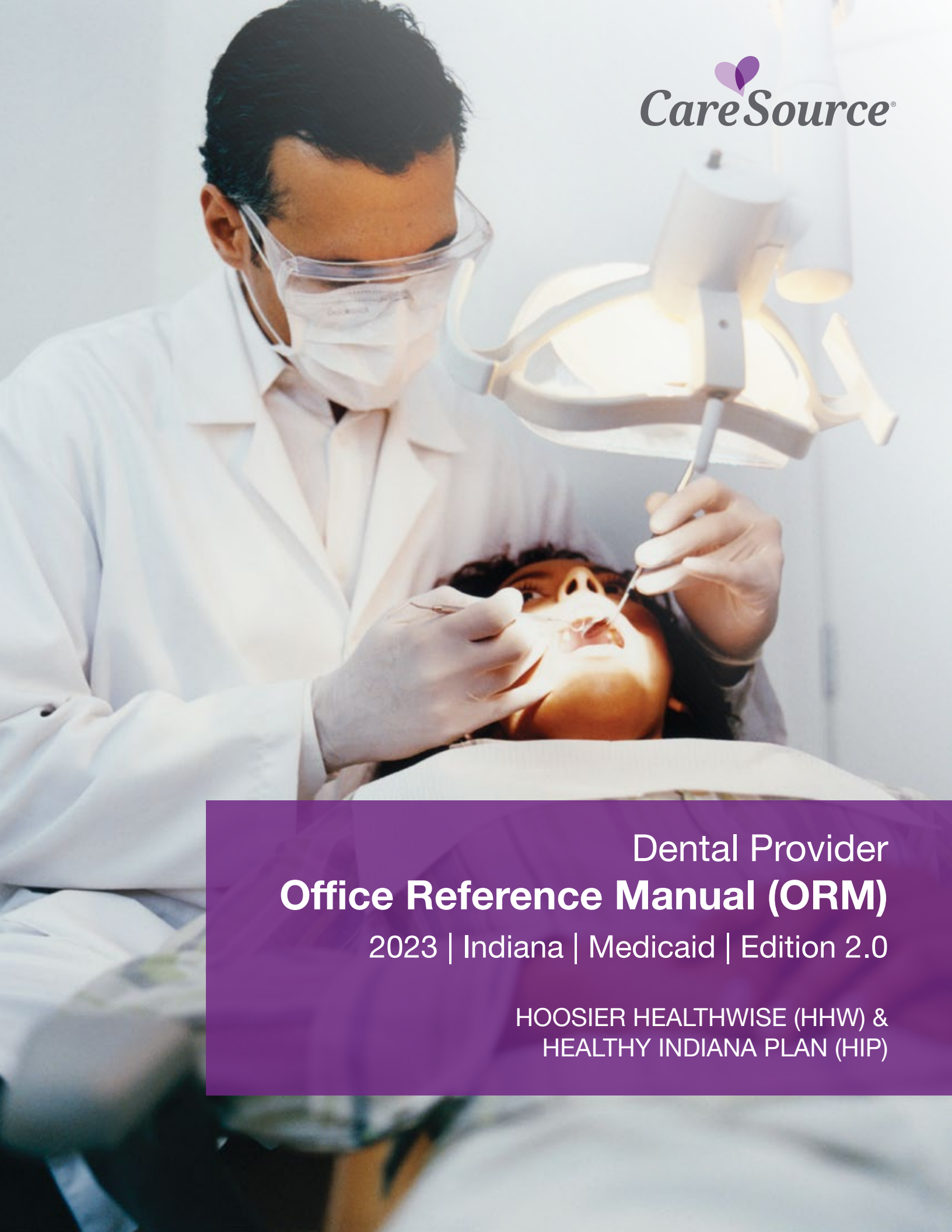


CareSource®

Dental Provider
Office Reference Manual (ORM)

2023 | Indiana | Medicaid | Edition 2.0

HOOSIER HEALTHWISE (HHW) &
HEALTHY INDIANA PLAN (HIP)

Dear CareSource® Dental Provider,

Thank you for being a leader in your community by caring for children and adults in partnership with Indiana Medicaid programs. CareSource welcomes your participation with our Indiana community and is pleased you have joined our **CareSource Provider Network**. CareSource is nationally recognized for leading the industry in providing member-centric health care coverage.

At CareSource, our goal is to help you improve and maintain the oral health and offer a better quality of life to our members. We are committed to providing accessible, quality, comprehensive oral health care for our members, in a cost-effective and efficient manner. We realize that to do so, strong partnerships with our providers are critical, and we value our relationship as an important mission, working continuously to strengthen that partnership.

The CareSource Dental/Oral Health Office Reference Manual (ORM) is designed as part of an initiative to improve efficiency and consistency in our care management services. Intended to be a comprehensive resource for you and a helpful link between your office and CareSource. Here you will find the tools and information needed to successfully administer the CareSource dental plans. It provides important information on topics such as covered services, claim submissions, attachment guidelines, coordination of benefits, services that require prior authorization and how to submit a prior authorization. We want to make your experience not only pleasant and gratifying by providing information about policies and process, to make billing easy and payment timely, but also, we hope to lessen administrative burden and make it easier for you to do business with us. We will continue to update information periodically and as changes and new information arise, we will send these updates to you or invite you to view additional information such as policies, newsletters, and other information via our website at **CareSource.com**.

Through our partnership with SKYGEN USA (formerly Scion Dental), we offer enhanced functionality for our dental providers. For your convenience, we offer access and availability to a secure online portal 24 hours a day. You will find a variety of tools available for web-based transactions. The SKYGEN web portal features an online provider inquiry tool for real-time eligibility, claims, and authorization management electronically. We encourage you to enroll for electronic funds transfer (EFT) to ensure faster payment. You can access the portal at https://pwp.sciondental.com/PWP/Landing.

If you have inquiries about claim issues, covered services, patient eligibility or other member-related concerns, please check our website or contact CareSource Provider Services at **1-844-607-2831**, 7 a.m. to 7 p.m., Monday through Friday, Eastern Standard Time.

Oral health is an integral part of overall health, and it is important for our members. Thank you for being a **"Health Care with Heart Provider"**. We know you have a choice, and we are pleased that you are part of our **network**.

Sincerely,

CareSource®
Health Care with Heart

CARESOURCE DENTAL INDIANA MEDICAID

At CareSource®, our goal is to help you improve and maintain the oral health of our members. This guide for our Dental Providers, shares general information and requirements on key administrative processes and includes an overview of covered services and authorizations. This Quick Reference section does not replace the detailed information and complete guidelines in the **CareSource Dental Office Reference Manual.**

Quick Reference Guide 2023

Covered Dental Services

HEALTHY INDIANA PLAN (HIP)

Members enrolled in HIP Plus, HIP State Plan – Plus, and HIP State Plan – Basic are eligible for dental benefits. In general, members enrolled in HIP Basic are not eligible for dental benefits. HIP Basic members of age 19- 20 are eligible for medically necessary services, as detailed in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch program and some limited preventive dental services. Pregnant women enrolled in HIP receive same services as HIP STATE PLAN. Enrollment and benefit eligibility should be confirmed for each Member.

HIP STATE PLAN – BASIC
HIP STATE PLAN – PLUS
Age 19 - 64

- Oral Evaluations
- Dental Cleanings and Preventive Services
- Radiographs
- Minor Restorative (fillings)
- Prefabricated Crowns and Root canals
- Periodontal Services
- Extractions and other oral surgery
- Partials, Complete Dentures and Repairs
- Sedation and General Anesthesia
- Orthodontics (up to age 20)
- Tobacco Counseling Services

HIP State Plan Basic $4 Co-Payment for non-exempt Members and for Service Categories other than Diagnostic and Preventive

HIP PLUS
Age 19 - 64

- Oral Evaluations
- Dental Cleanings
- Radiographs
- Minor Restorative (fillings)
- Extractions
- Major Restorative (i.e., prefabricated crowns
- Tobacco Counseling Services

HIP BASIC*
Age 19 or 20 (EPSDT)*

- Oral Evaluations Routine
- Radiographs
- Dental cleanings
- Fluoride
- EPSDT Services Age 19 or 20 (EPSDT)*

Age, frequencies, and limits may apply to some services

HOOSIER HEALTHWISE (HHW)

Both pregnant women and children (Package A) and Children Package C-(CHIP) who are enrolled in Hoosier Healthwise are covered for dental services

- Oral Evaluations
- Radiographs
- Dental cleanings and Preventive services
- Minor Restorative services (fillings)
- Prefabricated Crowns and Root canals
- Periodontal services
- Extractions and other oral surgery
- Partials, Complete Dentures and Repairs
- Orthodontics (Braces) (up to age 20)
- Sedation and General
- Anesthesia
- Tobacco Counseling Services

Age, frequencies, and limits may apply to some services

CareSource offers some Enhanced Dental Benefits for HIP and HHW Members. See Benefit Coverage guide for details

Dental Services That Require Prior Authorization*

- Periodontal Services and some Endodontic Surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Dentures (complete and partial) ≥ Age 21
- Sleep Apnea Appliances
- Frenectomy and Corticotomy
- General anesthesia and sedation ≥ Age 21
- Repairs and relines of dentures (complete and partial) for members ≥ Age 21
- Orthodontics

** Some dental services may require PA for specific age groups. Some services may require post treatment /prepayment review. Any unspecified services by report require prior authorization. The provider manual should be consulted for specific prior authorization requirements.*

Member Eligibility Verification

Providers are expected to verify member eligibility each time before a service is rendered. The CareSource Provider Portal can be used to verify member eligibility, the SKYGEN Provider Portal or check enrollee eligibility through the Eligibility Verification System (EVS) Web Interchange, which is managed by the state's fiscal agent.

Contracting and Credentialing

In partnership with the State of Indiana, CareSource must certify that all of its network providers are eligible and enrolled with IHCP. Providers can contract and credential with CareSource via our contracting portal at: https://www.caresource.com/in/providers/education/become-caresource-provider/medicaid/

If you have any questions related to the contracting process or need assistance, you can contact your dedicated Dental Health Partner/Provider Contracting Manager for your region, Provider Services or for any questions not answered on our website or policy manuals, contact the Indiana Provider Relations team at **1-844-607-2831**.

Provider Portal

CareSource offers a Dental Provider Web Portal through our partnership with Skygen USA (formerly Scion Dental). The provider web portal accessible directly at: https://pwp.sciondental.com/PWP/Landing. Providers can streamline patient management with the Portal by:

- Submitting electronic claims and authorizations
- Viewing and downloading guidelines, manual and resources
- Verifying patient eligibility
- Viewing patient service history
- Viewing Provider dental home member panels
- Viewing fee schedules
- Viewing Quality Metric reports
- Receiving remittance advice reports

For Skygen provider portal questions, please contact the web portal team at 1-855-434-9239. You may also visit the CareSource website provider page for newsletters and other resources and use the CareSource Provider Portal at https://providerportal.caresource.com/IN for other services. You must register to use the CareSource Provider Portal. You must register to use the CareSource Provider Portal. For questions on this portal, contact CareSource Provider Services Department at **1-844-607-2831**.

Dental Claims

Online: Submit claims at https://pwp.sciondental.com/PWP/Landing
Paper: CareSource
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401

Clearinghouse: The CareSource Payor ID is INCS1. This ID should be used for all clearinghouse dental claims.

For dental claims questions, please contact one of our CareSource team members at **1-844-607-2831**, follow the prompt to "healthcare provider" "claims" and when prompted state "dental claims." All claims, should be submitted within 90 days from the date of service for participating providers or within 180 days from the date of service for non-contracted (Out of Network) providers.

Coordination of Benefits (COB)

If the patient has other insurance coverage, all claims must be filed with the primary payer first prior to filing claims for reimbursement for services rendered to CareSource member.

Online: Submit COB claims at https://pwp.sciondental.com/PWP/Landing the EOB must be attached/ uploaded and the COB fields per service line item completed.

Paper: CareSource
ATTN: Claims Dept.
P.O. Box 3607
Dayton, OH 45401

Clearinghouse: For electronic claim submissions, the primary payer information must be included on the claim submission. The electronic claim must have the primary payer information completed in the correct segments (loops) and entered by service line, according to the clearinghouse's "Companion Guide," in addition to the Explanation of Payment attachment through NEA, FastAttach™, or your clearinghouse.

If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 90 calendar days of the primary carrier's EOP.

Prior Authorization

Online: Submit authorization requests: https://pwp.sciondental.com/PWP/Landing

Paper: CareSource IN Authorization
P.O. Box 745
Milwaukee, WI 53201

For dental authorization questions, please contact one of our CareSource PA team members at **1-844-607-2831**, follow the prompt to "authorizations" and then press prompt for "dental authorizations"

Note: PA requests and claims have different addresses and must be mailed to the appropriate address

Corrected Claim

In the event of incomplete, incorrect, or unclear information was originally submitted on a claim; corrected claims should be submitted within 60 days from the date of the EOP. Examples include missing tooth number or surface, the date of service, procedure/ diagnosis code, incorrect unit count, and/or modifier, provider, place of service, wrong provider NPI or facility location. Resubmit the entire claim with updated information as a "Corrected Claim". You do not need to file an appeal.

Submitting a Corrected Claim

1. Identify the claim as "corrected" by boldly and clearly marking the claim as "Corrected Claim" across the top of a paper claim form.
2. Identify the original Claim/Encounter Number by writing it in the Remarks section (Box 35) on a paper ADA form.
3. Attach any supporting documentation and send documentation in the same package with the paper claim form.

Send paper forms and documents to:

CareSource
ATTN: Corrected Claims Dept.
P.O. Box 3607
Dayton, OH 45401

Claim Dispute

If a service line on a claim was overpaid or underpaid—For example, if a claim is paid but Provider feels it was not paid at right amount then a claim dispute can be filed. https://www.caresource.com/documents/in-med-claim-dispute-form/ Adjustments to any overpayments will be made on subsequent reimbursements to the Health Partner/Provider or the Provider can issue refund checks to CareSource for any overpayments

Mail: CareSource
Coordinator Attn: Health Partner
Claims Disputes - Indiana
P.O. Box 2008
Dayton, OH 45401-2008

Fax: Provider Claims Disputes
Fax Number: 937-531-2398

Providers must complete a claim dispute prior to requesting an appeal. Providers/facilities have 60 days from the Explanation of Payment (EOP) to file a claim dispute. Applicable timely filing limits will apply. If CareSource fails to decision a claim within 30 days after receipt, the 90-day submission period for the dispute begins as of the claim submission date per 405 IAC 1-1.6-1.

Claim Appeal

Claim Appeals are administrative appeals of an adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member. After a provider has received a claim dispute resolution or 30 calendar days have passed since the dispute has been received by CareSource, a provider may submit a claim appeal to request reconsideration of a claim denial. Claim Appeals must be submitted within 60 days of the date of resolution on the informal dispute process. Claims appeals cannot reverse a utilization management determination.

To submit a Claims Appeal: 1) Submit the Claims Appeal Form, 2) Supporting Documentation, 3) Original Remittance Advice

Mail: CareSource
Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401

Fax: 937-531-2398

If Faxed all documentation including radiographs and photos must be clear and readable. Faxes must be in accordance with confidentiality guidelines and governed by the same authorization requirements as any other release of health care information.

Authorization Appeal

There are multiple ways to respond to an adverse determination of an authorization review request.

1. Before submitting a request for a clinical appeal, the requesting provider may request a peer-to-peer (P2P) conversation with the CareSource Dentist Reviewer or Dental Director at (1-877-479-0027). This request must be made and occur within 7 business days of the determination.

2. A treating provider may assist a member by submitting appeal on behalf of the member but must receive written consent from the member. The clinical appeal must be submitted within 60 days from date of the adverse benefit determination. For pre-service appeals submitted with written member consent, the standard appeal decision time frame is 30 calendar days from the date of receipt by CareSource. The standard decision time frame for post-service provider appeals is 30 calendar days. A 14 calendar-day extension may be requested by CareSource on any provider appeal. CareSource responds to all expedited appeal requests within 48 hours of receipt.

Mail: CareSource
Attn: Dental Health Partner
Clinical Appeals – IN
P.O. Box 1947
Dayton OH 45401-1947

Fax: 937-531-2398

Provider Complaints and Grievances

Providers may file grievances related to members, other providers, or operational issues of the plan. CareSource will thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying the CareSource written policies and procedures.

CareSource Provider Complaints – Indiana
P.O. Box 1947 Dayton OH 45401
Phone: 1-844-607-2831

A Member has the right also to file a Grievance at any time. Examples include:

- Member cannot get a timely appointment with a provider.
- Member thinks the provider's office staff did not treat them fairly.
- Member is not satisfied with the quality of care they received.

These types of grievances do not involve benefits or denial of benefits.

CareSource responds to all grievances reported by a member within 30 calendar days. Expedited grievances shall be resolved within 48 hours of receipt. If CareSource denies a request for an expedited review, we shall transfer the grievance to the standard grievance time.

Electronic Funds Transfer

We encourage dental providers to enroll in Electronic Funds Transfer (EFT) to enjoy efficient and reliable claim payments. SKYGEN offers several payment option solutions partnering with Zelis and via an E-Payment Center platform. A single connection with Zelis gives dental providers access to streamlined payments from over 150 payers, including SKYGEN/CareSource. Visit https://skygen.zelisenroll.com/ to register and enroll for EFT payments. For Providers seeking an alternative payment solution, SKYGEN is excited to introduce a new electronic payment (E-Payment) platform to accelerate and add efficiency to our claims payment process, E-Payment Center. By enrolling, providers have the ability to receive a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the E-Payment Center enrollment portal. Enrollment instructions and a detailed question and answer guide are available for download at https://skygen.epayment.center/Registration

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on **CareSource.com** for the most up-to-date information.

TABLE OF CONTENTS

Chapter 1: The CareSource Difference 8

1.1 Who We Are 8

1.2 Vision and Mission 8

1.3 Our Unique Approach to Improving Health Outcomes 9

1.4 Our Commitment to Oral Health and Health Equity 10

Chapter 2: General Standards and Policies 11

2.1 Compliance and Ethics 11

2.2 Personally Identifiable Information (PII) 12

2.3 Accreditation 13

2.4 Cultural and Linguistic Competency 13

2.5 Americans with Disabilities Act 14

2.6 Policy Methodology 15

Chapter 3: Member Enrollment and Eligibility 17

3.1 Member Enrollment 17

3.2 Eligibility Categories 18

3.4 Member Rights and Responsibilities 21

3.5 Member Support Services 23

Chapter 4: Provider Contracting and Credentialing 26

4.1 Credentialing and Contracting 26

4.2 Provider Data Maintenance/Changes 28

4.3 Communicating with Us 28

4.4 Dental Home – Primary Dental Provider (PDP) 29

4.5 Care Provider Rights and Responsibilities 30

4.6 Access and Availability Standards 31

Chapter 5: Care Provider/Administrative Procedures 34

5.1 Provider Portal 34

5.2 CareSource Website 37

5.3 Prior Authorization, Retrospective and Change Request Procedures 37
5.4 Claims Submission Procedures 43
5.5 Claims Disputes, Appeals and Provider Grievances 48
Chapter 6: Care Standards 50
6.1 Standards for Medical/Dental Records 50
6.2 Standards for Member Outreach Call Policy and Procedures 51
Chapter 7: Dental Benefits and Covered Services Clinical Criteria, Guidelines, Requirements.....53
7.1 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 53
7.2 Value Added-Services Enhanced Benefit.....55
7.3 Non-Covered Services 58
7.4 Covered Services Policy Guidelines.....59
7.4.1 Medical Necessity Criteria.....59
7.4.2 Services Requiring Prior Authorization 60
7.4.3 Document Standards 62
7.4.4 Place of Service (POS) 64
7.5 Covered Service Categories: Policy and Clinical Criteria
Benefit Grids/Frequencies, Limitations, Document Requirements 65
7.5.1 Diagnostic Services D0100-D0999 Coverage Guidelines.....68
7.5.2 Preventive Services D1000-D1999 Coverage Guidelines 75
7.5.3 Restorative Services D2000-D2999 Coverage Guidelines.....86
7.5.4 Endodontic Services D3000-D3999 Coverage Guidelines.....97
7.5.5 Periodontics D4000-D4999 Coverage Guidelines.....105
7.5.6 Prosthodontics, Removable D5000-D5999 Coverage Guideline.....114
7.5.7 Prosthodontics, Fixed D6200-D6999 Coverage Guideline 117
7.5.8 Oral and Maxillofacial Surgery D7000-D7999 Coverage Guideline 125
7.5.9 Orthodontics D8000-D8999 Coverage Guideline.....147
7.5.10 Adjunctive Services D9000-D9999 Coverage Guidelines 152
Chapter 8: Quality Management Program 171
Chapter 9: Utilization Management Program 173
Fraud, Waste & Abuse.....174
Appendix 178
Handicapping Labio-Lingual Deviation Index Scoring Instructions 183

CHAPTER 1: THE CARESOURCE DIFFERENCE

1.1 Who We Are

Our goal is to create an holistic model of care for our members, leading by example with commitment.

CareSource is a leading nonprofit managed care organization headquartered in Dayton, Ohio and has been meeting the needs of health care consumers for more than 30 years. Expanding and currently serving several states in the Midwest and Southeast regions, we have built a legacy of providing quality health care coverage for Medicaid consumers. Every year, CareSource is growing to meet the health care needs of Americans. We are champions for healthier lives and are excited to bring our "heartbeat" mission to Indiana.

We value integrity. Working with honesty and integrity is one of our corporate values at CareSource, and we recognize that doing the right thing is everyone's responsibility. Attention to integrity is emphasized among all CareSource employees. Our corporate compliance plan is a formal company policy that outlines how everyone that represents CareSource should conduct himself or herself internally and externally with those, we have business relationships with. It is an affirmation of CareSource's ongoing commitment to conduct business in a legal, ethical, and culturally competent manner.

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit organization, we are mission-driven to provide holistic, coordinated quality care for our members, collaborating with our health partners.

1.2 Vision and Mission

Our vision is transforming lives through innovative health and life services.

Our mission is to make a lasting difference in our members' lives by improving their health and well-being.

At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

At CareSource, we call health care providers our health partners. A "health partner" is any health care provider who participates in CareSource's provider network. You may find "health partner' and health care provider used interchangeably in our manual, provider agreements, and website.

Our goal is to create an integrated health care home for our members. This means we focus on prevention and partnering with our provider network to offer the services our members need to remain healthy. As a managed health care organization, we strive to improve the health of our members by utilizing a contracted network of participating health care partners. Primary care providers (PCPs) and primary dental providers (PDPs) within the network provide a range of care services for our members, and coordinate patient care by referring them to specialists when needed or obtaining applicable prior authorization from CareSource.

1.3 Our Unique Approach to Improving Health Outcomes

At CareSource, we have a unique care management approach to improving health outcomes and well-being through our process efficiencies and value-added benefits. We partner with providers and the community to serve our members with a **Whole Person Health** approach that brings all parts of the health system together to treat the 'Whole Person'. This collaborative care coordination model enables us to help members in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. While offering care plans to the uninsured and people who need it the most, CareSource understands the social determinants and barriers to accessing this needed care. It is about treating the whole member and recognizing that each person comes to the journey with his or her unique needs, challenges, preferences, and goals. Through our expanded life services, we can offer the support that can pave the way from where members are to where they want to be.

CareSource JobConnect and Life Services

CareSource addresses these social determinants of health well beyond health care

- Education
- Health Behaviors
- Access to Care & Quality Care
- Physical Environment/ Community
- Job Status
- Family/Social Support

CareSource Life Services is offered at no cost to Members. Each member signed up with the program, receive their own CareSource Life Coach who helps them build a personal plan for success. We provide training and partner with employers and organizations in the community to connect our members to resources and opportunities. Visit **CareSource.com** to learn more. We can help Members with:

- Employment Assistance
- Interview Skills and Job Training
- Reliable Childcare
- Dependable Transportation
- GED Class Access
- Stress Management
- Access to Healthy Foods and Nutritional Counseling
- Stress Management
- Access to Behavioral Health-Substance Use programs
- Social and Fitness Programing (i.e. Boys and Girls Club memberships)
- Newly initiated innovative partnership to affordable housing projects
- And More

The CareSource Foundation

The communities we serve drive us to action

Since 2006, the **CareSource Foundation** has awarded more than $21 million to nonprofits that are working to eliminate poverty, provide much-needed services to low-and moderate-income families, encourage healthy communities, develop innovative approaches to address critical health issues, and enhance the lives of a diverse array of children, adults, and families. We are so proud of our partnerships and ultimately, of the impact we are able to make together.

Additionally, in response to the COVID - 19 public health crisis, CareSource implemented a number of initiatives including providing funding to United Way Agencies in our market states, many corporate donations and sponsorship payments, as well as initiatives implemented with food banks, faith-based organizations, and frontline workers across our states.

For more information on the CareSource Foundation, please visit https://www.caresource.com/about-us/caresource-foundation/

1.4 Our Commitment to Oral Health and Health Equity

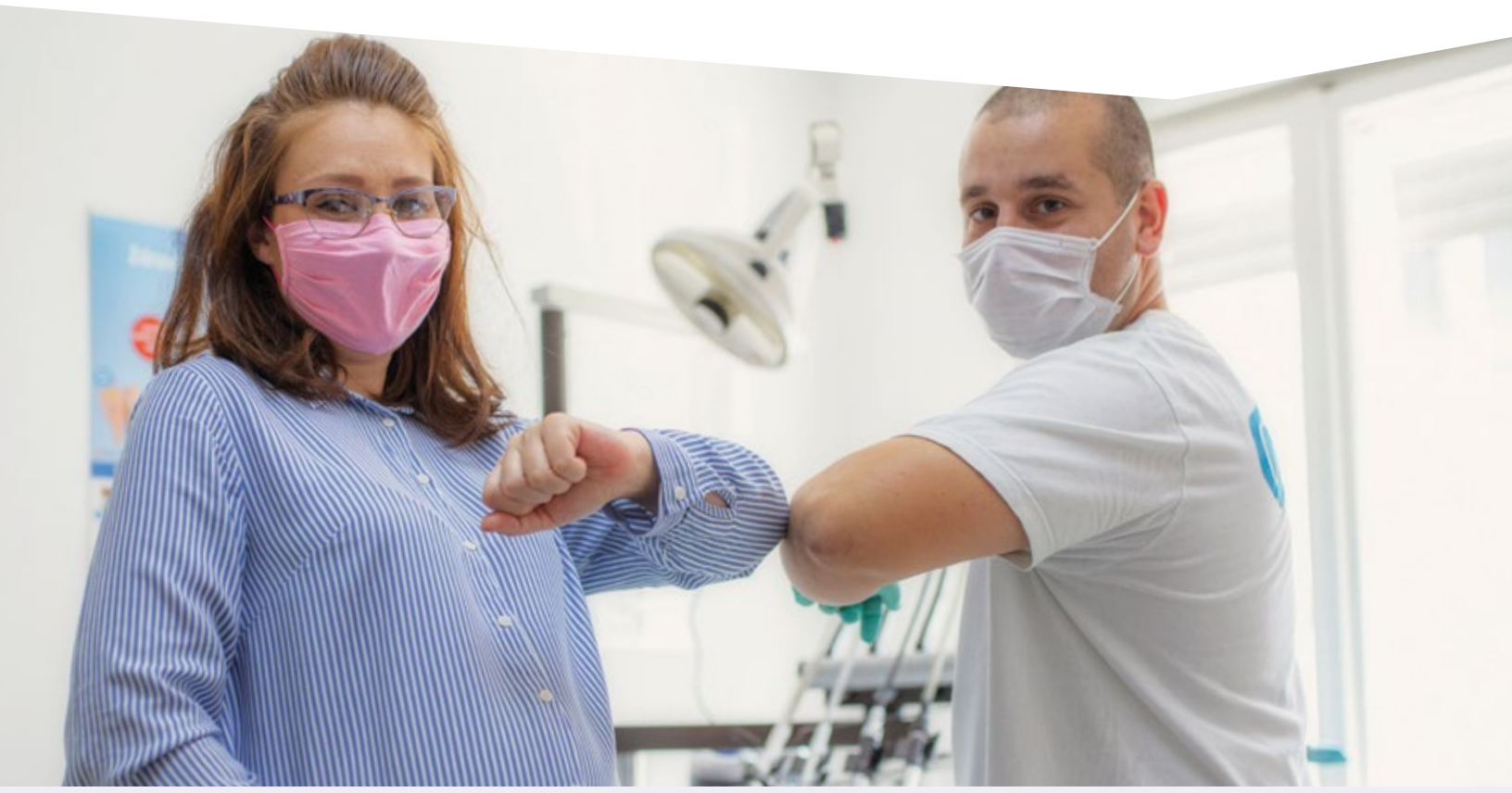
CareSource recognizes and understands the vital role oral health plays in the overall health and well-being of our members. We are committed to decreasing oral health disparities through 1) targeting primary prevention; 2) oral health education; 3) improving access to comprehensive quality oral health care; 4) engaging and collaborating with stakeholders, providers, and professional associations, as well as members and community engagement. An approach ensuring that our policies and programs streamline into positive experiences for our consumers and drive health equity.

CareSource is committed to improving oral health not just for children but also for the entire family. Uniquely offering comprehensive expanded adult coverage and extra value - added services in both the Indiana HIP and HHW plans. We additionally offer member incentives to promote oral health preventive care visits, host member educational events as well as provide oral health resources.

Healthy mouth, healthy body

Given the potential link between periodontitis and systemic health problems such as diabetes, heart disease, adverse birth outcomes, and many more conditions, CareSource offers expanded adult oral health services to promote better overall health outcomes.

To improve access and availability to quality care, CareSource and its team of Dental Directors, local and national leadership, are working innovatively to ensure optimized provider experiences with contracting, claims administration, timely payments, authorization reviews, updated policies, and provider resources. We offer unique provider quality and value-based incentive programs to promote prevention, early intervention, and quality wellness for our members.



CHAPTER 2: GENERAL STANDARDS AND POLICIES

2.1 Compliance and Ethics

At CareSource, we serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect, and integrity. Our Corporate Compliance Plan, along with state and federal regulations, outline the personal, professional, ethical, and legal standards we must all follow.

Our CareSource Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical environment, established to:

- Formalize CareSource's commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state, and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource policy
- This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties, and criminal sanctions.

CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents CareSource should conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants, and vendors.

General Compliance and Ethics Expectations of Providers

- Act according to the compliance standards.
- Let us know about suspected violations or misconduct.
- Let us know if you have questions.

For questions about provider expectations, please call your Provider Engagement Specialist or Provider Services at **1-844-607-2831**.

If you suspect potential violations, misconduct, or non-compliant conduct, which impacts CareSource or our members, please leverage one of the following methods to communicate the issue to CareSource:

- Ethics and Compliance Hotline: 877-LINKCSM (877-546-5276) or http://caresource.ethicspoint.com
- Compliance Officer: 937-487-5110

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously. The CareSource Corporate Compliance Plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

2.2 Personally Identifiable Information (PII)

In the day-to-day business of patient treatment, payment, and health care operations, CareSource and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that (PII) be appropriately protected wherever it is stored, processed, and transferred while conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and the Health Insurance Portability and Accountability Act (HIPAA) mandates providers to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment, or health care operations.

Member Consent

When you check eligibility on the CareSource Provider Portal, you can also determine if a member has granted consent to share their health information with their past, current, and future treating providers. A message displays on the Member Eligibility page if the member has not consented to sharing their health information.

Please encourage CareSource members who have not consented to complete our Member Consent/ HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located at CareSource.com > Forms.

The Member Consent/HIPAA Authorization Form can also be used to designate a person to speak on the member's behalf. This designated representative can be a relative, a friend, a physician, an attorney, or some other person that the member specifies.

2.3 Accreditation

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for our Ohio, Indiana, and Georgia Medicaid plans. NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency, and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement.

2.4 Cultural and Linguistic Competency

Cultural competency within CareSource is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population." It is the use of a systems perspective, which values differences and is responsive to diversity, at all levels in an organization. Cultural competency is developmental, community focused and family oriented. It is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs, and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills important in clinical practice, cross-cultural interactions and systems practices among health partners and staff to ensure that services are delivered in a culturally competent manner.

Participating health partners are expected to provide services in a culturally competent manner, which includes removing all language barriers to service and accommodating the unique ethnic, cultural, and social needs of the member. Participating health partners must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Health partners can address racial and ethnic gaps in health care with an awareness of cultural needs and improving communication with their growing numbers of diverse patients. CareSource recognizes cultural differences, including religious beliefs and ethical principles. In accordance with this, health partners are not required to perform any treatment or procedure that is contrary to their religious or ethical principles.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical/Dental care is provided with consideration of the members' race/ethnicity and language and its impact/influence on the members' health or illness.
- The office staff that is responsible for data collection make reasonable attempts to collect race, ethnicity, and language-specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify his/her own race/ethnicity and that of his/her children.
- Treatment plans are developed, and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physician abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Participating health partners must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

CareSource encourages its participating oral health providers to complete the U.S. Department of Health and Human Services Cultural Competency Program for Oral Health Providers, a free, online educational program accredited for oral health professionals. CareSource additionally offers cultural competency small group facilitated training, as well as access to our full Cultural Competency Plan, available online at **CareSource.com**. Contact your CareSource Provider Representative to inquire about group courses.

