillary		2 per calendar year allowed
D5411	adjust complete denture – mandibular		2 per calendar year allowed
D5421	adjust partial denture – maxillary		2 per calendar year allowed
D5422	adjust partial denture – mandibular		2 per calendar year allowed

Repairs to Complete Dentures-service authorization is required when more than 4 teeth per year are replaced, when replacing all teeth in the denture or partial denture, or when converting the denture from a partial denture to a full complete denture (subject to the 7-year limitation).			
Code	**Description**	**SA**	**Requirements/Policy**
D5511	repair broken complete denture base, mandibular		
D5512	repair broken complete denture base, maxillary		
D5520	replace missing or broken teeth – complete denture (each tooth) * if more than 4 teeth an SA is required.		authorization required when more than 4 teeth are replaced
Repairs to Partial Dentures-service authorization is required if more than 4 teeth per year are replaced, when replacing all teeth in the denture or partial denture, or when converting the denture from a partial denture to a full complete denture (subject to the 7-year limitation).			
Code	**Description**	**SA**	**Requirements/Policy**
D5611	repair resin partial denture base, mandibular		
D5612	repair resin partial denture base, maxillary		
D5621	repair cast partial framework, mandibular		
D5622	repair cast partial framework, maxillary		
D5630	repair or replace broken retentive/clasping materials – per tooth * If more than 4 teeth a SA is required.		authorization required when more than 4 teeth are replaced
D5640	replace broken teeth – per tooth * If more than 4 teeth a SA is required.		authorization required when more than 4 teeth are replaced
D5650	add tooth to existing partial denture * If more than 4 teeth a SA is required.		authorization required when more than 4 teeth are replaced
D5660	add clasp to existing partial denture – per tooth * If more than 4 teeth are being replaced, an SA is required.		authorization required when more than 4 teeth are replaced
Denture Rebase Procedures			
If a denture is rebased a complete denture would not be approved for 7 years from rebase date of service.			
Code	**Description**	**SA**	**Requirements/Policy**
D5710	rebase complete maxillary denture	Y	radiographs - if replacement the age of the current denture and reason for replacement required

D5711	rebase complete mandibular denture	Y	radiographs - if replacement the age of the current denture and reason for replacement required
D5720	rebase maxillary partial denture	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5721	rebase mandibular partial denture	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5725	Rebase hybrid prosthesis	Y	radiographs - if replacement the age of the current denture and reason for replacement required

Denture Reline Procedures There is a one-year time limitation on dentures and partial denture reline procedures. EXCEPTIONS on time limitations may be granted based on medical necessity. A Service authorization is required, and medical reason indicated.			
Code	**Description**	**SA**	**Requirements/Policy**
D5730	reline complete maxillary denture (direct)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5731	reline complete mandibular denture (direct)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed

D5740	reline maxillary partial denture (direct)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5741	reline mandibular partial denture (direct)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5750	reline complete maxillary denture (indirect)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5751	reline complete mandibular denture (indirect)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5760	reline maxillary partial denture (indirect)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
D5761	reline mandibular partial denture (indirect)		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed

D5765	Soft liner for complete or partial removable denture - indirect		allowed one year after denture placement and allowed once per year; authorization required if needed early or more often; authorization required after more than 3 relines needed
Interim Prosthesis (Temporary)			
Code	**Description**	**SA**	**Requirements/Policy**
D5820	interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary – flipper once per 7 years	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required
D5821	interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular – flipper once per 7 years	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement required

Other Removable Prosthetic Services			
Code	**Description**	**SA**	**Requirements/Policy**
D5850	tissue conditioning, maxillary		
D5851	tissue conditioning, mandibular		
D5863	overdenture – complete maxillary	Y	radiographs - if replacement the age of the current denture and reason for replacement, for consideration - the implants MUST be existing
D5864	overdenture – partial maxillary	Y	radiographs - if replacement the age of the current denture and reason for replacement, for consideration - the implants MUST be existing

D5865	overdenture – complete mandibular	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement; for consideration - the implants MUST be existing
D5866	overdenture – partial mandibular	Y	radiographs, tooth numbers included in the partial denture, if replacement the age of the current partial denture and reason for replacement; for consideration - the implants MUST be existing
D5876	add metal substructure to acrylic full denture (per arch)	Y	age of the denture required with documentation to support medical necessity

I. D5900-D5999 Maxillofacial Prosthetics

Maxillofacial prosthetics section requires a service authorization.

