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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policy listed below:
1A-16 Surgery of the Lingual Frenulum
1H Telehealth, Virtual Patient Communications, and Remote Patient Monitoring
1L-1 Anesthesia Services
1L-2 Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
4B Orthodontic Services

1.0 Description of the Procedure, Product, or Service

Dental services are defined as diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a beneficiary's oral or general health. Such services must maintain a high standard of quality and must be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations and exclusions specified in this policy. **Only the procedure codes listed in this policy are covered under the North Carolina (NC) Medicaid (Title XIX) Dental Program.**

NC Medicaid has adopted procedure codes and descriptions as defined in Section 1, Code on Dental Procedures and Nomenclature (CDT Code), of the *CDT 2023 Dental Procedure Codes* published by the American Dental Association (ADA).

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, experimental, or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.3 Limitations

Dental Services are not covered for a pregnant beneficiary during the presumptive eligibility period. For a pregnant Medicaid eligible beneficiary covered under the Medicaid for Pregnant Women program class "MPW", dental services as described in this policy are covered and extend to the last day of the month in which the twelfth month postpartum period ends. A Beneficiary covered under the Family Planning Waiver program class "MAFD" is not eligible for dental services as described in this policy. A beneficiary covered under the Medicare Qualified Beneficiaries program class "MQB" do not receive a Medicaid card and the only benefit that the beneficiary receives from Medicaid is the payment of the Medicare premium only. The beneficiary is not eligible for any dental services as described in this policy. A beneficiary enrolled with the Program of All-Inclusive Care for the Elderly (PACE) are not covered for dental services as described in this manual. Providers must ask the beneficiary for their PACE card and contact the PACE program for information regarding benefits. Refer to **Subsection 5.3, Limitations or Requirements,** for eligibility limitations for individual procedure codes.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Teledentistry Services

As outlined in **Section 5.0**, select services within this clinical coverage policy may be provided via teledentistry. Services delivered via teledentistry must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Dental Services when the beneficiary meets the following specific criteria as defined in **Section 2.0** and **Subsection 5.3**

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover dental services when the criteria specified in **Section 3.0 and Section 5.0** of this policy has not been met. Medicaid shall not cover the following:

a. cosmetic procedures;
b. all crowns except resin-based composite crowns, prefabricated crowns, and temporary crowns;
c. onlays and inlays;
d. fixed bridgework;
e. certain periodontal surgeries;
f. implants;
g. TMJ splints, night guards, or other maxillofacial prosthetics;
h. acupuncture, hypnosis, or other non-pharmacologic methods; and
i. non-intravenous conscious sedation.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover dental services when the criteria specified in **Section 3.0 and Section 5.0** of this policy has not been met.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Dental Services. The provider shall obtain prior approval before rendering Dental Services.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

As indicated in **Subsection 5.3,** the provider shall submit a request for prior approval before rendering certain dental services. Prior approval applies only to procedures, not to reimbursement amounts and does not guarantee payment. The beneficiary's eligibility for the date of service must be verified before rendering treatment. Failure to obtain required prior approval before rendering a service shall result in denial of payment for that service. The Medicaid program has the right to require prior approval for any services by providers who have been or are under investigation by NC Medicaid.

A prior approval request consists of the following:

a. Electronic entry into the NCTracks Prior Approval Portal or a completed 2019 American Dental Association (ADA) Dental Claim Form submitted by mail;
b. Properly arranged radiographic images that are clearly labeled with the date taken, the provider's name, and the beneficiary's name;
c. Documentation as specified in **Subsection 5.3 Limitations or Requirements;** and
d. Any additional information to clarify unusual circumstances or explain the complexity of the treatment plan such as a pre-treatment narrative, periodontal charting, photographic images, and etc.

When radiographic images cannot be obtained, the provider shall include a written explanation and shall complete the tooth chart in field 33 on the ADA Dental Claim Form. Panoramic radiographic images must be labeled clearly to

indicate the beneficiary's left and right. All radiographic images must be of diagnostic quality suitable for interpretation and must be retained in the beneficiary's record for a minimum of six years for the purpose of Medicaid post-payment review (minimum of 10 years per NC State Dental Board of Examiners rules). Prior approval requests must be entered in the NCTracks Prior Approval Portal or mailed to the address listed below.

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

Note: Dental prior approval is valid for one year from the effective begin date of the prior approval request.

Refer to **Attachment A, Dental Billing Guide,** for an example of a prior approval request.

5.2.3 Retroactive Prior Approval

Prior approval may be granted retroactively to the date of service in cases of retroactive Medicaid eligibility or when the beneficiary's condition prevents pretreatment oral evaluation and services are rendered in an inpatient hospital, outpatient hospital, or ambulatory surgical center. Requests submitted for retroactive approval must include:

a. dates of service;
b. a narrative explaining why prior approval was not obtained;
c. treatment notes;
d. operative notes;
e. charges; and
f. documentation as specified in **Subsection 5.3 Limitations or Requirements.**

5.2.4 Denied Prior Approval

Typically, prior approval for a procedure is denied for one of the following reasons:

a. The beneficiary already has received the procedure within the time limit described in **Subsection 5.3, Limitations or Requirements.**
b. The procedure does not meet the limitations described in **Subsection 5.3, Limitations or Requirements.**
c. The procedure is not covered by the Medicaid program.

If a procedure is denied for a reason other than one of the above, an explanation is provided.

5.2.5 Voiding a Prior Approval

Once prior approval is granted, the provider has one year from the effective begin date of the prior approval request to render the approved service. When the service is rendered, the provider has one year from the date of service to file a claim for payment. Therefore, the provider may need to void a dental prior approval request within a two-year period of the effective begin date for **one** of the following reasons:

a. the beneficiary's treatment plan has changed significantly;
b. the prior approval period has expired before the service could be rendered; or
c. the beneficiary wishes to have the service rendered by another provider.

In such cases, the provider shall choose **one** of the following methods to accomplish the process:

a. Submit electronically in the NCTracks Prior Approval Portal by clicking on the "Void PA Request" button to void the entire request; or
b. Submit by mailing a printed copy of the approved prior approval request from NCTracks and marking "VOID" on specific detail lines to be voided. Send this copy to NCTracks or to the beneficiary's new dentist if requested.

Note: Do not void any detail lines in which payment has been received for that service.

5.3 Limitations or Requirements

By State legislative authority, NC Medicaid applies service limitations to CDT Codes as they relate to individual beneficiaries. These service limitations are applied without modification of the CDT procedure nomenclature. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations shall be denied unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under 21 years of age. Refer to **Subsection 5.3.13, Request for Medicaid Special Approval of a Non-Covered Service or Service Outside the Policy Limitations.**

NC Medicaid has adopted procedure codes and descriptions as defined in Section 1, Code on Dental Procedures and Nomenclature (CDT Code), of the *CDT 2023 Dental Procedure Codes* published by the American Dental Association (ADA). *CDT 2023 Dental Procedure Codes* (including procedure codes, nomenclature, descriptors, and other data) is copyrighted by the American Dental Association. ©2023 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

5.3.1 ADA-Approved Materials

Only dental materials accepted by the ADA Council on Scientific Affairs shall be accepted for use in the dental care of Medicaid beneficiaries. Specific use of these materials must follow the guidelines of the ADA Council on Scientific Affairs.

5.3.2 Diagnostic

5.3.2.1 Clinical Oral Evaluations

A provider shall bill for only one clinical oral evaluation procedure for an individual beneficiary on a given date of service.

Code	Description	PA Needed?
D0120	Periodic oral evaluation – established patient * The first periodic oral evaluation must be at least six calendar months after the comprehensive oral evaluation (D0150) or at least six calendar months after an oral evaluation for a beneficiary under three years of age (D0145) for the same provider * Allowed once per six calendar month period for the same provider (for example, a beneficiary seen for a periodic oral evaluation exam on any date in January would be eligible for the next periodic oral evaluation on any date in July)	No
D0140	Limited oral evaluation – problem focused * Use as the emergency exam for the first visit for a specific problem; follow-up evaluations for the same problem must be coded as D0170 * Document in the beneficiary's chart the nature of the emergency and the treatment provided	No
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver * Evaluation includes recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen, and communication with and counseling the child's parent, legal guardian, or primary caregiver * The first oral evaluation for a patient under three years of age must be at least six calendar months after the comprehensive oral evaluation (D0150) or at least six calendar months after a periodic oral evaluation (D0120) for the same provider * Allowed once per six calendar month period for the same provider (for example, a patient seen for an oral evaluation for a patient under three years of age on any date in January would be eligible for the next oral evaluation for a beneficiary under three years of age on any date in July) * Allowed on beneficiaries under three years of age * Service must be provided in conjunction with topical fluoride varnish (D1206) * Procedure code D1206 must be billed on the detail line before D0145	No
D0150	Comprehensive oral evaluation – new or established patient * Use as the initial exam for a beneficiary * Allowed as an initial exam once per provider per beneficiary	No

Code	Description	PA Needed?
D0160	Detailed and extensive oral evaluation – problem focused, by report * Entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation * Requires integration of extensive diagnostic modalities to develop a treatment plan for a specific problem * The condition requiring this type of evaluation must be described and documented * Examples include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, and systemic diseases requiring multidisciplinary consultation * Not allowed as a routine office visit or for orthodontic records	No
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit) * Use as a follow-up exam for a specific problem that has been evaluated previously such as monitoring of a traumatic injury, evaluation of a soft tissue lesion, or evaluation of undiagnosed continuing pain * Document in the beneficiary's chart the nature of the emergency and the treatment provided	No

5.3.2.2 Diagnostic Imaging

Code	Description	PA Needed?
D0210	Intraoral – complete series of radiographic images * Limited to beneficiaries age six and older except in the hospital or ambulatory surgical center setting * Allowed one time in five years * Not allowed on the same date of service as D0330 * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Panoramic radiographic image and bitewing radiographic images taken on the same date of service shall not be billed as a D0210	No
D0220	Intraoral – periapical first radiographic image * Only one allowed per date of service per beneficiary per provider * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on the same date of service as D0210	No
D0230	Intraoral – periapical each additional radiographic image * Bill more than eight additional periapical radiographic images as a D0210 * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on the same date of service as D0210	No
D0240	Intraoral – occlusal radiographic image * Only two allowed per date of service per beneficiary per provider	No

Code	Description	PA Needed?
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No
D0270	Bitewing – single radiographic image * Allowed one time in a 12-calendar month period (for example, a beneficiary receiving bitewings on any date in January would be eligible for additional bitewings on any date the following January) * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on same date of service as D0272, D0273, or D0274 * Not allowed within the same 12 calendar month period as D0210, D0272, D0273, or D0274	No
D0272	Bitewings – two radiographic images * Allowed one time in a 12-calendar month period (for example, a beneficiary receiving bitewings on any date in January would be eligible for additional bitewings on any date the following January) * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on same date of service as D0270, D0273, or D0274 * Not allowed within the same 12-calendar month period as D0210, D0270, D0273, or D0274	No
D0273	Bitewings – three radiographic images * Limited to beneficiaries age 13 and older * Allowed one time in a 12-calendar month period (for example, a beneficiary receiving bitewings on any date in January would be eligible for additional bitewings on any date the following January) * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on same date of service as D0270, D0272, or D0274 * Not allowed within the same 12 calendar month period as D0210, D0270, D0272, or D0274	No
D0274	Bitewings – four radiographic images * Limited to beneficiaries age 13 and older * Allowed one time in a 12-calendar month period (for example, a beneficiary receiving bitewings on any date in January would be eligible for additional bitewings on any date the following January) * Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the maximum allowed fee for D0210 is reimbursed at the same fee as D0210 * Not allowed on same date of service as D0270, D0272, or D0273 * Not allowed within the same 12 calendar month period as D0210, D0270, D0272, or D0273	No
D0310	Sialography	No
D0320	Temporomandibular joint arthrogram, including injection	No

Code	Description	PA Needed?
D0330	Panoramic radiographic image * Limited to beneficiaries age six and older * Allowed one time in five years * Not allowed on the same date of service as D0210	No

5.3.2.3 Requests to Override the Panoramic Radiographic Image Limitations

An override of the five-year limitation on panoramic radiographic images is considered ***only*** under the following exceptional circumstances:

a. The provider finds clinical or radiographic evidence of ***new*** oral disease or a ***new*** problem that cannot be evaluated adequately using any other type of radiographic image; or
b. The beneficiary's previous provider is unable or unwilling to provide a copy of the previous panoramic radiographic image that is of diagnostic quality. (Such cases may result in recoupment of the Medicaid payment for the previous radiographic image.)

An override of the age limitation (allowed on beneficiaries age six and older) on panoramic radiographic images is considered ***only*** under the following exceptional circumstances:

a. The provider finds clinical or radiographic evidence of ***new*** oral disease or a ***new*** problem that cannot be evaluated adequately using any other type of radiographic image; or
b. The beneficiary has been involved in an accident or trauma which makes it medically necessary to take a panoramic radiographic image to evaluate the extent of the child's injuries.

To request a panoramic limitation override, submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D0330 (panoramic radiographic image) entered as the requested service and indicate that the request is for an override of the panoramic radiographic image five-year limit;
b. Copies of the current and previous panoramic radiographic images, as well as of any other radiographic images that support the override request; and
c. A narrative that clearly describes the circumstances of the case.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

5.3.2.4 Oral Pathology Laboratory

Code	Description	PA Needed?
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	No
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report * Use for lab reporting fee	No

5.3.3 Preventive

5.3.3.1 Dental Prophylaxis

Dental prophylaxis (D1110 or D1120) is allowed once per beneficiary per six calendar month period for the same provider. (For example, a beneficiary seen for a prophylaxis on any date in January would be eligible for the next prophylaxis on any date in July.)

Dental prophylaxis (D1110 or D1120) is not allowed on the same date of service as a periodontal procedure (D4210, D4211, D4240, D4241, D4341, D4342, D4346, D4355, or D4910).

Code	Description	PA Needed?
D1110	Prophylaxis – adult * Limited to beneficiaries age 13 and older	No
D1120	Prophylaxis – child * Limited to beneficiaries under 13 years of age	No

5.3.3.2 Topical Fluoride Treatment (Office Procedure)

Topical fluoride treatment (D1206 or D1208) is allowed once per beneficiary per six calendar month period for the same provider. (For example, a beneficiary seen for a topical fluoride treatment on any date in January would be eligible for the next topical fluoride treatment on any date in July.) Topical fluoride **must** be applied to **all** teeth erupted on the date of service.