2.5 Americans with Disabilities Act

The Americans with Disabilities Act (ADA), a federal law, prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications. Title III of the ADA applies to public entities, including hospitals, medical offices, and dental offices, which are considered "public accommodations" under the law.

Both public and private health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities and follow ADA accessibility standards for new construction and alteration projects. CareSource network providers must make reasonable accommodations to ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource and its network providers will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

According to the ADA, the following individuals are considered to have a disability:

- A person who has a physical or mental impairment that substantially limits one or more of that person's major life activities*;
- A person who has a history of such an impairment; or
- A person who, while not actually having a physical or mental impairment, is "regarded" or perceived as having such impairment.
- To achieve the goals of the ADA, "disability" is broadly defined. Physical impairment includes any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic, and lymphatic, skin and endocrine.

In providing goods and services, a public accommodation may not use eligibility requirements that exclude or segregate individuals with disabilities, including, for example, canceling or rescheduling appointments based on the availability of auxiliary aids, scheduling HIV-positive patients for the last appointment of the day, etc., unless the requirements are necessary for the operation of the public accommodation. Additionally, requirements that tend to screen out individuals with disabilities are also prohibited. Safety requirements may be imposed only if they are necessary for the safe operation of a place of public accommodation and based on actual risks and not on speculation, stereotypes, or generalizations about individuals with disabilities.

For more information about the ADA, go to https://www.ada.gov/.

2.6 Policy Methodology

To help support access to quality, cost-effective care for your patients, our members, with a CareSource health plan, we routinely review clinical, reimbursement and administrative policies, dental coverage positions, and our process and requirements. Policies are considered guidelines and are not intended to infer benefits or coverage for a specific member. Benefit determinations are based on the facts of each member's case.

Clinical Policies

Clinical policies offer guidance on determination of medical necessity and appropriateness of care for approved benefits. Benefit determinations and coverage decisions are subject to all the terms and conditions of CareSource including eligibility, definitions, specific inclusions or exclusions, and applicable state or federal laws. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical/dental practice; peer-reviewed medical/dental literature; government agency/program approval status; evidence-based guidelines and positions of leading national health and dental professional organizations; views of dentists practicing in relevant clinical areas affected by the policy; and other available clinical information.

The clinical policies do not constitute medical advice or medical/dental care. Treating health care providers are solely responsible for diagnosis, treatment, and medical/dental advice. CareSource is not responsible for, does not provide, and does not represent itself as a provider of medical/dental care.

Existing clinical policies are regularly reviewed and updated. New policies are added as appropriate while previous versions are maintained in the policy archive. These policy changes are updated as applicable in the electronic dental provider office reference manual. Additionally, between manual/handbook iterations, providers receive network notifications and website links to CareSource.com policies.

Administrative Policies

Administrative Policies intended to provide further information about the administration of CareSource benefit plans. Coverage determinations require consideration of 1) the terms of the applicable benefit plan document; and evidence of coverage (EOC) 2) any applicable state or federal laws/regulations; 3) any relevant collateral source materials including Administrative Policies and; 4) the specific facts of the situation. Administrative Policies are not recommendations for treatment and should never be used as treatment guidelines.

Reimbursement/Payment Policies

Reimbursement/Payment policies designed to assist you when submitting claims to CareSource. Routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. They include but are not limited to claims processing guidelines referenced by the Centers for Medicare and Medicaid Services (CMS), Code on Dental Procedures and Nomenclature (CDT Code) by the American Dental Association for reporting dental procedures and services, Current Procedural Technology guidance published by the American Medical Association (AMA) for reporting medical procedures and services, health plan clinical policies based on the appropriateness of health care and medical necessity, and any state-specific claims reimbursement guidance. Payments for claims may be subject to limitations and/or qualifications. Payment will be determined based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Providers and their office staff are encouraged to use self-service channels to verify member eligibility.

CHAPTER 3: MEMBER ENROLLMENT AND ELIGIBILITY

3.1 Member Enrollment

The Indiana Family and Social Services Administration is responsible for member enrollment into Healthy Indiana Plan (HIP), Hoosier Healthwise (HHW), or Hoosier Care Connect, Members can then choose their Medicaid Managed Care health plan. CareSource provides benefits for both the Healthy Indiana Plan and the Hoosier Healthwise plan.

3.2 Eligibility Categories

Medicaid offers many programs for a variety of people. There are several eligibility categories. It is important for providers to be familiar with these categories, to determine any applicable dental benefits.

Healthy Indiana Plan (HIP)			
Eligibility	**Member Description**	**General Benefits**	**Co-Payments**
HIP Basic	Not eligible for Medicare or another Indiana Medicaid program, but eligible for HIP if in one of these groups: Adults of age 19-64 with income ≤100% FPL	HIP Basic members have a more limited benefit plan No Dental Benefits However, EPSDT is applicable to Members of age 19 to 20 CareSource offers some additional preventive dental services.	None
HIP Plus	Not eligible for Medicare or another Indiana Medicaid program, but eligible for HIP Plus if in one of these groups: • Adults of age 19-64 with income ≤100% FPL • Adults of age 19-64 with income < 100% and ≥ 138% FPL • Pregnant women • Native Americans	HIP Plus members receive a full commercial benefit package that includes coverage for vision, dental, and chiropractic services Dental benefits include: • Oral Evaluations and cleanings • Routine radiographs • Minor restorative procedures (i.e. fillings) • Major restorative procedures, such as prefabricated crowns • Extractions	None except if you go to the ER for a non-emergency
HIP State Plan Basic	Members who are otherwise eligible for Medicaid or have a qualifying health condition have enhanced benefits. Members may be: • Medically Frail • Low-income Parents or Caretaker Adults • Low-income 19- and 20-year-old Transitional Medical Assistance	The HIP State Plan provides "medically frail" members access to comprehensive Indiana Medicaid State Plan services and includes cost-sharing responsibilities or copayments (HIP State Plan - Basic), as determined by a member's eligibility category and income level. Same dental benefits as Indiana Medicaid/ Hoosier Healthwise (comprehensive dental benefits). Limitations may apply based on age and to certain codes.	$4 outpatient co-pay per service category, per date of service for all services except diagnostic and preventive Some Members (i.e. Pregnant Women may be exempt from copay)

Healthy Indiana Plan (HIP)			
Eligibility	**Member Description**	**General Benefits**	**Co-Payments**
HIP State Plan Plus	Ensures members who are otherwise eligible for Medicaid or have a qualifying health condition have enhanced benefits. • Medically Frail • Low-income Parents or Caretaker Adults • Low-income 19- and 20-year-old • Transitional Medical Assistance • Native Americans	Includes all HIP Plus benefits. Members make a monthly POWER account contributions (PAC) based on income and family size Same dental benefits as Indiana Medicaid/ Hoosier Healthwise (comprehensive dental benefits). Limitations may apply to certain codes.	None except if Member goes to the ER for a non-emergency
HIP Pregnancy/ Maternity Plans	Pregnant women (members have the option to enroll in HIP Pregnancy Plans with the same HIP State Plan benefits) Pregnant women in HIP and HHW will get the same enhanced benefits. They will be assigned to HIP or HHW based on income level. HIP Pregnant members are not required to pay Power Account contributions or copays.	HIP Pregnancy members receive same benefits as HIP State Plan (age applicable services) throughout their pregnancy and for twelve months post-partum. There are no required financial contributions or copayments.	None
Hoosier Healthwise (HHW)			
Hoosier Healthwise (HHW)	**Package A: Standard Plan.** Package A is a full-service plan for children and pregnant women. (Children may include former foster children up to age 25) **Package C: Children's Health Insurance Program (CHIP).** Package C is a full-service plan for children. There is a small monthly payment and copay for some services. Based on family income.	Comprehensive dental benefits. Limitations may apply to certain codes and age	None
*Note: Not all categories are eligible for dental benefits and/or benefits may vary per program. Please see **Covered Benefits** section for specific dental benefits for each category and sub-category*			

3.3 Member Eligibility Verification

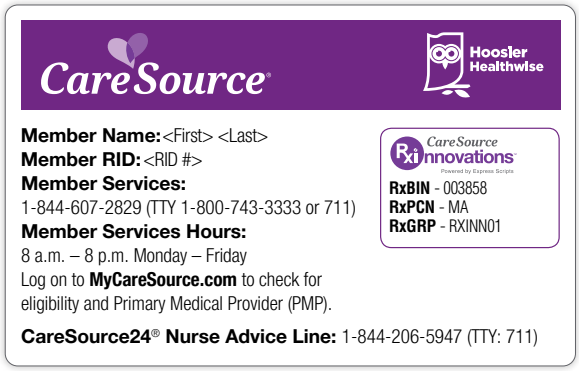
Participating Care Providers are responsible for verifying that Members are eligible at the time services rendered. Additionally, determine if recipients have other health insurance.

1. Eligibility Systems

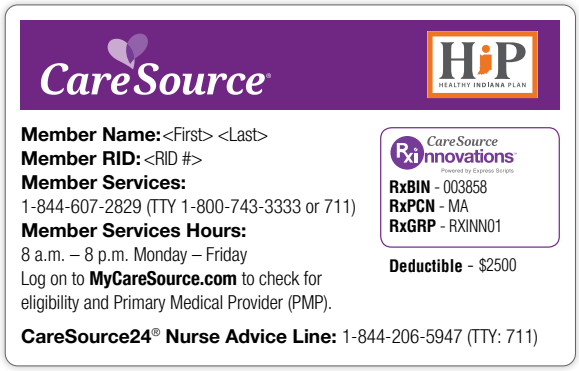
The Care Provider can use the Indiana Health Coverage Programs (IHCP) Provider Portal, our delegated dental vendor provider portal via https://pwp.sciondental.com/PWP/Landing or eligibility can also be checked via the CareSource Provider portal at CareSource.com. You will need to register to use the CareSource portal. Please note that due to possible eligibility status changes, this process does not guarantee payment and status is subject to change without notice. Prior to rendering services, print out a copy of the member's eligibility.

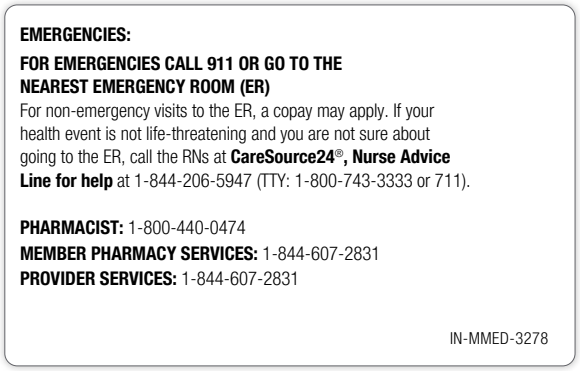
2. Member ID Card

Members receive identification cards from CareSource. Check the member's ID card at each visit and copy both sides for your files. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.


CareSource
Hoosier Healthwise
Member Name: <First> <Last>
Member RID: <RID #>
Member Services:
1-844-607-2829 (TTY 1-800-743-3333 or 711)
Member Services Hours:
8 a.m. – 8 p.m. Monday – Friday
Log on to **MyCareSource.com** to check for eligibility and Primary Medical Provider (PMP).
CareSource Rxinnovations
RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01
CareSource24® Nurse Advice Line: 1-844-206-5947 (TTY: 711)

EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
For non-emergency visits to the ER, a copay may apply. If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24®, Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).
PHARMACIST: 1-800-416-3632
MEMBER PHARMACY SERVICES: 1-844-607-2831
PROVIDER SERVICES: 1-844-607-2831
IN-MMED-3276a


CareSource
HIP HEALTHY INDIANA PLAN
Member Name: <First> <Last>
Member RID: <RID #>
Member Services:
1-844-607-2829 (TTY 1-800-743-3333 or 711)
Member Services Hours:
8 a.m. – 8 p.m. Monday – Friday
Log on to **MyCareSource.com** to check for eligibility and Primary Medical Provider (PMP).
CareSource Rxinnovations
RxBIN - 003858
RxPCN - MA
RxGRP - RXINN01
Deductible - $2500
CareSource24® Nurse Advice Line: 1-844-206-5947 (TTY: 711)


EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
For non-emergency visits to the ER, a copay may apply. If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24®, Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).
PHARMACIST: 1-800-440-0474
MEMBER PHARMACY SERVICES: 1-844-607-2831
PROVIDER SERVICES: 1-844-607-2831
IN-MMED-3278

3. Benefit Category

Check the Member's program category of eligibility as dental benefits may vary, and other verification processes may be applicable.

3.4 Member Rights and Responsibilities

In aligning with our mission, CareSource is committed to ensuring our members are treated in a manner that respects their rights and promotes effective health care. Likewise, it is important that members understand their responsibilities as a CareSource member. All members are encouraged to take an active and participatory role in their own health and the health of their family. CareSource members are informed of their rights and responsibilities via their member handbook. It is also important that our network of care providers have the same information about member rights and responsibilities to ensure that our members, their patients, get the care and services to which their benefit plan entitles them. The following is a statement of Member's rights and responsibilities:

Member Rights

1. **CareSource notifies members of their rights and responsibilities in the Member Handbook.**
2. **As a member of CareSource, members have the following rights:**

a. To receive information about CareSource, its services, its practitioners and health partners, and member rights and responsibilities.

b. To receive all services that CareSource must provide.

c. To be treated with respect and with regard for their dignity and privacy.

d. To be sure that their medical/dental records and personal information will be kept private.

e. To be given information about their health. This information may also be available to someone who the member has legally authorized to have the information or whom the member has said should be reached in an emergency when it is not in the best interest of the member's health to give it to him/her.

f. To get information on any appropriate or medically necessary treatment options for the member's condition.

g. To participate in decisions regarding his or her health care, including the right to refuse treatment.

h. To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

i. To be sure, that others cannot hear or see the member when he/she is getting medical care.

j. To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.

k. To request and receive a copy of his or her medical/dental records and request to amend or correct the record.

l. To be able to say yes or no to having any information about himself/herself given out unless CareSource must by law.

m. To be able to say no to treatment or therapy. If the member says no, the doctor or CareSource must talk to him/her about what could happen, and a note must be placed in the member's medical record about the treatment refusal.

n. To be able to file an appeal, a grievance (complaint) or state hearing, and that the exercise of those rights will not adversely affect the way the member is treated.

o. To be able to get all CareSource written member information from CareSource:
   1) At no cost to the member.
   2) In the prevalent non-English languages of members in CareSource's service area;
   3) In other ways, to help with the special needs of members who may have trouble reading the information for any reason.

p. To be able to get help free of charge from CareSource and its health partners if the member does not speak English or needs help in understanding information.

q. To be able to get help with sign language if the member is hearing impaired.

r. To be told if the health care health partner is a student and to be able to refuse his/her care.

s. To be told of any experimental care and to be able to refuse to be part of the care.

t. To make advance directives.

u. To freely exercise his or her rights, including those related to fling a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated.

v. To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.

w. To choose the health partner that gives the member care whenever possible and appropriate

x. To be able to get a second opinion from a qualified health partner on CareSource's panel. If a qualified health partner is not able to see the member, CareSource must set up a visit with a health partner not on its panel.

y. To not be held liable for CareSource's debts in the event of insolvency.

z. To not be held liable for the covered services provided to the member for which FSSA does not pay CareSource.

   (a) To not be held liable for covered services provided to the member for which FSSA or CareSource does not pay the health partner that furnishes the services

   (b) To not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if CareSource provided services directly.

   (c) To be responsible for cost sharing only in accordance with 42 CRF 447.50 through 42 CRF 447.60.

   (d) To not be billed for any service covered by Medicaid

aa. To make recommendations regarding CareSource's member rights and responsibility policy.

ab. To contact the United States Department of Health and Human Services Office of Civil Rights at the address below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70 61 Forsyth Street, SWAtlanta, GA 30303-8909

Fax: (202) 619-3818 TDD: (800) 537-7697

Customer Response Center: (800) 368-1019

Member Responsibilities

Members of CareSource are also informed of the following responsibilities:

1. Use only approved health partners, except in emergency or other situations approved by CareSource.
2. Keep scheduled doctor/dentist appointments, be on time and call 24 hours in advance of a cancellation.
3. Follow the advice and instructions for care he/she have agreed upon with his/her doctors and other health partners.
4. Always carry his/her ID card and present it when receiving services.
5. Never let anyone else use his/her ID card.
6. Notify his/her county Division of Family and Children Services (DFCS) and CareSource of a change in phone number or address.
7. Contact his/her PCP (primary care dental provider) after going to an ER, urgent care center or after getting medical care outside of CareSource's covered counties or service area.
8. Let CareSource and the county DFCS know if he/she has other health insurance coverage.
9. Provide the information that CareSource and his/her health partners need in order to provide care.
10. Understand as much as possible about his/her health issues and take part in reaching goals that the member and his/her health partner agree upon.

3.5 Member Support Services

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

CareSource24®, Nurse Advice Line

Members can call our nurse advice line 24-hours a day, seven days a week. With CareSource24®, Members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions, including oral health. Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support. Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care, including diversion from the hospital ED
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP/PDP member relationship
- CareSource24 nurses educate members about the benefits of preventive care and make referrals

Transportation Services

Transportation can be provided for member medical/dental appointments, Women, Infants and Children (WIC) appointments, and Medicaid redetermination appointments:

- For Package A members, the non-emergent transportation benefit has unlimited trips of less than 50 miles each year without prior authorization.
- For Package C members, the non-emergent transportation benefit is covered only between medical facilities, when requested by a participating provider. A copayment of $10 applies.

Members can arrange transportation by calling the Member Services phone number on their ID card and selecting the option for transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

Interpretation Services

Non-Hospital Health Partners

CareSource offers sign and language interpreters for members who are hearing impaired, do not speak English or have limited English-speaking ability. We can also provide, at no charge, printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services are available at no cost to potential members, members, or health partners. As a health partner, you are required to identify the need for interpreter services for your CareSource patients and aid them appropriately. To arrange services, please contact our Health Partner Services Department at 1-844-607-2831. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through other resources.

Hospital Health Partners

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. We can provide, at no charge, printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. These services should be available at no cost to members. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Health Partner Services at 1-844-607-2831. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through other resources.

Life Services

CareSource Life Services works with our members holistically to help remove the obstacles between them and their overall health and well-being. We help them make strides towards long-term self-sufficiency, improved health, and overall well-being.

Many of CareSource's members are healthy, highly motivated individuals with a strong desire to be gainfully employed, and our goal is to help them achieve and sustain that employment. This service is offered at no cost to our members.

Life Services offers tools to help members with:

- Employment assistance
- Interview skills
- Job training
- GED support
- Reliable childcare
- Dependable transportation
- Budgeting and personal finances
- Stress management
- And more!

Providers can have Members find out more about Life Services, by having them reach us by calling 1-844-607-2832, emailing lifeservicesindiana@caresource.com or by filling out the Life Services Interest Form.

MyHealth

All CareSource members over the age of 18 can use our new MyHealth tool on MyCareSource.com to explore healthy living tips and suggestions. They can take an online health risk assessment (HRA) and receive a plan to help live a healthier life.

MyStrength

Members can take charge of their mental health with our wellness tool called MyStrength. This safe and secure tool offers personalized support to help improve mood, mind, body, and spirit. The MyStrength program offers online learning, empowering self-help tools, wellness resources and inspirational quotes and articles.

CHAPTER 4: PROVIDER CONTRACTING AND CREDENTIALING

CareSource serves Medicaid, Medicare, and Health Insurance Exchange members, across multiple states and we are growing. So, joining our network means growth for our oral health care providers, too, as our members are encouraged to use oral health care professionals who participate with our plan.

Our goal is to make it easy for our provider health partners to do business with us by offering easy administration, knowledgeable and friendly customer advocates, UM representatives and provider engagement representatives who are available to answer your questions, convenient tools to service providers and members—online and IVR and fast turnaround time on clean claims.

As a CareSource Provider

You will be working with a company that has more than 30 years' experience and a dedicated dental operations team with extensive clinical and administrative experience in the dental industry.

4.1 Credentialing and Contracting

In partnership with the State of Indiana, CareSource must certify that all its network providers are eligible and enrolled with Indiana Health Coverage Programs (IHCP). To ensure our providers receive proper reimbursement, we encourage all our providers to enroll with IHCP via the State's website. For more information on IHCP enrollment please visit www.in.gov. Providers involuntarily disenrolled from CareSource will be reported to the IHCP and may subsequently be disenrolled as an IHCP provider. The IHCP is required to report involuntarily disenrolled providers to the Centers for Medicare & Medicaid Services (CMS).

CareSource credentials and recredentials all licensed independent practitioners, including physicians, facilities, and dentists with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Senior Medical Director is responsible for the credentialing and recredentialing program.

If your entity is an Independent Practice Association (IPA) or Provider Hospital Organizations (PHO) and requires delegated credentialing and recredentialing, please contact CareSource Health Partner contracting at **1-844-607-2831**.

A network of providers should be a great resource, supporting access to care. CareSource offers an open provider network to support certain health professional shortage areas of the state, where members can receive dental services from participating or non-participating providers with CareSource. CareSource still recruits a robust quality network to serve our members with continuous care and to support our **value-based dental home model** implementation. To contract with CareSource, please submit the following information when completing the New Health Partner Contract Form.

- Your W-9 tax form
- Name
- Specialty
- CAQH ID number
- Tax ID number
- NPI number

Need help? Refer to the User's Guide for Completing New Health Partner Contract Form. If you have additional general questions about the New Health Partner Contract Form, call Provider Services at: **1-844-607-2831**.

Council for Affordable Quality Health Care Application

CareSource is a participating organization with the Council for Affordable Quality Healthcare (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number:

- Log on to the CAQH website at www.CAQH.org, utilizing your account information.
- Select the "Authorization" tab and ensure CareSource is listed as an authorized health plan (if not, please check the "Authorized" box to add).

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)

Provider Network Selection

Dentists in the CareSource Provider Network are selected and credentialed based on established criteria reflecting professional standards for education, training, and licensure. Credentials are verified upon initial application and through the recredentialing process. Dentists must have and maintain the appropriate dental license, malpractice coverage, DEA certificate (if required), and specialty license, diploma, certificate, or permit, as applicable. We also consider geographic, and specialty need when recruiting providers.

Exclusions

CareSource will not include any health partners in our network who:

- Have been excluded by the United States Department of Health and Human Services
- Have been excluded by the Office of Inspector General
- Are on Indiana's list of excluded providers

CareSource monitors the exclusions list monthly and shall immediately terminate any health partner found to be excluded. We will notify any impacted members, per contractual requirements.

Transition Member Care Following Termination of Your Participation

A Provider can terminate their contract at any time per contractual guidelines by written notice given at least sixty-(60) days in advance of such termination to ensure continuity of care for our Members. If your network participation ends, you must transition your CareSource members to timely and useful care. This may include providing service(s) for a reasonable time at our in-network rate. Provider Services is available to help you and our members with the transition.

4.2 Provider Data Maintenance/Changes

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice helps us keep our records current. Your current information is critical for efficient claims processing. The CareSource Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials and selecting "Provider Maintenance" from the left-hand navigation. You can additionally email ProviderMaintenance@caresource.com.

If you have any questions related to the contracting process or need assistance, you can contact your dedicated Dental Health Partner/Provider Contracting Manager for your region or Provider Services at **1-844-607-2831**.

4.3 Communicating with Us

Assisting you is one of our top priorities to deliver better health outcomes for our members. CareSource communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, CareSource.com and network notifications. CareSource has designated provider relations representatives for our dental health partners that regularly engage and service providers in their respective assigned territories. We encourage you to reach out to your assigned regional Provider Relations Representative with any questions. The following are additional key contact numbers and communication modalities.

Communicating with CareSource and Skygen USA			
Phone: Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide self-service applications that allow you to verify member eligibility. Follow the prompts for the corresponding area of service needed.		**Email:** For General Provider Dental Inquiries ProviderRelations@CareSource.com	
		Fax: Please see the corresponding sections for the applicable use of these fax numbers, and what documentation or forms submission	
Provider Services	1-844-607-2831	Credentialing	1-866-573-0018
Claims	1-844-607-2831	Contract Implementation	1-937-396-3632
Credentialing and Contracting	1-844-607-2831	Provider Maintenance	1-937-396-3076
Member Services	1-844-607-2829	Fraud, Waste and Abuse	1-800-418-0248
CareSource24 Nurse Advice Line	1-844-206-5947	Dental Prior Authorization	1-877-479-0027

Fraud, Waste and Abuse Hotline	1-844-607-2829	Provider Appeals	1-844-417-6262 1-937-531-2398
Provider Regional Representative	1-844-607-2831	**Network Notifications, Resources and More** Skygen USA Portal URL: https://pwp.sciondental.com/PWP/Landing We regularly communicate policy and procedure updates to CareSource providers via network notifications. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements	
Skygen Portal Questions	1-855-434-9239		
TTY for the Hearing Impaired	1-800-743-3333 or 711		

4.4 Dental Home – Primary Dental Provider (PDP)

Starting in 2023, CareSource is excited to offer our Indiana members a "Dental Home" leveraging CareSource's Person & Family Centered Dental Home Program, establishing a Dental Home means that a child's oral health care is managed in a comprehensive, continuously accessible, coordinated, culturally effective, and family-centered way by a trusted licensed dentist (primary dental provider) assigned or chosen by that member. The concept of the dental home reflects the American Academy of Pediatric Dentistry and American Dental Association best principles for the proper delivery of quality oral health care to all, with an emphasis on initiating preventive strategies.

Dental Home is Where the Heart is Initiative

CareSource's "Dental Home" model has evolved since 2017 to an innovative approach to oral health and overall health that leverages the principles of collaborative interprofessional and coordinated care and shares actionable quality data information with providers to decrease care gaps and improve outcomes for members.

To learn more about CareSource's Dental Home Program, Quality Initiatives and incentives for Members and Providers, contact your CareSource Indiana Provider Relations Representative

Dental Home is Where the Heart is

CareSource wants to ensure our members have access to a full array of appropriate and timely dental/oral health services. Each member in the **HHW and HIP** programs should have Dental Homes, typically Pediatric or General Dentists with a primary role to provide, organize and coordinate access to oral health care and other healthcare professional referrals as indicated.

Our Goal is Partnering with Our Providers to Promote Care That Is:

- Person & Family Centered
- Continuous
- Comprehensive and Equitable
- Team Based & Collaborative
- Coordinated & Integrated
- Accessible
- High Value

CareSource communicates with its members to provide information about the importance of preventive dental care and establishing a primary dental caregiver for continuity of care. Although it is, preferred that our members go to their primary providers of care, members can go to any CareSource dental provider and receive treatment. CareSource continually assesses the quality of our network and dental homes to ensure members have access to the dental care they need. We perform periodic quality checks of our network to guarantee the timely and high-quality treatment of our members.

Providers can view gap reports of members with previous claims activity with their office, that are due for preventive visits by logging into your Provider Web Portal account at https://pwp.sciondental.com/PWP/Landing

4.5 Care Provider Rights and Responsibilities

Providers' responsibilities include the following:

- Treating CareSource members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Provide all services in a culturally competent manner
- Uphold all applicable responsibilities outlined in the Member Rights and Responsibilities Statement of this Provider Office Reference Manual.
- Comply with this Provider Manual, policies and procedures and the terms of the Provider Agreement
- Maintaining dental/medical records, including information about pharmaceuticals, anesthesia, treatment, referrals, dental history, etc.
- Complying with the quality standards of our health plan, state and federal requirements Incorporate and ensure compliance with patient safety regulations
- Cooperate with and participate in the member complaint and grievance process as necessary
- Maintaining clinical records in a format consistent with guidelines from applicable industry standards and state professional requirements; for a period no less than mandated by state statutes and regulations
- Complying with request for patient records for review and timely submission to CareSource

- Ensuring demographic and practice information is up to date for directory and member use.
- Identifying and diagnosing the member's health needs, maintaining open communication with a member to discuss treatment needs and recommended alternatives for medically necessary treatment and taking appropriate action; providing care directly or referring members to the best place for that care.

Primary Dental Caregivers responsibilities include:

- Promoting and providing preventive care and educating on oral hygiene and healthy lifestyle choices. One primary CareSource goal is focusing on prevention and early intervention, partnering with our providers to offer the preventive services our members need to remain healthy.
- Providing phone coverage for handling patient calls 24 hours a day, 7 days a week.
- Making referrals to medical or dental specialists or other social services when necessary. As a managed health care organization, we strive to improve the health of our members by utilizing a contracted network of participating providers, both primary medical and primary dental care providers to collaborate and provide a range of services to our members. Coordinating and referring them to specialists and support services offered by CareSource when needed.
- Providing 30 days of emergency coverage to any CareSource patient dismissed from the practice.
- Obtaining patient records from facilities visited by CareSource patients for emergency or urgent care dental care if notified of the visit and following up on definitive treatment.

Provider Rights

As a CareSource network provider, you have the right to an appeals procedure for timely resolution of any requests to reverse a CareSource determination regarding claims payment. Our claims dispute and appeal process are outlined in the appeals section of this manual. As a Care Provider, you have the right to receive payment in accordance with applicable laws and applicable provisions of the Provider Agreement.

4.6 Access and Availability Standards

CareSource has a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating health partners/ providers. Please keep in mind the following access standards for differing levels of care. Participating health partners are expected to have procedures in place to see patients within these timeframes and to offer office hours to their CareSource patients that are at least the equivalent of those offered to any other patient. Thank you for adhering to these standards.

Primary Dental Providers

Patients with…	Should be seen…
Emergency needs	Immediately upon presentation
Urgent dental needs (adult and pediatric)	Within 24 hours
Routine care needs	Within 14 calendar days

In-Network Specialists

Patients with…	Should be seen…
Emergency needs	Within 24 to 48 hours of initial contact with the dental office
Persistent symptoms	No later than 30 calendar days after the initial contact with the dental office
Routine care needs (stable condition)	Within 21 calendar days

Urgent and Emergency Care Health Partners

Patients with…	Should be seen…
Urgent dental care needs	Within 48 hours of contact with urgent care health partner
Emergency care needs	Immediately upon presentation (24 hours a day, 7 days a week), and without prior authorization Immediately upon presentation (24 hours a day, 7 days a week), and without prior authorization

A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a health partner is unable to see the member within the appropriate period, CareSource will facilitate an appointment with a participating health partner or a non-participating health partner, if necessary.

Emergency Care Versus Urgent Care

In dentistry, an emergency is a ***potentially*** life-threatening condition that requires immediate treatment, to stop ongoing tissue bleeding, alleviate severe pain or infection, and include:

- oral-facial trauma
- Cellulitis or a diffuse soft tissue bacterial infection with intra-oral or extra-oral swelling that potentially compromise the patient's airway
- prolonged or uncontrolled bleeding
- pain that cannot be managed by over-the counter medication
- other procedures that in the dentist's professional judgment are necessary in order to minimize potential life- threatening harm to patients

In dentistry, urgent care is the management and treatment of conditions that require immediate attention to relieve pain and/or risk of infection, including:

- severe dental pain from pulpal inflammation
- pericoronitis or third-molar pain
- surgical post-operative osteitis, dry socket dressing changes
- abscess or localized bacterial infection resulting in localized pain and swelling

- tooth fracture resulting in pain, pulp exposure or causing soft tissue trauma
- extensive caries or defective restorations causing pain
- dental trauma with avulsion/luxation
- final crown/bridge cementation if the temporary restoration is lost, broken, or causing gingival irritation
- biopsy of a suspicious oral lesion or abnormal oral tissue
- replacing a temporary filling in an endodontic access opening for patients experiencing pain
- snipping or adjusting an orthodontic wire or appliance piercing or ulcerating the oral mucosa
- treatment required before critical medical procedures can be provided
- suture removal
- denture adjustments or repairs when function is impeded
- other procedures that in the dentist's professional judgement are necessary in order to minimize harm to patients and/or relieve pain and suffering

Providers should ensure they have standards of care processes in alignment with state board practice requirements including after hour emergency procedures. If an urgent or emergency dental related condition manageable in the dental office setting, as identified in the dentist's professional judgement, cannot be treated within the emergent-urgent timeframe, you must contact CareSource at 1-844-607-2831 to allow CareSource Care Advocates the opportunity to arrange for timely care. CareSource requires that you provide sufficient access to ensure that members can receive services in your office for non-traumatic or non-life-threatening dental conditions rather than in a hospital emergency room.

CHAPTER 5: CARE PROVIDER/ADMINISTRATIVE PROCEDURES

5.1 Provider Portal

For our CareSource Indiana plan administration, we have partnered with our delegated dental vendor, SKYGEN USA to bring our provider network state-of-the-art, technology- enable solutions to help providers transition to the digital age of healthcare. Online access requires an Internet browser, a valid user ID and a password. From an Internet browser, health partners and authorized office staff can log in for secured access to the system anytime from anywhere to handle a variety of day-to-day tasks. SKYGEN adds as an additional security authentication process, requiring an email verification.