D5986	fluoride gel carrier	Y	documentation to support medical necessity

II. D6000 – D6199 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. 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.

Code	Description	SA	Requirements/Policy
D6096	remove broken implant retaining screw	Y	radiographs with documentation to support medical necessity

D6100	Surgical removal of implant body	Y	Radiographs with documentation to support medical necessity; implants must be existing
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Y	radiographs with documentation to support medical necessity; implants must be existing
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Y	radiographs with documentation to support medical necessity; implants must be existing
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Y	radiographs with documentation to support medical necessity; implants must be existing; tooth numbers included in the prosthesis required
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Y	radiographs with documentation to support medical necessity; implants must be existing; tooth numbers included in the prosthesis required
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	Y	radiographs with documentation to support medical necessity; implants must be existing
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	Y	radiographs with documentation to support medical necessity; implants must be existing
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	Y	radiographs with documentation to support medical necessity; implants must be existing; tooth numbers included in the prosthesis required
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	Y	radiographs with documentation to support medical necessity; implants must be existing; tooth numbers included in the prosthesis required
D6930	re-cement or re-bond fixed partial denture		

III. D7000 - D7999 ORAL AND MAXILLOFACIAL SURGERY DENTAL EXTRACTIONS

Dental extractions that are attempted but that 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. D7999 requires a service authorization, and a retro authorization will be considered per ND Medicaid's service authorization policy.

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

Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)			
Code	**Description**	**SA**	**Requirements/Policy**
D7111	extraction, coronal remnants – primary tooth		

D7140	extraction, erupted tooth, or exposed root (elevation and/or forceps removal)		
Surgical Extractions (Includes Local Anesthesia Suturing, If Needed, And Routine Postoperative Care)			
Code	**Description**	**SA**	**Requirements/Policy**
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		
D7220	removal of impacted tooth – soft tissue		
D7230	removal of impacted tooth – partially bony		
D7240	removal of impacted tooth – completely bony		
D7241	removal of impacted tooth – completely bony, with unusual surgical complications		
D7250	removal of residual tooth roots (cutting procedure)		
D7251	coronectomy – intentional partial tooth removal, impacted teeth only	Y	radiographs with documentation to support medical necessity

Other Surgical Procedures			
Code	**Description**	**SA**	**Requirements/Policy**
D7260	oroantral fistula closure		
D7261	primary closure of a sinus perforation		
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		
D7280	exposure of an unerupted tooth		
D7283	placement of device to facilitate eruption of impacted tooth		
D7285	incisional biopsy of oral tissue – hard (bone, tooth)		
D7286	incisional biopsy of oral tissue – soft		
D7290	surgical repositioning of teeth		
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report		
D7294	Placement of temporary anchorage device without flap	Y	Radiographs with documentation to support medical necessity
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant		
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant		

Alveoloplasty – Preparation of Ridge			
Code	**Description**	**SA**	**Requirements/Policy**
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		
D7311	alveoloplasty in conjunction with extractions, one to three teeth or tooth spaces, per quadrant		
D7320	alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		
D7321	alveoloplasty not in conjunction with extractions, one to three teeth or tooth spaces, per quadrant		
Vestibuloplasty			
Code	**Description**	**SA**	**Requirements/Policy**
D7340	vestibuloplasty – ridge extension (secondary epitheliaization)		
D7350	vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)		
Surgical Excision of Soft Tissue Lesions			
Code	**Description**	**SA**	**Requirements/Policy**
D7410	excision of benign lesion up to 1.25 cm		
D7411	excision of benign lesion greater than 1.25 cm		
D7412	excision of benign lesion, complicated		
D7413	excision of malignant lesion up to 1.25 cm		
D7414	excision of malignant lesion greater than 1.25 cm		
D7415	excision of malignant lesion, complicated		
Surgical Excision of Intra-Osseous Lesions		**SA**	**Requirements/Policy**
Code	**Description**		
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm		
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm		
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		

D7451	removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		
D7461	removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		
Excision of Bone Tissue			
Code	**Description**	**SA**	**Requirements/Policy**
D7471	removal of lateral exostosis (maxilla or mandible)		
D7472	removal of torus palatinus		
D7473	removal of torus mandibularis		
D7485	reduction of osseous tuberosity	Y	radiographs with documentation to support medical necessity