Code	Description	PA Needed?
D1206	Topical application of fluoride varnish * Limited to beneficiaries under 21 years of age * Procedure code D1206 must be billed on the detail line before D0145	No
D1208	Topical application of fluoride – excluding varnish * Limited to beneficiaries under 21 years of age	No

5.3.3.3 Other Preventive Services

Code	Description	PA Needed?
D1351	Sealant – per tooth * Covered for permanent first and second molars for beneficiaries under 16 years of age * Covered for primary molars for beneficiaries under eight years of age (for children age 8 through 20 years of age with special needs, refer to **Subsection 5.3.13** for special approval requirements) * Teeth to be sealed must have pits and fissures that are susceptible to caries * Teeth to be sealed must be free of proximal caries and free of restorations on the surface to be sealed * Teeth should be sealed after being identified at high risk for decay * Allowed once in a lifetime per tooth	No
D1354	Application of caries arresting medicament – 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 * Allowed for beneficiaries of all ages * Allowed once every six calendar months per tooth (for example, a beneficiary seen for interim caries arresting medicament application – per tooth on any date in January would be eligible for the next interim caries arresting medicament application – per tooth on any date in July) * Limited to a total of four applications per tooth * Valid tooth numbers (A-T, 1-32) * Recommended for beneficiary who is deemed to be at risk for progression of disease to pulpal infection * Since the potential for staining of carious enamel and dentin exists, providers must obtain informed consent from the beneficiary's parent or caregiver prior to rendering the service * Reapplication of the caries arresting medicament at recall visits is only indicated if the carious lesions do not appear arrested * Treated carious lesions can be restored after treatment with carious arresting medicament * Reimbursement is at 100 percent for the first tooth and cutback to 50 percent for three additional teeth for a total of four teeth reimbursed per date of service (D1354 or D1355). If more than four teeth need treatment, all teeth should be treated (reimbursement of a total of four teeth constitutes payment of all affected teeth)	No

Code	Description	PA Needed?
D1355	Caries preventive medicament application – per tooth * Treatment for primary prevention or remineralization * Allowed for beneficiaries ages five through fourteen years of age * Allowed for permanent first and second molars * Valid tooth numbers (02, 03, 14, 15, 18, 19, 30, and 31) * Allowed once per lifetime * Reimbursement is at 100 percent for the first tooth and cutback to 50 percent for three additional teeth for a total of four teeth reimbursed per date of service (D1354 or D1355). If more than four teeth need treatment, all teeth should be treated (reimbursement of a total of four teeth constitutes payment of all affected teeth)	No

5.3.3.4 Space Maintenance (Passive Appliances)

Reimbursement is not allowed by Medicaid for a non-deliverable space maintainer. All necessary preparation of the oral cavity must be completed prior to insertion of appliances. Placement of a space maintainer is not allowed when eruption of the permanent tooth is imminent.

Code	Description	PA Needed?
D1510	Space maintainer – fixed, unilateral – per quadrant * Includes band and loop, crown and loop, or distal shoe * Limited to beneficiaries under 21 years of age * Limited to replacement of primary molars and canines and permanent first molars * Requires a quadrant indicator in the area of oral cavity field * Use delivery date as date of service when requesting payment * If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service	No
D1516	Space maintainer – fixed – bilateral, maxillary * Limited to beneficiaries under 21 years of age * Limited to replacement of primary molars and canines and permanent first molars * Bill D6985 when appliance is to serve as a fixed pediatric partial denture to replace maxillary anterior teeth * Use the delivery date as date of service when requesting payment * If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service	No

Code	Description	PA Needed?
D1517	Space maintainer – fixed – bilateral, mandibular * Limited to beneficiaries under 21 years of age * Limited to replacement of primary molars and canines and permanent first molars * Use the delivery date as date of service when requesting payment * If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service	No
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant * Limited to a beneficiary under 21 years of age * Limited to replacement of primary molars and canines and permanent first molars * Requires a quadrant indicator in the area of oral cavity field * Use delivery date as date of service when requesting payment * If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service	No

5.3.4 Restorative

Each surface on the same tooth is covered only once per date of service. Connecting or adjoining surfaces must be billed under one procedure code. Payment for the restoration includes local anesthesia, and any necessary liners, bases, and pulp caps. Primary tooth restorations are not allowed when normal exfoliation is imminent.

5.3.4.1 Amalgam Restorations (Including Polishing)

Code	Description	PA Needed?
D2140	Amalgam – one surface, primary or permanent * Any combination of D2140, D2150, D2160, and D2161 rendered on a single **posterior primary or permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2161 is reimbursed at the same fee as D2161	No
D2150	Amalgam – two surfaces, primary or permanent * Any combination of D2140, D2150, D2160, and D2161 rendered on a single **posterior primary or permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2161 is reimbursed at the same fee as D2161	No
D2160	Amalgam – three surfaces, primary or permanent * Any combination of D2140, D2150, D2160, and D2161 rendered on a single **posterior primary or permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2161 is reimbursed at the same fee as D2161	No

Code	Description	PA Needed?
D2161	Amalgam – four or more surfaces, primary or permanent * Not allowed on the same date of service as D2950 for the same tooth * Any combination of D2140, D2150, D2160, and D2161 rendered on a single **posterior primary or permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2161 is reimbursed at the same fee as D2161	No

5.3.4.2 Resin-based Composite Restorations - Direct

Resin-based composite restorations are allowed to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Resin-based composite restorations are not covered as a preventive procedure and are not covered for treatment of cosmetic problems (such as diastemas, discolored teeth, developmental anomalies).

Code	Description	PA Needed?
D2330	Resin-based composite – one surface, anterior	No
D2331	Resin-based composite – two surfaces, anterior	No
D2332	Resin-based composite – three surfaces, anterior	No
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior) * Not allowed on the same date of service as D2950 for the same tooth	No
D2390	Resin-based composite crown, anterior * Allowed for **primary** anterior teeth only	No
D2391	Resin-based composite – one surface, posterior * Any combination of D2391, D2392, and D2393 rendered on a single **posterior primary tooth** on the same date of service that exceeds the maximum allowed fee for D2393 is reimbursed at the same fee as D2393 * Any combination of D2391, D2392, D2393, and D2394 rendered on a single **posterior permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2394 is reimbursed at the same fee as D2394	No
D2392	Resin-based composite – two surfaces, posterior * Any combination of D2391, D2392, and D2393 rendered on a single **posterior primary tooth** on the same date of service that exceeds the maximum allowed fee for D2393 is reimbursed at the same fee as D2393 * Any combination of D2391, D2392, D2393, and D2394 rendered on a single **posterior permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2394 is reimbursed at the same fee as D2394	No
D2393	Resin-based composite – three surfaces, posterior * For primary teeth, providers should consider rendering other covered restorative services (amalgam or stainless-steel crown) when indicated due to extent of decay, behavior management concerns, inability to maintain a moisture-free field, high caries risk, etc. * Any combination of D2391, D2392, and D2393 rendered on a single **posterior primary tooth** on the same date of service that exceeds the maximum allowed fee for D2393 is reimbursed at the same fee as D2393 * Any combination of D2391, D2392, D2393, and D2394 rendered on a single **posterior permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2394 is reimbursed at the same fee as D2394	No

Code	Description	PA Needed?
D2394	Resin-based composite – four or more surfaces, posterior * Allowed for **permanent** posterior teeth only * Not allowed on the same date of service as D2950 for the same tooth * Any combination of D2391, D2392, D2393, and D2394 rendered on a single **posterior permanent tooth** on the same date of service that exceeds the maximum allowed fee for D2394 is reimbursed at the same fee as D2394	No

5.3.4.3 Other Restorative Services

Code	Description	PA Needed?
D2930	Prefabricated stainless steel crown – primary tooth * Limited to beneficiaries under 21 years of age	No
D2931	Prefabricated stainless steel crown – permanent tooth * Limited to beneficiaries under 21 years of age * Limited to permanent premolars and first and second molars	No
D2932	Prefabricated resin crown * Limited to beneficiaries under 21 years of age * Limited to primary and permanent anterior teeth	No
D2933	Prefabricated stainless steel crown with resin window * Limited to beneficiaries under 21 years of age * Limited to primary anterior teeth	No
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth * Limited to beneficiaries under 21 years of age * Limited to primary anterior teeth	No

Medicaid will pay for a maximum of six crowns per beneficiary for a single date of service.

a. This limitation applies to procedure codes D2390, D2930, D2931, D2932, D2933, and D2934 or to any combination of these codes delivered on the same date of service.
b. This limitation **does not** apply to beneficiaries treated under general anesthesia in a hospital or ambulatory surgical center.
c. If a provider believes that medical necessity warrants delivery of more than six crowns for a beneficiary on a single date of service, the provider shall submit a prior approval request along with a letter describing the special circumstances of the case. (Refer to **Subsection 5.2, Prior Approval Requirements,** for specific instructions on submitting a prior approval request.)

Code	Description	PA Needed?
D2940	Protective restoration * Use for placement of restorative material to protect the tooth, relieve pain, promote healing, or prevent further deterioration * Not allowed for billing of a temporary filling while awaiting completion of endodontic therapy * Not allowed as a base or liner under a restoration	No

Code	Description	PA Needed?
D2949	Restorative foundation for an indirect restoration * Limited to recipients age 16 and older * Limited to teeth prepared for a crown that has been approved as a non-covered service * Placement of restorative material to yield a more ideal form, including the elimination of undercuts	Yes
D2950	Core buildup, including any pins when required * Not allowed on the same date of service as D2161, D2335, D2394, or D2951 for the same tooth	No
D2951	Pin retention – per tooth, in addition to restoration * Not allowed on the same date of service as D2950 for the same tooth	No

5.3.5 Endodontics

5.3.5.1 Pulpotomy

Code	Description	PA Needed?
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament * Not allowed for the same tooth on the same date of service as D3222, D3230, D3240, D3310, D3320, or D3330 * Not to be construed as the first stage of root canal therapy	No

Medicaid will pay for a maximum of six pulpotomies per beneficiary for a single date of service.

a. This limitation applies to procedure code D3220.
b. This limitation **does not** apply to a beneficiary treated under general anesthesia in a hospital or ambulatory surgical center.
c. If a provider believes that medical necessity warrants delivery of more than six pulpotomies for a beneficiary on a single date of service, the provider shall submit a prior approval request along with a letter describing the special circumstances of the case. (Refer to **Subsection 5.2, Prior Approval Requirements,** for specific instructions on submitting a prior approval request.)

Code	Description	PA Needed?
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development * Limited to beneficiaries under 21 years of age * Not allowed for the same tooth on the same date of service as D3220, D3230, D3240, D3310, D3320, or D3330 * Not to be construed as the first stage of root canal therapy	No

5.3.5.2 Endodontic Therapy on Primary Teeth

Radiographic images taken for diagnostic purposes may be billed separately, as needed. Progress radiographic images taken during root canal therapy and all appointments necessary to complete treatment must be included as part of the procedure and must not be billed separately. All radiographic images must be maintained in the beneficiary's record. Root canal therapy includes:

a. Diagnosis;
b. Extirpation (removal of pulp);
c. Temporary fillings;
d. Obturation and filling of all canals;
e. Progress radiographic images; and
f. Completed fill radiographic image.

Code	Description	PA Needed?
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) * Limited to beneficiaries under six years of age * Not allowed for the same tooth on the same date of service as D3220 or D3222	No
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration) * Limited to beneficiaries under nine years of age * Allowed for primary second molars only * Not allowed for the same tooth on the same date of service as D3220 or D3222	No

5.3.5.3 Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)

Radiographic images taken for diagnostic purposes may be billed separately, as needed. Progress radiographic images taken during root canal therapy and all appointments necessary to complete treatment must be included as part of the procedure and must not be billed separately. All radiographic images must be maintained in the beneficiary's record. Root canal therapy includes:

a. Diagnosis;
b. Extirpation (removal of pulp);
c. Temporary fillings;
d. Obturation and filling of all canals;
e. Progress radiographic images; and
f. Completed fill radiographic image.

Code	Description	PA Needed?
D3310	Endodontic therapy, anterior tooth (excluding final restoration) * Permanent anterior teeth only * Not allowed for the same tooth on the same date of service as D3220 or D3222 * Request reimbursement using the date of completion as the service date	No

Code	Description	PA Needed?
D3320	Endodontic therapy, premolar tooth (excluding final restoration) * Limited to beneficiaries under 21 years of age * Not allowed for the same tooth on the same date of service as D3220 or D3222 * Request reimbursement using the date of completion as the service date	No
D3330	Endodontic therapy, molar tooth (excluding final restoration) * Limited to beneficiaries under 21 years of age * Limited to permanent first and second molars * Not allowed for the same tooth on the same date of service as D3220 or D3222 * Request reimbursement using the date of completion as the service date	No

5.3.5.4 Apexification/Recalcification

Code	Description	PA Needed?
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) * For beneficiaries under 21 years of age, covered for permanent teeth * For beneficiaries 21 years of age and older, limited to permanent anterior teeth only * Not allowed for the same tooth on the same date of service as D3220, D3222, D3230, D3240, D3310, D3320, or D3330	No
D3352	Apexification/recalcification – interim medication replacement * Allowed four times per year * For beneficiaries under 21 years of age, covered for permanent teeth * For beneficiaries 21 years of age and older, limited to permanent anterior teeth only * Not allowed for the same tooth on the same date of service as D3220, D3222, D3230, D3240, D3310, D3320, or D3330	No
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) * For beneficiaries under 21 years of age, covered for permanent teeth * For beneficiaries 21 years of age and older, limited to permanent anterior teeth only * Not allowed for the same tooth on the same date of service as D3220, D3222, D3230, D3240, D3310, D3320, or D3330	No

5.3.5.5 Pulpal Regeneration

Code	Description	PA Needed?
D3355	Pulpal regeneration – initial visit * Limited to recipients under 21 years of age * Limited to permanent teeth only * Includes opening tooth, preparation of canal spaces, and placement of medication	No
D3356	Pulpal regeneration – interim medication replacement * Limited to recipients under 21 years of age * Limited to permanent teeth only	No

Code	Description	PA Needed?
D3357	Pulpal regeneration – completion of treatment * Limited to recipients under 21 years of age * Limited to permanent teeth only * Does not include final restoration	No

5.3.5.6 Apicoectomy/Periradicular Services

Code	Description	PA Needed?
D3410	Apicoectomy – anterior * Limited to permanent anterior teeth only	No

5.3.6 Periodontics

Dental prophylaxis (D1110 or D1120) and periodontal procedures (D4210, D4211, D4240, D4241, D4341, D4342, D4346, D4355, or D4910), in any combination, are not allowed on the same date of service for the same beneficiary.