Our Providers by accessing their account at https://pwp.sciondental.com/PWP/Landin can use the SKYGEN USA provider portal for several tasks:

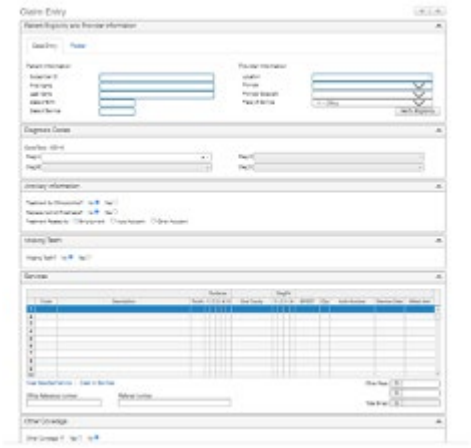
Verify Member Eligibility

- Perform one-step eligibility verification.
- Verify up to 250 members at one time.
- View member eligibility and treatment service history reports.
- Verify eligibility and prepopulate claim forms for online submission
- Manage patient rosters and schedule appointments on the patient calendar.
- Patient case management

SKYGEN USA Provider Portal > Patient Eligibility tab > enter Subscriber ID

Claims Submission and Management

- Submit claims for services performed
- Review and print or save a list of claims submitted today for your records, before they are sent on for processing
- Check the status of previously submitted authorizations
- Enter additional information under the ‘Notes’ tab
- Sending electronic attachments, such as digital X-rays, Explanations of Benefits (EOBs) and treatment plans
- Uploading and downloading documents using a secure encryption protocol



Authorization Submission and Management

- Submit authorizations before performing services to obtain approval.
- Attach electronic files, including x-rays and review authorizations submitted today, before sending for processing.
- Check the status of previously submitted authorizations

From an Authorization Summary, you can:

- Run any applicable authorization guidelines.
- Review a list of documentation required for each procedure code.
- Attach electronic files to the authorization record.
- Attach clearinghouse reference information to the authorization record.
- Print a copy of the Authorization Summary for your records.

Electronic Funds Transfer (EFT) and Virtual Cards

Several payment options are available for providers.

SKYGEN partners with Zelis to offer CareSource Indiana Dental Providers options to simplify processing payments through ACH and Virtual Card electronic solutions:

I. Zelis Electronic Options

- **Zelis ACH** - ACH is the most efficient way to maximize payments for your practice, facility, or health system by directly depositing electronic payments into your bank account. ACH payment delivery is CAQH CORE®- certified, which ensures compliance with ACA standards and HIPAA requirements. Once enrolled, your funds are automatically deposited into your bank account. ACH only allows funds to be directly deposited into your account, it does not allow funds to be recouped from your account.
- **Zelis Virtual Card** – Zelis has partnered with MasterCard (through Optum Financial) to provide payments for card-based payments. By utilizing the Zelis Virtual card office staff simply enters the virtual card information into the card terminal to receive payments for the claim(s) submitted. Card numbers and Explanations of Payment can either be delivered by fax or download from the Zelis Payments secure web portal.

By using Zelis, providers can lower their overall costs and speed up their payments with fast, automatic electronic ACH (direct deposit) or virtual card payment. A fee may apply for providers who are not currently receiving epayments from Zelis. That fee depends on a variety of factors, from the epayment product you choose to the volume of payments. For additional information, questions or to enroll, please follow the steps below.

Zelis Enrollment and Disenrollment steps:

- Providers who are already enrolled with Zelis do not need to make any changes and will automatically be paid through Zelis.
- To enroll please contact the Zelis Provider Enrollment Department at (855) 496-1571. All potential fees are discussed when you enroll and is dependent on that discussion and contract.
- To change your enrollment status (including disenrollment from Zelis), please contact the Zelis Client Service Department at (877) 828-8770.

II. SKYGEN E-Payment Center Option (Administered by Zelis)

- For Providers seeking an alternative payment solution, SKYGEN is excited to introduce a new electronic payment (E-Payment) platform to accelerate and add efficiency to our claims payment process, E-Payment Center.
- By enrolling, providers have the ability to receive a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the E-Payment Center enrollment portal.
- Enrollment instructions and a detailed question and answer guide are available for download at https://skygen.epayment.center/Registration.
- Follow the instructions to obtain a registration code. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
- For more information please call (855) 774-4392 or email help@epayment.center.

E-Payment Center allows you to:

- Improve cash flow with faster primary payments
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payment history up to 7 years back

III. Paper Check Option

- **Paper Checks** – Providers who chose not to enroll with Zelis – or – prefer to receive paper checks can still access their Remittance Reports online.
    - Providers will need to send an email message to SKYGEN Customer Services to request electronic remittances: providerservices@skygenusa.com.
    - Remittance Reports will be available online through the Provider Web Portal.

Electronic Remittance Reports

If you enroll in the EFT or E-Payment Center program, your Remittance Reports will be made available automatically from the Provider Web Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN USA Electronic Outreach team 855-434-9239.

If you prefer to receive paper checks rather than electronic funds transfers, you can still eliminate paper Remittance Reports and access your payment reports online. To have quick, easy access to Remittance Reports as soon as your claims are paid, send an email message to Provider Services to request electronic remittances: providerservices@skygenusa.com.

Other Tasks:

- Download Provider manuals, documents, and resources
- View CareSource Quality Management and Skygen Analytics Reports
- Participate in Provider Satisfaction Surveys
- View Fee Schedules

Fee Schedules

On Main Dashboard after account login > **select location entity** > Scroll to bottom of page > lower right-hand corner is a display of applicable fee schedule **for selected location entity**

Provider Manuals, Score Tools, other Resources

On Main Dashboard after account login > at top of page click the **Documents Tab** > **click the Insurer Document tab** > a list of all posted resources should display

Member Panel Reports, Quality Management Reports

On Main Dashboard after account login > at top of page click the **My Reports Tab** > click the **Insurer Document tab** > a list of all posted resources should display

5.2 CareSource Website

Our provider network partners should visit CareSource.com > DENTAL > Providers for valuable information, updates, network notifications, regulatory updates, newsletters, and additional resources.

5.3 Prior Authorization, Retrospective and Change Request Procedures

CareSource has specific utilization criteria based on industry standards, as well as a review process to determine if requested services are required and medically necessary. Whether prior authorization is required for a particular service, the criteria and required supporting documentation is defined in this provider manual in the **Covered Benefits section**. Please review these criteria as well as the Benefits covered to understand the decision-making process used to determine payment for services rendered. If a procedure requires a prior authorization and it is not submitted, a claim will deny automatically due to auto adjudication and the claims system searching for a matching authorization. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Prior Authorization

Prospective reviews include the initial review conducted prior to the start of treatment. All services that require prior authorization from CareSource should be authorized before the service is delivered. CareSource is not able to pay claims for services in which prior authorization is required, but not obtained by the provider. Non-emergency treatment started prior to the determination of coverage is performed at the financial risk of the dental office. If a procedure needs to be initiated to relieve pain and suffering in an emergency, you are to provide only treatment to alleviate the patient's condition and follow procedures for retrospective review. Prior authorization is not based solely on medical necessity, but on a combination of member and provider eligibility, medical necessity, medical appropriateness, and benefit limitations.

When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of the service. CareSource is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed. CareSource will notify you of prior authorization determinations by a letter mailed to the provider's address on file or the provider may view the determination via the SKYGEN provider portal.

Submission Procedures

Acceptable elements of documentation and required documentation for each procedure requiring prior or post/prepayment approval is noted in guidelines in chapter six of this manual. Any authorization submitted without the required documents will be moved to a development status. An outreach call will be made within 48 hours requesting the documents needed in order to review the authorization and make a determination. If the required documents are not received within 7 calendar days of the authorization submission date, the authorization will be denied. When an authorization is denied and due to missing the required documents it must be resubmitted with the required documents to obtain prior approval before services are rendered. Any claims submitted without the required approved authorization will be denied for reimbursement. Please review these guidelines prior to submitting any authorization requests.

CareSource accepts authorizations submitted in the following formats to SKYGEN USA:

1. SKYGEN Provider Web Portal
2. USPS Mail via Paper ADA Dental Claim Form 2019, available from the American Dental Association

1. Submitting Authorizations via Provider Web Portal

The most efficient and timely process for submission and review is through the provider web portal. Providers may submit authorizations along with any required treatment documentation directly to SKYGEN USA through the Provider Web Portal. Submit an authorization request via the Web Portal for only those services, which require prior approval as indicated in the covered benefits grid, or any EPSDT services per screening (as discussed in chapter 7 of this manual), that have either exhausted benefit limits, frequencies and/or the healthcare provider is requesting exception review for medical necessity.

Submitting authorizations via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the authorization form with member information, and make data entry quick and easy.
- The online authorization process indicates whether supporting documentation is required and allows you to attach and send documents as part of the authorization request —**for no charge**

- The online authorization process steps you through clinical guidelines, when applicable, giving you a quick indication of how your authorization request will be evaluated and whether it is likely to be approved. *(Successfully completing a clinical guideline does not guarantee payment)*
- Dental reviewers and consultants receive your authorization requests and supporting documentation as soon as you submit them online, meaning you will receive decisions faster.
- As soon as an authorization is determined, it is status is instantly updated online and available for review. You do not have to wait for a letter to find out the status of the authorization request

Steps for portal submission

1. Access the Authorization tab and complete the required information for the Member/ Patient. Select the treating Provider and treating location
2. When submitting a pre-authorization, the "Procedure Date/Tentative Service Date" should be listed for each service line. This tentative date listed must be at least one day after the date the authorization is received.
    - The authorization will be denied if a Procedure Date/Tentative Service Date is prior to the authorization received date.
    - If Procedure Date/Tentative Service Date is in the future or left blank the pre-authorization will be processed
3. Complete the information listing only those procedures, which require prior authorization or EPSDT exception review. Check the EPSDT box (see EPSDT Submission guidelines Chapter 6).
4. Attach/upload any required documentation to the authorization (per documentation requirements)

If you have questions about submitting authorizations online, attaching electronic documents, or accessing the Provider Web Portal, call the Skygen Electronic Outreach Team **855-434-9239**.

2. Submitting Authorizations on Paper Forms

To ensure timely processing of submitted authorizations, the following information must be included on the paper ©2019 American Dental Association J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D) Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)

Mail Authorizations to the following address:

CareSource IN: Authorization
P.O. Box 474
Milwaukee, WI 53201

Include any required documentation to the authorization (per documentation requirements (chapter 6). Missing, incorrect, or illegible information could result in the authorization being returned to the submitting provider's office, causing a delay in determination. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned.

X-Ray Return Policy. To request that x-rays are returned, providers must include a self-addressed stamped envelope with x-rays. Otherwise, x-rays are shredded.

Expedited Authorizations

Expedited authorizations must be noted as such on the authorization. These requests are for **emergency** and **extremely urgent** cases. An authorization request cannot be expedited to accommodate dental surgeries scheduled for outpatient/ASC or sedation procedures prior to the completion of the review by a CareSource Clinical Reviewer. The provider may schedule once the authorization has been approved.

Retrospective Authorization

CareSource shall not permit retrospective authorization submission after the date of service or admission where a prior authorization was required but not obtained (Retro Authorization) except in the following circumstances as outlined in the IAC rule, 405 IAC 5-3-9 Requirement Sec. 9.

IAC 5-3-9 Requirement Sec. 9 notes, prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

1. Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.
2. Mechanical or administrative delays or errors by the office.
3. Services rendered outside Indiana by a provider who has not yet received a provider manual.
4. Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.
5. The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:
    a. The provider's records document that the member refused or was physically unable to provide the member identification (RID) number.
    b. The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.
    c. The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review. Claims not meeting the necessary criteria as described above will be administratively denied.

Requests for retrospective review that exceed these time frames will be denied and are ineligible for appeal. If the request is received within these time frames and a medical necessity denial is issued, you may submit a request for an appeal within 180 days from the date of the service, date of discharge, or date of denial if service was not yet rendered. Please note: If you are appealing on our member's behalf with their written consent, you have 60 calendar days from the date of the action notice.

Retrospective Authorization Submission Procedures

Submitting Retro authorizations for review via SKYGEN provider web portal:

Prior to Claim Submission, submit the retrospective authorization

1. Login to SKYGEN provider portal and access the submit authorization tab follow steps as usual completing each entry. Include the services and the Date of Service for each entry line.
2. In Remarks section of the authorization portal entry add the note "Update to Retro"
3. Complete an ADA claim form and upload as an attachment. In Box 1 of the ADA claim form as shown in figure 1 below, Type of Transaction: There are three boxes that may apply to this submission. If services have been performed, mark the "Statement of Actual Services" box. If the services also required preauthorization check the box marked "Request for Predetermination / Preauthorization." If the claim is through the Early and Periodic Screening, Diagnosis and Treatment Program, check the box marked 'EPSDT/Title XIX' if applicable. Complete the remaining sections of the ADA claim.
4. Upload in supporting or required documentation as noted in chapter 6. Note: radiographs submitted should reflect preop status.

Submitting Retrospective Authorizations by Mail:

CareSource IN: Authorization
P.O. Box 474
Milwaukee, WI 53201

Complete the ADA claim form as noted in step 3 above and include any required documentation to the authorization (per documentation requirements (chapter 6).

Authorization Determination Timeframes

Review Category	Provider	Decision when all information is present	Extension*
Standard Preauthorization	N/A	7 Calendar Days	14 calendar days
Expedited Preauthorization	N/A	72 hours	14 calendar days
Urgent Concurrent		1 business day	48 hours
Retrospective	Must submit within 405 IAC 5-3-9 Requirement Sec. 9 timeframes	30 calendar days	14 calendar days

*Extensions may be granted if the member requests an extension, or if the Managed Care Entity (MCE) justifies a need for additional information and how the extension is in the member's best interest. Authorizations expire 12 months from date of determination.

For dental authorization questions, please contact one of our CareSource PA Specialist team members at 1-855-202-1058, follow the prompt to "authorizations" and then press prompt for "dental authorizations"

Post Review/Prepayment Claim Review

(See Section 5.4 CLAIMS SUBMISSION PROCEDURES)

Certain services identified by CareSource clinical teams via utilization review analysis, require prepayment/ post service review, to promote quality and appropriateness of care.

Prepayment or post service review means that the provider has already completed the services and has submitted the claim along with all supporting documentation for review **prior to payment**.

- Services subject to prepayment review are identified in the benefit grid of this manual (Chapter 7).
- When submitting a claim for post service/prepayment review, the provider must include all of the appropriate documentation with the claim. Appropriate documentation would include any **preoperative** radiographs, narratives of medical necessity, sedation records, etc.
- Prepayment review does carry some risk for the provider – if they perform the service and it is not approved, then they may not bill the beneficiary and must absorb the cost. In order to lessen this risk, the following measures are offered to providers to ensure they have a full understanding of medical necessity criteria to prevent them from performing services that will be denied for payment:
    - Providers may file an appeal if they believe the denial was in error. This will prompt a second review for medical necessity from a licensed dental consultant who was not involved in making the first clinical decision.
    - CareSource offers peer-to-peer consultations with our dental consultants. To understand why a service was denied or to ask questions, providers may request a conference call.
    - The clinical criteria CareSource uses to assess medical necessity are outlined in the clinical policies.

5.4 Claims Submission Procedures

Submission Procedures

At CareSource, our goal is to process all claims at initial submission. Before we can process a claim, it must be a “clean” or complete claim submission. Be sure to follow the guidelines of authorization requirements, clinical criteria, document requirements and submission requirements to ensure timely payment. Claims may be submitted in four possible formats. These formats include:

1. Electronic claims via the Provider Web Portal
2. Electronic submission via clearinghouses
3. Paper claims via ©2019 American Dental Association J430
   (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

1. Submitting Claims via Provider Web Portal

Providers may submit claims via the Provider Web Portal of our vendor partner Skygen USA Submitting claims via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility, pre-fill the claim form with member information, and make data entry quick and easy. Claims enter our benefits administration system faster—which means you receive payment faster.

- The online process allows you to attach and send electronic documents as part of submitting a claim —**for no charge**.
- Before submitting a claim, you can view a preclaim estimate. When you view an estimate for the claim information you entered, the system takes the claim through the edit and adjudication process, without actually submitting the claim. The result is a Preclaim Estimate report that allows you to see what amount will be paid for services provided, as well as any exceptions that may affect processing of the claim. A Preclaim Estimate is not a guarantee of benefits or of payment for services.
- As soon as a claim is paid, its status is instantly updated online, and a Remittance Report is available for review.

Steps for portal submission

1. To enter claim data and submit claims for processing, use the Claims > Submit Claims page.
2. To get started with a claim, first enter information to identify the patient with first and last name and Date of Birth OR Subscriber ID and Date of Birth, date of service, provider, and location. To load a patient's information directly from your patient roster instead of manually typing it, click the Roster tab and select the patient from the roster search list.
3. After entering information to identify the patient, date of service, provider, and location, you can verify eligibility. This check indicates not only whether the patient is eligible on the given date of service, but also whether that patient is eligible for services performed by the selected provider at the designated clinic location.
4. Enter service codes and related information in the Services section. Here you can provide billed amounts for each service, indicate other applicable fees, and provide optional reference/referral numbers. Note, when entering multiple units of the same service on the claims submission you will enter all units treatment completed, on one (1) line-item x qty. Note if EPSDT.
5. You can attach supporting documentation in the Attached Documents section as part of submitting a claim. Multiple files can be uploaded at once, but individual files are limited by the maximum file size indicated. Attach files within maximum file size 9.8 Megabytes and allowed file types: doc, docx, gif, jpg, jpg, jpeg, pdf, png, tif, tiff, txt, xls, xlsx, zip.

If you have questions about submitting claims online, attaching electronic documents, or accessing the Provider Web Portal, call the Electronic Outreach Team **855-434-9239**.

2. Electronic submission via clearinghouses

Providers may submit electronic claims via their dental clearinghouse, most common are Change Healthcare (formerly Emdeon), DentalXChange, VYNE Dental (Renaissance) or Dentrix eClaims clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN USA. The CareSource Payor ID is INCS1. This ID should be used for all clearinghouse dental claims.

It is important to ensure all information is correct to avoid denials and delays in claim adjudication. Most **dental clearinghouses** flag anything found wrong with the claim for the submitter including 1) validation errors (i.e. wrong/invalid NPI number, wrong/invalid TAX ID, incorrect code, etc). 2) rejected claims showing no coverage in effect (i.e. Member ineligible, not found, etc.) 3) Prompts claim attachments for necessary procedure codes (i.e. x-rays, narratives, perio charting, intraoral photos, etc.) 4) Invalid or missing COB info (i.e. if COB indicator checked). If error the clearinghouse sends a return of EDI not accepted and reason as the error is flagged for the submitter, so they can correct the claim and resubmit.

3. Submitting Claims on Paper Forms

To ensure timely processing of paper claims, the following information must be included on the paper ADA Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Billing Location and Provider Location
- Provider NPI
- Payee Tax Identification Number (TIN)
- Date of Service for each service line

Use approved ADA dental codes, as published in the current CDT book, or as defined in this manual, to identify all services. Include on the form: all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams, and resin fillings). CareSource/Skygen recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51. Likewise, if the nearest tooth is A, chart as code AS.

Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in payment. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned.

Submit Paper Claims: Indiana
CareSource Attn: Claims
P.O. Box 803
Dayton, OH 45401-8730

All claims should be submitted within 90 days from the date of service for participating providers or within 180 days from the date of service for non-contracted (Out of Network) providers of the actual month of service in order to be considered a timely submission. For dental claims questions, please contact one of our CareSource team members at **1-844-607-2831**, follow the prompt to "healthcare provider" "claims" and when prompted state "dental claims".

Submitting a Corrected Claim

A corrected claim should ONLY be submitted when an original claim or service was **PAID** based upon incorrect information. A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

If a claim or service originally DENIED due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a corrected claim.

1. Identify the claim as "corrected" by boldly and clearly marking the claim as "Corrected Claim" across the top of claim form.

2. Identify the original Claim/Encounter Number by writing it in the Remarks section (Box 35) on claim.
3. Attach any supporting documentation and send documentation in the same package with the paper claim form.

In the event of incomplete, incorrect, or unclear information was originally submitted on a claim; corrected claims should be submitted within 60 days from the date of the EOP. Examples include missing tooth number or surface, the date of service, procedure/ diagnosis code, incorrect unit count, and/or modifier, provider, place of service, wrong provider NPI or facility location. Resubmit the entire claim with updated information as a "Corrected Claim." You do not need to file an appeal.

Send forms and documents to:
CareSource
ATTN: Corrected Claims Dept.
P.O. Box 3607
Dayton, OH 45401

Coordination of Benefits (COB) – Other Coverage

If the patient has other insurance coverage that may affect claim processing for services, all claims must be filed with commercial insurance companies or third-party administrators, the primary payer first prior to filing claims with CareSource for reimbursement for services rendered to CareSource member.

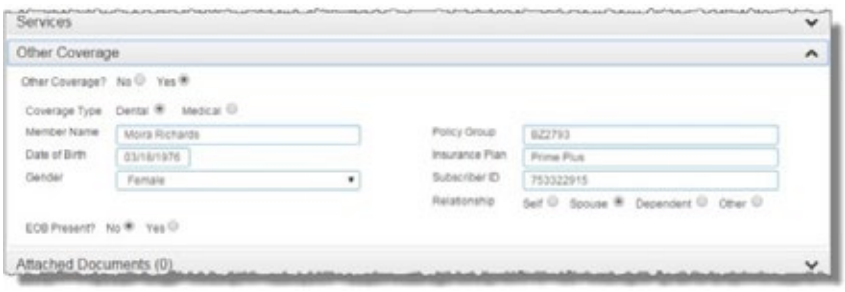
If the claim is filed initially with CareSource, the claim will be denied. If the primary payer pays less than the agreed upon fee, you may bill CareSource for the balance if a covered benefit of CareSource.

Remaining charges will be reimbursed up to the maximum contracted allowed amount had CareSource paid as the primary payer. A copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim.

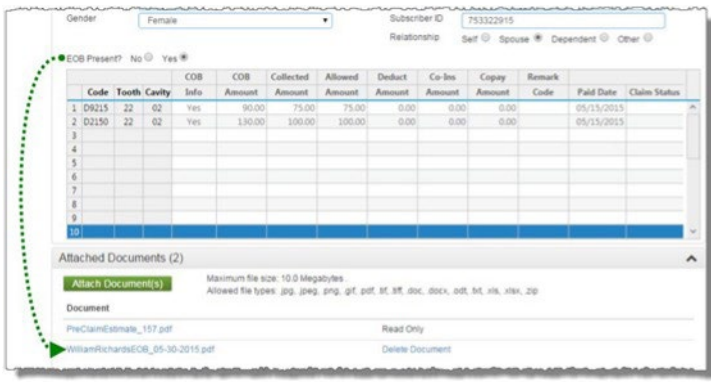
SKYGEN Provider Portal COB Submission

Submit COB claims at https://pwp.sciondental.com/PWP/Landing the EOB must be attached/uploaded and the COB fields per service line item completed.

On the SKYGEN Provider Portal under the Claims Entry tab, enter the other Payer's information in the **Other Coverage** section



Select whether the other insurance is dental or medical, enter information about the subscriber of that coverage, and indicate the patient's relationship to the subscriber. To include an Explanation of Benefits (EOB) for other insurance that may be used to cover the patient's services, select the EOB Present check box. Use the Attached Documents section to attach the EOB form from the other insurance plan. Failure to provide COB information for a claim with **EOB Present** indicated may result in denial of payment.



For each procedure code, select Yes or No to indicate whether COB Information applies, then enter the other insurance information from the EOB form. Different forms may have different fields and information. For efficient processing of the claim, complete as many fields as possible based on the information from the EOB form.

Do not just submit the attached EOB or claim will deny. The Provider must enter the amounts directly.

COB Paper Claim Submission

When a claim is submitted to CareSource as the secondary payer:

1. Complete the entire ADA claim form
2. Attach in supporting documentation (i.e. x-rays, periodontal charting, narratives, etc.
3. Attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.
4. Note the primary carrier paid amount in the "Remarks" field (Item 35).

Mail to the following address:
CareSource
ATTN: Claims Dept.
P.O. Box 803
Dayton, OH 45401

COB Clearinghouse Submission

For electronic claim submissions, the primary payer information must be included on the claim submission. The electronic claim must have the primary payer information completed in the correct segments (loops) and entered by service line, according to the clearinghouse's "Companion Guide," in addition to the Explanation of Payment attachment through NEA, FastAttach™, or your clearinghouse.

For electronic claim submissions, the payment made by the primary carrier must be indicated in the **appropriate COB field**. Remarks field (Item 35).(See clearinghouse claim submission in previous section).

If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 90 calendar days of the primary carrier's EOP.

5.5 Claims Disputes, Appeals and Provider Grievances

A **grievance** is a member's request for reconsideration of a decision regarding the medical necessity and appropriateness of services. Care Providers may also submit grievances and appeals on a member's behalf if the member's written consent is obtained. All grievances should be clearly documented.

An **appeal** is any of the procedures that deal with the review of adverse organization determinations on health care services a member believes he/she is entitled to receive. Including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service. These procedures include appeal by the health plan and if necessary, an independent review committee, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC) or judicial review.

Claim Dispute

If a service line on a claim was overpaid or underpaid—For example, if a claim is paid but Provider feels it was not paid at right amount then a claim dispute can be filed. https://www.caresource.com/documents/in-med-claim-dispute-form/ Adjustments to any overpayments will be made on subsequent reimbursements to the Health Partner/Provider or the Provider can issue refund checks to CareSource for any overpayments

Mail: CareSource
Coordinator Attn: Health Partner
Claims Disputes - Indiana
P.O. Box 2008
Dayton, OH 45401-2008

Fax: Provider Claims Disputes
Fax Number: 937-531-2398

Providers must complete a claim dispute prior to requesting an appeal. Providers/facilities have 60 days from the Explanation of Payment (EOP) to file a claim dispute. Applicable timely filing limits will apply. If CareSource fails to decision a claim within 30 days after receipt, the 90-day submission period for the dispute begins as of the claim submission date per 405 IAC 1-1.6-1.

Claim Appeal

Claim Appeals are administrative appeals of an adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member. After a provider has received a claim dispute resolution or 30 calendar days have passed since the dispute has been received by CareSource, a provider may submit a claim appeal to request reconsideration of a claim denial. Claim Appeals must be submitted within 60 days of the date of resolution on the informal dispute process. Claims appeals cannot reverse a utilization management determination.

To submit a Claims Appeal: 1) Submit the Claims Appeal Form, 2) Supporting Documentation, 3) Original Remittance Advice

Mail: CareSource Attn: Provider Appeals
P.O. Box 2008
Dayton, OH 45401

Fax: 937-531-2398
If Faxed all documentation including radiographs and photos must be clear and readable. Faxes must be in accordance with confidentiality guidelines and governed by the same authorization requirements as any other release of health care information.

Authorization Appeal

There are multiple ways to respond to an adverse determination of an authorization review request.

1. Before submitting a request for a clinical appeal, the requesting provider may request a peer-to-peer (P2P) conversation with the CareSource Dentist Reviewer or Dental Director at (1-877-479-0027). This request must be made and occur within 7 business days of the determination.
2. A treating provider may assist a member by submitting appeal on behalf of the member but must receive written consent from the member. The clinical appeal must be submitted within 60 days from date of the adverse benefit determination. For pre-service appeals submitted with written member consent, the standard appeal decision time frame is 30 calendar days from the date of receipt by CareSource. The standard decision time frame for post-service provider appeals is 30 calendar days. A 14 calendar-day extension may be requested by CareSource on any provider appeal. CareSource responds to all expedited appeal requests within 48 hours of receipt.

Mail: CareSource
Clinical Appeals – IN
P.O. Box 1947
Dayton OH 45401-1947

Fax: 937-531-2398 Attn: Dental Health Partner

Provider Complaints and Grievances

Providers may file grievances related to members, other providers, or operational issues of the plan. CareSource will thoroughly investigate each provider complaint using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties, and applying the CareSource written policies and procedures.

CareSource Provider Complaints – Indiana
P.O. Box 1947 Dayton OH 45401
Phone: 1-844-607-2831

A Member has the right also to file a Grievance at any time. Examples include:

- Member cannot get a timely appointment with a provider.
- Member thinks the provider's office staff did not treat them fairly.
- Member is not satisfied with the quality of care they received.

These types of grievances do not involve benefits or denial of benefits.

CareSource responds to all grievances reported by a member within 30 calendar days. Expedited grievances shall be resolved within 48 hours of receipt. If CareSource denies a request for an expedited review, we shall transfer the grievance to the standard grievance time.

CHAPTER 6: CARE STANDARDS

6.1 Standards for Medical/Dental Records

Care Providers must create and maintain dental records that contribute to the safety and continuity of care of Members. The provider shall confirm that all records conform to the applicable State Board of Dental Examiners and with any applicable Health Insurance Portability and Accountability Act (HIPAA) requirements. The records shall be carefully maintained at the dental office and readily available for CareSource staff during any review. If computerized, the records shall be non-changeable and properly backed-up for protection.

Per the American Dental Association guidelines and EPSDT medical record requirements, the following are components that should be included with the clinical record.

- database information, such as name, birth date, address, and contact information
- place of employment and telephone numbers (home, work, mobile)
- medical and dental histories, notes, and updates
- progress and treatment notes
- conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment
- diagnostic records, including Missing- Filled and Decayed teeth charting, periodontal charts, images, scans, study models
- medication prescriptions, including types, dose, amount, directions for use and number of refills
- radiographs
- diagnoses, oral hygiene status, and documented oral cancer screening, TMJ screening, caries risk assessment as performed
- should include a tobacco, alcohol, and substance abuse history for ages fourteen (14) and older
- treatment plan and treatment plan notes
- patient complaints and resolutions
- laboratory work order forms
- mold and shade of teeth used in bridgework and dentures and shade of synthetics and plastics
- referral letters and consultations with referring or referral dentists and/or physicians
- patient noncompliance and missed appointment notes
- follow-up and periodic visit records
- postoperative or home instructions (or reference to pamphlets given)
- consent forms
- waivers and authorizations
- sedation/anesthesia records
- consent and informed consent forms
- conversations with patients dated and initialed (both in-office and on telephone, even calls received outside the office)
- correspondence, including dismissal letter; if appropriate
- must include a date for return or follow up visit
- must include documentation that problems from previous visits were addressed
- signed HIPAA Confidentiality Statement
- must have all entries signed or initialed by the Provider
- must have all entries dated

All entries, whether paper or electronic, should be legible.

6.2 Standards for Member Outreach Call Policy and Procedures

CMS comprehensive and preventive child health program for individuals under the age of twenty-one (21) is called Early and Periodic Screening, Diagnostic, and Treatment Service (EPSDT). The explanation of this program can be found at www.cms.hhs.gov/Medicaid/epsdt. Based upon the requirements of the EPSDT program, each CareSource provider office is required to maintain and document the following Member recall policy and procedures:

1. For Members of record (under age 21), providers must attempt to make contact at least two (2) times per year
2. For Adult Members of record (over age 21), providers must attempt to make contact at least one (1) time per year

The recall policy must be written and implemented upon the commencement of the CareSource Dental program in your office. The office procedures may be determined by each dental office, but must include a written process of notification for Members including:

- Recall month for routine preventive care
- Date of a missed appointment(s)
- Date for follow up appointments

A log must be kept notating when a "Reminder Notice" was sent to the Member, or a telephone attempt was made to the Member prior to the appointment.

Documentation of contact attempts and results must be submitted to CareSource upon request.

Missed Appointment Procedure

The dentist or specialist shall conduct affirmative outreach whenever a Member misses an appointment. This outreach should be documented in the medical record. Such an effort shall be deemed reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call. Any time a member misses three or more consecutive appointments, health partners are asked to notify our Care Management department for assistance. Medicaid beneficiary members cannot be charged for Missed Appointments.

Member Dismissal

Participating health care partners can request that a CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include noncompliance with medication or treatment, skipping scheduled appointments or failure to modify behavior as requested.

CareSource requires that a provider/health partner's office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Prior to dismissal initiation. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, health partners may initiate the dismissal by following the guidelines below.

The health partner/provider office must notify the member of the dismissal by certified letter. A copy of the letter must be sent to CareSource at the following address:

CareSource
Attn: Member Services Manager
P.O. Box 1947
Dayton, OH 45401-1947 Fax: (937) 396-3095

CHAPTER 7: DENTAL BENEFITS AND COVERED SERVICES CLINICAL CRITERIA, GUIDELINES, REQUIREMENTS

This chapter provides comprehensive information on CareSource policies and guidelines pertaining to dental/oral health and associated ancillary services covered under the CareSource Indiana Medicaid program. There are several beneficiary categories, it is important to be aware of respective covered services for each category. In addition to the standard Indiana Health Coverage Program Medicaid benefits, and the federal EPSDT program, CareSource uniquely offers an enhanced benefit value-added program for HIP Basic and HIP Plus. Understanding these categories and respective covered, non- covered, value- added services, frequencies, limitations, and clinical guidelines used in determining medical necessity, assists the provider with informed care for our Members.

Mandatory and Optional Medicaid Benefits Defined

CareSource provides Medicaid benefits, which states are required to provide under federal law, and optional benefits that states or the Managed Care plan may cover if they choose.

- **Mandated Benefits** include Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Services: comprehensive and preventive health care services for children under age 21 and any state benefits.
- **Optional Benefits** include CareSource additional benefits; a comprehensive list of value-added services and some enhanced frequency and limitation allowances.

7.1 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

What is EPSDT?