Surgical Incision			
Code	**Description**	**SA**	**Requirements/Policy**
D7510	incision and drainage of abscess – intraoral soft tissue		
D7511	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		
D7520	incision and drainage of abscess – extraoral soft tissue		
D7521	incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)		
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		
D7540	removal of reaction producing foreign bodies, musculoskeletal system	Y	radiographs with documentation to support medical necessity
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	Y	radiographs with documentation to support medical necessity
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	Y	radiographs with documentation to support medical necessity

Reduction of Dislocation and Management of Other Temporomandibular Joint			
Dysfunctions			
Code	**Description**	**SA**	**Requirements/Policy**
D7810 thru D7899	must be submitted on SA with written report prior to treat treatment	Y	documentation to support medical necessity
D7880	occlusal orthotic device, by report – 1 per calendar year; service authorization required after limit has been met/exceeded		one per calendar year allowed; limit must be met/exceeded prior to consideration of an authorization
D7910	suture of recent small wounds up to 5 cm		included in the cost of extractions
D7911	complicated suture – up to 5 cm		included in the cost of extractions
D7912	complicated suture – greater than 5 cm		included in the cost of extractions
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Y	documentation to support medical necessity
D7961	buccal/labial frenectomy (frenulectomy)	Y	authorization required for members ages 2 and older; photos required
D7962	lingual frenectomy (frenulectomy)	Y	authorization required for members ages 2 and older; photos required
D7963	frenuloplasty	Y	photos required
D7970	excision of hyperplastic tissue – per arch	Y	documentation to support medical necessity
D7971	excision of pericoronal gingiva	Y	documentation to support medical necessity
D7999	unspecified oral surgery procedure, by report	Y	**utilized for attempted extractions; documentation to support medical necessity required

IV. D8000 - D8999 ORTHODONTICS – under 21 only

ORTHODONTICS

Orthodontic treatment requires a service authorization and is only allowed/reimbursed for recipients through the age of 20 years old.

Code	**Description**	**SA**	**Requirements/Policy**
D8020	Limited orthodontic treatment of the transitional dentition	Y	allowed for members thru the age of 20 years old only; State form SFN 61 required from the treating orthodontist and referring screener
D8030	Limited orthodontic treatment of the adolescent dentition	Y	allowed for members thru the age of 20 years old only; State form SFN 61 required from the treating orthodontist and referring screener

Comprehensive Orthodontic Treatment			
Code	**Description**	**SA**	**Requirements/Policy**
D8070	comprehensive orthodontic treatment of the transitional dentition	Y	allowed for members thru the age of 20 years old only; service is only considered when the member is in the middle of treatment; treatment plan with completed and remaining months required
D8080	comprehensive orthodontic treatment of the adolescent dentition	Y	allowed for members thru the age of 20 years old only; service is only considered when the member is in the middle of treatment; treatment plan with completed and remaining months required
D8090	comprehensive orthodontic treatment of the adult dentition	Y	allowed for members thru the age of 20 years old only; State form SFN 61 required from the treating orthodontist and referring screener
Minor Treatment to Control Harmful Habits			
Code	**Description**		
D8210	removable appliance therapy	Y	allowed for members thru the age of 20 years old only
D8220	fixed appliance therapy	Y	allowed for members thru the age of 20 years old only
Other Orthodontic Services			
Code	**Description**	**SA**	**Requirements/Policy**
D8660	pre-orthodontic treatment examination to monitor growth and development		allowed for members thru the age of 20 years old only
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	Y	allowed for members thru the age of 20 years old only
D8681	removable orthodontic retainer adjustment *Included in delivery of service unless over 1 year old or was made by another dentist		allowed for members thru the age of 20 years old only
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	Y	allowed for members thru the age of 20 years old only
D8696	repair of orthodontic appliance – maxillary		allowed for members thru the age of 20 years old only
D8697	repair of orthodontic appliance – mandibular		allowed for members thru the age of 20 years old only
D8698	re-cement or re-bond fixed retainer - maxillary		allowed for members thru the age of 20 years old only
D8699	re-cement or re-bond fixed retainer – mandibular		allowed for members thru the age of 20 years old only

D8701	repair of fixed retainer, includes reattachment - maxillary		allowed for members thru the age of 20 years old only
D8702	repair of fixed retainer, includes reattachment - mandibular		allowed for members thru the age of 20 years old only
D8703	replacement of lost or broken retainer - maxillary		allowed for members thru the age of 20 years old only; lifetime limit of 1
D8704	replacement of lost or broken retainer - mandibular		allowed for members thru the age of 20 years old only; lifetime limit of 1

X. D9000 - D9999 ADJUNCTIVE GENERAL SERVICES

Palliative Treatment

Palliative Treatment of Dental Pain – Code D9110 is reimbursed on a "per visit" basis. Procedures performed on the same date of service may be billed in addition to D9110. Palliative Treatment does not include an evaluation. The evaluation should be billed separately when performed in addition to other services performed such as radiographs.