5.3.6.1 Surgical Services (Including Usual Postoperative Care)

Code	Description	PA Needed?
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant * Includes scaling and root planing * Allowed once in a lifetime * Requires pretreatment narrative documenting underlying medical condition * Requires periodontal charting (pocket depth measurements must be abnormal) * Requires current diagnostic radiographic images of the proposed surgical site * Requires current diagnostic photographic images of the proposed surgical site * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4211, D4240, D4241, D4341, or D4342 on the same date of service	Yes
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant * Includes scaling and root planing * Allowed once in a lifetime * Requires pretreatment narrative documenting underlying medical condition * Requires periodontal charting (pocket depth measurements must be abnormal) * Requires current diagnostic radiographic images of the proposed surgical site * Requires current diagnostic photographic images of the proposed surgical site * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4210, D4240, D4241, D4341, or D4342 on the same date of service	Yes

Code	Description	PA Needed?
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant * Allowed once in a lifetime * Requires pretreatment narrative documenting underlying medical condition * Requires periodontal charting (pocket depth measurements must be abnormal) * Requires current diagnostic radiographic images of the proposed surgical site * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4210, D4211, D4241, D4341, or D4342 on the same date of service	Yes
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant * Allowed once in a lifetime * Requires pretreatment narrative documenting underlying medical condition * Requires periodontal charting (pocket depth measurements must be abnormal) * Requires current diagnostic radiographic images of the proposed surgical site * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4210, D4211, D4240, D4341, or D4342 on the same date of service	Yes

5.3.6.2 Non-Surgical Periodontal Service

Code	Description	PA Needed?
D4341	Periodontal scaling and root planing – four or more teeth per quadrant * Each quadrant is allowed one time per 24-month interval * Requires periodontal charting (probing depth measurements must be abnormal in multiple sites) or radiographic evidence of bone loss * Limited to no more than two quadrants of scaling and root planing on the same date of service. This limitation does not apply to beneficiaries treated under general anesthesia in a hospital or ambulatory surgical center * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4210, D4211, D4240, D4241, or D4342 on the same date of service	Yes
D4342	Periodontal scaling and root planing – one to three teeth per quadrant * Each quadrant is allowed one time per 24-month interval * Requires periodontal charting (probing depth measurements must be abnormal in multiple sites) or radiographic evidence of bone loss * Limited to no more than two quadrants of scaling and root planing on the same date of service. This limitation does not apply to beneficiaries treated under general anesthesia in a hospital or ambulatory surgical center * Requires a quadrant indicator in the area of oral cavity * Not allowed for the same quadrant as D4210, D4211, D4240, D4241, or D4341 on the same date of service	Yes

Code	Description	PA Needed?
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation * Limited to beneficiaries age 13 and older * Reported instead of an adult prophylaxis for beneficiaries who have swollen, inflamed gingiva, generalized suprabony pockets and moderate to severe bleeding upon probing * One procedure of D1110, D4346 or D4910 is allowed once per beneficiary per six calendar month period for the same provider * Not allowed for an individual beneficiary on the same date of service as a prophylaxis (D1110) or periodontal procedures (D4210, D4211, D4240, D4241, D4341, D4342, D4355 or D4910)	No
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit * Allowed one time per 12-month interval * Requires documentation in the beneficiary's chart of extenuating circumstances that warrant the comprehensive oral evaluation (D0150) or detailed and extensive oral evaluation (D0160) to be rendered on the same date of service following the full mouth debridement (for example, hardship due to issues regarding transportation, health, work, school, childcare, etc.) * Not allowed on the same date of service as D1110, D1120, D4210, D4211, D4240, D4241, D4341, D4342, D4346, or D4910	No

5.3.6.3 Other Periodontal Services

Code	Description	PA Needed?
D4910	Periodontal maintenance * Allowed only if D4210, D4211, D4240, or D4241 precedes this treatment * Allowed two (2) times per year * Procedure may be alternated with D1110 * Not allowed on same date of service as D1110, D1120, D4210, D4211, D4240, D4241, D4341, D4342, or D4355	No

5.3.7 Prosthodontics (Removable)

Appliances **shall not** be authorized when extractions are not medically necessary. Appliances shall not be authorized when a beneficiary's dental history indicates negligence in the proper care of appliances or physiological or psychological problems that have caused previous dentures to be unsatisfactory. Appliances shall not be authorized when repair or reline would make existing appliances serviceable. Appliances shall not be authorized when the appliances are lost by the beneficiary, hospital, or nursing home.

Beneficiaries with complex and compromised medical needs (multiple medical diagnosis, taking blood thinners, etc.) are often referred to an oral surgeon for extraction and ridge preparation for partial and complete dentures. If the beneficiary will receive a partial or complete denture on the same day that the extractions are rendered, the oral surgeon can deliver the denture. The beneficiary must return to the provider who fabricated the appliances for routine post-delivery care. The appliances must not be given to the beneficiary to take to

the oral surgeon. The general dentist /prosthodontist must forward the dentures directly to the oral surgeon. If the extractions are not rendered due to unforeseen circumstances, the oral surgeon must return the dentures directly to the general dentist/prosthodontist.

5.3.7.1 Complete Dentures (Including Routine Post-delivery Care)

Only one denture (complete or immediate) is allowed per arch every 10 years. Medicaid does not cover temporary or interim dentures. Codes D5110 and D5120 should be used for overdentures. All necessary preparation of the oral cavity must be complete prior to denture delivery. Hand delivery of an appliance to a beneficiary does not constitute delivery of an appliance. Immediate dentures delivered by another provider shall be forwarded directly to that provider. **Providers must use date of delivery as the date of service when requesting payment for a denture.** Payment for complete dentures (D5110 and D5120) includes any adjustments or relines necessary for six months after the date of delivery regardless of Medicaid eligibility status. Payment for immediate dentures (D5130 and D5140) includes all adjustments necessary for six months after the date of delivery regardless of Medicaid eligibility status.

Code	Description	PA Needed?
D5110	Complete denture – maxillary	Yes
D5120	Complete denture – mandibular	Yes
D5130	Immediate denture – maxillary	Yes
D5140	Immediate denture – mandibular	Yes

Note: When requesting prior approval for an immediate denture, request prior approval for the appropriate denture reline at the same time. Refer to note in **Subsection 5.3.7.7, Denture Reline Procedures.**

Note: Every prior approval request for fabrication of a denture (impression, try-in, or delivery) to be rendered in a nursing facility or adult care home must be accompanied by a Supplement to Dental Prior Approval form (DHB 6022). Refer to **Subsection 7.4, Supplement to Dental Prior Approval Form,** and to **Attachment A, Dental Billing Guide,** for additional information.

5.3.7.2 Partial Dentures (Including Routine Post-delivery Care)

Only one partial denture is allowed per arch every eight years. Medicaid does not cover temporary or interim dentures, cast metal partial dentures, or unilateral partial dentures. All necessary preparation of the oral cavity must be complete prior to denture delivery. Hand delivery of an appliance to a beneficiary does not constitute delivery of an appliance. Partial dentures delivered by another provider (for example, an immediate partial denture) shall be forwarded directly to that provider. **Providers must use date of delivery as the date of service when requesting payment for a denture.** Payment includes any adjustments or relines necessary for six months after the date of delivery regardless of Medicaid eligibility status.

Partial dentures are authorized **only** under the following criteria:

For beneficiaries under 21 years of age	For beneficiaries age 21 and older
• Any missing anterior teeth (incisors or canines) • Two missing first molars in an arch • Three missing posterior permanent teeth in an arch • Two adjacent missing posterior permanent teeth in an arch	• Any missing anterior teeth (incisors or canines) • Four missing posterior permanent teeth in an arch • Three adjacent missing posterior permanent teeth in an arch

Note: Missing third molars do not count when determining Medicaid coverage for a partial denture. Appliances shall not be authorized when radiographic images show substantial space closure after tooth loss due to tooth migration preventing replacement of the missing tooth. The provider must document mobility, pocket depth, presence of inflammation, and prognosis for periodontally compromised abutment teeth. The provider must also indicate whether it would be possible to add teeth to the partial or convert it to a complete denture if the compromised abutment teeth are lost.

Code	Description	PA Needed?
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes

5.3.7.3 Requests to Override the 8 and 10-Year Limitations on Complete and Partial Dentures

An override of the 8 and 10-year limitations on a complete or partial denture are considered **only** in the following exceptional circumstances:

a. Dentures were stolen: *requires a copy of the police report*
b. Dentures were lost in a house fire: *requires a copy of the fire report*
c. Dentures were lost in a hurricane, flood, or other natural disaster: *requires a copy of documentation from the Federal Emergency Management Agency (FEMA) or the American Red Cross indicating loss of possessions*
d. Dentures no longer fit due to a significant medical condition: *requires a letter signed by the beneficiary's physician, surgeon, or physician extender documenting the medical condition and a letter from the beneficiary's dentist stating that the existing denture cannot be made functional by adjusting or relining it and that a new denture is likely to be functional*

To request an override, the provider must submit the following:

a. A properly completed 2019 ADA Dental Claim Form, clearly marked **"Request for Denture Override"**
b. Copies of current radiographic images when requesting an override for a partial denture
c. Any applicable supporting documentation listed above
d. A cover letter that clearly describes the circumstances of the case

Enter a prior approval request in the NCTracks Prior Approval Portal or mail the request to the address listed below.

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

5.3.7.4 Adjustments to Dentures

Adjustments to complete or partial dentures are reimbursable beginning six months after delivery of the appliances.

Code	Description	PA Needed?
D5410	Adjust complete denture – maxillary	No
D5411	Adjust complete denture – mandibular	No
D5421	Adjust partial denture – maxillary	No
D5422	Adjust partial denture – mandibular	No

5.3.7.5 Repairs to Complete Dentures

If multiple repairs are made to one appliance on the same date of service, the first repair is reimbursed at 100 percent of the maximum allowed rate and subsequent repairs at 35 percent of the maximum allowed rate.

Code	Description	PA Needed?
D5511	Repair broken complete denture base, mandibular	No
D5512	Repair broken complete denture base, maxillary	No

Code	Description	PA Needed?
D5520	Replace missing or broken teeth – complete denture (each tooth) * Requires a tooth number in the tooth number field	No

5.3.7.6 Repairs to Partial Dentures

For multiple repairs made to one appliance on the same date of service, the first repair is reimbursed at 100 percent of the maximum allowed rate and subsequent repairs at 35 percent of the maximum allowed rate.

Code	Description	PA Needed?
D5611	Repair resin partial denture base, mandibular	No
D5612	Repair resin partial denture base, maxillary	No
D5621	Repair cast partial framework, mandibular	No
D5622	Repair cast partial framework, maxillary	No
D5630	Repair or replace broken retentive/clasping materials – per tooth * Requires a tooth number in the tooth number field	No
D5640	Replace broken teeth – per tooth * Requires a tooth number in the tooth number field	No
D5650	Add tooth to existing partial denture * Requires a tooth number in the tooth number field	No
D5660	Add clasp to existing partial denture * Requires a tooth number in the tooth number field	No

5.3.7.7 Denture Reline Procedures

The provider may request prior approval for the initial reline of a complete or partial denture beginning six months after the date of delivery of the denture. Subsequent relines are allowed once every five years. Medicaid does not cover tissue conditioning, soft relines, or rebase procedures.

Note: For an immediate denture (D5130 or D5140), the initial reline may be approved and rendered earlier than six months from denture delivery if the provider determines that healing of extraction sites is essentially complete and a reline is necessary to ensure proper fit and function of the denture. Subsequent relines are allowed once every five years.

Code	Description	PA Needed?
D5730	Reline complete maxillary denture (direct) * Allowed for a chairside reline	Yes
D5731	Reline complete mandibular denture (direct) * Allowed for a chairside reline	Yes
D5740	Reline maxillary partial denture (direct) * Allowed for a chairside reline	Yes
D5741	Reline mandibular partial denture (direct) * Allowed for a chairside reline	Yes
D5750	Reline complete maxillary denture (indirect) * Allowed for a laboratory reline	Yes
D5751	Reline complete mandibular denture (indirect) * Allowed for a laboratory reline	Yes

Code	Description	PA Needed?
D5760	Reline maxillary partial denture (indirect) * Allowed for a laboratory reline	Yes
D5761	Reline mandibular partial denture (indirect) * Allowed for a laboratory reline	Yes

5.3.7.8 Other Removable Prosthetic Services

Code	Description	PA Needed?
D5876	Add metal substructure to acrylic full denture (per arch) * Requires an arch indicator (UP, LO) in the area of oral cavity field	No

5.3.8 Maxillofacial Prosthetics and Implant —not covered by Medicaid

5.3.9 Implant Services—not covered by Medicaid

5.3.10 Other Fixed Partial Denture Services

Code	Description	PA Needed?
D6985	Pediatric partial denture, fixed * Limited to beneficiaries under six years of age * Use the delivery date as date of service when requesting payment * If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service	No

5.3.11 Oral and Maxillofacial Surgery

5.3.11.1 Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)

Payment for an extraction includes local anesthesia, any necessary sutures, and routine postoperative care. Primary tooth extractions are not allowed when normal exfoliation is imminent.

Code	Description	PA Needed?
D7111	Extraction, coronal remnants – primary tooth	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

5.3.11.2 Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)

Payment for an extraction includes local anesthesia, any necessary sutures, and routine postoperative care. Primary tooth extractions are not allowed when normal exfoliation is imminent.