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA ‘89) legislation. Additionally, section 42 U.S.C.§ 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The federally mandated (EPSDT) program, referred to as EPSDT/HealthWatch in Indiana, is a preventive healthcare program designed to improve the overall health of Medicaid and CHIP eligible individuals from birth through the month of their 21st birthday.

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children’s health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

The benefits covered under EPSDT are key to ensuring children and youth receive appropriate preventive medical, dental, vision, hearing, mental health, substance use disorder, developmental and specialty services, as well as all necessary services to address any defects, illnesses or conditions identified by "screening." The services covered under EPSDT are limited to those within the scope of the category of services listed in 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health, even if the service is not available under the state's medical assistance benefit plan. If a Provider is unable to conduct the necessary EPSDT screens for Members under age 21, the Provider is responsible for making a referral to another Participating Provider to ensure the Member has the necessary EPSDT screens performed.

EPSDT Dental Services and Periodicity Schedule

EPSDT dental services include those provided at intervals that meet reasonable standards of dental practice and at intervals necessary to determine the existence of a suspected illness or condition. Services should be provided at as early an age as necessary to provide relief of pain and infections, restoration of teeth and maintenance of oral health. Dental care includes emergency, preventive, and therapeutic services for dental disease, which, if left untreated, may become acute dental problems, or may cause irreversible damage to the teeth or supporting structures.

In accordance with the American Academy of Pediatric Dentistry (AAPD) Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents, dental providers should refer to the "Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling" Schedule. The AAPD intends these recommendations to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. The schedule may be assessed at http://www.aapd.org/assets/1/7/periodicity-aapdschedule.pdf

CareSource dental benefits consists of both the State Plan approved services as well as several value- added services (Section 7.2 of this ORM). Additionally, in accordance with EPSDT requirements, any medically necessary EPSDT service for children (under the age of 21). See section 7.3 Non-Covered Services for procedures on submitting EPSDT non-covered service requests.

American Academy of Pediatric Dentistry. Periodicity of examination, preventive dental services, anticipatory guidance/counseling, and oral treatment for infants, children, and adolescents. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:232-42.

7.2 Value Added-Services Enhanced Benefit

Value-added services are additional services outside of the standard Medicaid benefit package (i.e., State Plan and/or Medicaid managed care contract) that are delivered at the managed care entity's (MCE) discretion and paid at the MCE's expense. As part of our quality initiatives, addressing the social determinants of health (SDOH) and our deep commitment to whole person health reflected in our pursuit to provide essential oral health care for the entire family across the member's life span. CareSource uniquely offers a value-added enhanced benefit in the state for HIP and HHW members. These essential services not only prevent progressive oral disease leading to pain, infection, and more costly care, but the enhanced dental benefit is based on research that demonstrates a strong connection between oral health and physical health in which essential preventive and therapeutic oral health care can help improve overall health outcomes. Value - Added Services offered by CareSource are listed below and are listed in **Bold Highlighted codes** in the Covered Benefits section of the Dental Office Reference Manual (ORM). Benefit limitations and restrictions may apply.

HHW Package A and C **Some Services are age specific including Noninstitutionalized qualifying Adults (age ≥ 21) enrolled in HHW**					
D0180	comprehensive periodontal evaluation - new or established patient (age ≥ 21)	**D1351**	Sealant per tooth *(Enhanced frequency)*	**D4341**	Periodontal scaling and root planning-four or more teeth per quadrant *(Enhanced frequency)*
D1110	Adult Prophylaxis (age ≥ 21) Extra cleaning supplemental to 1 per 12 months)	**D2951**	Pin retention - per tooth, in addition to restoration	**D4342**	Periodontal scaling and root planning-one to three teeth, per quadrant (Enhanced frequency)
D1206	Fluoride Varnish *(Added Benefit for Age 21 and older)*	Root Canals are Enhanced Benefit for Age ≥ 21. Benefit subject to limitations		**D4910**	Periodontal Maintenance (age ≥ 21) supplemental maintenance 1 per 12
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	**D3310**	Anterior root canal (excluding final restoration)		
		D3320	Bicuspid root canal (excluding final restoration)	**D3330**	Molar root canal (excluding final restoration)

HIP STATE PLAN – BASIC, HIP STATE PLAN – PLUS (Some Services limited to Age 19 -20)					
D1110	Adult Prophylaxis (age ≥ 21) Supplemental cleaning	**D1351**	Sealant per tooth *(Enhanced frequency)*	**D4341**	Periodontal scaling and root planning-four or more teeth per quadrant *(Enhanced frequency)*
D1206	Fluoride Varnish *(Added Benefit for Age 21 and older)*	**D2951**	Pin retention - per tooth, in addition to restoration	**D4342**	Periodontal scaling and root planning-one to three teeth, per quadrant (Enhanced frequency)
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Root Canals are Enhanced Benefit for Age ≥ 21. Benefit subject to limitations		**D4910**	Periodontal Maintenance (age ≥ 21) supplemental maintenance 1 per 12 months)
		D3310	Anterior root canal (excluding final restoration)		
		D3320	Bicuspid root canal (excluding final restoration)		
		D3330	Molar root canal (excluding final restoration)		

HIP PLUS Diagnostic and Preventive (Some services limited to Age 19-20)					
D0170	Re-evaluation - limited, problem focused (established patient; not post-op visit)	**D0411**	HbA1c in-office point of service testing	**D1321**	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D0180	comprehensive periodontal evaluation - new or established patient (age ≥ 21)				
D0277	Vertical bitewings – 7 to 8 images	**D1206**	Topical Fluoride Varnish	**D1351**	Sealant per tooth *(Enhanced frequency)*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	**D1208**	Topical application of fluoride	**D1354**	Interim Caries Medicament
D0251	Extra-oral posterior dental radiographic image	**D1320**	Tobacco Counseling	**D1355**	Caries preventive medicament application - per tooth
HIP PLUS Comprehensive *(Some services limited to Age 19- 20)*					
CareSource enhanced benefit includes four additional (fillings or extractions) per year supplemental to the four allowed by standard Medicaid benefit.					
D2140	Amalgam - one surface, primary or permanent	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D7111	Extraction, coronal Remnants – primary tooth
				D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D2140	Amalgam - one surface, primary or permanent	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D7111	Extraction, coronal Remnants – primary tooth
				D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D2150	Amalgam - two surfaces, primary or permanent	D2390	resin-based composite crown, anterior	D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated
D2160	Amalgam - three surfaces, primary or permanent	D2391	resin-based composite - one surface, posterior	D7220	Removal of impacted tooth - soft tissue
D2161	Amalgam - four or more surfaces, primary or permanent	D2392	resin-based composite - two surfaces, posterior	D7230	Removal of impacted tooth – partially bony
D2330	Resin–based composite - one surface, anterior	D2393	resin-based composite - three surfaces, posterior	D7240	Removal of impacted tooth - completely bony
D2331	Resin-based composite - two surfaces, anterior	D2394	resin-based composite - four or more surfaces, posterior	D7241	Removal of impacted tooth - completely bony with unusual surgical complications
D2332	Resin-based composite - three surfaces, anterior	D2951	Pin retention - per tooth, in addition to restoration	D7250	Removal of residual tooth roots (cutting procedure)
Other Services					
D3220	Therapeutic pulpotomy (excluding final restoration	D4341	Periodontal scaling and root planning-four or more teeth per quadrant	D7286	Biopsy of oral tissue - soft
		D4342	Periodontal scaling and root planning-one to three teeth, per quadrant	D7510	Incision and drainage of abscess - intraoral soft tissue
		D4910	Periodontal maintenance	D9230	Inhalation of nitrous oxide/ anxiolytics, analgesia (For age 19-20)

HIP Basic Age 19- 20 Additional Diagnostic and Preventive Services			
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	**D0277**	Vertical bitewings – 7 to 8 images
D0411	HbA1c in-office point of service testing	**D1355**	Caries preventive medicament application – per tooth
D1351	Sealant - per tooth	**D1320**	Tobacco counseling
		D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use

7.3 Non-Covered Services

Covered versus non-covered

Covered dental services as defined by IAC

CareSource covered dental benefits program consists of both the State Plan approved services and CareSource expanded benefit value-added dental services (See Benefits Grid Section of the ORM).

Certain procedures, the state plan as well as CareSource considers these integral to a greater procedure and therefore a participating dentist may not bill the member. (Examples include adjustments to complete/ partial dentures within six months of delivery are considered part of the initial placement, the placement of amalgam or composite restorations includes liners, base, pulp cap, bonding adhesive and polishing and local anesthesia as part of the restorative procedure). See Clinical policies and criteria section for additional information.

In accordance with federal law, any medically necessary EPSDT service for children under the age of 21, can be submitted for review of medical necessity whether state plan covered or non-covered.

Non-covered Dental Services and Exception Benefit Requests

For beneficiaries **under the age of 21**, the benefit exception process occurs when a provider requests review of a service that is not a covered benefit to determine if an exception should be made based on medical necessity. The process also applies to benefit limitations, or when a provider requests additional treatment for a member who has exhausted the benefit limit (i.e., duration or quantity) of a service.

Submitting Non-covered Service Requests under EPSDT

Providers should obtain a prior authorization (PA) for all medically necessary noncovered services. A prior authorization request for a non-covered service should include:

- indication of EPSDT
- documentation of medical necessity

Providers requesting a PA or billing for EPSDT services must select the EPSDT box in section 1 of the ADA claim form or box 24H on the CMS-1500 claim form. In the Skygen provider portal, the EPSDT box should be checked when submitting the PA. PA request submitted correctly will be clinically reviewed for medical necessity. Approved PA's will be reimbursed based on contracted rate fee schedule upon successful claims adjudication. Medicaid's payment must be accepted as payment in full.

PA's that are denied will generate one of two possible denial reasons:

1. Per Dental Director/Consultant review, medical necessity has not been demonstrated to allow EPSDT benefits. The service failed to meet medical necessity based on the review of sufficient documentation from the dental provider. No billing to CareSource may occur since the service was not determined to be medically necessary. A dental provider may charge an eligible CareSource beneficiary for dental services that are considered not medically necessary if the beneficiary knowingly elects to receive the service(s) and enters into a written agreement with the dental provider to pay for such service(s) **prior** to their delivery.
2. Medical necessity has not been demonstrated to allow EPSDT benefit, due to insufficient or incomplete documentation. Services that are denied with this processing policy may not be billed to CareSource, nor may the beneficiary be charged at this time. The documentation submitted by the

dental provider justifying medical necessity was not sufficient to allow a determination of medical necessity to occur. The dental provider is encouraged to resubmit the PA, including all documentation required to render a medical necessity decision. No billing to CareSource or to the beneficiary may occur until a decision on medical necessity can be evaluated completely.

Non-Covered Services Disclosure

A provider may bill a Medicaid recipient for a noncompensable service or item if the recipient is told before the service is rendered that the program does not cover it. If, during the exam, you determine that the Member requires services not covered by the Program you will be expected to discuss possible options with the Member. Should the Member choose to receive Non-Covered Services, the Non-Covered Services Disclosure Form provided herein (**Appendix section**), should be completed, and signed by provider and the member. This form should be kept in the member's patient record. If the member elects to receive the non-covered procedure(s) or treatment(s), the member would pay your usual and customary rate as payment in full for the agreed upon procedure(s) or treatment(s). The member is financially responsible for such services.

7.4 Covered Services Policy Guidelines

CareSource has developed Dental Clinical Policies and Dental Coverage Guidelines to assist us in administering dental plan benefits. As detailed in the section below on "medical necessity," our clinical policies help identify whether services are medically necessary and express our determination for prior authorization, pre-payment, post-payment review and retrospective review of whether a dental service (e.g. procedure or technology) is proven to be effective based on the published clinical evidence and information found in generally accepted standards. Services determined to be experimental, investigational, unproven, or not clinically necessary by the clinical evidence are typically not covered. These policies and guidelines do not constitute clinical advice. Care providers are solely responsible for determining what care to provide to their patients. Members should always consult their dentist or physician before making any decisions about dental or medical care.

Benefit coverage for dental services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Indiana Health Coverage Programs Plan Description, and applicable laws that may require coverage for a specific service. CareSource uses as a guide the state specific "Dental Services Policy Manual" document that identifies which services are covered, which are excluded, periodicity and which are subject to limitations. As noted, additional CareSource value-added benefits are included with applicable limitations, and frequencies.

7.4.1 Medical Necessity Criteria

Submission of all service codes for eligible enrollees, must be medically necessary purview to CareSource guidelines and as defined by Indiana Administrative Code (IAC) Title 33- 20A-31 (7).

Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical/dental practice; peer-reviewed literature; government agency/ program approval status; evidence-based guidelines and positions of leading national health and dental professional organizations; views of dentists practicing in relevant clinical areas affected by the policy; and other available clinical information. Using these sources of information, CareSource begins with evidence - based guidelines as the basic platform to define established standards of effective care. Scientific evidence is the vital element in the development of an informed decision-making process for patients and their oral

health clinicians. Effective treatment is ultimately linked to the consistent use of these evidence-based dental clinical practices and the ability of oral health clinicians to effectively execute these therapies. CareSource has additionally adopted context of nationally developed and published guidelines, including those of the American Dental Association, the American Association of Pediatric Dentistry, the American Association of Oral and Maxillofacial Surgeons, American Society of Anesthesiologists and American Association of Orthodontists due to their acceptance as the best of evidence-based practice for oral health and related conditions. Our criteria then serve as a decision support tool to help define the most appropriate treatment, treatment setting and help assure consistency of care for each Member.

These criteria become a working document to help set expectations and to facilitate a partnership and shared responsibility between CareSource and our network of care providers. With open communication, we appreciate the active and meaningful role that care providers, members, advisory committees, and advocates have in determining how the scientific evidence is applied in our criteria. These criteria do not replace clinical judgement. Treatment decisions that are made in alignment with these criteria must be first clinically based. Care must be patient-centered and consider the individuals' needs, clinical and personal values to achieve optimal, patient-centered outcomes. Finally, our criteria, and their application, are always governed by the terms of each member's benefit plan and in accordance with applicable federal and state laws and regulations. Aligning with the CMS's commitment to ensuring program integrity (as defined in chapter 9 of this manual), dental services are reimbursable when the services meet the criteria of Medical Necessity. Providing every member with access to quality, evidence-based, patient-centered "medically necessary" care is the core tenet of our approach at CareSource.

7.4.2 Services Requiring Prior Authorization

See section 5.3 for submission procedures and section 7.5 for document requirements

Requires Prior Authorization	
The following procedures require prior authorization	
1. D1516 Space maintainer fixed bilateral, maxillary (< age 3)	29. D5284 Removable unilateral partial denture - one-piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant
2. D1517 Space maintainer fixed bilateral, mandibular (< age 3	30. D5286 Removable unilateral partial denture - one-piece resin (including retentive/clasping materials, rests, and teeth), per quadrant (≥ Age 21)
3. D1526 Space maintainer removable bilateral, maxillary (< age 3)	31. D5511 Repair broken complete denture base, mandibular (≥ Age 21)
4. D1527 Space maintainer removable bilateral, mandibular (< age 3)	32. D5512 Repair broken complete denture base, maxillary (≥ Age 21)
5. D1999 Unspecified preventive procedure, by report	33. D5611 Repair resin denture base, mandibular (≥ Age 21)
6. D4210 Gingivectomy or gingivoplasty – four or more teeth	34. D5612 Repair resin denture base, maxillary (≥ Age 21)
7. D4211 Gingivectomy or gingivoplasty – one to three teeth	35. D5621 Repair cast framework, mandibular (≥ Age 21)
8. D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth	36. D5622 Repair cast framework, maxillary (≥ Age 21)
9. D4240 Gingival flap procedure, four or more teeth	37. D5876 Add metal substructure to acrylic full denture (per arch)
10. D4241 Gingival Flap, one to three contiguous teeth	38. D5999 Maxillofacial Prosthesis
11. D4260 Osseous surgery four or more contiguous teeth or bounded teeth spaces per quadrant	39. D7296 Corticotomy – one to three teeth or tooth spaces, per quadrant
12. D4261 Osseous surgery one to three contiguous teeth or bounded teeth spaces per quadrant	40. D7297 Corticotomy – four or more teeth or tooth spaces, per quadrant
13. D4341 Periodontal scaling and root planing-four or more teeth per quadrant	41. D7961 buccal/labial frenectomy (Frenulectomy)
14. D4342 Periodontal scaling and root planing- One to three teeth	42. D7962 lingual frenectomy
15. D5110 Complete denture-maxillary (≥ Age 21)	43. D7999 Unspecified oral surgery procedure, by report
16. D5120 Complete denture -mandibular (≥ Age 21)	44. D8010 Limited orthodontic treatment of the primary dentition
17. D5130 Immediate denture maxillary (≥ Age 21)	45. D8020 Limited orthodontic treatment of the transitional dentition \
18. D5140 Immediate denture mandibular (≥ Age 21)	
19. D5211 Maxillary partial denture - resin base (≥ Age 21)	
20. D5212 Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) (≥ Age 21)	

21. D5213 Maxillary partial denture - cast metal framework with resin denture base (including retentive/clasping materials, rests, and teeth) (≥ Age 21) 22. D5214Mandibular partial denture - cast metal framework with resin denture base(≥ Age 21) 23. D5225 Maxillary partial denture - flexible base (including retentive/ clasping materials, rests, and teeth) 24. D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) 25. D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) 26. D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) 27. D5282 Removable unilateral partial denture one-piece cast metal (including retentive/clasping materials, rests, and teeth) maxillary(≥ Age 21) 28. D5283 Removable unilateral partial denture one-piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular (≥ Age 21)	46. D8030 Limited orthodontic treatment of the adolescent dentition 47. D8040 Limited orthodontic treatment of the adult dentition 48. D8070 Comprehensive orthodontic treatment of the transitional dentition 49. D8080 Comprehensive orthodontic treatment of the adolescent dentition 50. D8090 Comprehensive orthodontic treatment of the adult dentition 51. D8210 Removable appliance therapy 52. D8220 Fixed appliance therapy 53. D9222 Deep sedation/ general anesthesia - first 15 minutes 54. D9223 Deep sedation/ general anesthesia - each subsequent 15 minutes 55. D9239 Intravenous (IV) moderate (conscious) sedation/ analgesia- first 15 minutes (Age 21 and Older) 56. D9243 Intravenous (IV) moderate (conscious) sedation/ analgesia- each additional 15 minutes (Age 21 and Older) 57. D9947 Custom sleep apnea appliance fabrication and placement 58. Any EPSDT Non-Covered Services

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits, and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Prepayment/Post Review

Certain identified services by CareSource clinical teams via utilization review analysis, require prepayment/ post service claim review. The following services, provider should submit supporting documentation with claim submission.

D0180 Comprehensive periodontal evaluation - new or established patient
D1516 Space maintainer - fixed – bilateral-maxillary
D1517 Space maintainer - fixed – bilateral-mandibular
D1526 Space maintainer - removable – bilateral-maxillary
D1527 Space maintainer - removable – bilateral-mandibular
D1575 Distal shoe space maintainer- fixed- unilateral
D3410 Apicoectomy/ periradicular surgery – anterior
D3421 Apicoectomy /periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/ periradicular surgery -each additional root
D3430 Retrograde filling-per root
D3471 Surgical repair of root resorption – anterior
D3472 Surgical repair of root resorption – premolar
D3473 Surgical repair of root resorption - molar
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture
D5750 Reline complete maxillary denture -indirect (≥ Age 21)
D5751 Reline complete mandibular denture - indirect (≥ Age 21)
D5760 Reline maxillary partial denture – indirect (≥ Age 21)
D5761 Reline mandibular partial denture – indirect (≥ Age 21
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant
D7251 Coronectomy - intentional partial tooth removal
D7261 Primary closure of a sinus perforation
D7310 Alveoloplasty in conjunction with extractions - per quadrant (Four or more teeth)
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions Four Or More Teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7610 Maxilla - open reduction (teeth immobilized, if present)
D7620 Maxilla - closed reduction (teeth immobilized, if present)
D7630 Mandible - open reduction (teeth immobilized, if present)
D7640 Mandible - closed reduction (teeth immobilized, if present)
D7650 Malar and/or zygomatic arch - open reduction
D7660 Malar and/or zygomatic arch - closed reduction
D7670 Alveolus - closed reduction may include stabilization of teeth
D7671 Alveolus, open reduction may include stabilization of teeth
D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710 Maxilla open reduction
D7720 Maxilla - closed reduction
D7730 Mandible - open reduction
D7740 Mandible - closed reduction
D7750 Malar and/or zygomatic arch - open reduction
D7760 Malar and/or zygomatic arch - closed reduction
D7770 Alveolus - open reduction stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7972 Surgical reduction of fibrous tuberosity
D7979 Non-surgical silaolithotomy
D9120 Fixed partial denture sectioning

7.4.3 Document Standards

Radiographs

When submitting x-rays for the authorization process, all teeth or areas involved in the treatment request must be visible on x-rays. Radiographs presented for review must meet the following specific criteria:

- Radiographs must be properly mounted, or digital film must be adequately printed, recent, clearly readable, free from defect, and dated. All clinical crowns and root tips must be observable on periapical x- rays. Bitewing images should have reduced overlap.
- The density and clarity must be such that interpretation can be made without difficulty. Defective or illegible radiographs will not be considered for review and must be remade without additional cost to CareSource or the Member.

- Digital x-rays should be attached to the authorization when submitted via the SKYGEN portal. Hard copy x-ray film should be labeled with the patient's name, Medicaid/CareSource ID number and date of the x-ray. When it is necessary to send hard copy film by mail, and the authorization is submitted online, the radiograph should be attached to a printed copy of the authorization.

Periodontal Charting

When required for specific procedures, it is expected that a periodontal charting should be accurate and complete. The periodontal charting should provide a complete record of the pocket depths, mobilities, recession (free gingival margin), mucogingival junction (essential for submissions for mucogingival surgery), location of implants, etc.

Oral / Facial Photographic Images

Images are required when dental radiographs do not adequately indicate the necessity for the requested treatment in situations such as soft tissue surgery requests such as frenectomy, prior to gingivectomy; all orthodontic cases, buccal and lingual decalcification/caries if indicated. Oral / facial photographic images must be of good diagnostic quality and must indicate the necessity for the requested treatment.

Treatment Plans, Narratives, Letters of Medical Necessity

Complete or clear proposed treatment plan rendered, should be submitted. If required or submitted as support documentation, Narrative Descriptions or Letters of Medical Necessity should be "patient- specific" and outline the specific symptoms or abnormalities, the service intended to alleviate. Provide the medical/ dental justification needed for the evaluation of this Request. This item must contain sufficient documentation to justify the medical necessity for all requested services. Per Industry standards, a standard treatment plan should include:

- pertinent dental history
- pertinent medical history, if applicable
- the strategic importance of the tooth
- the condition of the remaining teeth
- the existence of all pathological conditions and ICD- 10 diagnoses*
- preparatory services performed and completion date(s)
- documentation of all missing teeth in the mouth
- the oral hygiene of the mouth;
- all proposed dental work
- identification of existing crowns, periodontal services, etc.
- identification of the existence of full and/ or partial denture(s), with the date of initial insertion
- the periodontal condition of the teeth, including pocket depth, mobility, osseous level, vitality, and prognosis
- identification of abutment teeth by number

ICD-10-CM is the Health Insurance Portability & Accountability Act of 1996 (HIPAA) standard diagnostic code set for use in electronic transactions such as electronic claims. ICD-10-CM is the 10th revision to International Classification of Diseases (ICD), Clinical Modification (CM). Its primary purpose is epidemiological tracking of illness and injury. Due to the so-far limited adoption of ICD reporting requirements by most payers, dental practices may not find that they must adapt to this change immediately. Submission of ICD-10 codes for dental is currently not a requirement per IN FSSA or IN CMO plans; however, it assists in communicating medical necessity of certain procedures. Most commonly used dental diagnosis codes are now available for quick reference in the ADA CDT 2020 Guide and can be accessed via the American Dental Association and is available through the following resource ICD10 Data.com Diseases of oral cavity and salivary glands K00-K14.

7.4.4 Place of Service (POS)

PLACE OF TREATMENT on line 38 of the ADAJ430 Claim form, enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. The full list is available online at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

The place of service (POS) on the submitted claim form must match the setting where the service is performed. CareSource may audit claims with an incorrect POS and payment may be recouped.

Frequently used codes are:

03	School	A facility whose primary purpose is education.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Dental Services in an Ambulatory Surgical Center (ASC) / Hospital POS (19, 21. 22. 24)

The dentist providing the service must send in a request for authorization to perform the procedure in these settings. The request must:

- Contain at least one procedure code.
- List all applicable codes that require PA.
- Include all required documentation (See Covered Benefits Grid "Required Documentation" Column))
- Meet clinical criteria for ASC/Hospital setting (see Clinical Criteria and Policy Guidelines)

CareSource requires site-of-service/facility prior authorization, in addition to prior authorization of the dental services, as applicable, for non-emergency services performed in a hospital or an ASC.

NOTE: PLEASE INCLUDE A STATEMENT IDENTIFYING WHERE THE SERVICE WILL BE PROVIDED.
*See **section 7.5.10** Adjunctive Services for Hospital/ASC policy guidelines and Criteria*

FQHC/RHC wraparound supplemental dental claim processing change

Effective July 1, 2021, per IHCP, federally qualified health center (FQHC) and rural health clinic (RHC) Place of Services dental wraparound (supplemental) payments will be systematically processed on a claim-by-claim basis. This update replaces the monthly and year-end settlement process for services reported on dental claims. Providers will no longer submit to Myers and Stauffer to receive the difference between the managed care entity (MCE) payment and the FQHC/RHC encounter rate for dental claims. The FQHC or RHC provider should bill for one unit of code D9999 – Unspecified adjunctive procedure, by report on the claim in the fee-for-service (FFS) delivery system.

7.5 Covered Service Categories: Policy and Clinical Criteria Benefit Grids/Frequencies, Limitations, Document Requirements

This section of the Office Reference Manual provides **clinical policy guidelines** and **medical necessity criteria** that should be used concurrently with the corresponding covered benefit grids.

Covered Benefits Grid Detail:

- For easy guidance and quick reference, the covered service CDT Codes for each beneficiary group are listed first in each service category, It is important to be aware of respective covered services across beneficiary categories.
- **Bold** highlighted codes denote **value-added** enhanced benefits offered by CareSource in each plan category. Value-added services are services that are not offered in the standard State Medicaid benefit coverage and are voluntarily provided by CareSource to improve health outcomes.
- The CDT codes covered for each plan beneficiary group in a service category are then followed by the code descriptions, benefit limitations, authorization requirements, document requirements and any additional information. This manual and the supplemental Covered Benefits Compendium are not intended to be a complete statement of all CareSource's policies or procedures. Other policies and procedures not included in these resources may be posted on our website or published in specially targeted communications, including but not limited to letters, network notifications and newsletters.
- These are intended to be online resources. Keeping the compendium and manual electronic allows us to provide you with the most up-to-date information. All revisions are controlled electronically. Paper copies and screen prints are considered uncontrolled and may not be the most recent revision. Please ensure we have the most current email address for the Provider so you can receive network notifications of any updated provider resources, policy changes or other pertinent information. Archived versions are available upon request. Please visit our Updates and Announcements Page
- Dental Clinical Policies and Coverage Guidelines are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support CareSource coverage decision making. The information presented in these policies and guidelines is believed to be accurate and current as of the date of publication, it should be noted that situations may arise in which discrepancies or ambiguities are encountered when applying the policies contained within the Provider Office Reference Manual. In such situations, CareSource will make every attempt to clarify the language. Indiana state policy and the contracted provider agreement will supersede those items and requirements contained in the most current iteration of the Provider Manual if CareSource has not provided language clarification. All services must be medically necessary as defined by Section 405 IAC 5-2-17 and CareSource guidelines.

- Services requiring prior authorization and services subject to or requiring prepayment/post service **claim review** as well as any document requirements to be **submitted with** authorization or claim are identified. Dental records for any services should be available upon request.
- Age limits in each enrollment category are until the end of the month of the beneficiary's termination birthdate (e.g. HHW Package A - Age 0-19; Member is eligible from birth **through the end of the month** of the child's 20th birthday).

If you have, any questions feel free to reach us at **1-844-607-2831**. See QRG for additional communication methods.

7.5.1 Diagnostic Services D0100-D0999 Coverage Guidelines

Diagnostic Services D0100 - D0999	
Coverage Clinical Guideline Oral Evaluations and Diagnostic Imaging	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Two of the most common procedures performed in a dental office are oral evaluations and radiographs (now collectively grouped as Diagnostic Imaging). As with all CDT codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Oral evaluations may be inclusive of EPSDT screenings. Early detection and management of oral conditions can improve a child's oral health, general health and well-being, and school readiness.

Diagnostic Imaging must be necessary for clinical reasons. Radiographic images are adjunctive to diagnostic services and should be prescribed in accordance with the guidelines of the Food and Drug Administration in conjunction with the American Dental Association. The ADA, in collaboration with the FDA, developed recommendations for dental radiographic examinations to serve as an adjunct to the dentist's professional judgment of how to best use diagnostic imaging. These guidelines should be followed, and the care provider must weigh the benefits of taking dental radiographs against the risk of exposing a patient to x-rays, the effects of which accumulate from multiple sources over time. Although the state plan and CareSource currently allows for certain frequencies of radiographs including bitewings per 6 months period, literature and ADA recommendations has noted it is best to limit this frequency in low and moderate risk caries patients (as shown). The dentist, knowing the patient's health history and vulnerability to oral disease, is in the best position to make the judgement.

Recall Patient* with clinical caries or at increased risk for caries**

Type of Encounter	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous
Recall Patient* with clinical caries or at increased risk for caries	Posterior bitewing exam at 6-12-month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18-month intervals
Recall Patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24-month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36-month intervals	Posterior bitewing exam at 24-36-month intervals

Radiographs should be of diagnostic quality, properly identified and met the care standards as outlined in section 7.4.3 of the Provider Office Reference Manual (ORM).

CareSource Diagnostic policies are based upon evidenced based guidelines and peer reviewed literature as identified in the references noted.

HbA1c in-office point of service testing

Hemoglobin A1c, also known as glycated hemoglobin, is a measure of the amount of glucose attached to the hemoglobin in red blood cells and is directly proportional to the average circulating glucose levels. For the D0411 procedure, the analyzing device reports the percentage of hemoglobin that is glycosylated.

Indications

Check your state's Dental Practice Act to determine if testing is within the scope of your license. There are also federal and state regulations that may affect your business decision to provide this service. Remember the purpose of these tests is to understand the risk of glycemia related complications at the time of the scheduled appointment and not to render a diagnosis of diabetes.

DEFINITIONS

Periodic Oral Evaluation – An evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation. This includes an oral cancer screening and periodontal screening when indicated and may require interpretation of information acquired through additional diagnostic procedures.

Limited Oral Evaluation – This is an evaluation limited to a specific oral health problem or complaint. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This evaluation will include any necessary palliative treatment. Evaluations solely for adjusting dentures or in conjunction with multi-visit procedures are not covered (for example endodontics and orthodontia).

Comprehensive Oral Evaluation – Used by a general dentist and/or specialist when evaluating a patient comprehensively. This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances by report, or established patients who have been absent from an active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This code includes evaluation and recording of the patient's dental and medical history and a general health assessment. It also typically includes evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, TMJ limited screening, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and an oral cancer screening.

Comprehensive Periodontal Evaluation – This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes and for perinatal patients. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history, oral cancer evaluation and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer screening.

Intraoral - Comprehensive Series of radiographic images – A radiographic survey of the entire mouth (dentition or dentulous ridges where applicable). intended to display the crowns and roots of all teeth, periapical areas, interproximal areas, and alveolar bone including edentulous areas.

Intraoral periapical radiograph- Intended to display the roots or teeth and alveolar bone.

Occlusal radiographic image – placed on the occlusal surfaces of one of the arches. It shows the relationship of teeth to underlying structures in the alveolar process, such as cysts and abscesses.

Bitewing radiographic image – Intended to show complete visibility of clinical crowns with no overlapping. They cannot be substituted for periapical films in cases where endodontic treatment is requested.

Sialography – Inspection of the salivary ducts and glands by radiograph after the injection of a radiopaque medium.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D0120 Periodic oral evaluation
D0140 Limited oral evaluation- problem focused
D0145 Oral evaluation, for a patient under three years of age and counseling with primary caregiver
D0150 Comprehensive oral evaluation – new or established patient
D0160 Detailed and extensive oral evaluation – problem focused by report
D0170 Re-evaluation – limited problem focused (established patient not post-operative visit)
D0180 Comprehensive periodontal evaluation - new or established patient
D0210 Intraoral – comprehensive set of radiographic images including bitewings
D0220 Intraoral - periapical radiographic image
D0230 Intraoral - additional periapical image

D0240	Intraoral - occlusal radiographic image
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0251	Extra-oral posterior dental radiographic image
D0270	Bitewing - single image
D0272	Bitewings - two images
D0273	Bitewings – three images
D0274	Bitewings - four images
D0277	Bitewings – Vertical
D0310	Sialography
D0330	Panoramic radiographic image
D0340	Cephalometric 2D cephalometric image
D0411	HbA1c in-office point of service testing
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report
D0606	Molecular testing for a public health related pathogen (including coronavirus)

GENERAL DESCRIPTION OF SERVICES

Comprehensive and periodic evaluations, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Health check exams include, but are not limited to evaluations of all hard and soft tissue of the oral cavity; periodontal charting; recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships; and typically temporomandibular joint and oral cancer screenings. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist.