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 restoration or incising an abscess.

Code	Description	SA	Requirements/Policy
D9110	palliative treatment of dental pain – per visit		
Anesthesia			
Code	**Description**		
D9210	local anesthesia not in conjunction with operative or surgical procedure		
D9211	regional block anesthesia		
D9212	trigeminal division block anesthesia		
D9215	local anesthesia in conjunction with operative or surgical procedures		
D9222	deep sedation/general anesthesia – first 15 minutes		
D9223	deep sedation/general anesthesia – each subsequent 15-minute increment		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis		
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes		

D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment		
Professional Consultation			
Code	**Description**		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician (telephone consult not covered. If the consulting provider provides the treatment, it will be considered a referral: no consultation fee will be allowed).		
Professional Visits			
Code	**Description**	**SA**	**Requirements/Policy**
D9410	house/extended care facility call		authorization is required for members through the age of 5 years old; service is not payable in the office setting
D9420	hospital or ambulatory surgical center		service is not payable in the office setting; payable only when service has been performed in the hospital or ambulatory surgical center
D9440	office visit – after regularly scheduled hours (requires description)		

Drugs			
Code	**Description**	**SA**	**Requirements/Policy**
D9610	therapeutic parenteral drug, single administration		
D9612	therapeutic parenteral drugs, two or more administrations, different medications		
D9613	infiltration of sustained release therapeutic drug – per quadrant		
Miscellaneous Services			
Code	**Description**		
D9910	application of desensitizing medicament		
D9920	behavior management, by report (D.D. patients only; if medically necessary)	Y	State Form SFN 64 Required
D9930	treatment of complications (post-surgical) – unusual circumstances, by report		

D9943	occlusal guard adjustment. **Included in delivery of service unless is over 1 year old or was made by another dentist		
D9944	occlusal guard - hard appliance, full arch – 1 per calendar year		one per calendar year allowed; limit must be met/exceeded prior to consideration of an authorization
D9945	occlusal guard - soft appliance, full arch – 1 per calendar year		one per calendar year allowed; limit must be met/exceeded prior to consideration of an authorization
D9946	occlusal guard - hard appliance, partial arch – 1 per calendar year		one per calendar year allowed; limit must be met/exceeded prior to consideration of an authorization
D9947	Custom sleep apnea appliance fabrication and placement	Y	documentation to support medical necessity - documentation must include compliance with CPAP/BIPAP and current sleep study results
D9948	Adjustment of custom sleep apnea appliance	Y	documentation to support medical necessity
D9949	Repair of custom sleep apnea appliance	Y	documentation to support medical necessity
D9950	occlusion analysis – mounted case	Y	documentation to support medical necessity
D9951	occlusal adjustment – limited	Y	documentation to support medical necessity
D9952	occlusal adjustment – complete	Y	documentation to support medical necessity
D9990	certified translation or sign-language services - per visit		
D9991	dental case management – addressing appointment compliance barriers		Limit of 2/calendar year (D9991-D9994, D9997) SA required for additional services with documentation to support
D9992	dental case management – care coordination		Limit of 2/calendar year (D9991-D9994, D9997) SA required for additional services with documentation to support
D9993	dental case management – motivational interviewing		Limit of 2/calendar year (D9991-D9994, D9997) SA required for additional services with documentation to support
D9994	dental case management – patient education to improve oral health literacy		Limit of 2/calendar year (D9991-D9994, D9997) SA required for additional services with documentation to support
D9995	teledentistry – synchronous; real-time encounter		Required when billing teledentistry services, place of service 02 or 10
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review		Required when billing teledentistry services, place of service 02 or 10

D9997	dental case management – patients with special health care needs		Limit of 2/calendar year (D9991-D9994, D9997) SA required for additional services with documentation to support
D9999	unspecified adjunctive procedure, by report	Y	documentation to support medical necessity