Code	Description	PA Needed?
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No
D7220	Removal of impacted tooth – soft tissue	Medicaid – No

Code	Description	PA Needed?
D7230	Removal of impacted tooth – partially bony	Medicaid – No
D7240	Removal of impacted tooth – completely bony	Medicaid – No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications * Requires documentation of clinical or radiographic conditions that qualify the extraction as unusually complicated (for example, full impaction requiring multisectioning of the tooth, full impaction high in the maxillary sinus area or low in the mandibular canal area, full vertical or horizontal impaction)	Medicaid - No
D7250	Removal of residual tooth roots (cutting procedure)	No
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only * Requires documentation of medical necessity * Requires documentation that the beneficiary was informed that a portion of the tooth remains	No

5.3.11.3 Other Surgical Procedures

Code	Description	PA Needed?
D7260	Oroantral fistula closure	No
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	No
D7280	Exposure of an unerupted tooth * Not allowed on the same date of service as an extraction for the same tooth	No
D7283	Placement of device to facilitate eruption of impacted tooth * Report the surgical exposure separately using D7280 * Not allowed on the same date of service as an extraction for the same tooth	No
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	No
D7286	Incisional biopsy of oral tissue – soft	No
D7288	Brush biopsy – transepithelial sample collection	No
D7295	Harvest of bone for use in autogenous grafting procedure * Report in addition to those autogenous graft procedures that do not include harvesting of bone	Yes

5.3.11.4 Alveoloplasty—Surgical Preparation of Ridge

Code	Description	PA Needed?
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant * Requires a quadrant indicator in the area of oral cavity	No

Code	Description	PA Needed?
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * Must be three edentulous units in a quadrant to qualify for payment for alveoloplasty * Requires a quadrant indicator in the area of oral cavity	No
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant * Requires a quadrant indicator in the area of oral cavity * Requires current diagnostic photographic images of the proposed surgical site	Yes
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant * Must be three edentulous units in a quadrant to qualify for payment for alveoloplasty * Requires a quadrant indicator in the area of oral cavity * Requires current diagnostic photographic images of the proposed surgical site	Yes

5.3.11.5 Vestibuloplasty

Code	Description	PA Needed?
D7340	Vestibuloplasty – ridge extension (secondary epithelialization) * Requires an arch indicator (UP, LO) in the area of oral cavity	Yes
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) * Document the exact procedure to be performed and the estimated fee * Requires an arch indicator (UP, LO) in the area of oral cavity	Yes

5.3.11.6 Surgical Excision of Soft Tissue Lesions

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Note: A pathology report is required as an attachment to the claim for payment to receive reimbursement of any excision of lesion.

Code	Description	PA Needed?
D7410	Excision of benign lesion up to 1.25 cm	No
D7411	Excision of benign lesion greater than 1.25 cm	No
D7412	Excision of benign lesion, complicated	No
D7413	Excision of malignant lesion up to 1.25 cm	No
D7414	Excision of malignant lesion greater than 1.25 cm	No
D7415	Excision of malignant lesion, complicated	No
D7465	Destruction of lesion(s) by physical or chemical method, by report	No

5.3.11.7 Surgical Excision of Intra-osseous Lesions

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Note: A pathology report is required as an attachment to the claim for payment to receive reimbursement of any excision of lesion, cyst or tumor.

Code	Description	PA Needed?
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	No
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	No
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	No
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	No
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	No
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	No

5.3.11.8 Excision of Bone Tissue

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7471	Removal of lateral exostosis (maxilla or mandible) * Allowed as an arch procedure * Requires an arch indicator (UP, LO) in the area of oral cavity	No

Code	Description	PA Needed?
D7472	Removal of torus palatinus * Allowed as an upper arch procedure	No
D7473	Removal of torus mandibularis * Allowed as a lower arch procedure	No
D7485	Reduction of osseous tuberosity	No
D7490	Radical resection of maxilla or mandible * Requires documentation of medical necessity * Requires a pathology report to be submitted as an attachment to the claim for payment	No

5.3.11.9 Surgical Incision

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7509	Marsupialization of odontogenic cyst	No
D7510	Incision and drainage of abscess – intraoral soft tissue * Involves incision through mucosa; document area of incision * Not allowed in the same site as a surgical tooth extraction	No
D7520	Incision and drainage of abscess – extraoral soft tissue * Document the area of the incision	No
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue * Use for removal of bony spicules	No
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	No
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	No
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	No

5.3.11.10 Treatment of Fractures—Simple

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7610	Maxilla – open reduction (teeth immobilized, if present)	No
D7620	Maxilla – closed reduction (teeth immobilized, if present)	No
D7630	Mandible – open reduction (teeth immobilized, if present)	No
D7640	Mandible – closed reduction (teeth immobilized, if present)	No
D7650	Malar and/or zygomatic arch – open reduction	No
D7660	Malar and/or zygomatic arch – closed reduction	No
D7670	Alveolus – closed reduction, may include stabilization of teeth	No
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	No

5.3.11.11 Treatment of Fractures—Compound

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7710	Maxilla – open reduction	No
D7720	Maxilla – closed reduction	No
D7730	Mandible – open reduction	No
D7740	Mandible – closed reduction	No
D7750	Malar and/or zygomatic arch – open reduction	No
D7760	Malar and/or zygomatic arch – closed reduction	No
D7770	Alveolus – open reduction stabilization of teeth	No
D7780	Facial bones – complicated reduction with fixation and multiple ~~surgical~~ approaches	No

5.3.11.12 Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions

For prior approval, include a narrative documenting medical necessity. Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7810	Open reduction of dislocation * Not allowed on same date of service as D7873	No
D7820	Closed reduction of dislocation * Not allowed on same date of service as D7873	No
D7830	Manipulation under anesthesia * Not allowed on same date of service as D7873	Yes
D7840	Condylectomy * Not allowed on same date of service as D7873	No
D7850	Surgical discectomy, with/without implant * Not allowed on same date of service as D7858, D7865, or D7873	No
D7858	Joint reconstruction * Not allowed on same date of service as D7850, D7860, or D7873	Yes
D7860	Arthrotomy * Not allowed on same date of service as D7858, D7865, or D7873	No
D7865	Arthroplasty * Not allowed on same date of service as D7850, D7860, or D7873	Yes
D7870	Arthrocentesis	No
D7872	Arthroscopy – diagnosis, with or without biopsy * Not allowed on same date of service as D7873	No
D7873	Arthroscopy: lavage and lysis of adhesions * Not allowed on same date of service as D7810, D7820, D7830, D7840, D7850, D7858, D7860, D7865, or D7872	No

5.3.11.13 Repair of Traumatic Wounds

Code	Description	PA Needed?
D7910	Suture of recent small wounds up to 5 cm * Used exclusively for injuries * Not allowed for extraction or periodontal surgery sites	No

5.3.11.14 Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure)

Code	Description	PA Needed?
D7911	Complicated suture – up to 5 cm * Used exclusively for injuries * Not allowed for extraction or periodontal surgery sites	No
D7912	Complicated suture – greater than 5 cm * Used exclusively for injuries * Not allowed for extraction or periodontal surgery sites	No

5.3.11.15 Other Repair Procedures

Certain second surgeries (for example, bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7920	Skin grafts (identify defect covered, location and type of graft) * Document the exact procedure to be performed and the estimated fee * Not allowed to correct periodontal problems	Yes
D7940	Osteoplasty – for orthognathic deformities	Yes
D7941	Osteotomy – mandibular rami	Yes
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Yes
D7944	Osteotomy – segmented or subapical	Yes
D7945	Osteotomy – body of mandible	Yes
D7946	LeFort I (maxilla – total)	Yes
D7947	LeFort I (maxilla – segmented)	Yes
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Yes
D7949	LeFort II or LeFort III – with bone graft	Yes
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Yes
D7955	Repair of maxillofacial soft and/or hard tissue defect	Yes

Note: The following records are required when submitting a prior approval request for combined comprehensive orthodontic treatment of the adolescent dentition (D8080) and orthognathic surgery to correct a skeletal imbalance:

a. Diagnostic Casts;
    1. Trimmed to centric occlusion with markings that identify the beneficiary's accurate occlusion
    2. Bite registration required

3. Description of centric relation-centric occlusion shifts greater than 2mm

b. Three Extraoral Photographic Images;
   1. Full face with beneficiary at rest
   2. Right profile with beneficiary at rest
   3. Full face with beneficiary smiling as fully as possible
c. Five Intraoral Photographic Images;
   1. Maxillary occlusal view
   2. Mandibular occlusal view
   3. Right lateral view in centric occlusion
   4. Left lateral view in centric occlusion
   5. Frontal view in centric occlusion
d. Radiographic Images;
   1. Panoramic (labeled right and left)
   2. Lateral cephalometric with tracing and analysis (right lateral with teeth in occlusion and the beneficiary is in a relaxed lip posture)
   3. Posterior-anterior cephalometric if asymmetry is present
   4. Individual periapical films as needed for special diagnostic concerns
e. Treatment Plan; and
   1. Necessary extractions
   2. Pre-surgical orthodontic treatment goals with specific measurements in all three dimensions
   3. Pre-treatment lateral cephalometric predictions showing anticipated orthodontic and surgical movements and resulting soft tissue profile
   4. Estimated time to complete pre-surgical orthodontics
   5. Post-surgical orthodontic treatment goals and estimated time to complete treatment
   6. Retention plan
f. Consultation notes from the provider who will be rendering the orthognathic surgery services indicating agreement with the proposed treatment plan.

Refer to **Clinical Coverage Policy 4B, Orthodontic Services,** regarding additional information pertaining to combined orthognathic surgery and comprehensive orthodontic treatment.

Code	Description	PA Needed?
D7961	Buccal / labial frenectomy (frenulectomy) * Document necessity (for example, impairing speech, hindering mastication, preventing seating of a denture) * Requires current diagnostic photographic images of the proposed surgical site	Yes
D7962	Lingual frenectomy (frenulectomy) * Document necessity (for example, impairing speech, hindering mastication, preventing seating of a denture) * Requires current diagnostic photographic images of the proposed surgical site * Limited to once per lifetime for lingual frenulectomy	Yes (age 1 and older) No (under 1 year of age)
D7963	Frenuloplasty * Document necessity (for example, impairing speech, hindering mastication, preventing seating of a denture) * Requires current diagnostic photographic images of the proposed surgical site * Limited to once per lifetime for lingual frenuloplasty	Labial - Yes Lingual –Yes (age 1 and older) Lingual - No (under 1 year of age)

Note: Surgery of the lingual frenulum is covered when

a. there is evidence of recession in the gingival tissues adjacent to the lower anterior teeth, or
b. the tongue-tip cannot extend upward to the posterior alveolar ridge and/or molars, or the anterior alveolar ridge and/or incisors; and
c. there is significant dysfunction in feeding, speaking, or maintaining oral hygiene, as indicated by medical record or dental record documentation of one of the following:
    1. the type of feeding difficulty, beneficiary's height and weight (when ankyloglossia treatment is indicated due to an impact upon growth), and the results of other treatment measures attempted; or
    2. the severity of the articulation disorder, as determined by a formal speech/language evaluation; or
    3. the oral hygiene issues involved, and the results of other treatment measures attempted.

Prior approval is not required for the lingual procedure for beneficiaries under 1 year of age when all of the following conditions are met:

a. The criteria in **Section 3.0** are met;
b. Diagnosis of ankyloglossia (tongue-tied),
c. The procedure to be performed is one of the following:
    1. Incision of lingual frenulum (frenotomy);
    2. Excision of lingual frenum (frenectomy); or
    3. Surgical revision of frenum, eg, with Z-plasty (frenuloplasty); and

4. The procedure is performed in the **physician's office or dentist's office only**.

d. Prior approval is not required for newborns with ankyloglossia and feeding difficulties while in the hospital after delivery and beneficiaries under 1 year of age diagnosed with ankyloglossia and feeding difficulties while in the hospital for another unrelated procedure, as long as the procedure is performed prior to discharge from the hospital.

Code	Description	PA Needed?
D7971	Excision of pericoronal gingiva * Use for operculectomy * Not allowed on the same date of service as an extraction for the same tooth * Not allowed for crown lengthening or gingivectomy * Requires a tooth number in the tooth number field	No
D7972	Surgical reduction of fibrous tuberosity	No
D7979	Non-surgical sialolithotomy * Not allowed on the same date of service as D7980	Yes
D7980	Surgical sialolithotomy * Not allowed on the same date of service as D7979	Yes
D7981	Excision of salivary gland, by report	Yes
D7982	Sialodochoplasty	Yes
D7983	Closure of salivary fistula	Yes
D7990	Emergency tracheotomy	No
D7991	Coronoidectomy	No

5.3.12 Adjunctive General Services

5.3.12.1 Unclassified Treatment

Code	Description	PA Needed?
D9110	Palliative (emergency) treatment of dental pain – per visit * Use for minor dental procedures to relieve oral pain * Document in the beneficiary's chart the nature of the emergency and the specific treatment provided * Not allowed for writing prescriptions, dispensing drugs or medicaments through the office, or administering drugs orally	No

5.3.12.2 Anesthesia

The administration of local anesthesia is considered part of a procedure and no additional fee is allowed. Medicaid does not cover acupuncture, hypnosis, or other non-pharmacologic methods.

Code	Description	PA Needed?
D9222	Deep sedation/general anesthesia – first 15 minutes * Allowed once per date of service * Allowed only in an office setting * Deep sedation/general anesthesia performed in the dental office must include documentation in the record of pharmacologic agents, monitoring of vital signs, and complete anesthesia time * Reimbursement includes all drugs and/or medicaments necessary for adequate anesthesia * Reimbursement includes monitoring and management	No
D9223	Deep sedation/general anesthesia – each subsequent 15- minute increment * Allowed only in an office setting * Allowed up to a total of six hours of anesthesia time	No
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis * Reimbursement includes monitoring and management	No
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes * Allowed once per date of service * Allowed only in an office setting * Intravenous conscious sedation performed in the dental office must include documentation in the record of pharmacologic agents, IV site, monitoring of vital signs, and complete anesthesia time * Reimbursement includes all drugs or medicaments necessary for adequate anesthesia * Reimbursement includes monitoring and management	No
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment * Allowed only in an office setting * Allowed up to a total of six hours of anesthesia time	No

5.3.12.3 Professional Visits

Code	Description	PA Needed?
D9410	House/extended care facility call * Includes visits to nursing facilities, long-term care facilities, adult care homes, hospice sites, institutions, etc. * A dentist can be reimbursed for one facility call per date of service for each beneficiary treated in the facility * Must be billed with other definitive treatment (other CDT codes) rendered on that date of service * Procedure codes for treatment must be billed on the detail lines before D9410 on the dental claim * Not allowed for post-surgical follow-up care or initial six months post-delivery care for appliances when other definitive treatment is not being rendered	No
D9420	Hospital or ambulatory surgical center call * One visit per surgery * Necessity of hospitalization shall be documented on paper claims or in the record if billing electronically * Submit operative notes with the paper claim or maintain in the record if billing electronically * Hospitalization does not require admission pre-certification * A Community Care of North Carolina (Carolina ACCESS) beneficiary requires referral from his or her primary care physician for hospital admission	No
D9440	Office visit – after regularly scheduled hours	No

5.3.12.4 Drugs

Code	Description	PA Needed?
D9610	Therapeutic parenteral drug, single administration * Allowed for a single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications * Not allowed for the administration of sedatives, anesthetic, reversal agents, medications available in over-the-counter formulations, and prescription medications that can be self-administered by the beneficiary prior to treatment * Identify drug, dosage, and rationale in the beneficiary's dental record and on the claim form if filed as a paper claim * Not allowed on the same date of service as D9612	No

Code	Description	PA Needed?
D9612	Therapeutic parenteral drugs, two or more administrations, different medications * Allowed for the administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications when two or more different medications are necessary * Not allowed for the administration of sedatives, anesthetic, reversal agents, medications available in over-the-counter formulations, and prescription medications that can be self-administered by the beneficiary prior to treatment * Identify drug, dosage, and rationale in the beneficiary's dental record and on the claim form if filed as a paper claim * Not allowed on the same date of service as D9610	No
D9613	Infiltration of sustained released therapeutic drug, per quadrant * Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control * Not for local anesthesia purposes * Allowed per quadrant	Yes

5.3.13 Teledentistry Eligible Services

Note: Teledentistry eligible services may be provided to both new and established patients by the eligible providers listed within this policy.