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Diagnostic Services D0100-D0999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Diagnostic	D0120 D0230 D0277 D0140 D0240 D0310 D0145 D0250 D0330 D0150 D0251 D0340 D0160 D0270 D0411 D0170 D0272 D0486 D0210 D0273 D0606 D0220 D0274	D0120 D0230 D0277 D0140 D0240 D0310 D0150 D0250 D0330 D0160 D0251 D0411 D0170 D0270 D0486 **D0180** D0272 D0606 D0210 D0273 D0220 D0274	D0120 D0230 D0277 D0140 D0240 D0310 D0150 D0250 D0330 D0160 D0251 D0340* D0170 D0270 D0411 **D0180** D0272 D0486 D0210 D0273 D0606 D0220 D0274	D0120 D0220 D0274 D0140 D0230 **D0277** D0150 D0240 D0330 D0160 D0270 **D0411** **D0170** D0272 D0606 D0210 D0273	D0120 D0220 D0273 D0140 D0230 D0274 D0150 D0240 **D0277** D0160 **D0250** D0330 **D0170** **D0251** **D0411** **D0180** D0270 D0606 D0210 D0272

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
Comprehensive and periodic evaluations, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Health check exams include but are not limited to evaluations of all hard and soft tissue of the oral cavity; periodontal charting; recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships; and typically temporomandibular joint and oral cancer screenings. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist. Multiple oral evaluations (D0120, D0140, D0150) by the same provider or provider group on the same date of service is not payable*.					
D0120	Periodic oral evaluation	One of (D0120, D0150) per 6 Month(s)	No	NONE	The periodic evaluation may not occur in combination with the comprehensive oral evaluation and not until 180 days after the comprehensive oral evaluation.
D0140	Limited oral evaluation-problem focused	Not subject to unit limits, should be used in accordance with clinical policy	No	NONE	Note: This procedure code is to be used for **emergency examinations** during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). ***Closely monitored and subject to post review***
D0145	Oral evaluation, for a patient under three years of age	One per year, per member, any provider -Payable Under three (3) years of age	No	NONE	Oral evaluation for a patient under three years of age and counseling with primary caregiver

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D0150	Comprehensive oral evaluation	One of (D0150) per Lifetime Per Provider "or" Location. One of (D0120, **D0150**, D0180) per 6 Month(s)	No	NONE	This code is typically used when evaluating a patient comprehensively. D0150 or D0120 may not occur same date of service in conjunction with D0140
D0160	Detailed and extensive oral evaluation-problem focused	One of (D0160) per 1 Lifetime Per Provider "or" Location	No	NONE	
D0170	Re-evaluation – limited problem focused	Not subject to unit limits, should be used in accordance with policy manual	No	NONE	This code is for established patient visits and not related to post-operative visits.
D0180	Comprehensive periodontal evaluation - new or established patient	(Enhanced Benefit Covered only Age ≥ 21) One of (D0180) per 1 Lifetime Per Provider "or" Location. One of (D0120, D0150, D0180) per 6 Month(s) Per patient.	Post Review	Perio Charting/ Radiographs	An enhanced benefit targeted for high risk medical- dental conditions (i.e. Pregnant Members, Diabetes, Hypertension, Respiratory, etc.)
Diagnostic services such as **radiographic images** must be necessary for clinical reasons. Radiographic images are adjunctive to diagnostic services and should be prescribed in accordance with the guidelines of the Food and Drug Administration in conjunction with the American Dental Association. n. Bitewing and intraoral-periapical radiographs are not covered for the same date of service as a full-mouth comprehensive series of radiograph images. The complete series is inclusive of bitewing and intraoral-periapical radiographs. o. Charges for duplication (copying) of radiographic images for insurance purposes are disallowed. p. Radiographic images used intraoperatively or considered a component of the primary procedure are not payable.					
D0210	Intraoral – Comprehensive set of radiographic images including bitewings	One of (D0210, D0330) per 36 Month(s)	No	NONE	The two types of full-mouth radiographs reimbursable are Full Mouth Series (D0210) and Panoramic (D0330). These two types of full mouth radiographs are mutually exclusive within a three (3) calendar year period.
D0220	Intraoral - periapical radiographic image	One (D0220) per 12-month period. Any additional periapical films (D0230 should be used)	No	NONE	For endodontic treatment, one pre-operative diagnostic radiograph is benefited. Working and post-operative radiographic images by the same dentist/dental office are considered a component of the complete treatment procedure and separate benefits are not reimbursable.

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D0230	Intraoral - additional periapical image	Intraoral-periapical each additional film up to seven (D0230) per 12-month period Up to eight periapical images per 12- month period	No	NONE	405 IAC 5-14-3(3) limits intraoral radiographs to one first film (D0220) and seven additional films (D0230) per member every 12 months
D0240	Intraoral - occlusal radiographic image	Intraoral-occlusal film up to two (D0240) per date of service.	No	NONE	
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	Due to FDA recommendations and extent of radiation these services are limited to Four of (D0250, D0251) per 12-month period If additional images medically necessary, submit authorization request	No	NONE	D0250 These images include, but are not limited to: Lateral Skull; Posterior-Anterior Skull; Submentovertex; Waters; Reverse Tomes; Oblique Mandibular Body; Lateral Ramus
D0251	Extra-oral posterior dental radiographic image		No	NONE	D0251 Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image. Accepted only when intra-oral radiographs are unable to be taken.
D0270	Bitewing - single image	A total of four horizontal bitewing films in any combination of D0270, D0272, D0273,or D0274 per 12 Month(s) "Or" One set of vertical bitewings (D0277) per 12 Month(s) Horizontal and vertical bitewings cannot be billed in same 12 Month(s)	No	NONE	Bitewing and/or intraoral-periapical radiographs are not reimbursed for the same date of service as a full-mouth complete series of radiograph images. The complete series is inclusive of bitewings and intraoral-periapical radiographs.
D0272	Bitewings – two mages		No	NONE	
D0273	Bitewings - three images		No	NONE	
D0274	Bitewings - four images		No	NONE	
D0277	Bitewings – Vertical		No	NONE	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D0310	Sialography	Not subject to unit limits, should be used in accordance with policy manual	No	NONE	
D0330	Panoramic radiographic image	One of (D0210, D0330) per 36 Month(s) Per patient.	No	NONE	See note above under D0210.
D0340	Cephalometric 2D cephalometric image	**Covered only for orthodontic services** and limited to provider specialty 273 – Orthodontists **ADA and FDA guidelines on limited radiation exposure should be followed** Covered only up to age 20	No	NONE	acquisition, measurement, and analysis
D0411	HbA1c in-office point of service testing	In accordance with medical standards	No	NONE	
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report	Not subject to unit limits, should be used in accordance with policy manual and medical standards	No	NONE	
D0606	Molecular testing for a public health related pathogen, including coronavirus	Not subject to unit limits, should be used in accordance with CDC and FDA standards	No	NONE	

7.5.2 Preventive Services D1000-D1999 Coverage Guidelines

Preventive Services D1000 - D1999	
Coverage Clinical Guideline Prophylaxis, Fluoride	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements
COVERAGE RATIONALE and CLINICAL CRITERIA	

Prophylaxis

Applicable for patients with a generally healthy periodontium, where any supragingival and subgingival deposits are removed to control irritational factors and for patients with localized gingivitis to prevent further progression of the disease.

Topical Application of Fluoride – Excluding Varnish

The topical application of fluoride in the form of gel, foam, and rinses applied in the dental office as a caries preventive agent is a generally recommended treatment for children through the age of eighteen and can also be used to treat adults “at-risk” for dental cavities.

Topical Application of Fluoride Varnish

The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation. Varnish is also FDA approved for desensitizing of teeth.

Indicated for Infants, children, and adults with a moderate or high risk of developing cavities. And/or any of the following:

- As the preferred caries prevention agent for children under age 6
- For members receiving head and neck radiation therapy
- Sensitivity that does not resolve with an over-the-counter desensitizing dentifrice
- For moderate to high caries risk members with a medical or cognitive impairment that limits cooperation with a tray or rinse delivery method
- Xerostomia
- For members in active orthodontic treatment
- For the Remineralization of incipient or white spot enamel carious lesions
- Contraindications
- Individuals with a low risk of cavity formation who consume optimally fluoridated water or who receive routine fluoride treatments through a dental office
- Fluoride varnish should not be used if there are noticeable sores in the mouth or on the gums (Stomatitis or ulcerative gingivitis)
- It also should not be used if there is an allergy to one of the ingredients in the varnish or to pine nuts
- Bronchial asthma

CareSource encourages interprofessional integration and referrals to prevent early childhood caries and promotes anticipatory guidance, counseling, fluoride application and referral to a dental home by the primary care provider or pediatrician. Primary Care Providers can use the CareSource Toolkit: ***Working together to prevent Childhood Caries: What Pediatricians and Primary Care Providers Need to Know About Fluoride Varnish and How to Promote Early Childhood Good Oral Health*** *accessible at CareSouce.com*

Preventive Medicaments (Silver Diamide Fluoride- SDF)

Application of caries arresting medicament

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 (Most commonly used medicament, Silver Diamine Fluoride.

See the ADA Guide to Reporting Caries Arresting Medicament

Caries preventive medicament application

For primary prevention or remineralization.

See the ADA Guide to Reporting Carries Preventive Medicament Application

Medicaments applied do not include topical fluorides. Informed consent from patient/guardian should be obtained before application of SDF

Primary indications for topical treatment with silver diamine fluoride:

- As conservative treatment for active, non-symptomatic carious lesions
- Treat dentinal hypersensitivity;
- Stabilize uncontrolled caries for patients at high risk of experiencing new lesions; (e.g., those experiencing xerostomia);
- Treat vulnerable tooth structure (e.g., exposed root);
- Caries that are difficult to treat with traditional restorations (e.g., in a furcation or at the margin of a fixed bridge);
- nstances when standard restorative treatment is difficult to perform. For example:
  - Individuals with cognitive disabilities (e.g., autism or dementia)
  - An uncooperative child
  - Frail elderly individuals
- Treat patients with limited or no access to restorative dental care; and/or
- Treat patients with limited life expectancy.

Reapplication may be required when the dentist determines that there is a clinical need. Time should be given between applications to allow for clinical outcomes.

Contraindications:

Silver diamine fluoride should not be used if a patient has:

- An allergy to silver;
- Mucosal irritation, including oral ulcerations, desquamative gingivitis or mucositis;
- Carious lesions that have symptoms of irreversible pulpitis.
- Pregnant women
- During the first six months of breast feeding

Counseling in the Dental Office Setting

1. **Tobacco counseling for the control and prevention of oral disease**
2. **Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use**

As an oral health provider, you can make an impact on reducing tobacco use by asking your patients if they smoke and providing even brief counseling, pharmacotherapy, and referral to cessation resources. Beginning July 1, 2021,Indiana Medicaid covers tobacco cessation treatment delivered by dental practitioners.

Medicaid Coverage is limited to patients with a history of tobacco use regardless of age. This service must be provided in conjunction with another dental service (i.e. oral evaluation). Documentation of tobacco use, extent of counseling session, and provision of cessation assistance or referral must be maintained in the clinical record.

As an enhanced benefit for Indiana HHW and HIP members, CareSource also covers Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.

Please use the following CareSource resource on how to conduct brief intervention counseling, document, treatment and/or referral. Available at www.caresource.com/providers/education/patient-care/dental/

Tobacco and Substance Use Cessation RESOURCE AND PATIENT INTERVENTION TOOLKIT FOR ORAL HEALTH PROFESSIONALS

DEFINITIONS

Fluoride: A compound of fluorine with a metal, a nonmetal, or an organic radical; the anion of fluorine; inhibits enolase; found in bone and tooth apatite; Fluoride has a cariostatic effect; high levels are toxic.

Prophylaxis - primarily preventive treatment intended to control local irritational factors by the removal of plaque, calculus, and stains from

Remineralization: A process enhanced by the presence of Fluoride whereby partially decalcified enamel, dentin, and cementum become recalcified by mineral replacement.

Silver Diamine Fluoride (SDF) is a liquid mixture of 24-29 percent silver and 5-6 percent fluoride; the silver is antimicrobial and the fluoride remineralizes tooth structure. It is a topical treatment used in dentistry to prevent tooth decay and arrest some carious lesions

Xerostomia: Dryness of the mouth caused by cessation of normal salivary secretion. The condition is a symptom of various diseases such as diabetes, acute infections, hysteria, and Sjögren's syndrome and can be caused by paralysis of facial nerves. It may also result from radiation treatments for cancers of the face, head, or neck. It is also caused by an adverse reaction to drugs.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D1110 Prophylaxis – Adult
D1120 Prophylaxis – Child
D1206 Topical Fluoride – Varnish
D1208 Topical application of fluoride (excluding prophylaxis)
D1320 Tobacco counseling for the control and prevention of oral disease
D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1354 Application of caries arresting medicament – per tooth
D1355 Caries Med App per tooth
99188 Application of topical fluoride varnish by a physician or other qualified health care professional

GENERAL DESCRIPTION OF SERVICES

Oral fluoride supplementation, also known as dietary fluoride supplementation, in children who have low levels of fluoride in their water and application of fluoride varnish to the primary teeth of all children can provide moderate benefit in preventing dental caries.(USPSTF,2015) Fluoride is a naturally occurring mineral commonly found in the environment. It has been well established as a caries prevention agent. Fluoride can be delivered topically and systemically. Topical fluorides strengthen teeth already present in the mouth, making them more decay resistant. Topical fluorides encourage remineralization of enamel, and inhibit bacterial metabolism, reducing the growth of plaque bacteria. Modes of topical fluoride delivery include toothpastes, gels, mouth rinses, and professionally applied fluoride therapies. Topical fluoride treatments are typically applied with prescription strength products in a dental setting by a licensed dental professional; however, fluoride varnish may also be applied in a medical setting by licensed providers as part of preventive services for children.

REFERENCES

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Preventive Services D1000 - D1999

Coverage Clinical Guideline Space Maintenance

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Sealants are indicated for the following:

- Caries prevention in pit and fissures on permanent teeth
- Caries prevention in children with documented high caries risk with a reasonable prognosis for sealant retention
- Non-cavitated carious lesions on permanent teeth in children and adolescents

Risk factors must be thoroughly documented by the provider in the dental record, and include:

- Mother or primary caregiver have active caries
- White spot lesions or enamel defects
- Visible caries, more than one interproximal lesion or previous restorations
- Poor oral hygiene
- Sub-optimal systemic fluoride intake
- Frequent exposure to cavity-producing foods and drinks
- Individuals with special health care needs
- Low socioeconomic status
- Xerostomia
- Deep pits and fissures

Sealants are not indicated for the following:

- Presence of rampant caries and interproximal lesions
- Extrinsic staining of pits and fissures

Preventive Resin Restorations

Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits.

DEFINITIONS
Sealant: A resinous material designed to be applied to the occlusal surfaces of posterior teeth to penetrate anatomic surface pits and fissures and form a physical barrier on the tooth surface to prevent caries.
APPLICABLE COVERED CODES
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.
D1351 Sealant - per tooth D1352 Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
GENERAL DESCRIPTION OF SERVICES
An evidence-based clinical practice guideline released in 2016 by the ADA and AAPD found that: 1) Sealants are effective in preventing and arresting pit-and-fissure occlusal carious lesions of primary and permanent molars in children and adolescents compared with the nonuse of sealants or use of fluoride varnishes. 2) Sealants could minimize the progression of non-cavitated occlusal carious lesions (also referred to as initial lesions).
REFERENCES
American Dental Association. **Glossary of Dental Clinical and Administrative Terms**. Retrieved from: www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms
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Preventive Services D1000 - D1999

Coverage Clinical Guideline Space Maintenance

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

The premature loss of primary teeth due to caries, infection, trauma, ectopic eruption, or crowding deviates from the normal exfoliation pattern and may lead to loss of arch length. The American Academy of Pediatric Dentistry notes arch length deficiency can produce or increase the severity of malocclusions with crowding, rotations, ectopic eruption, crossbite, excessive overjet, excessive overbite, and unfavorable molar relationships.

Space maintainers are indicated for the following:

- Maintaining space due to premature loss of a primary tooth (teeth)
- To regain space

AAPD Treatment considerations: Factors to consider include: (1) specific tooth lost; (2) time elapsed since tooth loss; occlusion and space assessment; (3) dental age; (4) presence and root development of permanent successor; (5) amount of alveolar bone covering permanent successor; (6) patient's health history and medical status; (7) patient's cooperative ability; (8) active oral habits; and (9) oral hygiene.

Space maintainers are contraindicated for the following:

- When tooth/teeth is/are close to eruption
- Member is not compliant or has poor oral hygiene
- Severe crowing already exists
- Space has already been lost
- If sufficient amount of space already exists

DEFINITIONS

Space Maintainer: A passive appliance, usually cemented in place, that holds teeth in position.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D1510 Space maintainer – fixed – unilateral per quadrant
D1516 Space maintainer – fixed – bilateral-maxillary
D1517 Space maintainer – fixed – bilateral-mandibular
D1520 Space maintainer - removable – unilateral - per quadrant
D1526 Space maintainer - removable – bilateral- maxillary
D1527 Space maintainer - removable – bilateral- mandibular
D1551 Re-cement or rebond bilateral space maintainer - maxillary
D1552 Re-cement or rebond bilateral space maintainer- mandibular
D1553 Re-cement or rebond unilateral space maintainer- per quadrant
D1556 Removal of fixed unilateral space maintainer - per quadrant
D1557 Removal of fixed bilateral space maintainer – maxillary
D1558 Removal of fixed bilateral space maintainer – mandibular
D1575 Distal shoe space maintainer - fixed – unilateral

GENERAL DESCRIPTION OF SERVICES

Space Maintainers are passive appliances designed to prevent tooth movement following premature loss of primary teeth so permanent teeth can erupt into proper position. Additionally, the goal of space maintenance is to prevent loss of arch length, width, and perimeter by maintaining the relative position of the existing dentition. Appliances can be fixed or removable, unilateral, or bilateral.

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Preventive Services D1000-D1999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Preventive	D1110 D1354 D1551 D1120 D1355 D1552 D1206 D1510 D1553 D1208 D1516 D1556 D1320 D1517 D1557 **D1321** D1520 D1558 **D1351** D1526 D1575 D1352 D1527 D1999	**D1110** **D1321** D1558 **D1206** D1556 D1999 D1320 D1557	D1110 D1354* D1551* **D1206** D1355* D1552* D1208* D1510* D1553* D1320 D1516* D1556 **D1321** D1517* D1557 D1351* D1520* D1558 D1352* D1526* D1575* D1527* D1999	D1110 **D1320** **D1355** D1206 **D1321** D1208 **D1351**	D1110 **D1354*** **D1206** **D1355*** D1208* D1351* **D1320** **D1321**

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D1110 or D1120 prophylaxis performed on the same date by the same dentist/dental office as a Periodontal Maintenance (D4910) or Scaling and Root Planing (D4341/D4342) is considered part of those procedures and not payable.					
D1110	Prophylaxis – Adult	Age 1 to 20 or institutionalized Members (any age) = One of (D1110, D1120) per 6 Month(s) Age 21 and older = One of (D1110) per 6 Month(s) *(Standard is one per 12 months, additional cleaning is **enhanced benefit** for Age 21 and older)* Under age 12 months – EPSDT Request	No	NONE	This service code used for permanent dentition. Prophylaxis (D1110 or D1120) should not be billed for the same date of service as periodontal root planing and scaling (D4341 or D4342), full-mouth debridement (D4355), or full-mouth scaling (D4346). Reimbursement of prophylaxis is included in the payment for these services.
D1120	Prophylaxis – Child		No	NONE	This service code used for primary dentition. Prophylaxis (D1110 or D1120) should not be billed for the same date of service as periodontal root planing and scaling (D4341 or D4342), full-mouth debridement (D4355), or full-mouth scaling (D4346). Reimbursement of prophylaxis is included in the payment for these services.

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D1206	Topical Fluoride – Varnish	One of (D1206, D1208) per 6 Month(s). Age 0 – 20 ***Enhanced Benefit*** *One (**D1206**) per 6 month(s) (Reimbursable for **Age ≥ 21** with documented high caries risk or medical condition increasing susceptibility to caries)*	No	NONE	Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. Per clinical standards, the following treatments are not covered: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • Application of sodium fluoride as a desensitizing agent. • The use of self or home fluoride application
D1208	Topical Fluoride Application-Excluding Varnish		No	NONE	
D1320	Tobacco counseling for the control and prevention of oral disease.	One (D1320, D1321) session per date of service. Only allowed same DOS as eligible D0120, D0140, D0150, D0160, D0180. Must be submitted with applicable ICD-10 coding	No	Documentation of Counseling method used, and time spent should be documented in patient record, available for review upon request	For guidance on Counseling tips, download the **CareSource Tobacco and Substance Use Cessation** **RESOURCE AND PATIENT INTERVENTION TOOLKIT FOR ORAL HEALTH PROFESSIONALS CareSource.com**
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	One (D1320, D1321) session per date of service. **D1321 (Enhanced Benefit)** Only allowed same DOS as eligible D0120, D0140, D0150, D0160, D0180. Must be submitted with applicable ICD-10 coding	No		

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D1351	Sealant - per tooth - unrestored permanent molars	Age 0 – 20 Permanent teeth only One of (D1351) per lifetime per premolar tooth (4, 5, 12, 13, 20, 21, 28, 29) One of (D1351) per 48 month(s) per molar tooth (2, 3, 14, 15, 18, 19, 30, 31) (Standard benefit is one per lifetime per tooth, increased frequency is **enhanced benefit**)	No	NONE	Sealants are reimbursable for unrestored (**no restorations** on occlusal surfaces) caries free premolars and molars. Sealed teeth must be free of occlusal and proximal caries. Sealant material must be ADA approved.
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Age 0 – 20 Permanent teeth only One of (D1352) per lifetime per tooth Teeth 2 - 5; 12 - 15;18 - 21;28 - 31	No	NONE	Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.
D1354	Application of caries arresting medicament – per tooth	Age 0 - 20 only One of (D1354, D1355) per 6 Month(s) per tooth. Teeth covered: A-T, 1-32. Not allowed within 90d of D1351. Only one of the following per tooth per 6mo: D1354 or D1355	No*	Caries Documentation and/or Narrative of medical necessity submitted with claim	Patient Written Consent (which includes warning of tooth staining) must be obtained before use. Sample consent form from Elevate.org See Clinical Policy for clinical rationale and coverage guidance. Greater than 10 teeth per date of service subject to post service prepayment or post payment review*
D1355	Caries preventive medicament application - per tooth	Reimbursement is prorated on a per tooth application	No*	Caries Documentation and/or Narrative of medical necessity submitted with claim	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D1510	Space maintainer – fixed – unilateral per quadrant	Age 0 – 20 only One (D1510, D1520, D1575) per 24 months per quadrant	No	NONE	**Space Maintenance Therapy** Covered when indicated due to premature loss of posterior primary teeth. See further clinical guidelines per AAPD standards and CareSource clinical guidelines manual Appropriate Quadrant/Arch code or applicable tooth code must be put on the claim form UR - upper right =10 UL - upper left = 20 LL - lower left. = 30 LR - lower right = 40 Upper 01 Lower 02
D1516	Space maintainer – fixed – bilateral-maxillary	Age 0 – 20 only One (D1516, D1526) bilateral maxillary space maintainer per 24 months per arch	Ages 1-2: PA required Ages 3-20: Post Review required	Narrative/ Radiographs	
D1517	Space maintainer – fixed – bilateral-mandibular	Age 0 – 20 only One (D1517, D1527) bilateral mandibular space maintainer per 24 months per arch	Ages 1-2: PA required Ages 3-20: Post Review required	Narrative/ Radiographs	
D1520	Space maintainer - removable – unilateral - per quadrant	Age 0 – 20 only One (D1510, D1520, D1575) per 24 months per quadrant	No	NONE	
D1526	Space maintainer - removable – bilateral- maxillary	Age 0 – 20 only One (D1516, D1526) bilateral maxillary space maintainer per 24 months per arch	Ages 1-2: PA required Ages 3-20: Post Review required	Narrative/ Radiographs	
D1527	Space maintainer - removable – bilateral- mandibular	Age 0 – 20 only One (D1517, D1527) bilateral mandibular space maintainer per 24 months per arch	Ages 1-2: PA required Ages 3-20: Post Review required	Narrative/ Radiographs	
D1551	Re-cement or rebond bilateral space maintainer – maxillary	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D1552	Re-cement or rebond bilateral space maintainer- mandibular	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	**Space Maintenance Therapy** Covered when indicated due to premature loss of posterior primary teeth. See further clinical guidelines per AAPD standards and CareSource clinical guidelines manual Appropriate Quadrant/Arch code or applicable tooth code must be put on the claim form UR - upper right =10 UL - upper left = 20 LL - lower left. = 30 LR - lower right = 40 Upper 01 Lower 02
D1553	Re-cement or rebond unilateral space maintainer- per quadrant	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	
D1556	Removal of fixed unilateral space maintainer - per quadrant	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	
D1557	Removal of fixed bilateral space maintainer – maxillary	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	
D1558	Removal of fixed bilateral space maintainer-mandibular	Age 0 – 20 only Not reimbursable within six (6) months by provider/group of initial placement	No	NONE	
D1575	Distal shoe space maintainer-fixed- unilateral	Age 0 – 20 only One (D1510, D1520, D1575) unilateral space maintainer per 24 months per quadrant	Post Review	Narrative/ Radiographs	Used to guide the eruption of the first molar.
D1999	Unspecified preventive procedure, by report	Determined by Report	PA	Narrative/ Radiographs	Not reimbursable used as an aid in covering the cost for additional Personal Protective Equipment

7.5.3 Restorative Services D2000-D2999 Coverage Guidelines

Restorative Services D2000 – D2999	
Coverage Clinical Guideline Direct Restorations	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Direct Restorations

Direct restorations include non-esthetic direct restoration materials such as amalgam and direct filling gold as well as esthetic direct restoration materials such as composite resin, glass ionomer cement, resin modified GIC, compomers.

Direct Restorations are indicated for the following:

- Replace tooth structure lost to caries or trauma
- Replace restorative material lost while accessing pulp chamber for endodontic therapy
- Replace existing restorations that exhibit recurrent decay, fracture, or marginal defects

Glass Ionomer restorations may be indicated for the following:

- When teeth cannot be isolated properly to allow placement of resin restorations
- As an alternative to resin sealants when the teeth cannot be properly isolated (patient cooperation, partially erupted teeth)
- Class I, II, III and V restorations on primary teeth
- Class III and V restorations on permanent teeth that cannot be isolated in high-risk patients
- As a caries control plan for high-risk patients using atraumatic techniques

Direct Restorations are not indicated for the following:

- Teeth with a hopeless prognosis
- Incipient enamel only lesions extending less than halfway to the dentinoenamel junction (DEJ)
- Teeth that are sound as defined by ADA Caries Classification system*
- Primary teeth that are near exfoliation or less than 50% of the tooth root remains
- Composite resin restorations are not indicated for patients with heavy bruxism
- Composite resin restorations are not indicated for patients with extensive active caries, or high caries risk
- Amalgam restorations are not indicated for placement on teeth in which they will have contact with gold restorations
- May not be indicated in an arrested, remineralized, noncavitated lesion (white or brown) is acid resistant and no longer an indicator of active caries disease
- May not be indicated in “initial” or incipient lesions as defined by the ADA Caries classification system* in low carries risks patients unless a preventive resin restoration (not currently covered by health plan)

Protective Restoration (Intermediate Restorative Material)

A protective restoration is indicated for the following:

- Relieve pain
- Promote healing
- Prevent further deterioration
- Retain tissue form

A protective restoration is not indicated for the following:

- As a liner or base for a definitive restoration
- Not for endodontic access closure
- Not for pulp capping
- As a definitive restoration

Interim Therapeutic Restoration - Primary Dentition

The (AAPD) recognizes that unique clinical circumstances can result in challenges in restorative care for infants, children, adolescents, and persons with special health care needs. When circumstances do not permit traditional cavity preparation and/or placement of traditional dental restorations or when caries control is necessary prior to placement of definitive restorations, interim therapeutic restorations (ITR) may be beneficial and are best utilized as part of comprehensive care in the dental home.

- For very young, uncooperative, or special needs patients
- When traditional tooth preparation for restoration is not feasible or must be postponed
- As a caries control plan for high-risk patients using atraumatic techniques

Note: The tooth is restored in these instances with an adhesive restorative material such as glass ionomer or resin-modified glass ionomer cement. **D2330- D2394 should not be used**.

DEFINITIONS

Amalgam: An alloy used in direct dental restorations. It is typically composed of mercury, silver, tin, and copper along with other metallic elements added to improve physical and mechanical properties.

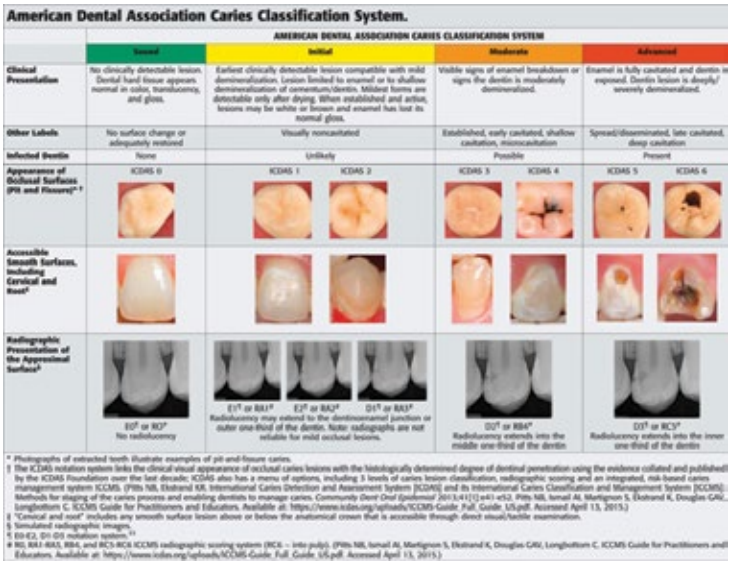
Composite: A dental restorative material made up of disparate or separate parts (e.g., resin and quartz particles).

Direct Restoration: A restoration fabricated inside the mouth.

Glass Ionomer: Polyelectrolyte cement in which the solid powder phase is a fluoride-containing aluminosilicate glass powder to be mixed with polymeric carboxylic acid. The cement can be used to restore teeth, fill pits and fissures, lute, and line cavities. Also known as glass polyalkenoate cement, ionic polymer cement, polyelectrolyte cement.

Intermediate Restorative Material (IRM) is designed for intermediate restorations intended to remain in place for up to one year. The eugenol content in the polymer-reinforced zinc oxide-eugenol composition gives the material sedative like qualities on hypersensitive tooth pulp and is a good thermal insulator as well.

American Dental Association Caries Classification System*



Source: (Young, et, al; ADA, 2015)

G.V. Black's Classification of Dental Caries

Class I: Caries affecting pits and fissures on occlusal third of molars and premolars, occlusal two-thirds of molars and premolars, and lingual part of anterior teeth.

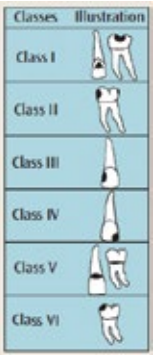
Class II: Caries affecting proximal surfaces of molars and premolars.

Class III: Caries affecting proximal surfaces of central incisors, lateral incisors, and cuspids without involving the incisal angles.

Class IV: Caries affecting proximal including incisal angles of anterior teeth.

Class V: Caries affecting gingival one-third of facial or lingual surfaces of anterior or posterior teeth.

Class VI: Caries affecting cusp tips of molars, premolars, and cuspids



Source: Dimensions of Dental Hygiene Journal (2017)

McGuire and Nunn Prognosis Classification System

Prognosis	One or More of the Following for Each Category
Good	Control of the etiologic factors and enough clinical and radiographical periodontal support to enable the tooth to be maintained by the patient and clinician with proper maintenance
Fair	Approximately 25% attachment loss, as measured clinically and radiographically. Class I furcation involvement. The severity of the furcation involvement would allow adequate maintenance.
Poor	50% attachment loss and Class II furcations. The location and degree of the furcations would accommodate proper maintenance — although with difficulty.
Questionable	> 50% attachment loss, poor crown/root ratio, Class II (not easily accessed) or Class III furcation involvement. Class II mobility or more; significant root proximity
Hopeless	Severe attachment loss; extraction performed or suggested

Source: McGuire MK, Nunn ME, 1996 in Decisions in Dentistry, 2017

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions and benefit categories.

D2140 Amalgam – one surface, primary or permanent
D2150 Amalgam – two surface, primary or permanent
D2160 Amalgam – three surface, primary or permanent
D2161 Amalgam – for or more surfaces, primary or permanent
D2330 Resin-based composite – one surface, anterior
D2331 Resin-based composite – two surface, anterior
D2332 Resin-based composite – three surface, anterior
D2335 Resin- based composite – four or more surfaces or involving incisal angle (anterior)
D2390 Resin-based composite crown, anterior
D2391 Resin-based composite – one surface, posterior
D2392 Resin-based composite – two surface, posterior
D2393 Resin-based composite – three surface, posterior
D2394 Resin-based composite – four or more surfaces, posterior
D2940 Protective restoration
D2941 Interim therapeutic restoration – primary dentition

GENERAL DESCRIPTION OF SERVICES

Direct restoration procedures are the placement of restorative material directly into the defective, injured, or diseased tooth to re-establish normal form and function. Tooth preparation, all liners, or bases, etching and curing, as well as occlusal adjustments are inclusive. For non-amalgam restorations, resin-based composite is the material of choice. When conditions do not allow for complete isolation of the tooth, and salivary contamination is likely, a glass ionomer is considered an acceptable substitute. Preventive resin restorations are a conservative approach to restore a tooth that has active incipient caries in pits and fissures. Protective restorations are placed to relieve pain, prevent further deterioration, and promote healing.

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American Academy of Pediatric Dentistry. **Policy on Interim Therapeutic Restorations(ITR**). Revised 2016. Retrieved from: www.aapd.org/research/oral-health-policies--recommendations/interim-therapeutic-restorations/

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Rasines Alcaraz MG, Veitz-Keenan A, Sahrmann P, et al. **Direct composite resin fillings versus amalgam fillings for permanent or adult posterior teeth**. Cochrane Database Syst Rev. 2014 Mar.

Swift E, Sturdevant J, Boushell L. Sturdevant's Art and Science of Operative Dentistry,6th ed. St. Louis: Mosby c2013. Chapter 11, Indirect Tooth Colored Restorations; p.280

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Restorative Services D2000 – D2999

Coverage Clinical Guideline Prefabricated Crowns

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Prefabricated crowns (i.e. stainless-steel) **may be indicated** for the following:

- Restoration of teeth with more than two surfaces affected with carious lesions, or where extensively decayed one or two surface lesions are present
- Carious lesions **and documented high caries risk** children; risk factors must be thoroughly documented by the provider in the dental record/risk assessment form and include:

1. Mother or primary caregiver has active caries
2. White spot lesions or enamel defects
3. Visible caries or previous restorations or multiple interproximal lesions
4. Poor oral hygiene
5. Sub-optimal systemic fluoride intake
6. Frequent exposure to cavity-producing foods and drinks

7. Individuals with special health care needs
8. Xerostomia

- Cervical decalcification and/or developmental defects (hypoplasia, hypocalcification, enamel hypoplasia, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)
- Interproximal caries extending beyond line angles
- Following pulpotomy or pulpectomy
- Restoration of a primary tooth that is to be used as an abutment for a space maintainer
- Intermediate restoration of fractured teeth
- Restoration and protection of teeth exhibiting extensive tooth surface loss due to attrition, abrasion, or erosion
- In individuals with impaired oral hygiene in which the breakdown of intra-coronal restorations is likely
- When the tooth cannot be effectively isolated for moderate to large amalgam or composite restorations

Prefabricated crowns **are not indicated** for the following:

- A primary tooth that is close to exfoliation with more than half the roots resorbed
- Excessive tooth crown loss resulting in the inability for mechanical retention
- Loss of space due to tipping of neighboring teeth into carious defect interfering with proper fit attainability
- Solely for cosmetic purposes
- As a preventive measure for teeth with no evidence of pathology or minimal decay that can be restored with a minor restoration. Radiographs should display caries.
- Low decay (dental caries) risk

DEFINITIONS

As noted in description

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D2930 Prefabricated stainless-steel crown – primary tooth
D2931 Prefabricated stainless-steel crown – permanent tooth
D2932 Prefabricated resin crown
D2933 Prefabricated stainless-steel crown with resin window
D2934 Prefabricated esthetic coated stainless-steel crown – primary tooth

GENERAL DESCRIPTION OF SERVICES

Prefabricated crowns are full tooth coverage restorations that may be made of stainless steel, porcelain/ceramic, or acrylic. Stainless Steel Crowns are designed to provide long-term coverage of primary molar teeth and long-term provisional coverage of permanent molar teeth. The dentist selects the best fit and adapts the crown as needed and cements it with a biocompatible luting agent. Prefabricated crowns are most used for primary teeth to retain the tooth until it naturally exfoliates, and permanent tooth erupts. They are not considered a definitive restoration for permanent teeth.

REFERENCES

American Academy of Pediatric Dentistry Council on Clinical Affairs. **Guideline on Caries-risk Assessment and Management for Infants, Children, and Adolescents**. Adopted 2002. Revised 2019. Available at: https://webcache.googleusercontent.com/search?q=cache:KrHiHfljXQ0J:https://www.aapd.org/media/Policies_Guideli nes/BP_CariesRiskAssessment.pdf+&cd=1&hl=en&ct=clnk&gl=us. (Accessed January 7, 2020).

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Restorative Services D2000 – D2999

Coverage Clinical Guideline Other Restorative

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Restorative Foundation for an Indirect Restoration

Restorative foundation for an indirect restoration is indicated as a filler to eliminate undercuts, voids and other irregularities that have occurred during tooth preparation to create a more favorable tooth form for the retention of an indirect restoration.

Core Buildup (Including Any Pins When Required)

Indicated for teeth with significant loss of coronal tooth structure due to caries or trauma in which insufficient tooth structure remains to adequately retain an indirect restoration.

Not indicated for the following:

- As a filler to correct irregularities in preparation
- As a definitive composite or amalgam restoration
- For retention of intracoronal restorations

Post and Core (EPSDT as medically necessary)

Indicated for the following:

- For teeth with significant loss of coronal tooth structure in endodontically treated teeth in which insufficient tooth structure remains to adequately retain an indirect restoration
- For Posts: when there is inadequate remaining tooth structure to support a core

Not indicated:

- for teeth with short roots.
- When anatomic features are available to retain the core (e.g., when canals and pulp chamber can retain a core), a Post is not indicated.

Pin Retention

Indicated for teeth with significant loss of coronal tooth structure to allow retention of a direct restoration.

Not indicated for the following:

- For restoration of teeth with significant malocclusion
- If the tooth cannot be properly restored with a direct restoration due to anatomic or functional considerations

Repair/Recement/Rebond of Single Tooth Indirect Restorations

These procedures are indicated for an Inlay, Onlay, Crown or veneer in which the functional area is involved due to restorative material failure.

Resin infiltration/smooth surface

The resin infiltration technology is indicated:

- As a minimally invasive treatment for the arrest of carious lesions. The resin material blocks the porosity in the lesion, fills the pores of the tooth fully and prevents caries from progressing.
- Resin infiltration is indicated to mask white spot lesions and early enamel caries.
- It differs from pit and fissure sealants in that it creates a barrier within the carious lesion rather than on the lesion's surface.

It is not considered medically necessary for cosmetic reasons only to mask white spots.

DEFINITIONS

Crown: An artificial replacement that restores missing tooth structure by surrounding the remaining coronal tooth structure or is placed on a dental implant. It is made of metal, ceramic or polymer materials or a combination of such materials. It is retained by luting cement or mechanical means.

Pin: A small metal rod, cemented or driven into dentin to aid in retention of a restoration.

Post: Rod-like component designed to be inserted into a prepared root canal space so as to provide structural support. This device can either be in the form of an alloy, carbon fiber or fiberglass, and Posts are usually secured with appropriate luting agents.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D2910 Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration
D2920 Re-cement or re- bond crown
D2921 Reattachment of tooth fragment, incisal edge, or cusp
D2949 Restorative foundation for an indirect restoration
D2951 Pin retention – per tooth, in addition to restoration
D2980 Crown repair, by report
D2990 Resin infiltration/smooth surface

GENERAL DESCRIPTION OF SERVICES

In situations when a tooth does not have sufficient remaining tooth structure to support the planned restoration, the anatomical crown may be “built up” using a restorative material foundation. Posts and cores (for endodontically treated teeth) and pins may also be indicated to aid in retention. These procedures should be performed on teeth that have an overall favorable long-term prognosis.

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Restorative Services D2000-D2999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Restorative	D2140 D2391 D2932 D2150 D2392 D2933 D2160 D2393 D2934 D2161 D2394 D2940 D2330 D2910 D2941 D2331 D2920 D2949 D2332 D2921 **D2951** D2335 D2930 D2980 D2390 D2931 D2990	D2140 D2391 D2931 D2150 D2392 D2934 D2160 D2393 D2940 D2161 D2394 D2941 D2330 D2910 D2949 D2331 D2920 **D2951** D2332 D2921 D2980 D2335 D2930 D2990 D2390	D2140 D2391 D2932* D2150 D2392 D2933* D2160 D2393 D2934 D2161 D2394 D2940 D2330 D2910 D2941 D2331 D2920 D2949 D2332 D2921 **D2951** D2335 D2930 D2980 D2390 D2931 D2990	EPSDT as Medically Necessary	**D2140** **D2391** D2932* **D2150** **D2392** D2933* **D2160** **D2393** D2934 **D2161** **D2394** D2940 **D2330** D2910 D2941* **D2331** D2920 **D2951** **D2332** D2921 D2980 **D2335** D2930 **D2390** D2931

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
Any Amalgam or Resin-Based Composite Restoration that is billed with more than 1 unit for a one-service area code will be reconfigured to the defined multiple service surface code (i.e., 2 units of D2140 would be 1 unit of D2150 or 2 units of D2330 would be 1 unit of D2331). Bases and liners placed under a restoration are considered an integral procedure of the restoration and are not reimbursable as separate procedures. (CDT code D3120) is not reimbursable as a separately covered service. Local anesthesia is included in the fee for all restorative services. Preventive resin-based restorations are not covered services. Restorations noted below D2140 - D2932 are reimbursed at different rates for primary and permanent teeth. ***Any restorations done on the same tooth by the same provider or provider location within a 12-month period may be subject to post review."**					

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D2140	Amalgam - one surface, primary or permanent	**HHW, HIP Pregnancy, HIP State Plans** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface Teeth 1 – 32; 51 - 82 (SN); A - T; AS - TS (SN) **HIP Plus, (Enhanced Benefit- Up to 8 restorations or extractions per calendar year versus standard of 4)** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface	No	NONE	Composite and amalgam restorations are reimbursable based upon total number of restored surfaces. For example, non- contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three-surface restoration. Each claim line for restorative services must relate to only one tooth number. See Provider Manual for Surface code table
D2150	Amalgam - two surfaces, primary or permanent		No	NONE	
D2160	Amalgam - three surfaces, primary or permanent		No	NONE	
D2161	Amalgam- four or more surfaces, primary or permanent		No	NONE	
D2330	Resin–based composite - one surface, anterior	**HHW, HIP Pregnancy, HIP State Plans** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface Teeth 6 – 11, 22 - 27; 56 - 61(SN), 72 - 77 (SN); C - H, M – R; CS – HS (SN), MS - RS (SN) are reimbursable for D2330-D2335. D2390 **HIP Plus, (Enhanced Benefit- Up to 8 restorations or extractions per calendar year versus standard of 4** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface	No	NONE	The fee for resin-based composite restorations will include any necessary acid etching and bonding agents Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three-surface restoration. Each claim line for restorative services must relate to only one tooth number. Please see provider manual for surface code table
D2331	Resin-based composite - two surfaces, anterior		No	NONE	
D2332	Resin-based composite - three surfaces, anterior		No	NONE	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)		No	NONE	
D2390	Resin-based composite crown, anterior		No	NONE	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D2391	resin-based composite - one surface, posterior	**HHW, HIP Pregnancy, HIP State Plans** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390 D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface Teeth 1 - 5, 12 - 21, 28 – 32; 51 - 55 (SN), 62 - 71(SN) 78 - 82 (SN), A, B, I - L, S, T; AS (SN), BS (SN), IS - LS (SN), SS (SN),TS (SN) are reimbursable for D2391-D2394. **HIP Plus, (Enhanced Benefit- Up to 8 restorations or extractions per calendar year versus standard of 4** One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 12 Month(s)* per tooth, per surface	No	NONE	Composite and amalgam restorations are reimbursable based upon total number of restored surfaces. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three-surface restoration. Each claim line for restorative services must relate to only one tooth number.
D2392	resin-based composite - two surfaces, posterior		No	NONE	
D2393	resin-based composite - three surfaces, posterior		No	NONE	
D2394	resin-based composite - four or more surfaces, posterior		No	NONE	
D2910	Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration	One of (D2910) per 12 Month(s) Per Tooth. Not billable within 6 months of initial placement by same provider/location	No	NONE	Re-cement or re-bond done on the same tooth by the same dentist within a 12-month period, reimbursement will be subject to post review. * Must indicate tooth on claim. Teeth 1 - 32, A - T
D2920	Re-cement or re- bond crown	One of (D2920) per 12 Month(s) per tooth. Not billable within 6 months of initial placement by same provider/location	No	NONE	
D2921	Reattachment of tooth fragment, incisal edge, or cusp	Teeth 1 – 32 One per 12 months per tooth	No	NONE	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D2930	Prefabricated stainless-steel crown - primary tooth	Only one unit of (D2930- D2934) per tooth per lifetime D2930 teeth A - T D2931 teeth 1 - 32 D2932 teeth A- T , 1 – 32 (Age 0 - 20) D2933 teeth A- T , 1 – 32 (Age 0 -20) D2934 teeth A – T *(See clinical policies for medical necessity criteria)* HIP Plus Per State Core Only one unit of (D2930- D2934) per tooth per lifetime and one crown per member per benefit year	No* More than 8 units per date of service subject to prepayment/ post review	*Preoperative radiographs and intraoral images (to document circumferential decay as applicable) submitted with claims (See additional information)	*More than **eight (8) teeth** per 12-month period per member per provider or location of any combination of D2931, D2932, D2934 **subject to prepayment/ post review*** **Pre-operative radiographs should** be submitted with claims. Chart notes should be available upon request for utilization or documentation review of any prefabricated crown services.*
D2931	Prefabricated stainless-steel crown - permanent tooth				
D2932	Prefabricated resin crown				
D2933	Prefabricated stainless-steel crown with resin window				
D2934	Prefabricated esthetic coated stainless steel crown – primary				
D2940	Protective Restoration	One (D2940) per tooth per lifetime. Teeth 1- 32; A - T	No	NONE	Multiple teeth same date of service subject to post review
D2941	Interim therapeutic restoration - primary dentition	One (D2941) per tooth per lifetime Teeth A - T	No	NONE	Multiple teeth same date of service subject to post review
D2949	Restorative foundation for an indirect restoration	Teeth 1- 32	No	NONE	
D2951	Pin retention - per tooth, in addition to restoration	***(Enhanced Benefit- Value-Added Service)*** A maximum of three (3) pins per tooth per lifetime	No	NONE	
D2980	Crown repair, by report	Teeth 1- 32; A – T One per 12 month(s) per tooth Not billable within 6 months of initial crown placement	No	NONE	
D2990	Resin infiltration/ smooth surface	Teeth 1- 32; A – T One of (D2990) per 1 Lifetime per tooth.	No	NONE	

7.5.4 Endodontic Services D3000-D3999 Coverage Guidelines

Endodontic Services D3000 – D3999	
Coverage Clinical Guideline Nonsurgical and Surgical Endodontics	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Vital Pulp Therapy

Vital pulp therapy for teeth diagnosed with a normal pulp or reversible pulpitis may include, a protective liner, direct pulp cap, indirect pulp cap or a therapeutic pulpotomy. Explained for clinical reference, *Pulp caps and protective liners are considered integral to the restorative procedure and not reimbursed separately as part of (IN Medicaid plans).

Protective Liner*

Indications: In a tooth with a normal pulp, when all caries is removed for a restoration, a protective liner may be placed in the deep areas of the preparation to minimize injury to the pulp, promote pulp tissue healing, and/or minimize post-operative sensitivity.

Indirect Pulp Cap*

Indications: Indirect pulp treatment is indicated in a primary or permanent tooth with no pulpitis or with reversible pulpitis when the deepest carious dentin is not removed to avoid a pulp exposure. Tooth should have no subjective pretreatment symptoms.

Direct Pulp Cap*

Indications: Direct pulp cap is indicated in a permanent tooth if:

- Tooth has a vital pulp or been diagnosed with reversible pulpitis
- All caries has been removed
- Mechanical exposure of a clinically vital and asymptomatic pulp occurs
- Bleeding is controlled at the exposure site

Direct pulp cap is *not indicated* for primary teeth unless instances of a small mechanical or traumatic exposure and not direct pulp capping of a carious pulp exposure

Therapeutic Pulpotomy

Therapeutic Pulpotomy is indicated for the following:

- Primary tooth with extensive caries but without evidence of radicular pathology when caries removal results in pulp exposure in a primary tooth with a normal pulp or reversible pulpitis or after a traumatic pulp exposure.
- Exposed vital pulps or irreversible pulpitis of primary teeth where there is a reasonable period of retention expected (approximately one year)
- Any bleeding was controlled within several minutes
- As an emergency procedure in permanent teeth until root canal treatment can be accomplished
- As an interim procedure for permanent teeth with immature root formation to allow continued root development

Therapeutic Pulpotomy is not indicated for the following:

- Primary teeth with insufficient root structure, internal resorption, furcal perforation or periradicular pathosis that may jeopardize the permanent successor

Non-Vital Pulp Therapy

Pulpal Debridement (Pulpectomy)

Pulpal Debridement (Pulpectomy) is indicated for the following:

- A restorable permanent tooth with irreversible pulpitis or a necrotic pulp in which the root is apexified
- The relief of acute pain prior to complete root canal therapy
- A primary tooth, where there is a reasonable period of retention expected (approximately one year). The roots should exhibit minimal or no resorption.

Pulpal Debridement (Pulpectomy) is not indicated as definitive endodontic therapy.

Apexification

Indications: This procedure is indicated for non-vital permanent teeth with incompletely formed roots to induce root end closure (apexification) at the apices of immature roots

Endodontic Therapy

Endodontic therapy is indicated for the following:

- A restorable mature, completely developed permanent or primary tooth with irreversible pulpitis, necrotic pulp, or frank vital pulpal exposure
- Teeth with radiographic periapical pathology
- Primary teeth without a permanent successor
- Trauma
- When needed for prosthetic rehabilitation, subject to medical necessity

Endodontic therapy *is not indicated* for the following:

- Teeth with a poor long-term prognosis
- Teeth with inadequate bone support or advanced or untreated periodontal disease
- Teeth with incompletely formed root apices

Apicoectomy, Surgical exposure of root surface without apicoectomy or repair of root resorption, Surgical repair of root resorption

Apicoectomy may be indicated for the following:

- Failed retreatment of endodontic therapy
- When the apex of tooth cannot be accessed due to calcification or another anomaly
- Where visualization of the Periradicular tissues and tooth root is required when perforation or root fracture is suspected
- Further diagnosis when post endodontic therapy symptoms persist
- A marked over extension of obturating materials interfering with healing
- When a biopsy of periradicular tissue is necessary

Apicoectomy is not indicated for the following:

- Unusual bony or root configurations resulting in lack of surgical access
- The possible involvement of neurovascular structures
- Teeth with a hopeless prognosis

DEFINITIONS

Apexogenesis: The vital pulp therapy performed to encourage continued physiological formation and development of the tooth root.

Indirect pulp treatment. Indirect pulp treatment is a procedure performed in a tooth with a deep carious lesion approximating the pulp but without signs or symptoms of pulp degeneration.

Direct Pulp Cap: A procedure when a pinpoint mechanical exposure of the pulp is encountered during cavity preparation or following a traumatic injury in which the exposed vital pulp is treated with a therapeutic material, followed with a base and restoration, to promote healing and maintain pulp vitality.

Endodontics: The branch of dentistry which is concerned with the morphology, physiology, and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

Indirect Pulp Cap: A procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin.

Perforation: The mechanical or pathologic communication between the root canal system and the external tooth surface. Protective liner: A protective liner is a thinly applied liquid placed on the pulpal surface of a deep cavity preparation, covering exposed dentin tubules, to act as a protective barrier between the restorative material or cement and the pulp.

Pulpal Debridement (Pulpectomy): The complete removal of vital and non-vital pulp tissue from the root canal space.

Regenerative Endodontics: Biologically based procedures designed to physiologically replace damaged tooth structures, including dentin and root structures, as well as cells of the pulp-dentin complex.

Recalcification: A procedure used to encourage biologic root repair of external and internal resorption defects.

Therapeutic) Pulpotomy: The removal of a portion of the pulp, including the diseased aspect, with the intent of maintaining the vitality of the remaining pulpal tissue by means of a therapeutic dressing.

Furcation: The anatomic area of a multirooted tooth where the roots diverge. A Furcation involvement refers to loss of periodontal support in a Furcation). **The Glickman Classification of Tooth Furcation Grading**

Class I:	Class II:	Class III:	Class IV:
Curvature of the concavity between the roots can be detected with the probe tip but it cannot enter the space.	Probe penetrates the furcation but does not completely pass through to the other side.	Probe passes completely through the furcation but is not clinically visible because the soft issue still fills the furcation defect.	Probe passes completely through the furcation and the entrance to the furcation is clinically visible because of gingival recession.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D3220 Therapeutic pulpotomy (excluding final restoration)
D3222 Partial pulpotomy for Apexogenesis - permanent tooth with incomplete root development
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration)
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit
D3352 Apexification/recalcification – interim medication replacement
D3353 Apexification/recalcification - final visit
D3410 Apicoectomy/ periradicular surgery – anterior

D3421	Apicoectomy /periradicular surgery - bicuspid (first root)
D3425	Apicoectomy/periradicular surgery - molar (first root)
D3426	Apicoectomy/ periradicular surgery (each additional root)
D3430	Retrograde filling-per root
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption - premolar
D3473	Surgical repair of root resorption - molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar
D3911	Intraorifice barrier
D3921	Decoronation or submergence of an erupted tooth

GENERAL DESCRIPTION OF SERVICES

Vital pulp therapy (VPT) is a biologic and conservative treatment modality to preserve the vitality and function of the coronal or remaining radicular pulp tissue in vital permanent teeth. When retreatment of endodontic therapy is unsuccessful or not possible, surgical treatment may be required. Surgical endodontics encompasses the elimination of pathology through periradicular surgery, root amputation and hemisectioning of multirooted teeth. Nonvital pulp therapy for primary teeth with irreversible pulpitis or necrotic pulp include pulpectomy and lesion stabilization/tissue repair.

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Endodontic Services D3000-D3999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Endodontics	D3220 D3348 D3471 D3222 D3351 D3472 D3230 D3352 D3473 D3240 D3353 D3501 D3310 D3410 D3502 D3320 D3421 D3503 D3330 D3425 D3911 D3346 D3426 D3921 D3347 D3430	D3220 **D3310** D3921 D3222 **D3320** D3230 **D3330** D3240 D3911	D3220 D3348* D3471* D3222 D3351* D3472* D3230 D3352* D3473* D3240 D3353* D3501* **D3310** D3410* D3502* **D3320** D3421* D3503* **D3330** D3425* D3911 D3346* D3426* D3921 D3347* D3430*	EPSDT as Medically Necessary	**D3220**

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
All Endodontic Procedures are subject to Post Review. Submit preoperative radiographs with all claim submissions. Root canals are not covered as a standard Medicaid benefit for Adults of age 21 and older. CareSource provides the service as an enhanced benefit subject to limitations. Services performed on primary teeth for age 12 and older should only be on retained primary teeth without a permanent successor.					
D3220	Therapeutic pulpotomy (excluding final restoration)	Teeth 1 - 32, A - T One (D3220) per tooth per lifetime. Not billable with D3310, D3320, D3330 on the same date of service. **HIP Plus Enhanced Benefit** Age 19 and older One (D3220) per tooth per lifetime. **Up to 2 teeth per calendar year**	No**	Submit preoperative radiographs and narrative or chart notes with claim	See clinical guidelines and indications. *D3220 monitored via UM analysis and subject to post review medically necessity
D3222	Partial pulpotomy for Apexogenesis - **permanent tooth** with incomplete root development	Permanent Teeth 1- 32 One (D3222) per tooth per lifetime Not billable with D3310, D3320, D3330 on the same date of service.	No*	Submit preoperative radiographs and narrative or chart notes with claim	See clinical guidelines and indications. *D3222 monitored via UM analysis and subject to post review medically necessity

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration	Teeth C – H; M - R One (D3230) per tooth per lifetime Not billable with D3310, D3320, D3330 on the same date of service.	No*	Submit preoperative radiographs and narrative or chart notes with claim	See clinical guidelines and indications. *D3230 monitored via UM analysis and subject to post review medically necessity
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration)	Teeth A - B; I – L; S -T One (D3240) per tooth per lifetime Not billable with D3310, D3320, D3330 on the same date of service.	No*	Submit preoperative radiographs and narrative or chart notes with claim	See clinical guidelines and indications. *D3240 monitored via UM analysis and subject to post review medically necessity
D3310	Anterior root canal (excluding final restoration)	One (D3310) per tooth per lifetime Teeth covered: 6-11, 22-27 Age 1- 20 One (D3320) per tooth per lifetime Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29 Age 1- 20 One (D3330) per tooth per lifetime Teeth covered: 1 – 3, 14 – 19, 30 – 32 Age 1- 20 Adults ≥ 21 HHW and HIP State Plans can receive two root canals (D3310, D3220, D3330) per lifetime as (**enhanced benefit**)	No*	**Pre-op** Radiographs submitted with claim	*D3310, D3320, D3330 monitored via UM analysis and subject to post review medical necessity Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, x-rays during treatment, and postoperative x-rays. CareSource will reimburse for either root canal therapy (codes D3310 or D3320) or Emergency - Open Pulp Chamber (code D3220—, but not on same date of service. Radiographs and documentation must show restorability of tooth and health of surrounding alveolar structures.
D3320	Bicuspid root canal (excluding final restoration)				
D3330	Molar root canal (excluding final restoration)				
D3346	Retreatment of previous root canal therapy-anterior	Age 1 - 20 One (D3346) per tooth per lifetime Teeth covered: 6-11, 22-27	No*	**Pre-op** Radiographs submitted with claim	*D3346, D3347,D3348 monitored via UM analysis and subject to post review medical necessity
D3347	Retreatment of previous root canal therapy-bicuspid	Age 1 - 20 One (D3347) per tooth per lifetime Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29	No*	**Pre-op** Radiographs submitted with claim	
D3348	Retreatment of previous root canal therapy-molar	Age 1 - 20 One (D3348) per tooth per lifetime Teeth covered: 1 – 3, 14 – 19, 30 – 32	No*	**Pre-op** Radiographs submitted with claim	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D3351	Apexification/ recalcification – initial visit	Age 1 - 20 One (D3351) per tooth per lifetime Teeth Covered 1 -32	No*	**Pre-op** Radiographs submitted with claim	*D3351, D3352, D3353 monitored via UM analysis and subject to post review medically necessity
D3352	Apexification/ recalcification – interim medication replacement	Age 1 - 20 One (D3352) per tooth per lifetime Intra-canal medication is replaced with new medication. Teeth Covered 1 – 32	No*	**Pre-op** Radiographs submitted with claim	
D3353	Apexification/ recalcification - final visit	Age 1 - 20 One (D3353) per tooth per lifetime Teeth Covered 1 – 32	No*	**Pre-op** Radiographs submitted with claim	
D3410	Apicoectomy/ periradicular surgery – anterior	Age 1 - 20 One (D3410) per tooth per lifetime Teeth covered: 6-11, 22-27	Post Review	Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case.	See Clinical Policy
D3421	Apicoectomy /periradicular surgery - bicuspid (first root)	Age 1 - 20 One (D3421) per tooth per lifetime Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29	Post Review		See Clinical Policy
D3425	Apicoectomy/ periradicular surgery - molar (first root)	Age 1 - 20 One (D3425) per tooth per lifetime Teeth covered: 1 – 3, 14 – 19, 30 – 32	Post Review	Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case.	See Clinical Policy
D3426	Apicoectomy/ periradicular surgery (each additional root)	Age 1 - 20 Two (D3426) per tooth per lifetime. Teeth covered: 1 – 5, 12 – 21, 28 – 32	Post Review		See Clinical Policy
D3430	Retrograde filling-per root	Age 1 - 20 Three (D3430) per tooth per lifetime	Post Review	Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case	See Clinical Policy

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D3471	Surgical repair of root resorption - anterior	Age 1 - 20 One (D3471) per tooth per lifetime Teeth covered: 6-11, 22-27	Post Review	Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case	See Clinical Policy
D3472	Surgical repair of root resorption - premolar	Age 1 - 20 One (D3472) per tooth per lifetime Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29	Post Review		See Clinical Policy
D3473	Surgical repair of root resorption - molar	Age 1 - 20 One (D3473) per tooth per lifetime Teeth covered: 1 – 3, 14 - 19, 30 - 32	Post Review		See Clinical Policy
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	Age 1 - 20 One (D3501) per tooth per lifetime Teeth covered: 6-11, 22-27	Post Review	Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case	See Clinical Policy
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	Age 1 - 20 One (D3502) per tooth per lifetime Teeth covered: 4, 5, 12, 13, 20, 21, 28, 29	Post Review		See Clinical Policy
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	Age 1 - 20 One (D3503) per tooth per lifetime Teeth covered: 1 – 3, 14 - 19, 30 - 32	Post Review		See Clinical Policy
D3911	Intraorifice barrier	One (D3911) per lifetime per tooth Per Permanent teeth only	No	Pre-Operative Radiograph with claims	
D3921	Decoronation or submergence of an erupted tooth	One (D3921) per lifetime per tooth Per Permanent teeth only	No	Pre-Operative Radiograph with claims	

7.5.5 Periodontics D4000-D4999 Coverage Guidelines

Periodontic Services D4000 – D4999	
Coverage Clinical Guideline Surgical Periodontal Therapy	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements Non- Surgical Periodontal Therapy Coverage Guidelines

COVERAGE RATIONALE and CLINICAL CRITERIA

Periodontal Surgical procedures are classified into two categories of consideration: Resective procedures (gingivectomy/gingivoplasty, gingival flaps, osseous surgery) and Mucogingival procedures (tissue graft procedures).

Resective Procedures

Gingivectomy/Gingivoplasty

Indication for performance of the gingivectomy is the following:

- Elimination of the periodontal pocket (Suprabony pockets- exceeding 3mm), if the pocket wall is fibrous and firm and there is an adequate zone of keratinized tissue
- Elimination of gingival overgrowth (e.g. hyperplasia, gingival fibromatosis) or a periodontal abscess
- To allow restorative access for subgingival caries
- Access for Subgingival located crown margins.
- To reestablish the physiologic design of the free gingival margin by surgical means - gingivoplasty,

It is *not* indicated for the following:

- Swelling of gingiva is due to inflammation
- When osseous surgery is required for infrabony defects
- Situations in which the bottom of the pocket is apical to the mucogingival junction
- In areas with a shallow palatal vault or prominent external oblique ridge

Flap Procedures: Gingival Flap and Apically Positioned Flap

Flap procedures are indicated for the following:

- The presence of moderate to deep probing depths
- Moderate/severe gingival enlargement or extensive areas of overgrowth
- Loss of attachment
- The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful
- The diagnosis of a cracked tooth, fractured root, or external root resorption when this cannot be accomplished by non-invasive methods

Osseous Surgery

Indicated for the following:

- Patients with a diagnosis of moderate to advanced or Refractory periodontal disease
- When less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease

Osseous Surgery is not indicated for teeth with a hopeless prognosis.

DEFINITIONS

Clinical Crown: That portion of tooth normally covered by, and including, enamel.

Flap: A loosened section of tissue separated from the surrounding tissues except at its base.

Furcation: The anatomic area of a multirooted tooth where the roots diverge. A Furcation involvement refers to loss of periodontal support in a Furcation.

Osseous surgery (gum pocket reduction surgery) is a dental procure to remove areas of bone infected by bacteria from periodontal gum disease

Glickman Classification of Tooth Furcation Grading:

- Grade I:
  - Incipient
  - Just barely detectable with examination hand instruments
  - No horizontal component of the Furcation is evident on probing
- Grade II:
  - Early bone loss
  - Examination hand instrument goes partially into the Furcation, but not all the way through
  - Furcation may be grade II on both sides of the tooth, but are not connected
- Grade III:
  - Advanced bone loss
  - Examination hand instrument goes all the way through Furcation, to other side of tooth
  - Furcation is through-and-through
- Grade IV:
  - Through-and-through, plus Furcation is clinically visible due to gingival recession

Gingival Flap: A Flap that does not extend apical to the mucogingival junction.

Gingivectomy: The excision or removal of gingiva. Gingivoplasty: Surgical procedure to reshape gingiva.

Graft: Defined by any of the following:

- Any tissue or organ used for implantation or transplantation
  - A piece of living tissue placed in contact with injured tissue to repair a defect or supply deficiency
  - To induce union between normally separate tissues

McGuire Classification of Tooth Prognosis

- Good: Teeth with adequate periodontal support where the etiologic factors can be controlled, including systemic factors
- Fair: No more than 25% attachment loss with Grade 1 Furcation invasion which can be maintained. Plaque control and systemic factors can be maintained
- Poor: As much as 50% bone loss with Grade II Furcation invasions, poor crown: root ratio; Mobility greater than Miller Class I; systemic factors; poor patient participation in treatment
- Questionable: Teeth with greater than 50% attachment loss; Grade II or III Furcation involvements; the tooth is not easily maintained either with professional hygiene or by the patient
- Hopeless: Inadequate attachment to support the tooth; Class III or IV Furcation involvement; Miller Class III Mobility; the tooth cannot be maintained with adequate plaque control by the clinician or by the patient.