Code	Description	PA Needed?
D9995	Teledentistry – synchronous; real-time encounter * Medicaid enrolled dentists may render provider to provider teledentistry services via synchronous, live audio and video transmission * Dentist in the distant site must have enough information and evidence to make a diagnosis * Must be billed with oral evaluation codes D0140 or D0170 * Reported in addition to other procedures delivered on the same date of service * Dental treatment rendered through teledentistry must be documented in the beneficiary record including the date/time/duration of encounter, reasons for the encounter, technology used, records reviewed, diagnosis, and treatment recommendations * Limited to four teledentistry services (D9995 or D9996) in a six-month period * The originating site is the facility in which the beneficiary is located * The distant site is the facility from which the provider furnishes the teledentistry service * All services sites/providers must be Medicaid enrolled * Consultation must take place by an encrypted two-way real-time interactive audio and video telecommunications system * Enter “02” (Telehealth) as the place of treatment for teledentistry claims	No

Code	Description	PA Needed?
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review * Medicaid enrolled dentists may render provider to provider teledentistry services via asynchronous, store and forward or eConsults * Dentist in the distant site must have enough information and evidence to make a diagnosis * Must be billed with oral evaluation codes D0140 or D0170 * Reported in addition to other procedures delivered on the same date of service * Dental treatment rendered through teledentistry must be documented in the beneficiary record including the date/time/duration of encounter, reasons for the encounter, technology used, records reviewed, diagnosis, and treatment recommendations * Limited to once per recipient, per provider for a one-week period * Limited to four teledentistry services (D9995 or D9996) in a six-month period * The originating site is the facility in which the beneficiary is located * The distant site is the facility from which the provider furnishes the teledentistry service * All services sites/providers must be Medicaid enrolled * Consultation must take place by an encrypted telecommunications system * Enter “02” (Telehealth) as the place of treatment for teledentistry claims	No

5.3.14 Request for Medicaid Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Dental providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid beneficiary under 21 years of age as described in **Subsection 2.2.1** of this policy. All such requests must be submitted and approval granted prior to delivery of the service. Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code of service being requested entered and indicate that the request is for special approval of a non-covered service;
b. any materials needed to document medical necessity (such as radiographic and photographic-images, dental and periodontal charting, a letter from the beneficiary's medical care provider); and
c. the completed Non-Covered State Medicaid Plan Services Request Form for a beneficiary Under 21 Years of Age or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

If the procedure(s) receives special approval and the beneficiary is Medicaid eligible on the date the service is rendered, the dentist then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form for Beneficiaries Under 21 Years of Age can be found on the NCTracks Prior Approval page at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: All dental providers participating in the Medicaid program shall provide services in accordance with the rules and regulations detailed in this policy.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

To obtain a dental specialty taxonomy, the provider shall submit proof of the residency program completion and a copy of the specialty certification to NC Medicaid with the initial enrollment application or through a Manage Change Request (MCR) in the NCTracks Provider Portal.

6.3 Locum Tenens

Locum tenens is defined as substituting in an office for a time or temporarily taking the place of another – used especially for a doctor. The provider acting in a *locum tenens* capacity shall comply with the requirements outlined in **Section 6.0, Provider(s) Eligible to Bill for the Procedure, Product, or Service**. The *locum tenens* provider shall be an enrolled Medicaid provider and be affiliated with the practice and each applicable location in which services will be rendered. For additional information, refer to: https://www.govregs.com/regulations/expand/title42_chapterIV_part455_subpartE_section455.440#title42_chapterIV_part455_subpartE_section455.405

6.4 Change of Ownership (CHOW)

For information regarding change of ownership, refer to: https://www.nctracks.nc.gov/content/public/providers/faq-main-page/Change-of-Ownership--CHOW--FAQs.html

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Nursing Facility and Adult Care Home Charts

When providing dental services to a resident of a nursing facility or adult care home, the dental provider shall document the resident's chart at the facility with the date of service, the treatment provided, and either a plan of treatment or follow-up care or an indication that no further treatment is needed. Filing a copy of the claim form in the beneficiary's record is ***insufficient*** documentation of treatment provided.

7.3 Postoperative Care for Residents of Nursing Facilities or Adult Care Homes

Providers are reminded that the fee for dentures includes six months of post-delivery care. Visits to nursing facilities or adult care homes must be scheduled in order to provide postoperative denture care in a timely manner.

7.4 Supplement to Dental Prior Approval Form (DHB 6022)

Prior approval for fabrication of a partial or complete denture (impression, try-in, or delivery) to be rendered in a nursing facility or adult care home is granted ***only*** if it is accompanied by a completed **Supplement to Dental Prior Approval Form** (DHB 6022). The signature of the attending physician must be included. The facility is responsible for completing Section II of the form, securing the attending physician's signature, and retaining a copy of the form as part of the beneficiary's medical record. The treating dentist shall retain a copy and a copy must be submitted with the prior approval request. This form is intended to assist in the review of denture requests by the NCTracks Prior Approval Unit, to determine medical necessity, and to assess potential use of dentures by the beneficiary. Refer to **Attachment A, Dental Billing Guide,** for additional information and an example of the form.

7.5 Health Record Documentation

Providers are responsible for maintaining all financial, medical, and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of at least six years from the date of service, unless a longer retention period is required by federal or state law, regulations, or agreements. The provider shall furnish upon request appropriate documentation—including beneficiary records, supporting material, and any information regarding payments claimed by the provider—for review by NC Medicaid, its agents, the Centers for Medicare and Medicaid Services (CMS), the Medicaid Investigations Division of the NC Attorney General's Office, and other entities as required by law. Providers cannot charge for records requested by Medicaid.

The NC State Board of Dental Examiners applicable rule regarding patient records [21 NCAC 16T. 0101(a)] states that a dentist shall maintain complete treatment records on all patients treated for a period of at least 10 years. The complete rule is available for review at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2021%20-%20Occupational%20Licensing%20Boards%20and%20Commissions\Chapter%2016%20-%20Dental%20Examiners

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.6 Transfer of Beneficiary Dental Records

Providers are reminded to provide records of diagnostic quality when transferring dental records to another provider or directly to a beneficiary. Since bitewing radiographic images are allowed once a year and panoramic radiographic images and intraoral complete series of radiographic images are allowed once every five years, it is imperative that the images that are transferred are of diagnostic quality so the provider receiving the images can make a proper diagnosis regarding treatment.

The provider shall comply with 21 NCAC 16T.0102, Transfer of Records Upon Request, which states: *"A dentist shall, upon request by the patient of record, provide all information required by the Health Insurance Portability and Accountability Act (HIPAA) and this Rule, including original or diagnostic copies of radiographs and a legible copy of all treatment records to the patient or to a licensed dentist identified by the patient. The dentist may charge a fee not exceeding the actual cost of duplicating the records. The records shall be provided within 30 days of the request and production shall not be contingent upon current, past or future dental treatment or payment of services."*

Medicaid policy does not prohibit a dentist from charging a record duplication fee to a beneficiary, provided the same fee is charged to private-pay patients. Board rules do not set a maximum level for this duplication fee. When NC Medicaid or the DHHS Utilization Review Contractor requests records to verify medical necessity or accuracy of billing, providers do not receive compensation.

8.0 Policy Implementation and History

Original Effective Date: July 1, 2002
History:

Date	Section Revised	Change
10/01/2003	All sections and attachments	Implementation of CDT-4 procedure codes and style and grammar revisions.
02/01/2004	Primarily sections 1.0 and 5.3	Conversion from CPT to CDT-4 codes for selected surgical dental services; other minor policy clarifications have been incorporated in this revision.
07/01/2004	5.3.4, 5.3.5, 5.3.10, 8.4.3, and 8.4.5	Clarification of policy for codes D7280 and D7971; correction of minor typographical errors.
10/01/2004	5.0, 5.1, 5.3, 7.4, and 8.0	Added or deleted selected procedure codes; revised descriptions and/or coverage limitations on selected procedure codes; revised billing guidelines; general revisions throughout the policy to improve clarity, grammar, and style.
01/01/2005	Primarily sections 1.0 and 5.3	Implementation of CDT-2005 procedure codes.
02/01/2005	Section 5.3	Added procedure code D2933 that was inadvertently removed from the January 1, 2005, revision. Added statements regarding local anesthesia.
09/01/2005	Sections 2.3, 5.3, and 5.3.12	A special provision related to EPSDT was added.
09/01/2005	Section 5.3.10	Added criteria for frenectomy procedure codes.
12/01/2005	Section 2.3	The Web address for DMA's EPSDT policy instructions was added to this section.
12/01/2006	Section 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, 5.0, 8.5.6 and Attachment A12	Added a note regarding EPSDT to Sections 3.0, 4.0, and 5.0; corrected typographical errors in Section 8.5.6 and Attachment A.12.
01/01/2007	Sections 2.0, 5.3, 7.3, 8.5.6, and 9.0	Added statement related to the Family Planning Waiver; implemented CDT-2007/2008 procedure codes; revised coverage limitation for code D0320; revised age limitation for sealants on primary teeth for procedure code D1351; clarified resin-based composite restorations policy; added clarifying statements related to appliance and the Supplement to Dental Prior Approval Form (DMA 6022).
05/01/2007	Sections 2.3, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
05/01/2007	Section 8.5.8	Added UB-04 as an accepted claim form.
06/01/2007	Section 5.3.12	Revised to include the Non-Covered State Medicaid Plan Services Request Form for beneficiaries under 21 Years of Age.
06/01/2007	Section 8.2 and Attachment A (Dental Billing Guide)	Revised billing guidelines and the Dental Billing Guide to include NPI and the 2006 ADA Dental Claim Form.

Date	Section Revised	Change
05/01/2008	Section 5.1, 5.4.1, 5.4.6, 7.4	Added heading for ADA-Approved Materials; added procedure code D0145; corrected typographical error in 5.4.6; deleted "Medicaid Post-Payment Review" information and replaced it with "Medical Record Documentation."
10/01/2009	Sections 2.2, 4.2, 5.4, 5.4.1.2, 5.4.1.3, 5.4.2.3, 5.4.3.2, 5.4.4.1, 5.4.5.2, 5.4.6.3, 5.4.11.4, 7.6, 8.2.1, 8.2.2, 9.0, and Attachment A	Removed "pink" regarding the Medicaid for Pregnant Women Medicaid card; removed "blue" regarding the Family Planning Waiver Medicaid card; added statements regarding beneficiaries covered under the Medicare Qualified Beneficiaries program; added statements regarding beneficiaries covered under the Program of All-Inclusive Care for the Elderly (PACE) program; added "Specific Criteria" heading; updated CDT 2009/2010 procedure code descriptions; added age limitation for D0330; included override criteria for D0330 under six years of age; discontinued coverage of D1351 for premolars; revised the age limitations for D1351; removed policy limitation for D2393 to allow for primary molars; added D3222; added policy limitations for D4341 and D4342 to require periodontal charting and to allow no more than two quadrants on the same date of service; changed the language regarding requests to override the 10 year limit on dentures to require documentation signed by a physician; added additional guidance on the use of D9610; added coverage of D9612; added section on the transfer of beneficiary dental records; removed Field 58 as a required field on the ADA Dental Claim Form; made general revisions throughout the policy to improve clarity, grammar, and style; and incorporated standard statements where appropriate.
01/01/2011	Sections 1.0, 2.0, 3.0, 4.0, 5.0, 5.4.1.1, 5.4.1.2, 5.4.3.2, 6.0, 7.0, 8.0, and Attachment A	The following revisions are effective with date of service 12/1/2010 - Updated policy to standard DMA language; changed the EDS company name to HP throughout the document; correction of typographical error under procedure code D0170; added age limitation for D0210 and D0273; added limitation for posterior primary composites rendered on the same date of service; moved the information in Section 8 (Billing Guidelines) to Attachment A; and added clarifying statements for hospital dental admissions.
01/01/2011	Sections 5.4 and Attachment A	Added new CDT-2011/2012 procedure codes and updated procedure code descriptions effective with date of service 1/1/2011.

Date	Section Revised	Change
10/01/2011	Throughout	Session Law 2011-145 "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the NC Health Choice Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program." DMA was given the timeframe October 1, 2011 to March 12, 2012 to fully implement the NCHC transition to a Medicaid look-alike program.
11/01/2011	Section 5.4.3.1, 5.4.3.2, 5.4.3.3, 5.4.5.2, 5.4.6.2, and 5.4.6.3	Added limitation for posterior primary and permanent amalgams rendered on the same date of service; added limitation for posterior permanent composites rendered on the same date of service; clarification of policy for D2940; revised the policy limitations for D4341 and D4342 to once every 24 months; clarified the prior approval requirements for D4341 and D4342; revised the policy limitation for acrylic partial dentures (D5211 and D5212) to once every 8 years; and discontinued coverage of cast metal partial dentures (D5213 and D5214).
03/12/2012	All sections and attachments	Technical changes to merge Medicaid and NCHC current coverage into one policy.
03/01/2013	Sections 1.0, 5.2, 5.3, 5.3.2.2, 5.3.2.3, 5.3.3.2, 7.6, and Attachment A	Added new CDT-2013 procedure code D1208, deleted procedure codes D1203 and D1204, and updated procedure code descriptions effective with date of service 1/1/2013; changed the standard language of recipient to beneficiary throughout the document.
10/01/2015	All Sections and Attachments	Changed fiscal agent references from HP to CSC throughout the document; Added new CDT-2014 procedure codes D2949, D3355, D3356, and D3357; deleted procedure code D3354; and updated procedure code descriptions effective with date of service 1/1/2014; Updated CDT-2015 procedure code descriptions effective with date of service 1/1/2015; Updated place of service references to HIPAA standards; Updated instructions related to CSC processing; and updated electronic billing instructions for dental facility charges by an Ambulatory Surgical Centers (ASC).
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.

Date	Section Revised	Change
01/10/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/15/2023	2.3	Effective 4/1/2022, updated policy for dental services provided under the Medicaid for Pregnant Women (MPW) program. Removed "through the day of delivery". Added "extend to the last day of the month in which the twelfth month postpartum period ends".
12/15/2023	A.14	Effective 7/1/2022, updated the Medicaid copayment amount to $4.00.
12/15/2023	Related Clinical Coverage Policies	Effective 7/1/2022, 1A-16 Surgery of the Lingual Frenulum 1H Telehealth, Virtual Patient Communications, and Remote Patient Monitoring 1L-1 Anesthesia Services 1L-2 Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA) 4B Orthodontic Services
12/15/2023	Added Subsection 3.1.1	Effective 7/1/2022, Added, "As outlined in Section 5.0, select services within this clinical coverage policy may be provided via teledentistry. Services delivered via teledentistry must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring."
12/15/2023	5.3.3.3, A.2	Effective 7/1/2022, Dental COVID flexibilities which were made permanent. Allow application of silver diamine fluoride D1354 for all ages and all permanent teeth (1-32).
12/15/2023	5.3.13	Effective 7/1/2022, Added teledentistry (D9995 and D9996) limitations implemented during the dental COVID flexibilities that will continue permanently. Allow provider-to-provider teledentistry services D9995 and D9996 when reported with oral evaluation codes D0140 or D0170. Asynchronous teledentistry D9996 is limited to once per recipient, per provider for a one-week period. Limited to four teledentistry services (D9995 or D9996) in a six-month period.
12/15/2023	A.21	Effective 01/01/2023 Addition of HCPCS 2023 procedure code G0330 for facility services rendered in a dental ambulatory surgical center. Removed references to CDT codes with the "D" prefix.

Date	Section Revised	Change
12/15/2023	A.21	Effective 10/01/2023 Removed ambulatory surgical center facility charges priced based on total time using the four ASC groups. Effective 10/4/2023, claims are reimbursed based on the Ambulatory Surgical Center Fee Schedule.
12/15/2023	Table of Contents	Removed policy template language that does not apply to dental providers, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/15/2023	All Sections and Attachments	Updated policy template language. Updated due to CDT 2016, 2017, 2018, 2019, 2020, 2021, 2022, and 2023 additions, deletions, and revisions. Added D0414, D1354, D1355, D1516, D1517, D1575, D4346, D5511, D5512, D5611, D5612, D5621, D5622, D5876, D7509, D7961, D7962, D9222, D9223, D9239, D9243, D9613, D9995, and D9996. Deleted D0260, D0290, D1515, D2970, D5510, D5610, D5620, D5620, D7960, D9220, D9221, D9241, D9242, and D9630. Updated CDT 2023Copyright disclaimer.
12/15/2023	2.3	Added "Dental services are not covered for pregnant beneficiaries during the presumptive eligibility period."
12/15/2023	5.2.2, 5.2.3, 5.2.5	Added clarification language.
12/15/2023	5.2.6	Deleted subsection "Submitting a Treatment Plan" as redundant material.
12/15/2023	5.3.1	Replaced "ADA Council on Dental Therapeutics" to "ADA Council on Scientific Affairs" due to ADA revision.
12/15/2023	5.3.2.1	CDT Code D0170: Removed "Use as a follow-up exam for a specific problem that has been evaluated previously using D0140"; Added "Use as a follow-up exam for a specific problem that has been evaluated previously such as monitoring of a traumatic injury, evaluation of a soft tissue lesion, or evaluation of undiagnosed continuing pain."
12/15/2023	5.3.2.2	CDT Code D0240: Added "Only two allowed per date of service per beneficiary per provider."
12/15/2023	5.3.4.3	CDT Code D2940: Added "Use for placement of restorative material to protect the tooth, relieve pain, promote healing, or prevent further deterioration."
12/15/2023	5.3.5.2, 5.3.5.3	Added clarification language.
12/15/2023	5.3.5.4	CDT Codes D3351, D3352 and D3353: Added "For beneficiaries under 21 years of age, covered for permanent teeth; For beneficiaries 21 years of age and older, limited to permanent anterior teeth only, Not allowed for the same tooth on the same date of service as D3220, D3222, D3230, D3240, D3310, D3320, or D3330."

Date	Section Revised	Change
12/15/2023	5.3.5.5	CDT Codes D3355, D3356, D3357: Added "Limited to permanent teeth only."
12/15/2023	5.3.5.6	CDT Code D3410: Added "Limited to permanent anterior teeth only."
12/15/2023	5.3.6.1	CDT Codes D4210 and D4211: Added "Requires current diagnostic radiographic images of the proposed surgical site; Requires current diagnostic photographic images of the proposed surgical site"; CDT Codes D4240 and D4241: Added "Requires current diagnostic photographic images of the proposed surgical site";
12/15/2023	5.3.6.2	CDT Codes D4341 and D4342: Removed "Requires periodontal charting (pocket depth measurements must be abnormal in multiple sites)," and "Requires radiographic evidence of root surface calculus or noticeable loss of bone support"; Added "Requires periodontal charting (probing depth measurements must be abnormal in multiple sites) or radiographic evidence of bone loss." CDT Code D4355: Added "Requires documentation in the beneficiary's chart of extenuating circumstances that warrant the comprehensive oral evaluation (D0150) or detailed and extensive oral evaluation (D0160) to be rendered on the same date of service following the full mouth debridement (for example, hardship due to issues regarding transportation, health, work, school, childcare, etc.)."
12/15/2023	5.3.7	Added "Appliances **shall not** be authorized when extractions are not medically necessary" and guidance pertaining to delivery of appliances by an oral surgeon.
12/15/2023	5.3.7.1	Added clarification that payment for immediate dentures includes all adjustments necessary for six months after the date of delivery regardless of Medicaid or NCHC eligibility status. Removed "Note: Radiographs are not required when requesting prior approval for complete denture(s)."
12/15/2023	5.3.7.3	Added "physician extender" as qualified to submit medical documentation on behalf of the beneficiary.
12/15/2023	5.3.10	CDT Code D6985: Added "Use the delivery date as date of service when requesting payment, If the beneficiary's Medicaid or NCHC eligibility expires between the final impression date and delivery date, the provider shall use the final impression date as the date of service."
12/15/2023	5.3.11.2	CDT Code D7251: Added "Requires documentation of medical necessity. Requires documentation that the beneficiary was informed that a portion of the tooth remains."

Date	Section Revised	Change
12/15/2023	5.3.11.4	CDT Codes D7320 and D7321: Added "Requires current diagnostic photographic images of the proposed surgical site."
12/15/2023	5.3.11.6	Added "Note: A pathology report is required as an attachment to the claim for payment to receive reimbursement of any excision of lesion."
12/15/2023	5.3.11.7	Added "Note: A pathology report is required as an attachment to the claim for payment to receive reimbursement of any excision of lesion, cyst or tumor."
12/15/2023	5.3.11.8	CDT Code D7490: Added "Requires documentation of medical necessity; Requires a pathology report to be submitted as an attachment to the claim for payment."
12/15/2023	5.3.11.15	Added note regarding records information needed for combined orthognathic surgery and comprehensive orthodontic treatment and referenced the Clinical Coverage Policy 4B, Orthodontic Services. CDT Codes D7961, D7962, and D7963: Added "Requires current diagnostic photographic images of the proposed surgical site"; For D7962 and D7963: Added lifetime limit for lingual procedures; Clarified PA requirements; Added criteria for surgery of the lingual frenulum; Added conditions that allow lingual procedures under 1 year of age without prior approval. CDT Code D7979: Added "Not allowed on the same date of service as D7980." CDT Code D7980: Added "Not allowed on the same date of service as D7979."
12/15/2023	5.3.12.3	CDT Code D9410, removed "A dentist can be reimbursed for only one house call per date of service per facility, regardless of the number of beneficiaries seen on that day." Added "Includes visits to nursing facilities, long-term care facilities, adult care homes, hospice sites, institutions, etc.; A dentist can be reimbursed for one facility call per date of service for each beneficiary treated in the facility; Must be billed with other definitive treatment (other CDT codes) rendered on that date of service; Procedure codes for treatment must be billed on the detail lines before D9410 on the dental claim; Not allowed for post-surgical follow-up care or initial six months post-delivery care for appliances when other definitive treatment is not being rendered."
12/15/2023	6.2	Provider Certifications: Removed "None Apply." Added "To obtain a dental specialty taxonomy, the provider shall submit proof of the residency program completion and a copy of the specialty certification to NC Medicaid with the initial enrollment application or through a Manage Change Request (MCR) in the NCTracks Provider Portal."

Date	Section Revised	Change
12/15/2023	Added Subsection 6.3	Added Locum Tenens.
12/15/2023	Added Subsection 6.4	Added Change of Ownership (CHOW).
12/15/2023	A.1, Field 38	Added "02 = Telehealth" as the place of treatment for teledentistry claims.
12/15/2023	A.2	CDT Codes D1354, D1355, D2949, D3355, D3356 and D3357: Valid tooth numbers listed; CDT Codes D3351, D3352 and D3353: Removed A-T as valid tooth numbers.
12/15/2023	A.3	CDT Codes D1575, D5876, and D9613: Valid quadrant/arch indicators listed.
12/15/2023	A.7	Updated example to the 2019 ADA Dental Claim Form.
12/15/2023	A.8, Field 38	Added "02 = Telehealth" as the place of treatment for teledentistry claims.
12/15/2023	A.10	Updated example to the 2019 ADA Dental Claim Form.
12/15/2023	A.11	Updated example to the 2020 Supplement to Dental Prior Approval Form (DHB 6022).
12/15/2023	A.12	Added "Note: If fabrication of the denture has started but cannot be delivered before the prior approval effective end date due to unforeseen circumstances (sickness, transportation issues, etc.), an extension of the effective end date may be granted to the date of delivery. Contact NC Medicaid at 919-855-4280 for assistance obtaining an extension of the effective end date."
12/15/2023	A.22	Added CDT code D7979 to the list of codes that must be billed to Medicare.
12/15/2023	All Sections and Attachments	Updated policy template language
12/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 12/15/2023 with an effective date of 4/1/2023.

Attachment A: Dental Billing Guide

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

A.1 Instructions for Filing a Dental Claim

Prior to submitting electronic claims, providers shall enroll with NC Medicaid. The enrollment application is completed online via the NCTracks provider portal. To login to the provider portal you will need a North Carolina Identity (NCID). Reference the "Getting Started" page of the portal located at https://www.nctracks.nc.gov/content/public/providers/getting-started.html for step by step instructions.

Claims are expected to be submitted electronically. Only claims that comply with the exceptions on the NCTracks website at https://www.nctracks.nc.gov/content/public/providers/claims.html may be submitted on paper. Exceptions include time limit overrides, Medicare overrides, and certain adjustment requests.

For those claims that are required to be billed on paper, Medicaid accepts dental claims on the 2019 ADA Dental Claim Form. The following instructions are specific to that form. Paper dental claims ***must*** be completed in black ink only (do not highlight any portion of the claim) to allow the DHHS Utilization Review Contractor to image all dental claim forms electronically. List one procedure code per line on the claim form and no more than 10 codes per form.

The following fields ***must be completed as described*** to allow proper processing of dental claims on the 2019 ADA Dental Claim Form.

Field No.	Field Name	Explanation
1	Type of Transaction	Check the appropriate box: • Statement of Actual Services (claim) • Request for Predetermination/Preauthorization (prior approval request) • EPSDT/Title XIX
12	Name	Enter the beneficiary's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the beneficiary's date of birth using eight digits (example: May 7, 1965 – 05/07/1965).
14	Gender	Check the appropriate box: M=male, F=female, or U=unknown.
15	Subscriber Identifier	Enter the beneficiary's 10-digit identification number listed on the Medicaid card.
23	Patient ID/Account #	Enter the beneficiary's medical record number if used by your office. It will appear on your Remittance and Status Report (RA), if entered.
24	Procedure Date	Enter the date the procedure was completed using eight digits (example: November 1, 2019 – 11/01/2019).
25	Area of Oral Cavity	Enter a valid code for procedures that require a quadrant or arch indicator in field 25.

Field No.	Field Name	Explanation
27	Tooth Number(s) or Letter(s)	Enter a valid code for procedures that require a tooth number or letter.
28	Tooth Surface	Enter a valid code for procedures that require a tooth surface.
29	Procedure Code	Enter the five-digit dental procedure code for the service rendered. **Note:** All procedure codes must begin with the letter "D."
30	Description	Enter the description of the procedure.
31	Fee	**Enter your usual and customary charge for the procedure, *not* the established Medicaid fee.** For a schedule of rates, refer to: https://ncdhhs.servicenowservices.com/fee_schedules
31a	Other Fee(s)	If applicable, enter the amount of payment received from third-party insurance plan(s). ***Do not*** include any payments from Medicare Part B or allowable Medicaid co-payments.
32	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid co-payments or third-party insurance payments listed in field 31a. The DHHS Utilization Review Contractor will calculate the maximum amount payable by taking into account any co-payments or third-party payments.
35	Remarks	Enter the **billing provider's taxonomy**.
38	Place of Treatment	Enter the appropriate code (below) for the facility where the beneficiary was treated. Only one place of treatment can be entered per claim. 02 = Telehealth 03 = School 11 = Provider's Office 12 = Home 13 = Assisted Living Facility 14 = Group Home 15 = Mobile Unit 21 = Inpatient Hospital 22 = Outpatient Hospital 24 = Ambulatory Surgical Center 31 = Skilled Nursing Facility 32 = Nursing Facility 50 = Federally Qualified Health Center 54 = Intermediate Care Facility 71 = State or Local Public Health Clinic 72 = Rural Health Clinic
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and ZIP+4 code of the dentist or practice that is to receive payment.