Mobility: The movement of a tooth in its socket resulting from an applied force.

Miller Index of Tooth Mobility

- Class 0: Normal physiologic tooth movement
- Class I: First distinguishable signs of movement beyond normal

- Class II: Tooth movement up to 1mm in any direction
- Class III: Tooth can be moved more than 1mm in any direction and/or the tooth can be depressed into the socket

Quadrant: One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.

Recession: Location of marginal periodontal tissues apical to the cemento-enamel junction

Miller's Classification of Gingival Recession:

- Class I: Marginal tissue Recession does not extend to the mucogingival junction. There is no loss of bone or soft tissue in the interdental area. This type of Recession can be narrow or wide.
- Class II: Marginal tissue Recession extends to or beyond the mucogingival junction. There is no loss of bone or soft tissue in the interdental area. This type of Recession can be subclassified into wide and narrow.
- Class III: Marginal tissue Recession extends to or beyond the mucogingival junction. There is bone and soft tissue loss interdentally or malpositioning of the tooth.
- Class IV: Marginal tissue Recession extends to or beyond the mucogingival junction. There is severe bone and soft tissue loss interdentally or severe tooth malposition

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D4210 Gingivectomy or gingivoplasty – four or more teeth
D4211 Gingivectomy or gingivoplasty – one to three teeth
D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth
D4240 Gingival flap procedure, four or more teeth
D4241 Gingival Flap, one to three contiguous teeth
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant
D4261 Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant

GENERAL DESCRIPTION OF SERVICES

Periodontal surgery performed in the management of periodontitis typically involves flap reflection to gain visual access to the root surfaces and alveolar bone. After reflection, the dentist removes granulation tissue and performs scaling and root planing. Gingival and osseous tissue heights and contours may be altered to idealize the bony architecture and reduce probing depths. Mucogingival Treatment generally refers to treatment for better root coverage to correct gingival recession or receding gums.

REFERENCES

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Periodontic Services D4000 – D4999

Coverage Clinical Guideline Non- Surgical Periodontal Therapy

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements Surgical Periodontal Therapy Coverage Guideline

COVERAGE RATIONALE and CLINICAL CRITERIA

Scaling and Root Planing

Scaling and Root planing reported as codes D4341 and D4342 are therapeutic procedures and are indicated for patients who require scaling and root planing due to bone loss and subsequent loss of attachment. Instrumentation of the exposed root surface to remove deposits is an integral part of this procedure. Required diagnostic materials as identified in benefit grid must be included.

Scaling and Root Planing is indicated for any of the following:

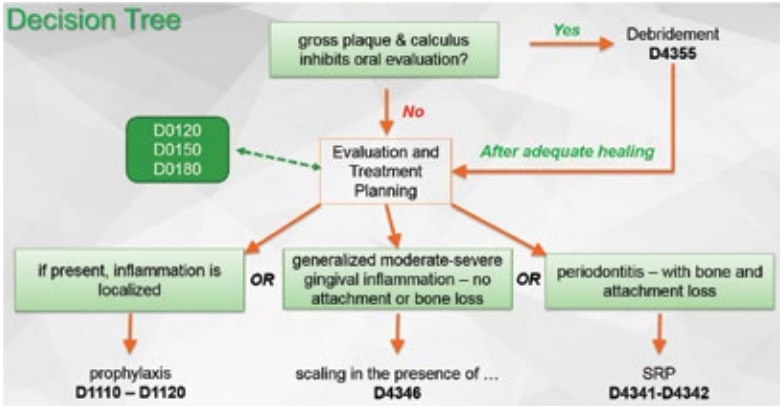
- Localized or generalized mild or moderate chronic Periodontal Disease
  - Periodontal probing depths 4 mm up to 6 mm with clinical attachment loss of up to 4 mm; radiographic evidence of bone loss and tooth mobility may be present. In molars, Furcation Involvement should not exceed Class 1.
- Localized or generalized severe chronic Periodontal Disease
  - Periodontal probing depths greater than 6 mm with attachment loss greater than 4 mm; radiographic evidence of bone loss and tooth mobility are present.
- Refractory or recurrent Periodontal Disease
- Periodontal abscess

For PSRP to be considered for a benefit, the diagnostic materials must demonstrate the following, consistent with professional standards:

- Clinical loss of periodontal attachment and/or
- Radiographic evidence of crestal bone loss or changes in crestal lamina dura and/or
- Radiographic evidence of root surface calculus

Scaling and Root Planing is not indicated for the following:

- For the removal of heavy deposits of calculus and plaque in the absence of clinical attachment loss
- Gingivitis as defined by inflammation of the gingival tissue without loss of attachment (bone and tissue
- As a sole treatment for refractory chronic, aggressive, or advanced Periodontal Diseases
- When clinical decisions are considered on the applicable code/procedure based on condition, the following decision tree of the American Dental Association provides some visualization.(ADA, 2018)



Periodontal Maintenance

Periodontal Maintenance is indicated for the following:

- To maintain the results of surgical and non-surgical periodontal treatment
- As an extension of active periodontal therapy at selected intervals

Periodontal Maintenance is not indicated for the following:

- No history of Scaling and Root Planing (SRP) or surgical procedures
- Gingivitis

Full Mouth Debridement

Per IHCP, Full-mouth debridement and full-mouth scaling services are intended for patients with excessive plaque or calculus that inhibits the dental professional's ability to perform comprehensive periodontal evaluations. Either service is indicated only in situations when the patient has not had a dental visit for several years.

DEFINITIONS

Chronic periodontitis: when 30% or more of the patient's teeth at one or more sites are involved, and it is reasonable to extend this definition to a patient with gingivitis

Gingival Irrigation: Irrigation of gingival pockets with a medicinal agent. Not to be used to report use of mouth rinses or non-invasive chemical debridement.

Gingivitis: Inflammation of gingival tissue without loss of connective tissue

Localized Delivery of Antimicrobial Agents: FDA approved subgingival delivery devices containing antimicrobial medication(s) that are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.

Periodontal Disease: Inflammatory process of the gingival tissues and/or periodontal membrane of the teeth, resulting in an abnormally deep gingival sulcus, possibly producing periodontal pockets and loss of supporting alveolar bone.

Periodontal Maintenance: This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific Scaling and Root Planing where indicated and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.

Root Planing: A definitive treatment procedure designed to remove cementum and/or dentin that is rough, may be permeated by calculus, or contaminated with toxins or microorganisms

Scaling: Removal of plaque, calculus, and stain from teeth

Scaling and Root Planing: This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

Splint: A device used to support, protect, or immobilize oral structures that have been loosened, replanted, fractured, or traumatized. Also refers to devices used in the treatment of temporomandibular joint disorders.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D4322 Splint - intra-coronal; natural teeth or prosthetic crowns D4323 Splint - extra-coronal; natural teeth or prosthetic crowns D4341 Periodontal scaling and root planing – four or more teeth per quadrant D4342 Periodontal scaling and root planing – one to three teeth per quadrant D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis D4910 Periodontal maintenance
GENERAL DESCRIPTION OF SERVICES
The American Academy of Periodontology (AAP) guidelines stress that periodontal health should be achieved in the least invasive and cost-effective manner. With non-surgical periodontal therapy, many patients can be treated and maintained without the need for surgical intervention. Non- surgical periodontal therapy includes localized or generalized scaling and root planing, the use of antimicrobials and ongoing periodontal maintenance.
REFERENCES
American Dental Association. **Glossary of Dental Clinical and Administrative Terms**. Retrieved from: www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-terms American Dental Association. **ADA Guide to Reporting D4346**.Verison 4- July 11, 2018. Retrieved from: www.ada.org/~/media/ADA/Publications/Files/CDT_Code_D4346EducationGuidelines_V3_2017Oct25.pdf?la=en American Academy of Periodontology **Glossary of Periodontal Terms**. Retrieved from: https://members.perio.org/libraries/glossary?ssopc=1 American Academy of Periodontology. **Task Force Report on the Update to the 1999 Classification of Periodontal Diseases and Conditions** [Original reference – Consensus Report: Chronic Periodontitis. 1999 International Workshop for a Classification of Periodontal Diseases and Conditions. Ann Periodontol 1999;4:38])J. Perio July 2015. Carranza F, Camargo P, Takei H. **Newman and Carranza's Clinical Periodontology**, 13th ed.St. Louis: Elsevier c2019 Chapter 24, Bone Loss and Patterns of Bone Destruction; p.316-327.

Periodontics D4000-D4999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Periodontics	D4210 D4240 D4261 D4342 D4211 D4241 D4322 D4346 D4212 D4260 D4323 D4355 D4341 D4910	D4210 D4240 D4261 D4342 D4211 D4241 D4322 D4346 D4212 D4260 D4323 D4355 D4341 **D4910**	D4210 D4240 D4261 **D4342** D4211 D4241 D4322 D4346 D4212 D4260 D4323 D4355 **D4341 D4910**	EPSDT as Medically Necessary	**D4341 D4910** **D4342**

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
These services are not considered emergency procedures and must be submitted as prior approvals. When requesting prior approval for procedure codes **D4210 - D4341**, the codes should be listed as separate line items for each quadrant needed (on the prior authorization) or each quadrant rendered (when filing for reimbursement on a dental claim).					
Quadrants should be documented when submitting authorization or claims for procedures payable per quadrant (10, 20, 30, 40; LL, LR, UL, UR) A treatment plan with a poor and/ or uncertain periodontal, restorative, or endodontic outcome may be denied due to the unfavorable prognosis of the involved tooth/teeth. Special consideration/exception may be made by submission of a narrative report.					
D4210	Gingivectomy or gingivoplasty – four or more teeth	One (D4210, D4211) per quadrant per 24 months. A minimum of four (4) teeth in the affected quadrant.	PA	1. Pre-Operative Radiographs (D0210 or Bitewings and periapicals) 2. Complete Perio charting 3. Letter of medical necessity documenting periodontal diagnosis	Limited to patients with gingival overgrowth due to drug induced causes See clinical policy for additional considerations such as hereditary gingival fibromatosis (HGF) and neurofibromatosis. D4210, D4240, D4241, D4260, D4341, D4342 are not payable on same date of service. Services required less than 24 months will have to be reviewed and approved for medical necessity Quadrant (10, 20, 30, 40; LL, LR, UL, UR)
D4211	Gingivectomy or gingivoplasty – one to three teeth	One (D4210, D4211) per quadrant per 24 months. One to three teeth in the affected quadrant.	PA		
D4212	Gingivectomy or gingivoplasty - with restorative procedures, per tooth	One (D4212) per tooth per 24 months to allow access for restorative procedure. Not payable if D4210 or D4211 has been previously billed in the same quadrant.	PA		
D4240	Gingival flap procedure, four or more teeth	One (D4240, D4241) per quadrant per 24 months. A minimum of four (4) teeth in the affected quadrant.			D4210, D4240, D4241, D4260, D4341, D4342 are not payable on same date of service If periodontal surgery is performed in less than 30 days after scaling and root planing, the benefit paid for scaling and root planing will be deducted from the surgery.
D4241	Gingival Flap, one to three contiguous teeth	One (D4240, D4241) per quadrant per 24 months. One to three teeth in the affected quadrant.	PA		

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D4260	Osseous surgery (four or more contiguous teeth or bounded teeth spaces) per quadrant	One (D4260, D4261) per quadrant per 24 months. A minimum of four (4) teeth in the affected quadrant.	PA	1. Pre-Operative Radiographs (D0210 or Bitewings and periapicals) 2. Complete Perio charting 3. Letter of medical necessity documenting periodontal diagnosis	D4210, D4240, D4241, D4260, D4341, D4342 are not payable on same date of service. (including flap entry and closure) If periodontal surgery is performed in less than 30 days after scaling and root planing, the benefit paid for scaling and root planing will be deducted from the surgery.
D4261	Osseous surgery (one to three contiguous teeth or bounded teeth spaces) per quadrant	One (D4240, D4241) per quadrant per 24 months. One to three teeth in the affected quadrant	PA		
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	One of (D4322 or D4323) per arch per lifetime	No	Narrative with claim	
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	One of (D4322 or D4323) per arch per lifetime	No	Narrative with claim	
D4341	Periodontal scaling and root planing-four or more teeth per quadrant	Age 3 – 21 and institutionalized members One (D4341, D4342) per quadrant per 24 month(s) Age ≥ 21, One (D4341, D4342) per quadrant per lifetime and eligible per 24 month(s) with qualifying medical condition (as **enhanced benefit**) **Enhanced Benefit** for **HIP Plus** One (D4341, D4342) per lifetime per quadrant and eligible per 24 month(s) with qualifying medical condition	PA	1. Pre-Operative Radiographs (D0210 or Bitewings and periapicals) 2. Letter of medical necessity documenting periodontal diagnosis 3. Oral photographic images if applicable 4. Periodontal charting performed within 12 months, including six-point probing, furcation, mucogingival relationship, bleeding, case type and oral hygiene status required.	To be considered for a benefit, the diagnostic materials must demonstrate the following, consistent with professional standards: √ Clinical loss of periodontal attachment and/or probing depths of 5 mm or greater and/or √ Radiographic evidence of crestal bone loss or changes in crestal lamina dura and/or √ Radiographic evidence of Generalized subgingival calculus If these criteria are not evident upon professional review, the authorization cannot be approved.
D4342	Periodontal scaling and root planing- One to three teeth				

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral eval	One (D4346, D4355) per 36 Month(s) Not billable within 6 months of D1110, D1120. Not billable with D1110, D4341, or D4342	No	Pre-Operative Radiographs (D0210 or Bitewings and periapicals) and perio charting available upon request	Per ADA policy, should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	One (D4346, D4355) per 36 Month(s) Not billable within 6 months of D1110, D1120. Not billable with D1110, D4341, or D4342	Post Review	Pre-Operative Radiographs (D0210 or Bitewings and periapicals) and charting available upon request	Per ADA policy, should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.
D4910	Periodontal Maintenance	One (D4910, D1110) per 6 Month(s) Age 3 - 20 or for institutionalized members. One (D4910, D1110) per 6 Month(s) (Age ≥ 21) *(Standard is one per 12 months, additional periodontal maintenance is **enhanced benefit** for Age 21 and older)* **(D4910) Enhanced Benefit** for HIP Plus	No	Pre-Operative Radiographs (D0210 or Bitewings and periapicals) and perio charting upon request	Claims history or record notes must show history of recent periodontal treatment services (D4240, D4241, D4260, D4261, D4341, D4342) Cannot bill for D1110 if member receiving perio maintenance **(IHCP)**. D1110 is for healthy tissue. D4910 is used after perio Tx to describe a more in-depth procedure in the presence of a disease state.

7.5.6 Prosthodontics, Removable D5000-D5999 Coverage Guideline

Prosthodontics Removable D5000 – D5999	
Coverage Clinical Guideline Removable	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Complete and Partial Dentures

Removable Complete or Partial Dentures are indicated for:

- Replacement of missing teeth lost due to disease, trauma, or injury.

Complete and Partial Dentures are not indicated for the following:

- Partial dentures are not indicated for members with chronic poor oral hygiene unsuitable abutment teeth
- When there has been extensive bone atrophy resulting in an inadequate edentulous ridge
- Poor neuro-muscular control
- Unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis)

Immediate Dentures are placed at the time of extractions. Claims for Immediate Denture must show extractions same date of service. Before rendering any patient edentulous the Dentist or Oral Surgeon must ensure that dentures have been authorized.

Complete and Partial Denture Rebase and Reline Procedures

Denture Rebasing is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
- When replacing or rearranging teeth on a partial denture
- When the base has fractured or cracked

Denture Rebasing is not indicated for the following:

- When the prosthesis is broken or worn to the extent that replacement is warranted
- When the occlusion or structural integrity of the denture teeth are no longer functional
- When a Reline is sufficient

Denture Relining is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
- Denture Rebasing AND Relining are not indicated for the following:
- When the prosthesis is broken or worn to the extent that it is no longer functional and replacing the appliance is warranted
- Unresolved soft tissue hyperplasia or stomatitis

Tissue Conditioning

Tissue conditioning is indicated for the following:

- The presence of inflammation and irritation of the mucosa or normal anatomic structures
- Subsequent to placement of Immediate Dentures

Tissue conditioning is not indicated for long term appliance stability and/or comfort.

General Exclusions

- Any Dental Procedure performed solely for cosmetic/aesthetic reasons
- Replacement of complete dentures, and removable partial dentures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
- Removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
- Attachments to conventional removable prostheses. This includes semi-precision or precision attachments associated with partial dentures, full or partial Overdentures, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure

DEFINITIONS

Dental Prosthesis: An artificial replacement (prosthesis) of one or more teeth (up to the entire dentition in either arch) and associated dental/alveolar structures. Dental prostheses usually are subcategorized as either fixed dental prostheses or removable dental prostheses.

Fixed Partial Denture: A prosthetic replacement of one or more missing teeth cemented or otherwise attached to the abutment teeth or implant replacements.

Immediate Denture: Any removable Dental Prosthesis fabricated for placement immediately following the removal of a natural tooth/tooth.

Overdenture: Any removable Dental Prosthesis that covers and rests on one or more remaining natural teeth, the roots of natural teeth, and/or dental implants; a Dental Prosthesis that covers and is partially supported by natural teeth, natural tooth roots, and/or dental implants.

Rebase: The laboratory process of replacing the entire denture base material on an existing prosthesis.

Reline: The procedures used to resurface the tissue side of a removable Dental Prosthesis with new base material, thus producing an accurate adaptation to the denture foundation area.

Removable Complete Denture Prosthesis: A Removable Dental Prosthesis that replaces the entire dentition and associated structures of the maxillae or mandible.

Removable Partial Denture Prosthesis: Any prosthesis that replaces some teeth in a partially dentate arch. It can be removed from the mouth and replaced at will – also called partial Removable Dental Prosthesis.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular
D5211 Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5212 Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5213 Maxillary partial denture - cast metal framework with resin denture base
D5214 Mandibular partial denture - cast metal framework with resin denture base
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)
D5282 Removable unilateral partial denture one-piece cast metal (maxillary)
D5283 Removable unilateral partial denture one-piece cast metal (mandibular)
D5284 Removable unilateral partial denture - one-piece flexible base per quadrant

D5286 Removable unilateral partial denture - one-piece resin per quadrant
D5511 Repair broken complete denture base, mandibular
D5512 Repair broken complete denture base, maxillary
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5611 Repair resin denture base, mandibular
D5612 Repair resin denture base, maxillary
D5621 Repair cast framework, mandibular
D5622 Repair cast framework, maxillary
D5630 Repair or replace broken clasp
D5640 Replace broken teeth – per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture – per tooth
D5730 Reline complete maxillary denture - direct
D5731 Reline complete mandibular denture - direct
D5740 Reline maxillary partial denture - direct
D5741 Reline mandibular partial denture - direct
D5750 Reline complete maxillary denture (indirect)
D5751 Reline complete mandibular denture (indirect
D5760 Reline maxillary partial denture – indirect
D5761 Reline mandibular partial denture - indirect
D5765 Soft liner for complete or partial removable denture - indirect
D5876 Add metal substructure to acrylic full denture (per arch)
D5951 Feeding aid
D5952 Pediatric speech aid
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral), by report
D5999 Unspecified maxillofacial prosthesis

GENERAL DESCRIPTION OF SERVICES

Removable dentures are a component of prosthodontics, which denotes the branch of dentistry pertaining to the restoration and maintenance of oral function, comfort, appearance, and health of the member by the restoration of natural teeth and/or the replacement of missing teeth and craniofacial tissues with artificial substitutes.

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7.5.7 Prosthodontics, Fixed D6200-D6999 Coverage Guideline

Prosthodontics Fixed D6200 – D6999	
Coverage Clinical Guideline **Fixed Partial Dentures and Implants**	
COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements

COVERAGE RATIONALE and CLINICAL CRITERIA

Fixed Partial Dentures (FPD) are not a covered benefit under IHCP

Fixed partial dentures may be indicated for the following:

In the event of EPSDT medical necessity, fixed prosthodontics is limited to members whose medical or mental condition precludes the use of removable prosthodontics. Additionally, the following are exclusions.

- Fixed prosthodontic restoration procedures for complete oral rehabilitation or reconstruction
- Attachments to fixed bridgework
- Procedures related to the reconstruction of a member's correct vertical dimension of occlusion (VDO)
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability

IHCP does cover fixed partial repair and re-cementation.

DEFINITIONS

Fixed Prosthesis: A dental prosthesis that is luted, screwed, or mechanically attached or otherwise securely retained to natural teeth, tooth roots, and (or dental implant Abutments) that furnish the primary support for the prosthesis.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant
D6096 Remove broken implant retaining screw
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

GENERAL DESCRIPTION OF SERVICES

Fixed prosthodontics involves the replacement of missing teeth with custom made restorations that are permanently cemented and not removable. The term "fixed partial denture" is synonymous with "fixed bridge" or "bridgework." The restoration used to replace a missing tooth is called a pontic and the restorations placed on teeth on either side of it are called retainer restorations or abutments and are typically an onlay or a crown. A resin bonded bridge consists of a pontic that is bonded to an adjacent teeth/tooth that have not been restored with an indirect restoration. While Indiana Medicaid does not cover fixed prosthodontics and implants, it does cover repairs to fixed bridges, the removal of broken implant screws, scaling and debridement around single implants and recement/bond of fixed bridges as medically necessary and indicated.

REFERENCES

American Dental Association (ADA). **Glossary of Dental Clinical and Administrative Terms**. Available at: www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter

Academy of Prosthodontics. **Glossary**. Available at: www.academyofprosthodontics.org/_Library/ap_articles_download/GPT8.pdf.

Rosenstiel S, Land M, Fujimoto J. C**ontemporary Fixed Prosthodontics**, 5th ed. St. Louis: Mosby c2016. Part 1: Planning and Preparation, Chapter 3 Treatment Planning; p.77-85.

Prosthodontics, Removable D5000-D5999 and Fixed D6222- D6999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20 (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Prosthodontics	D5110 D5511 D5741 D5120 D5512 D5750 D5211 D5520 D5751 D5212 D5611 D5760 D5213 D5612 D5761 D5214 D5621 D5765 D5225 D5622 D5876 D5226 D5630 D5951 D5227 D5640 D5952 D5228 D5650 D5993 D5282 D5660 D5999 D5283 D5730 D6081 D5284 D5731 D6096 D5286 D5740 D6930 D6980	D5110 D5283 D5660 D5120 D5284 D5730 D5130 D5286 D5731 D5140 D5511 D5740 D5211 D5512 D5741 D5212 D5520 D5750 D5213 D5611 D5751 D5214 D5612 D5760 D5225 D5621 D5761 D5226 D5622 D5765 D5227 D5630 D5876 D5228 D5640 D5999 D5282 D5650 D6081 D6096	D5110 D5286 D5741 D5120 D5511 D5750 D5130 D5512 D5751 D5140 D5520 D5760 D5211 D5611 D5761 D5212 D5612 D5765 D5213 D5621 D5876 D5214 D5622 D5951* D5225 D5630 D5952* D5226 D5640 D5993* D5227 D5650 D5999 D5228 D5660 D6081 D5282 D5730 D6096 D5283 D5731 D6930* D5284 D5740 D6980*	EPSDT as Medically Necessary	N/A

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The **fee** for complete and partial dentures i**ncludes all necessary corrections and adjustments for six months after the denture has been seated.** The dental provider must submit **documentation** supporting the need for dentures (full or partial), including the following:

- The member is edentulous, and unable to masticate properly, clinically due to fewer than eight posterior teeth in occlusion. Eight (8) natural or prosthetic teeth in occlusion [four maxillary and four mandibular teeth in functional contact with each other are generally considered adequate for functional purposes]. If a member has been edentulous for 3 or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time. The documentation must include a favorable prognosis, an analysis of the oral tissue status (such as muscle tone, ridge height, and muscle attachments), and justification of the reason the patient has been without a prosthesis. – If the provider's request indicates that the member has not worn an existing prosthesis for 3 or more years and the provider documents no mitigating circumstances warranting the authorization of a new prosthesis, CareSource denies the PA request.
- The member is physically and psychologically able to wear and maintain the prosthesis.

All Prosthetic services are **subject to post review**. Providers are responsible for maintaining supporting documentation within the member's medical/dental record for members of all ages. Only one complete or partial denture per arch is allowed in an six-year (72-month) period.

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5110	Complete denture - maxillary	One of (D5110, D5130) per (72) Month(s) One of (D5120, D5140) per (72) Month(s) Immediate Denture D5130, D5140 payable only for ≥ Age 21	PA ≥ Age 21 Post Review Ages 0 - 20	The following must be submitted for review: 1. Panoramic radiograph series (even if edentulous) or FMX radiograph series 2. Narrative/Tx plan must include teeth to be extracted and for partials include teeth to be replaced by partial 3. Photographs	The expectation is a fully functional denture
D5120	Complete denture - mandibular				
D5130	Immediate denture - maxillary	One of (D5110, D5130) per (72) Month(s) One of (D5120, D5140) per (72) Month(s) Immediate Denture D5130, D5140 payable only for ≥ Age 21 For replacement of dentures or partials less than 72 Month(s) old medical necessity must be established	PA ≥ Age 21	1. Panoramic radiograph series (even if edentulous) or Full Mouth radiograph series 2. Photographs of the Member's Mouth 3. Narrative/Tx plan must include teeth to be extracted and for partials include teeth to be replaced by partial	Reimbursement made upon DELIVERY (completion) of immediate maxillary or mandibular denture. D5130, D5140 can be reimbursed only on the same date of service as the extraction of all remaining teeth.
D5140	Immediate denture - mandibular		PA ≥ Age 21		
As aligned with IHCP policy, CareSource does not approve requests for partial dentures that replace only anterior teeth.					

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	One (D5211, D5213, D5225, D5227, D5282, D5284, D5286) per (72) Month(s) One (D5212, D5214, D5226, D5228, D5283, D5284, D5286) per (72) Month(s) For replacement of dentures or partials less than 72 Month(s) old medical necessity must be established	PA ≥ Age 21 Post Review Ages 0 - 20	1. Panoramic radiograph series (even if edentulous) or Full Mouth radiograph series 2. Photographs of the Member's Mouth 3. Narrative/Tx plan must include teeth to be extracted and for partials include teeth to be replaced by partial 4. For Flexible partials **submission of documented allergic reaction** to other denture martials.	**Cast Metal partials** (D5213, D5214, D5282, D5283) covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast-metal partial must be documented in the member's medical record for all members who require this type of denture. **Flexible base partials** (D5225, D5226, D5227, D5228, D5284) Covered only for members with one of the following: • A documented allergic reaction to other denture materials • A facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial The need for a flexible-base partial must be documented in the member's medical record for all members who require this type of denture.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)		PA ≥ Age 21 Post Review Ages 0 - 20		
D5213	Maxillary partial denture - cast metal framework with resin denture base (including clasping materials, rests, and teeth)		PA ≥ Age 21 Post Review Ages 0 - 20		
D5214	Mandibular partial denture - cast metal framework with resin denture base		PA ≥ Age 21 Post Review Ages 0 - 20		
D5225	Maxillary partial denture - **flexible base** (including retentive/clasping materials, rests, and teeth)		PA		
D5226	Mandibular partial denture - **flexible base** (including retentive/clasping materials, rests, and teeth)		PA		
D5227	Immediate maxillary partial denture - **flexible base** (including any clasps, rests, and teeth)		PA		
D5228	Immediate mandibular partial denture - **flexible base** (including any clasps, rests, and teeth)		PA		

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5282	Removable unilateral partial denture one-piece cast metal (including retentive/clasping materials, rests, and teeth) maxillary	One (D5211, D5213, D5225, D5227, D5282, D5284, D5286) per (72) Month(s)	PA ≥ Age 21	1. Panoramic radiograph series (even if edentulous) or Full Mouth radiograph series 2. Photographs of the Member's Mouth 3. Narrative/Tx plan must include teeth to be extracted and for partials include teeth to be replaced by partial 4. For Flexible partials **submission of documented allergic reaction** to other denture martials.	**Cast Metal partials** (D5213, D5214, D5282, D5283) covered only for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast-metal partial must be documented in the member's medical record for all members who require this type of denture. **Flexible base partials (D5225, D5226, D5227, D5228, D5284)** Covered only for members with one of the following: • A documented allergic reaction to other denture materials • A facial deformity due to congenital, developmental, or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial The need for a flexible-base partial must be documented in the member's medical record for all members who require this type of denture.
D5283	Removable unilateral partial denture one-piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	One (D5212, D5214, D5226, D5228, D5283, D5284, D5286) per (72) Month(s)	PA ≥ Age 21		
D5284	Removable unilateral partial denture - one-piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	One (D5284) per arch per 72 Month(s). One partial denture (D5211 – D5286) per arch per 72 months	PA		
D5286	Removable unilateral partial denture - one-piece resin (including retentive/ clasping materials, rests, and teeth), per quadrant	One (D5286) per arch per 72 Month(s). One partial denture (D5211 – D5286) per arch per 72 months	PA ≥ Age 21		
D5511	repair broken complete denture base, mandibular	One denture base repair (D5511, D5611) per day Not payable within 6 months of denture placement	PA ≥ Age 21	PA Narrative indicating that the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis	Repairs payable when the repair extends the useful life of a medically necessary denture that is six or more years old.
D5512	repair broken complete denture base, maxillary	One denture base repair (D5512, D5612) per day Not payable within 6 months of denture placement	PA ≥ Age 21	PA Narrative indicating that the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5520	Replace missing or broken teeth - complete denture (each tooth)	One (D5520) per tooth per day Not payable within 6 months of denture placement	No	Narrative required with claim	Repairs payable when the repair extends the useful life of a medically necessary denture that is six or more years old.
D5611	Repair resin denture base, mandibular	One denture base repair (D5511, D5611) per day Not payable within 6 months of denture placement	PA ≥ Age 21	**PA Narrative** indicating that the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis	
D5612	Repair resin denture base, maxillary	One denture base repair (D5512, D5612) per day Not payable within 6 months of denture placement	PA ≥ Age 21		
D5621	Repair cast framework, mandibular	One (D5621) per day Not payable within 6 months of partial placement	PA ≥ Age 21	**PA Narrative** indicating that the individual is eligible for a new prosthesis, but a repair will extend the useful life of the existing prosthesis	
D5622	Repair cast framework, maxillary	One (D5622) per day Not payable within 6 months of partial placement	PA ≥ Age 21	**PA Narrative** indicating that the individual is eligible for a new prosthesis, but a repair will extend the useful life of the existing prosthesis	
D5630	Repair or replace broken clasp	Two (D5630) per day Not payable within 6 months of partial placement	Post Review	Narrative with claim	
D5640	Replace broken teeth - per tooth	One (D5640) missing or broken teeth replaced, payable per day per tooth Not payable within 6 months of denture/partial placement	Post Review	Narrative with claim	
D5650	Add tooth to existing partial denture	Three (D5650) per date of service Not payable within 6 months of partial placement	Post Review	Narrative with claim	

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5660	Add clasp to existing partial denture	Two (D5660) per date of service Not payable within 6 months of partial placement	Post Review	Narrative with claim	Repairs payable when the repair extends the useful life of a medically necessary denture that is six or more years old.
D5730	Reline complete maxillary denture - **direct**	One (D5730, D5750) per 12 month(s) Not payable within 6 months of denture placement.	No	Narrative of medical necessity of reline	>21yrs old, the prosthesis must be benefit eligible (term limits met, > 6yrs old) and the reline will extend the life of the prosthesis. One per lifetime per eligible prosthesis. D5730 and D5731 not benefit eligible in-conjunction with D5130-D5140 All complete and partial denture-relining procedures include all necessary corrections for six months after the denture reline.
D5731	Reline complete mandibular denture - **direct**	One (D5731, D5751) per 12 month(s) Not payable within 6 months of denture placement.	No		
D5740	Reline maxillary partial denture - **direct**	One (D5740, D5760) per 12 month(s) Not payable within 6 months of denture placement.	No		
D5741	Reline mandibular partial denture - **direct**	One (D5741, D5761) per 12 month(s) Not payable within 6 months of denture placement.	No		
D5750	Reline complete maxillary denture **- indirect**	One (D5730, D5750) per 12 months . Not payable within 6 months of denture placement.	Post Review	Narrative of medical necessity of reline	>21yrs old, the prosthesis must be benefit eligible (term limits met, > 6yrs old) and the reline will extend the life of the prosthesis. One per lifetime per eligible prosthesis. D5750 and D5751 not benefit eligible in-conjunction with D5130-D5140 All complete and partial denture-relining procedures include all necessary corrections for six months after the denture reline.
D5751	Reline complete mandibular denture - **indirect**	One (D5731, D5751) per 12 months. Not payable within 6 months of denture placement.	Post Review		
D5760	Reline maxillary partial denture **- indirect**	One (D5740, D5760) per 12 months. Not payable within 6 months of denture placement.	Post Review		
D5761	Reline mandibular partial denture **- indirect**	One (D5741, D5761) per 12 months. Not payable within 6 months of denture placement.	Post Review		
D5765	Soft liner for complete or partial removable denture - **indirect**	One (D5765) per 6 months. Not payable within 3 months of denture placement	No*	Narrative with claims	History of Denture or partial with claims. More than 2 soft relines subject to prepayment review*

Code	Service Description	Benefit Limitations/Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D5876	Add metal substructure to acrylic full denture (per arch)	One (D5876) per arch per lifetime	PA	Narrative of medical necessity	
D5951	Feeding aid	Covered only for Age 0-20 One (D5951) per lifetime	No*	Narrative Intraoral images submitted with claim subject to post payment review*	Used on an interim basis, this prosthesis achieves separation of the oral and nasal cavities in infants born with wide clefts necessitating delayed closure
D5952	Pediatric speech aid -	Covered only for Age 0- 19 One (D5952) per lifetime	No*	Narrative Intraoral images submitted with claim subject to post payment review*	A temporary or interim prosthesis used to close a defect in the hard and/or soft palate. It may replace tissue lost due to developmental or surgical alterations. It is necessary to produce intelligible speech.
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report	Covered only for Age 0- 20 One (D5993) per 12 Month(s)	No	NONE	
D5999	Maxillofacial Prosthesis	One (D5999) per day by report	Yes	Narrative, Radiographs, Images as applicable	**D5999 Maxillofacial Prosthesis should no longer be used for Sleep Apnea effective 1/1/2022. See code D9947**
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant	One (D6081) per Implant per date of service	Post Review	Radiographs, Periodontal Charting, Narrative	Including cleaning of the implant surfaces, without flap entry and closure
D6096	Remove broken implant retaining screw	One (D6096) per Implant per date of service	No	NONE	
D6930	Recement fixed partial denture	Age 1-20 One (D6930) per Implant per date of service	No	NONE	
D6980	Fixed partial denture repair, by report	Age 1-20 One (D6980) per date of service Not payable within 6 months of initial placement	No*	Narrative Intraoral images submitted with claim subject to post payment review*	

7.5.8 Oral and Maxillofacial Surgery D7000-D7999 Coverage Guideline

Oral and Maxillofacial Surgery D7000 - D7999

Coverage Clinical Guideline **Non-Surgical Extractions**

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements Surgical Extraction: Erupted Teeth Retained Roots Guideline Surgical Extraction: Impacted Wisdom Teeth Guideline

COVERAGE RATIONALE and CLINICAL CRITERIA

Patient Informed Consent must be obtained for all Extractions

- A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone and/or affected by a pathological condition.
- Extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given, except in an absolute emergency. Documentation must be provided to support the absolute emergency removal of teeth.