Field No.	Field Name	Explanation
49	NPI	Enter the ***billing provider's NPI number*** of the dentist or practice that is to receive payment. • If payment is to be made to a ***group practice***, then enter the ***group NPI number***. • If payment is to be made to an ***individual dentist,*** then enter the ***individual dentist's NPI number***.
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
53	Signed (Treating Dentist), Date	Signature of the provider rendering the service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the beneficiary's oral health. The provider's signature on Medicaid documents and claims is binding and certifies that all information is accurate and complete." Enter the signature date using eight digits (example: December 1, 2019 – 12/01/2019.
54	NPI	Enter the ***attending provider's NPI number*** for the individual dentist rendering service. (This number must correspond to the signature in field 53.)
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and ZIP+4 code.
56a	Provider Specialty Code	Enter the **attending provider's taxonomy**.

If exceptions apply, mail claims to:
NCTracks Claims Unit
PO Box 30968
Raleigh, NC 27622

ADA Dental Claim Forms may be ordered directly from the ADA.
Website: http://ebusiness.ada.org/productcatalog

Address:
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611-2678

A.2 Procedures Requiring a Tooth Number

For the procedure codes listed below, a valid tooth number ***must*** be entered in the tooth number (field 27). Only the tooth numbers shown in the table are valid for the given procedure code.

Procedure Code	Valid Tooth Numbers
D1351	A, B, I-L, S, T, 2, 3, 14, 15, 18, 19, 30, 31
D1354	A-T, 1-32
D1355	2, 3, 14, 15, 18, 19, 30, 31
D2140	A-T, 1-32, AS-TS, 51-82
D2150	A-T, 1-32, AS-TS, 51-82
D2160	A-T, 1-32, AS-TS, 51-82
D2161	A-T, 1-32, AS-TS, 51-82
D2330	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2331	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2332	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2335	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2390	C-H, M-R, CS-HS, MS-RS
D2391	A, B, I-L, S, T, 1-5, 12-21, 28-32, AS, BS, IS-LS, SS, TS, 51-55, 62-71, 78-82
D2392	A, B, I-L, S, T, 1-5, 12-21, 28-32, AS, BS, IS-LS, SS, TS, 51-55, 62-71, 78-82
D2393	A, B, I-L, S, T, 1-5, 12-21, 28-32, AS, BS, IS-LS, SS, TS, 51-55, 62-71, 78-82
D2394	1-5, 12-21, 28-32, 51-55, 62-71, 78-82
D2930	A-T, AS-TS
D2931	2-5, 12-15, 18-21, 28-31
D2932	C-H, M-R, 6-11, 22-27, CS-HS, MS-RS, 56-61, 72-77
D2933	C-H, M-R, CS-HS, MS-RS
D2934	C-H, M-R, CS-HS, MS-RS
D2940	A-T, 1-32
D2949	A-T, 1-32
D2950	A-T, 1-32
D2951	A-T, 1-32
D3220	A-T, 1-32
D3222	1-32
D3230 D3240	C-H, M-R A, J, K, T

Procedure Code	Valid Tooth Numbers
D3310	6-11, 22-27
D3320	4, 5, 12, 13, 20, 21, 28, 29
D3330	2, 3, 14, 15, 18, 19, 30, 31
D3351	1-32
D3352	1-32
D3353	1-32
D3355	1-32
D3356	1-32
D3357	1-32
D3410	6-11, 22-27
D5520	1-32
D5630	1-32
D5640	1-32, C-H
D5650	1-32
D5660	1-32
D7111	A-T, AS-TS
D7140	A-T, 1-32, AS-TS, 51-82
D7210	A-T, 1-32, AS-TS, 51-82
D7220	A-T, 1-32, AS-TS, 51-82
D7230	A-T, 1-32, AS-TS, 51-82
D7240	A-T, 1-32, AS-TS, 51-82
D7241	A-T, 1-32, AS-TS, 51-82
D7250	A-T, 1-32, AS-TS, 51-82
D7251	A-T, 1-32, AS-TS, 51-82
D7270	A-T, 1-32
D7280	A-T, 1-32
D7283	A-T, 1-32
D7971	A-T, 1-32

A.3 Procedures Requiring a Quadrant or Arch Indicator

For the procedure codes listed below, a valid quadrant or arch indicator ***must*** be entered in the area of oral cavity (field 25). Absence of a valid indicator on the claim form shall result in denial of payment for that procedure. Only the indicators shown in the table below are valid for the given procedure code. Valid quadrant indicators are **UL** (upper left), **UR** (upper right), **LL** (lower left), and **LR** (lower right). Valid arch indicators are **UP** (upper/maxillary arch) and **LO** (lower/mandibular arch).

Procedure Code	Valid Quadrant/Arch Indicator
D1510	UR, UL, LL, LR
D1575	UR, UL, LL, LR
D4210	UR, UL, LL, LR
D4211	UR, UL, LL, LR
D4240	UR, UL, LL, LR
D4241	UR, UL, LL, LR
D4341	UR, UL, LL, LR
D4342	UR, UL, LL, LR
D5876	UP, LO
D7310	UR, UL, LL, LR
D7311	UR, UL, LL, LR
D7320	UR, UL, LL, LR
D7321	UR, UL, LL, LR
D7340	UP, LO
D7350	UP, LO
D7471	UP, LO
D9613	UR, UL, LL, LR

A.4 Procedures Requiring a Tooth Surface(s)

For the procedure codes listed below, a valid tooth surface(s) ***must*** be entered in the tooth surface (field 28). Absence of valid tooth surface(s) on the claim form shall result in denial of payment for that procedure. Valid tooth surface codes are **M** (mesial), **O** or **I** (occlusal/incisal), **D** (distal), **F** or **B** (facial/buccal), and **L** (lingual).

Procedure Code	Valid Tooth Surfaces
D2140	M, I or O, D, F or B, L
D2150	M, I or O, D, F or B, L
D2160	M, I or O, D, F or B, L
D2161	M, I or O, D, F or B, L
D2330	M, I, D, F or B, L
D2331	M, I, D, F or B, L
D2332	M, I, D, F or B, L
D2335	M, I, D, F or B, L
D2391	M, O, D, F or B, L
D2392	M, O, D, F or B, L
D2393	M, O, D, F or B, L
D2394	M, O, D, F or B, L

A.5 Billing for Supernumerary Teeth

The American Dental Association has determined that supernumerary teeth are to be coded based on the natural tooth space to which they are nearest. In the permanent dentition, use tooth numbers 51 through 82 beginning in the upper right third molar area and continuing around the upper and then the lower arches. In the primary dentition, an "S" is added after the normal tooth letter, so that supernumerary teeth are numbered from AS to TS beginning in the upper right primary second molar area**.**

A.6 Billing for Assistant Surgeon Fees

Reimbursement for assistant surgeon fees is determined on a case-by-case basis. Submit a prior approval request clearly marked "assistant surgeon," list each procedure code in which the assistant participated, include the date of service (date the surgery was performed), and attach a copy of the operative notes.

Enter a prior approval request in the NCTracks Prior Approval Portal or mail the request to the address listed below.

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC. 27622

A.7 Example of a Completed Dental Claim

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5 -11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender [ ] M [ ] F [ ] U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Baker, Frances

13. Date of Birth (MM/DD/CCYY): 05/07/1965 | 14. Gender [ ] M [X] F [ ] U | 15. Policyholder/Subscriber ID (Assigned by Plan): 598994859H

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender [ ] M [ ] F [ ] U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/01/2019					D0120			Periodic oral evaluation	40.00
2	11/01/2019					D1110			Prophylaxis - adult	85.00
3	11/01/2019					D0274			Bitewings - two films	75.00
4	11/01/2019			30	MO	D2392			Resin-based composite – two surfaces	175.00
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 **8 9** 10 11 12 13 14 15 16
32 31 30 29 28 27 26 **25 24 23 22** 21 **20 19 18 17**

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis is "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee: 375.00

35. Remarks
XXXXXXXXXX

AUTHORIZATIONS

36. I have been informed **of the treatment plan and associated fees. I agree to be** responsible for all charges for **dental services and materials not paid by my** dental **benefit** pla , unless prohibited by law, or the **treating dentist or dental practice has a contractual** agreement with my plan prohibiting all or a portion **of such charges. To the extent permitted by law, I** consent to your use and disclosure of my **protected health information to carry out payment activities in** connection with this claim.

X _____
Patient/Guardian **Signature** Date

37. I hereby authorize **and direct payment of the dental** benefits otherwise payable to me, directly to the below named **dentist or dental entity.**

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

Dr. John Hancock
567 Any Street
City, NC 27777-7777

49. NPI: 9999999999 | 50. License Number | 51. SSN or TIN

52. Phone Number: (919) 000-0000 | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis [ ] No [ ] Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X *John Hancock, DDS* *12/01/2019*
Signed (Treating Dentist) Date

54. NPI: 9999999999 | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code: XXXXXXXXXX

Dr. John Hancock
567 Any Street, City, NC 27777-7777

57. Phone Number: (919) 000-0000 | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

A.8 Instructions for Submitting a Prior Approval Request

Prior approval requests are expected to be submitted electronically. In the event a written request must be submitted, the following fields ***must be completed as described*** to allow proper processing of prior approval requests on the 2019 ADA Dental Claim Form. List one procedure code per line on the claim form, and no more than 10 codes per form. **Do not list fees;** prior approval applies only to procedures, not to reimbursement amounts.

Field No.	Field Name	Explanation
1	Type of Transaction	Check the appropriate box: • Statement of Actual Services (claim) • Request for Predetermination/Preauthorization (prior approval request) • EPSDT/Title XIX
12	Name	Enter the beneficiary's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the beneficiary's date of birth using eight digits (example: May 7, 1965 – 05/07/1965).
14	Gender	Check the appropriate box: M=male, F=female, or U=unknown.
15	Subscriber Identifier	Enter the beneficiary's 10-digit identification number listed on the Medicaid card.
25	Area of Oral Cavity	Enter a valid code for procedures that require a quadrant or arch indicator in field 25.
27	Tooth Number(s) or Letter(s)	Enter a valid code for procedures that require a tooth number or letter.
29	Procedure Code	Enter the five-digit dental procedure code. **Note:** All procedure codes must begin with the letter "D."
30	Description	Enter the description of the procedure.
33	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
35	Remarks	Enter the **billing provider's taxonomy**.

Field No.	Field Name	Explanation
38	Place of Treatment	Enter the appropriate code (below) for the facility where the beneficiary was treated. Only one place of treatment can be entered per claim. 02 = Telehealth 03 = School 11 = Provider's Office 12 = Home 13 = Assisted Living Facility 14 = Group Home 15 = Mobile Unit 21 = Inpatient Hospital 22 = Outpatient Hospital 24 = Ambulatory Surgical Center 31 = Skilled Nursing Facility 32 = Nursing Facility 50 = Federally Qualified Health Center 54 = Intermediate Care Facility 71 = State or Local Public Health Clinic 72 = Rural Health Clinic
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and ZIP+4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the ***billing provider's NPI number*** of the dentist or practice that is to receive payment. • If payment is to be made to a ***group practice***, then enter the ***group NPI number***. • If payment is to be made to an ***individual dentist,*** then enter the ***individual dentist's NPI number***.
52	Phone Number	Enter the area code and telephone number of the billing dentist or practice.
53	Signed (Treating Dentist), Date	Signature of the dentist requesting approval. PA requests ***require*** an original signature or signature stamp to certify that: "Services for which payment is requested are medically necessary and indicated in the best interest of the beneficiary's oral health. The provider's signature on Medicaid documents and claims is binding and certifies that all information is accurate and complete." Approval constitutes only medical approval for services. Eligibility for care must be verified for the beneficiary for the month in which services are provided. Enter the signature date using eight digits (example: December 1, 2019 – 12/01/2019.

Field No.	Field Name	Explanation
54	NPI	Enter the ***attending provider's NPI number*** for the individual dentist rendering service. (This number must correspond to the signature in field 53.)
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and ZIP+4 code.
56a	Provider Specialty Code	Enter the **attending provider's taxonomy**.

A.9 Provider Numbers for Prior-Approved Services

A. Individual Practice

Prior approvals granted to an **individual practice** are issued to the attending dentist's individual National Provider Identifier (NPI).

a. When requesting prior approval for service, the dentist must enter that individual NPI as the billing and attending NPI (fields 49 and 54).
b. When filing a claim for payment for these services, the dentist must enter that individual NPI as the billing and attending NPI (fields 49 and 54).

B. Group Practice

Prior approvals granted to a **group practice** are issued to the group National Provider Identifier (NPI). This allows any dentist enrolled with Medicaid as a member of that group to render the prior-approved services.

a. When requesting prior approval for services, the dentist must enter the group NPI in field 49.
b. When filing a claim for payment for these services, the dentist must enter that group NPI as the billing NPI (field 49). Such claims also must include the individual NPI of the dentist who actually rendered treatment as the attending NPI (field 54).

A.10 Example of a Completed Prior Approval Request

ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☒ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Baker, Frances

13. Date of Birth (MM/DD/CCYY): 05/07/1965
14. Gender: ☐ M ☒ F ☐ U
15. Policyholder/Subscriber ID (Assigned by Plan): 598994859H

16. Plan/Group Number
17. Employer Name

OTHER COVERAGE (Mark applicable box and complete items 5 -11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F ☐ U
8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F ☐ U
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1		UR				D4341			Periodontal scaling & root planing	
2		UL				D4341			Periodontal scaling & root planing	
3		LR				D4342			Periodontal scaling & root planing	
4		LL				D4342			Periodontal scaling & root planing	
5		UP				D5211			Maxillary partial denture – resin base	
6		LO				D5212			Mandibular partial denture – resin base	
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 ☒ 2 3 4 5 6 ☒ ☒ ☒ ☒ 11 12 13 14 15 ☒
32 ☒ ☒ ☒ ☒ ☒ 27 26 25 24 23 22 ☒ ☒ ☒ ☒ ☒ ☒

34. Diagnosis Code List Qualifier (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

31a. Other Fee(s)
32. Total Fee

35. Remarks
XXXXXXXXXX

AUTHORIZATIONS

36. I have been informed **of the treatment plan and associated fees. I agree to be** responsible for all charges for **dental services and materials not paid by my** dental **benefit** pla , unless prohibited by law, or the **treating dentist or dental practice has a contractual** agreement with my plan prohibiting all or a portion **of such charges. To the extent permitted by law,** I consent to your use and disclosure of my **protected health information to carry out payment activities in** connection with this claim.

X _____
Patient/Guardian **Signature** Date

37. I hereby authorize **and direct payment of the dental** benefits otherwise payable to me, directly to the below named **dentist or dental entity.**

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment
43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Dr. John Hancock
567 Any Street
City, NC 27777-7777

49. NPI: 9999999999
50. License Number
51. SSN or TIN
52. Phone Number: (919) 000-0000
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X John Hancock, DDS 12/01/2019
Signed (Treating Dentist) Date

54. NPI: 9999999999
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code: XXXXXXXXXX
Dr. John Hancock
567 Any Street, City, NC 27777-7777
57. Phone Number: (919) 000-0000
58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

A.11 Supplement to Dental Prior Approval Form (DHB 6022)

This form is available in NCTracks at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html. Refer to Subsection 7.4 for additional information.

NORTH CAROLINA MEDICAID PROGRAM
SUPPLEMENT TO DENTAL PRIOR APPROVAL FORM

FULL DENTURE / PARTIAL DENTURE REQUEST			
I. THIS FORM MUST ACCOMPANY ANY PRIOR APPROVAL REQUEST FOR FULL OR PARTIAL DENTURES TO BE DELIVERED IN A LONG-TERM CARE FACILITY (E.G., SKILLED NURSING FACILITY, INTERMEDIATE CARE FACILITY, ADULT CARE HOME).			
PATIENT'S NAME (Last, First, Middle)	DATE OF BIRTH (MM/DD/YY)	SEX	MEDICAID ID NUMBER
II. THIS PORTION TO BE COMPLETED BY FACILITY STAFF			
FACILITY / ADDRESS / TELEPHONE NUMBER			
ATTENDING PHYSICIAN / TELEPHONE NUMBER	RELATIVE NAME / ADDRESS / TELEPHONE NUMBER		
DIAGNOSIS / PRIMARY / SECONDARY	MEDICATIONS		
PATIENT INFORMATION (Describe briefly)			
LEVEL OF DISORIENTATION:			
PERSONAL CARE ASSISTANCE:			
ACTIVITIES/SOCIAL:			
TYPE OF DIET:			
CAN PATIENT COMMUNICATE NEEDS?			
PROGNOSIS:			
COMMENTS: _____			
COMPLETED BY: _____ TITLE: _____ DATE: _____			
III. THIS PORTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN			
STATEMENT: IN MY OPINION THIS PATIENT IS ABLE TO TOLERATE DENTURES. THIS PATIENT DESIRES DENTURES. THIS PATIENT NEEDS DENTURES FOR AN IMPROVED QUALITY OF LIFE.			
ATTENDING PHYSICIAN (Signature): _____ DATE: _____			
IV. THIS PORTION TO BE COMPLETED BY THE ATTENDING DENTIST			
STATEMENT: BASED ON ORAL EXAMINATION FINDINGS AND AN EVALUATION OF THIS PATIENT'S POTENTIAL TO UTILIZE DENTURES IT IS MY OPINION THAT DENTURES SHOULD BE PROVIDED. I WILL PROVIDE POST-OPERATIVE CARE FOLLOWING DENTURE INSERTION TO THE PATIENT AS NEEDED IN ACCORDANCE WITH MEDICAID GUIDELINES.			
ATTENDING DENTIST (Signature): _____ DATE: _____			

DHB–6602 (Revised 2020)

A.12 Billing for Partial and Complete Dentures

Providers must use the **date of delivery** as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed and delivered. Therefore, claims for complete or partial dentures ***must not*** be filed until the date the appliances are delivered to the beneficiary. Medicaid payment may be recouped for claims filed using a date other than the delivery date.

Note: If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service. This exception is allowed ***only*** when the dentist has completed the final impression on a date for which the beneficiary is eligible ***and*** has actually delivered the denture(s). The delivery date ***must*** be recorded in the beneficiary's chart.

Note: If fabrication of the denture has started but cannot be delivered before the prior approval effective end date due to unforeseen circumstances (sickness, transportation issues, etc.), an extension of the effective end date may be granted to the date of delivery. Contact NC Medicaid at 919-855-4280 for assistance obtaining an extension of the effective end date.

A.13 Billing for Non-deliverable Partial and Complete Dentures

Dentists shall make every effort to schedule partial and complete denture delivery ***before*** requesting payment for a non-deliverable denture. This must include contact with the beneficiary's county social worker, who must be allowed at least two weeks to assist in scheduling an appointment for denture delivery. If a reasonable time has elapsed and circumstances beyond the dentist's control prevent denture delivery, then a claim for payment of non-deliverable dentures may be filed. The dentist shall submit the following:

a. A completed claim form clearly marked "Non-deliverable dentures"
b. Any supporting material documenting the reason for non-delivery
c. A copy of the lab bill indicating a charge for the dentures
d. A copy of the dental record indicating dates and methods by which the beneficiary was notified and dates of any appointments for impressions or try-ins

These claims must be sent to NC Medicaid at the address listed below.

NC Medicaid Dental Program – 20
2501 Mail Service Center
Raleigh, NC 27699-2501

Reimbursement is determined on a case-by-case basis. The dentist shall retain the dentures, lab work orders, lab bills, and record documentation for six years as proof that dentures were constructed. Dentures ***must not*** be mailed to NC Medicaid.

A.14 Co-Payment Amounts for Medicaid Beneficiaries

Medicaid beneficiaries (except as listed below) are responsible for a $4.00 co-payment for each visit to the dentist. For services billed under one procedure code, only one co-payment may be collected even if the procedure requires more than one visit. The following categories of dental service are ***exempt*** from any co-payment:

a. Services for beneficiaries under 21 years of age

b. Services provided to Medicaid for Pregnant Women (MPW) beneficiaries
c. Services delivered in a hospital emergency department
d. Services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MRs), or state-owned psychiatric hospitals
e. Services provided to participants in a Community Alternatives Program (CAP)
f. Services covered by both Medicare and Medicaid

For Medicaid refer to Medicaid State Plan:

https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

A.15 Billing of Medicaid Beneficiaries

If a Medicaid beneficiary needs a dental service that is not covered by Medicaid, the provider shall discuss this with the beneficiary in advance and handle any payments the same way as for a private-pay patient. Medicaid beneficiaries may not be billed for missed or broken appointments or for the difference between the billed amount and the amount paid by Medicaid or other third-party insurance carrier. Also, the provider may not bill the beneficiary when Medicaid denies payment because the provider failed to follow Medicaid policy.

A.16 Billing for Clinic Dental Services

Dental services rendered at Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), local health departments, or outpatient hospital dental clinics must be billed on the ADA Dental Claim Form using 2023 CDT dental procedure codes. These facilities shall indicate "office" as the place of treatment (field 38). FQHCs shall bill using the appropriate dental provider number, designated by a "D" as the last or seventh digit. Services that require prior approval are handled in the usual manner as described in **Subsection 5.2, Prior Approval Requirements,** regardless of the type of clinic or office setting.

A.17 Billing for Inpatient and Outpatient Hospital Emergent or Urgent Dental Admissions

If a Medicaid beneficiary is physically unmanageable, medically compromised, or severely developmentally delayed and will not cooperate for treatment in the dental office, treatment may be completed in the inpatient or outpatient hospital setting. "Emergent" hospital admissions are those necessary to prevent death or permanent health impairment for a Medicaid beneficiary. "Urgent" admissions are those necessary when a beneficiary's condition requires immediate treatment that cannot wait for normal scheduling. Hospitals ***do not*** need prior approval for either emergent or urgent dental admissions. In form locator 14 on the UB-04 form, enter admission type "1" for emergent admissions and admission type "2" for urgent admissions.

A.18 Billing for Inpatient or Outpatient Hospital Dental Admissions for Community Care of North Carolina and Carolina ACCESS Beneficiaries

Hospitals shall obtain authorization from the primary care provider (PCP) before admitting Community Care of North Carolina (CCNC/Carolina ACCESS) beneficiaries for inpatient dental treatment. The PCP's name, address, and telephone number are listed on the beneficiary's Medicaid card.

For paper claims on the UB-04 claim form, enter the PCP NPI referral authorization or the CCNC/Carolina ACCESS override number with the 1D qualifier in form locator 78. For electronic claims, enter the PCP NPI referral authorization in form locator 11.

Note: Dentists rendering services in an inpatient hospital setting shall obtain prior approval for any dental service that requires prior approval.

A.19 Billing for Dental Treatment in an Ambulatory Surgical Center

If a Medicaid beneficiary is physically unmanageable, medically compromised, or severely developmentally delayed and will not cooperate for treatment in the dental office, treatment may be completed in an ambulatory surgical center (ASC). Dental providers enter "24" under place of treatment in field 38 on the 2019 ADA Dental Claim Form. Services that normally require prior approval are handled in the usual manner.

A.20 Billing for Anesthesia Services in an Ambulatory Surgical Center

Anesthesiologists and certified registered nurse anesthetists (CRNAs) bill for anesthesia services rendered in ambulatory surgical centers using a CMS-1500 claim form. Claims are paid based on total anesthesia time. Anesthesia time begins when the anesthesiology provider prepares the beneficiary for induction of anesthesia and ends when the beneficiary can be placed under postoperative supervision and the anesthesiology provider is no longer in personal attendance.

Providers must complete the CMS-1500 claim form as follows:

a. Enter a dental ICD-10-CM diagnosis codes in block 21.
b. Enter place of service code "24" for the ambulatory surgical center in block 24B.
c. Enter CPT anesthesia code "00170" *(anesthesia for intraoral procedures, including biopsy; not otherwise specified)* in block 24D.
d. Enter one of the following modifiers in block 24D:
   QX—Services performed by CRNA with medical direction by a physician
   QZ—Services performed by CRNA without medical direction by a physician
   QY—Medical direction of one CRNA by an anesthesiologist
   QK—Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
   AA—Anesthesia services performed personally by anesthesiologist
   QS—Monitored anesthesia care service (must be billed along with one of the modifiers listed above)
e. Enter total anesthesia time in minutes in block 24G on the claim form.

A.21 Billing for Facility Charges by an Ambulatory Surgical Center

The Ambulatory Surgical Center (ASC) must submit claims for dental facility use with an **electronic professional CMS-1500 claim** in NCTracks. Paper claims are not accepted.

Providers must complete the claim as instructed below:

a. Enter the place of service code as "24" for the Ambulatory Surgical Center.
b. Enter HCPCS procedure code "G0330" (Facility services for dental rehabilitation procedure(s) performed on a beneficiary who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room).
c. Enter modifier SG with the procedure code.
d. **Enter the total of all usual and customary facility charges on detail line 1 of the claim.**
e. **Enter the total operating room time on detail line 1 of the claim (1 unit = 1 minute). Inclusion of this data on the claim is for informational purposes only.**

These claims are reimbursed based on the Ambulatory Surgical Center Fee Schedule located at https://ncdhhs.servicenowservices.com/fee_schedules.

A.22 Billing for Services Covered by Medicare and Medicaid

Federal law mandates that Medicaid be the payer of last resort when beneficiaries are covered by both Medicare and Medicaid. According to the *Medicare Benefit Policy Manual* published by CMS, Medicare ***does not cover*** "services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth…. 'Structures directly supporting the teeth' means periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process."

Medicare Part B ***does*** cover certain oral surgical services performed by dentists or oral surgeons as long as they are not provided primarily for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Examples of Medicare-covered services include extractions in preparation for radiation therapy, reduction of jaw fractures, and removal of tumors of the jaw.

Services that are ***not covered*** by Medicare but ***are covered*** by Medicaid shall be filed directly with Medicaid on the 2019 ADA Dental Claim Form. Services ***covered*** by Medicare and performed either in the emergency room or in the office must first be filed with the Medicare Part B carrier using the CMS-1500 claim form.

Note: For dually eligible Medicare and Medicaid beneficiaries, dental services covered by Medicare ***do not*** require Medicaid prior approval.

The dental services listed below must be filed first with the beneficiary's Medicare Part B carrier on a CMS-1500 claim form. Typically, it is necessary to file such Medicare claims using *Current Procedural Terminology* (CPT) codes, published by the American Medical Association; therefore, convert the CDT codes shown here to CPT codes.

D7285	D7465	D7740	D7872	D7948
D7286	D7490	D7750	D7873	D7949
D7288	D7540	D7760	D7910	D7950
D7410	D7610	D7780	D7911	D7955
D7411	D7620	D7810	D7912	D7979
D7412	D7630	D7820	D7920	D7980
D7413	D7640	D7830	D7940	D7981
D7414	D7650	D7840	D7941	D7982
D7415	D7660	D7850	D7943	D7983
D7440	D7680	D7858	D7944	D7990
D7441	D7710	D7860	D7945	D7991
D7460	D7720	D7865	D7946	
D7461	D7730	D7870	D7947	

Professional claims filed to Medicare as the primary payer should be crossed over automatically to Medicaid. In order for the crossover claim to process, the NPI on the Medicare claim must be on file for a North Carolina Medicaid Provider Number (MPN). It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction by completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at http://wpc-edi.com and the NC Medicaid HIPAA Companion Guide on NC Medicaid's website at https://medicaid.ncdhhs.gov/draft-daily-weekly-eb-monthly-834o-companion-guide-20190605-v2-0/open for instructions on completing the 837 professional transaction.

Claims that do not cross over, have been paid by Medicare, and are included on the electronic submission exceptions list at https://www.nctracks.nc.gov/content/public/providers/claims.html can be filed on a CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached. If claims do not cross over, have been paid by Medicare, and are not included on the electronic submission exceptions list, the claims must be submitted electronically.

When the procedure(s) is denied by Medicare, the provider shall submit the comparable 2023 CDT code(s) directly to Medicaid on a paper 2019 ADA Dental Claim Form with the Medicare voucher and Medicaid Resolution Inquiry form attached. This will allow the claim to process appropriately according to NC Medicaid policy.