Non-Surgical Extractions

Non-surgical Extractions are indicated for the following:

- For non-restorable teeth
- For teeth with a poor prognosis
- Supernumerary teeth
- Crowding/nonfunctional teeth
- Orthodontic considerations
- For primary teeth that are interfering with the eruption of permanent teeth
- Interference with prosthodontic needs

Extraction includes local anesthesia, suturing if needed and routine post-operative care

DEFINITIONS

Extraction Coronal remnants: removal of soft tissue retained coronal remnants

Extraction, erupted tooth or exposed root: (elevation and/or forceps removal) Includes removal of tooth structure, minor smoothing of socket bone and closure as necessary

How to code for supernumerary teeth
Health partners must use the below codes when submitting supernumerary tooth removal claims:

Coding for Supernumerary Teeth

Teeth 1-4	Supernumerary 51-54	Teeth 17-20	Supernumerary 67-70
Teeth 5-8	Supernumerary 55-58	Teeth 21-24	Supernumerary 71-74
Teeth 9-12	Supernumerary 59-62	Teeth 25-28	Supernumerary 75-78
Teeth 13-16	Supernumerary 63-66	Teeth 29-32	Supernumerary 79-82
Deciduous teeth A-C Supernumerary AS-CS Deciduous teeth D-G Supernumerary DS-GS Deciduous teeth H-J Supernumerary HS-JS		Deciduous teeth K-M Supernumerary KS-MS Deciduous teeth N-Q Supernumerary NS-QS Deciduous teeth R-T Supernumerary RS-TS	

APPLICABLE COVERED CODES
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.
D7111 Extraction, coronal remnants – primary tooth D7140 Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)

GENERAL DESCRIPTION OF SERVICES

Non-surgical extractions are performed for erupted teeth. Instruments are used to separate the periodontium from the tooth to remove it from its position in the jaw. This procedure includes routine removal of tooth structure, minor smoothing of the socket, and sutures if indicated.

REFERENCES

American Dental Association (ADA). **Glossary of Dental Clinical and Administrative Terms**. Available at: www.ada.org/en/publications/cdt/glossary-of-dental-clinical-and-administrative-ter

Hall K., Klene C. **Atlas of Oral and Maxillofacial Surgery**. St. Louis: Mosby c2016. Chapter 10, Routine Extraction of Teeth; p. 83-84.

Oral and Maxillofacial Surgery D7000 - D7999

Coverage Clinical Guideline **Surgical Extraction: Erupted Teeth and Retained Roots**

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements Non-Surgical Extractions Surgical; Extraction: Impacted Wisdom Teeth

COVERAGE RATIONALE and CLINICAL CRITERIA

Patient Informed Consent must be obtained for all Extractions

- A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone and/or affected by a pathological condition.
- Extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given, except in an absolute emergency. Documentation must be provided to support the absolute emergency removal of teeth.

Surgical Extraction of an Erupted Tooth

Surgical Extraction of an Erupted Tooth is indicated for any of the following:

- No clinical crown is visible in the mouth
- The fracture of a tooth or roots during a non-surgical extraction procedure
- Erupted teeth with unusual root morphology (dilacerations, cementosis)
- Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm
- When fused to an adjacent tooth
- In the presence of periapical lesions
- For maxillary posterior teeth, whose roots extend into the maxillary sinus
- When tooth has been crowned or been treated endodontically

The procedure and benefit are based on surgical indications, not on the specialty of provider. D7210 should not be automatically submitted if OMFS Specialty. Teeth must be medical necessary of surgical extraction.

Surgical Removal of Residual Tooth Roots

Surgical Removal of Residual Tooth Roots is indicated when tooth roots or fragments of tooth roots remain in the bone following a previous incomplete tooth extraction.

- "Residual tooth roots" do not represent a current extraction of a tooth, but of root remnants left from a previous extraction. Radiographs, treatment history, and/or clinical record documentation should reflect this.
- If the crown of the tooth has been fractured or destroyed by caries, and the removal of the root is performed, the appropriate ADA code should be used (i.e. D7140 -extraction, erupted tooth, or exposed root; or D7210 surgical extraction of retained root per indications.

D7250 is not reimbursable to dentist or dental group that performed initial extraction, within 90 days of initial extraction.

DEFINITIONS

Surgical Extraction of an Erupted Tooth: A tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

Surgical Removal of Residual Tooth Roots: The surgical removal of residual tooth roots (cutting procedure) includes cutting of soft tissue and bone, removal of tooth structure and closure.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

D7250 Removal of residual tooth roots (cutting procedure)

GENERAL DESCRIPTION OF SERVICES

Surgical extraction is the removal of a tooth that presents clinically with a condition that does not safely or adequately allow access using a non-surgical approach. Surgical extractions require an incision, elevation, and bone removal when indicated. It may be an entire tooth, or any part of a tooth, including retained roots.

REFERENCES

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Oral and Maxillofacial Surgery D7000 - D7999

Coverage Clinical Guideline **Surgical Extraction: Impacted Wisdom Teeth**

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information
	Covered Benefit Grid- Limitations, Frequencies, Requirements Non-Surgical Extractions Surgical; Extraction: Erupted Teeth and Retained Roots

COVERAGE RATIONALE and CLINICAL CRITERIA

Surgical Extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth

Radiographic Documentation must demonstrate the definitions of complete bony, partial bony and soft tissue impaction.

Surgical extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth is indicated for the following:

- The facilitation of orthodontic treatment
- For a tooth/teeth in the line of a jaw fracture or complicating fracture management
- As part of comprehensive treatment in orthognathic surgery
- Moderate to severe or acute pain, or recurrent episodes that do not respond to conservative treatment (i.e., pain medication or antibiotics)
- Non restorable caries
- Management of, or limiting the progression of periodontal disease
- In the case of acute/chronic infection (abscess, cellulitis, pericoronitis)
- Non restorable pulpal or periapical lesion
- Internal resorption
- As a prophylactic procedure for an underlying medical or surgical condition (e.g., organ transplants, alloplastic implants, chemotherapy, radiation therapy prior to intravenous bisphosphonate therapy for cancer)
- Tumor resection
- Ectopic position
- For purposes of medically necessary prosthetic rehabilitation (partial dentures and complete dentures)

Surgical extraction of Soft Tissue, Partially Bony and Complete Bony Impacted Teeth is not indicated for the following:

- For prophylactic reasons other than an underlying medical condition
- For pain or discomfort related to normal tooth eruption

Coronectomy

Coronectomy is indicated for the following:
When above criteria are met and; The removal of complete tooth would likely result in damage to the neurovascular bundle

DEFINITIONS

Anatomical crown: That portion of tooth normally covered by, and including, enamel

Clinical crown: That portion of a tooth not covered by tissues.

Impacted Tooth: An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

Coronectomy: Intentional partial tooth removal performed when a neurovascular complication is likely if the entire impacted tooth is removed.

Removal of impacted tooth soft tissue - occlusal surface of tooth covered by soft tissue, requires mucoperiosteal flap elevation

Removal of impacted tooth partially bony - part of crown covered by bone, Requires mucoperiosteal flap elevation and bone removal. Partial eruption of a tooth with portions of the crown at or above the occlusal plane does not disqualify this tooth from being classified a partial bony impaction if bone covers the greatest convexity of the distal portion of the crown; for example, a distoangular position within the ramus of the mandible.

Removal of impacted tooth completely bony - Most or all of crown covered by bone; Requires mucoperiosteal flap elevation and bone removal.

For a horizontally impacted lower third molar to be classified as a complete bony impaction, the central groove of the crown must not be above the occlusal plane.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D7220 Removal of impacted tooth – soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth – complete bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7251 Coronectomy - intentional partial tooth removal

GENERAL DESCRIPTION OF SERVICES

Surgical extraction of impacted teeth is required when the tooth is not erupted in the oral cavity and is covered by soft tissue and/or bone. Extraction requires the cutting of tissue and bone. The most commonly affected teeth are third molars and maxillary canines, but impaction can occur with any teeth.

REFERENCES

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Oral and Maxillofacial Surgery D7000 - D7999

Coverage Clinical Guideline **Other Surgical Procedures**

COVERAGE RATIONALE **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid**- Limitations, Frequencies, Requirements Non-Surgical Extractions Guidelines Surgical; Extraction: Erupted Teeth and Retained Roots Surgical Extraction; Impacted Wisdom Teeth

COVERAGE RATIONALE and CLINICAL CRITERIA

Surgical Access of Unerupted Tooth

Surgical access of unerupted tooth is indicated for the following:

- When a normally developing permanent tooth is unable to erupt into a functional position
- For labially impacted teeth if there will be 2-3 mm of gingival cuff present after eruption

Surgical access of unerupted tooth is not indicated for the following:

- For supernumerary teeth and third molars
- When surgical access of impacted tooth would threaten vital structures
- Individuals with unmanaged medical conditions that result in excessive bleeding, reduced resistance to infection, or poor healing response

Placement of Device to Facilitate Eruption of Impacted Tooth

This is the placement of an orthodontic bracket, band or other device and attached with a chain, on an unerupted tooth, after surgical exposure, to aid in its eruption. This procedure is done following the surgical access of an unerupted tooth. Not reimbursed as a separate procedure (as noted in benefit grid)

Oroantral Fistula

An Oroantral Fistula closure is indicated when it has been determined will not heal spontaneously and must be surgically repaired

Alveoloplasty

Alveoloplasty may be indicated for the following:

- In conjunction with multiple extractions
- Irregular alveolus with sharp bony projections
- Pre-prosthetic bone contouring
- Prior to radiation therapy for head and neck malignancy
- Prior to cardiac surgery with valve replacement
- In conjunction with any medical diagnosis where there is a risk of complications from oral infections

Alveoloplasty is not indicated for the following:

- Individuals who have undergone valve replacement or radiation therapy (medical consultation should occur) and individuals with unmanaged medical conditions that result in excessive or uncontrolled bleeding. Medical consultation should occur prior to treatment for individuals on oral bisphosphonates
- When vital structure may be compromised

Note: Surgical extractions, should include smoothing of the bone and removal of bony spicules. Similarly, a claim/authorization request for alveoloplasty submitted within a short period of time following a claim for a surgical extraction and performed by the same practitioner will be denied on the same basis.

Incisional and Excisional Surgical Procedures

Incisional Biopsy

This type of oral biopsy is performed only to sample a representative portion (architecturally intact specimen) of the oral lesion. If the lesion is large or has many differing characteristics, it may require sampling of more than one area. Reimbursement includes pathology laboratory microscopic examination. A pathology report from the dentist is required. It should be attached to the claim that is submitted for processing.

Indications include:

- Inflammatory changes in the oral cavity of unknown cause that persist for long periods;
- An unresolved oral lesion interferes with proper oral function;
- For bone lesions that are not specifically identified by clinical examination and radiographs, or any oral lesion that has the characteristics of a malignancy.

Exclusions:

Biopsies of hard and soft oral tissue are a noncovered dental service and are considered medical in nature when the condition diagnosed and/or treated is non-contiguous to the teeth and /or gingiva. Please consult medical benefits.

Incision and Drainage of Abscess

Dental-related intraoral and extraoral soft tissue incision and drainage of abscess can be periapical, gingival, or periodontal in origin.

- Indicated as medically necessary when an extraction, root canal treatment or periodontal procedure cannot be performed to resolve infection on visit due to health reasons, severe inflammation or other reasons that necessitate delay of definitive procedure.

Surgical Excision of Cysts or Tumors

Cysts may be odontogenic or nonodontogenic in origin

Odontogenic Cysts

Odontogenic cysts arise from tissues involved in tooth formation. Odontogenic cysts may be inclusive of inflammatory cysts or developmental cysts

CareSource considers the removal of odontogenic cysts medically necessary when a differential diagnosis has accurately identified the lesion. Odontogenic cyst enucleation is a distinct reimbursable procedure when performed independently of other related surgical procedures.

Exclusion:

Not reimbursable when performed concomitantly and in the same location as an extraction or apical surgery, CareSource considers this to part of the related surgical procedure.

Non-Odontogenic Cysts

Non odontogenic cysts are grouped into Developmental and Inflammatory cysts . All the developmental non odontogenic cysts are true cysts (i.e. pathological cavity lined by the epithelium, usually containing fluid or semisolid material) All the inflammatory non odontogenic cysts are pseudo cysts. CareSource considers the removal of non-odontogenic cysts medically necessary when a differential diagnosis has accurately identified the lesion.

The most common sites are:

- Epidermoid cyst: floor of the mouth
- Dermoid cyst/teratoma: most common site is soft tissue of floor of mouth
- Globulomaxillary cyst: historically, described between the maxillary lateral incisor and canine teeth
- Median palatine cyst: midline of the hard palate, posterior to the incisive canal
- Nasolabial cyst: nasolabial region of the facial soft tissues
- Nasopalatine duct cyst: anterior midline of the hard palate
- Palatine cyst: midline palate soft tissue
- Surgical Ciliated Cyst: intraosseous, posterior maxilla; may be bilateral
- Oral foregut duplication cyst: floor of mouth and ventral tongue
- Lymphoepithelial cyst, intraoral: superficial mucosa of floor of mouth or posterior lateral oral tongue
- Pathology Reports should be included with claims submission

Odontogenic and Non- Odontogenic Tumors

Odontogenic tumors are any kind of abnormal growth in and around the jaw and teeth. Many of these tumors are benign, in less typical cases, odontogenic tumors are malignant,

There are several types of odontogenic tumors:

- Epithelial
- Mesenchymal
- Mixed
- Most common, called an odontoma, typically occurs before age 20 and can prevent new teeth from developing in children.

CareSource considers the removal of odontogenic tumors medically necessary when a differential diagnosis has accurately identified the lesion. Pathology Reports should be included with claims submission

Non-Odontogenic Tumors of the Jaw

Provider should also consult medical policies when evaluating and treating tumors of the Jaw. Advanced imaging sometimes used for evaluation such as computed tomography (CT), magnetic resonance imaging (MRI) including positron emission tomography CT (PET CT) is not a covered benefit under the dental program but may be under the medical program.

CareSource considers the removal of tumors of the Jaw medically necessary when a differential diagnosis has accurately identified the lesion. Pathology Reports should be included with claims submission

Frenulectomy/Frenuloplasty

Frenulectomy and Frenuloplasty effective 2021, has been coded into buccal/labial frenum and lingual frenum.

- Lingual frenum – The vertical band of thin tissue that connects the tongue to the bottom of the mouth
- Labial frenum – The connective webbing that attaches the lips to the gum above the top two front teeth and below the bottom two front teeth
- Buccal frena – The thin strands of tissue that connect the gums to the insides of the cheeks are indicated for the following:

Frenectomy is typically considered medically necessary by CareSource for the following indications:

- In cases of ankyloglossia (tongue-tied)
- When attachment of the frenum is coronal to the mucogingival junction, within the free gingiva, or in the papilla causing gingival recession, gingival stripping, or a severe diastema
- Prior to the construction of a removable prosthesis replacing teeth in frenal attachment interference are
- When there is a functional interference to mastication, swallowing, feeding and speech

Treatment of Fractures- Simple and Traumatic Wounds

CareSource considers the treatment of conditions such as the following medically necessary

- Facial lacerations
- Intra oral lacerations
- Avulsed teeth
- Fractured facial bones (cheek, nose, or eye socket)
- Fractured jaws (upper and lower jaw)

Post Review is allowed for emergency situations. Some services may be covered under the medical program.

Corticotomy

(also known as periodontally accelerated osteogenic orthodontics [PAOO] or surgically assisted osteogenic orthodontics [SAOO]) Due to the limited peer- reviewed literature evidence of efficacy., CareSource requires complete medical documentation support for medical necessity review.

Surgical Reduction of Fibrous Tuberosity

Excision of Hyperplastic tissue and surgical reduction of a fibrous tuberosity is indicated when the presence of excess tissue interferes with the fit of a partial or complete denture (existing or new)

Removal of Lateral Exostosis (Maxilla or Mandible), Torus Palatinus and Torus Mandibularis

Removal of lateral Exostoses, Torus Palatinus and Torus Mandibularis is indicated for the following:

- Interference or soft tissue trauma with adaption of a partial or complete denture
- For unusually large protuberances that are prone to recurrent traumatic injury
- When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

Medical history should be assessed before performing any bony excisional procedures, as they are not indicated for patients with unmanaged medical conditions that result in excessive or uncontrolled bleeding, reduced resistance to infection, or poor healing response

Salivary Gland and Duct Procedures

Salivary gland procedures may be indicated when there is obstruction of the glands hindering salivary function. Procedures include the removal of sialoliths, surgical excision of portions of, or the entire gland, repair of salivary fistulas and defects of salivary ducts, and may be completed intraorally or extraorally.

DEFINITIONS

Alveoloplasty: A "surgical procedure for recontouring supporting bone, sometimes in preparation for a prosthesis," other treatments such as radiation therapy and transplant surgery, or to address sharp or significantly irregular bony areas.

Avulsion: Complete displacement of the tooth out of socket; the periodontal ligament is severed, and fracture of the alveolus may occur.

Cyst: A cyst is a pathologic cavity lined by epithelium and may be located within the oral soft tissues or an intra- osseous location within the jaws

Exostosis: Bony protuberance

Intrusion: Apical displacement of tooth into the alveolar bone. The tooth is driven into the socket, compressing the periodontal ligament and commonly causes a crushing fracture of the alveolar socket.

Lateral Luxation: Displacement of the tooth in a direction other than axially. The periodontal ligament is torn, and contusion or fracture of the supporting alveolar bone occurs.

Oroantral Fistula: An open connection between the maxillary sinus usually caused by extraction of maxillary posterior teeth.

Subluxation: Injury to tooth-supporting structures with abnormal loosening but without tooth displacement.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D7260 Oroantral fistula closure
D7261 Primary closure of a sinus perforation
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Exposure of an unerupted tooth
D7282 Mobilization of erupted or malpositioned tooth to aid eruption
D7285 Incisional biopsy of oral tissue-hard (bone, tooth)
D7286 Biopsy of oral tissue – soft
D7288 Brush biopsy – transepithelial sample collection
D7295 Harvest of bone for use in autogenous grafting procedure

D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7410	Radical excision - lesion diameter up to 1.25cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7471	Removal of exostosis
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7510	Incision and drainage of abscess – intraoral soft tissue
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction may include stabilization of teeth
D7671	Alveolus, open reduction may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7961	Buccal/labial frenectomy
D7962	Lingual frenectomy (frenulectomy

D7972 Surgical reduction of fibrous tuberosity
D7979 Non-surgical silaolithotomy
D7980 Sialolithotomy
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7999 Unspecified oral surgery procedure, by report

GENERAL DESCRIPTION OF SERVICES

Oral and Maxillofacial procedures can be incisional or excisional. Excisional procedures involve the removal of lesions or pathology and/or alteration of hard and soft oral tissues to achieve normal physiologic function or allow the proper fit of prosthetic appliances. Incisional procedures can involve biopsy to examine and diagnose pathology or incisional drainage of an abscess done to provide analgesia and limit further and deeper spread of the infection

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Oral and Maxillofacial Surgery D7000-D7999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW)Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25)Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20* (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Oral & Maxillofacial Surgery	D7111 D7411 D7660 D7140 D7412 D7670 D7210 D7413 D7671 D7220 D7414 D7680 D7230 D7415 D7710 D7240 D7440 D7720 D7241 D7441 D7730 D7250 D7450 D7740 D7251 D7451 D7750 D7260 D7460 D7760 D7261 D7461 D7770 D7270 D7471 D7771 D7280 D7472 D7780 D7282 D7473 D7810 D7285 D7485 D7820 D7286 D7509 D7910 D7288 D7510 D7911 D7295 D7511 D7912 D7296 D7520 D7961 D7297 D7521 D7962 D7310 D7560 D7972 D7311 D7610 D7979 D7320 D7620 D7980 D7321 D7630 D7982 D7410 D7640 D7983 D7650 D7999	D7111 D7413 D7671 D7140 D7414 D7680 D7210 D7415 D7710 D7220 D7440 D7720 D7230 D7441 D7730 D7240 D7450 D7740 D7241 D7451 D7750 D7250 D7460 D7760 D7251 D7461 D7770 D7260 D7471 D7771 D7261 D7472 D7780 D7270 D7473 D7810 D7280 D7485 D7820 D7282 D7509 D7910 D7285 D7510 D7911 D7286 D7511 D7912 D7288 D7520 D7961 D7295 D7521 D7962 D7310 D7560 D7972 D7311 D7610 D7979 D7320 D7620 D7980 D7321 D7630 D7982 D7410 D7640 D7983 D7411 D7650 D7999 D7412 D7660 D7670	D7111 D7412 D7670 D7140 D7413 D7671 D7210 D7414 D7680 D7220 D7415 D7710 D7230 D7440 D7720 D7240 D7441 D7730 D7241 D7450 D7740 D7250 D7451 D7750 D7251 D7460 D7760 D7260 D7461 D7770 D7261 D7471 D7771 D7270 D7472 D7780 D7280 D7473 D7810 D7282 D7485 D7820 D7285 D7509 D7910 D7286 D7510 D7911 D7288 D7511 D7912 D7295 D7520 D7961 D7296* D7521 D7962 D7297* D7560 D7972 D7310 D7610 D7979 D7311 D7620 D7980 D7320 D7630 D7982 D7321 D7640 D7983 D7410 D7650 D7999 D7411 D7660	EPSDT as Medically Necessary	**D7111 D7286 D7140 D7510 D7210 D7220 D7230 D7240 D7241 D7250**

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
Must submit X-rays with claims for extraction procedure codes D7210, D7220, D7230, D7240 and D7250 even if authorization not required. Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Effective 01/01/2021frenectomy D7960 is deleted and replaced with D7961 Buccal/labial frenectomy or D7962 lingual frenectomy. ***All OMFS services may be subject to post review, when determined applicable by Dental Director.**					
D7111	Extraction, coronal remnants - deciduous tooth	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	NONE	If multiple teeth are being extracted for the same member on the same date of service, procedure code D7111 and D7140 can be used for the first tooth extracted and each additional tooth See Clinical Policy

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7140	Extraction, erupted tooth, or exposed root (elevation and/ or forceps removal)	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	NONE	
D7210	Extraction erupted tooth requiring removal of bone and/or section of tooth, and including elevation of mucoperiosteal flap if indicated	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No*	Preoperative Radiographs should be submitted with claims	Surgical extraction is the removal of a tooth that presents clinically with a condition that does not safely or adequately allow access using a non-surgical approach. See indications in provider manual. Surgical extractions require an incision, elevation, and bone removal when indicated. It may be entire tooth, or any part of a tooth, including retained roots. The procedure and benefit are based on surgical indications, not on the specialty of provider. D7210 should not be automatically submitted if OMFS Specialty See clinical guidelines and indications. *D7210 monitored and **subject to post payment review** and recoupment if found not medically necessary or clinical guidelines/ criteria not met
D7220	Removal of impacted tooth - soft tissue	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS RS, SS, TS	No*	Pre-op radiographs submitted with claims.	X-rays must be consistent with clinical definition: Occlusal surface of tooth covered by soft tissue requires mucoperiosteal flap elevation. *D7220, S7230, D7240, D7241 monitored and **subject to post payment review** for clinical guidelines/criteria

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7230	Removal of impacted tooth – partially bony	Teeth 1 - 32, 51– 82	No*	Pre-op radiographs. Panoramic radiograph series or FMX preferred. Submitted with claim Narrative/Tx notes if applicable.	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic. Usage of complete bony impaction code for approval should be consistent with the clinical definition: **Most or all of crown covered by bone; as demonstrated by radiographic image**; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth. *D7220, S7230, D7240, D7241 monitored and **subject to post payment review** for clinical guidelines/criteria
D7240	Removal of impacted tooth– completely bony	Teeth 1-32, 51-82	No*	Pre-operative radiographs. Panoramic radiograph series or FMX preferred. Submitted with claim Narrative/Treatment notes if applicable.	*D7220, S7230, D7240, D7241 monitored and **subject to prepayment or post payment review for medical necessity and clinical guidelines/criteria**
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	Teeth 1-32, 51-82	No*		
D7250	Removal of residual tooth roots (cutting procedure)	1 - 32, 51 - 82, A - T, AS – TS	No*	Pre-operative radiographs submitted with claim. Narrative/treatment notes if applicable	"Residual tooth roots" do not represent a current extraction of a tooth, but of root remnants left from a previous extraction. Radiographs, treatment history, and/or clinical record documentation should reflect this. Cutting procedure implies a surgical flap, removal of bone, and removal of the root remnants. If the crown of the tooth has been fractured or destroyed by caries, and the removal of the root is performed, the appropriate ADA code should be used (i.e. D7140 -extraction, erupted tooth, or exposed root; or D7210 surgical extraction of retained root per indications.

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
					The fee for this service is included in the initial extraction fee when performed by the original treating dentist or group and may not be billed to the member. ***D7250 monitored and subject to post service prepayment review or post payment review**
D7251	Coronectomy - intentional partial tooth removal	Teeth 1- 32 (impacted teeth only)(ADA CDT 2023)	Post Review	Pre-operative radiographs submitted with claim Narrative/treatment notes if applicable	Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.
D7260	Oroantral fistula closure	One (D7260) per day	No*	Pre-op radiographs. Narrative/Tx notes must be included documenting circumstances. Submitted with claim	Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap. *Subject to post service prepayment review or post payment review
D7261	Primary closure of a sinus perforation	One (D7261) per maxillary tooth site per lifetime	Post Review	Narrative, radiographs submitted with claim	
D7270	Tooth reimplantation and/ or stabilization of accidentally avulsed or displaced tooth	Reimbursement is per accident regardless of the number of teeth involved and covers all needed services (i.e., splints, suturing, and follow-up care)	No*	Pre-op and Post-op radiographs. A narrative/Tx notes must be included documenting circumstances. Submitted with claim	Accidental/Trauma related cases. Permanent dentition *Subject to post service prepayment review or post payment review
D7280	Exposure of an unerupted tooth	Teeth 1 – 32 One (D7280) per tooth per lifetime	No*	Pre-op radiographs. Narrative. Submitted with claim Orthodontic Authorization number if applicable.	Clinical notes of tissue reflected, and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted. Also includes tooth exposure for orthodontic purposes, including the orthodontic attachments. Prior orthodontic authorization must be obtained in this instance. D7283 is not payable as a separate benefit. *Subject to post service prepayment review or post payment review
D7282	mobilization of erupted or malpositioned tooth to aid eruption	A-T, AS-TS, 1-32, 51-82 One (D7282) per tooth per lifetime	No*	Pre-op radiographs submitted with claim	*Subject to prepayment/post review or post payment review

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	One (D7285) per day	No	A pathology report from the dentist is required. It should be attached to the claim that is submitted for processing.	For surgical removal of an architecturally intact specimen only.
D7286	Biopsy of oral tissue – soft	One (D7286) per day **Enhanced Benefit HIP Plus**	No	A pathology report from the dentist is required. It should be attached to the claim that is submitted for processing.	For surgical removal of an architecturally intact specimen only. Use procedure code D7286 and the appropriate coding scheme indicated for each lesion site.10 = upper right 20 = upper left 30 = lower right 40 = lower left
D7288	brush biopsy – transepithelial sample collection	One (D7288) per day	No	A pathology report from the dentist is required. It should be attached to the claim that is submitted for processing.	
D7295	Harvest of bone for use in autogenous grafting procedure	One (D7295) per day	No	Pre-op radiographs/Narrative attached to claim	
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant	Age 0 - 20 Four (D7296, D7297) per day	PA	Pre-op radiographs. Narrative of medical necessity.	Limited only to **orthodontic related cases** when periodontally accelerated osteogenic orthodontics [PAOO] or surgically assisted osteogenic orthodontics has been shown to be medically necessary
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant	Age 0 - 20 Four (D7296, D7297) per day	PA	Pre-op radiographs. Narrative of medical necessity.	

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7310	Alveoloplasty in conjunction with extractions - per quadrant (Four or more teeth)	One of the following per lifetime, per quadrant: D7310, D7311, D7320, D7321 Minimum of four (4) ext. in the affected quadrant.	Post Review	Post Review	Member is allowed maximum of 1 single unit per UR, UL, LL, LR of either D7310, D7311, D7320 or D7321 per lifetime and not a combination in same quad. Surgical preparation of ridge for dentures. The coding scheme below is to be used for Alveoplasty in conjunction with or without extractions. These codes are to be used in the tooth number field. UR = upper right UL = upper left LR = lower right LL = lower left D7320, D7321 not payable to same provider that performed recent extractions (within 30 days) in same quadrant, services may be integral to post op care
D7311	Alveoloplasty in conjunction with extractions one to three teeth or tooth spaces, per quadrant	One of the following per lifetime, per quadrant: D7310, D7311, D7320, D7321 One to three teeth/tooth spaces	Post Review	Pre-op radiographs. Narrative of medical necessity.	
D7320	Alveoloplasty not in conjunction with extractions Four or More Teeth or tooth spaces, per quadrant	One of the following per lifetime, per quadrant: D7310, D7311, D7320, D7321 Minimum of four (4) ext. in the affected quadrant	Post Review	Pre-op radiographs. Narrative of medical necessity.	
D7320	Alveoloplasty not in conjunction with extractions Four or More Teeth or tooth spaces, per quadrant	One of the following per lifetime, per quadrant: D7310, D7311, D7320, D7321 Minimum of four (4) ext. in the affected quadrant	Post Review	Pre-op radiographs. Narrative of medical necessity.	
D7321	Alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant	One of the following per lifetime, per quadrant: D7310, D7311, D7320, D7321 One to three teeth/tooth spaces	Post Review	Pre-op radiographs. Narrative of medical necessity.	
D7410	radical excision - lesion diameter up to 1.25cm	May be considered a benefit under the medical program. If submitted under medical, cannot be submitted under dental program. Unit of reimbursement is a flat rate per cyst or tumor area. If multiple lesions or compound lesion, a prior authorization is required for multiple units of D7410 - D7461.	No	Narrative of medical necessity. Operative and pathology reports attached with claim and maintained in medical/dental record	Documentation must be submitted with claims and any authorizations. Appropriate code must be put in the tooth number field on the claim form: UR - upper right LR - lower right UL - upper left LL - lower left

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7410	radical excision - lesion diameter up to 1.25 cm	May be considered a benefit under the medical program. If submitted under medical, cannot be submitted under dental program. Unit of reimbursement is a flat rate per cyst or tumor area. If multiple lesions or compound lesion, a prior authorization is required for multiple units of D7410 - D7461.	No	Narrative of medical necessity. Operative and pathology reports attached with claim and maintained in medical/ dental record	Documentation must be submitted with claims and any authorizations. Appropriate code must be put in the tooth number field on the claim form: UR - upper right LR - lower right UL - upper left LL - lower left
D7411	excision of benign lesion greater than 1.25 cm				
D7412	excision of benign lesion, complicated				
D7413	Excision of malignant lesion up to 1.25 cm				
D7414	Excision of malignant lesion greater than 1.25 cm				
D7415	Excision of malignant lesion, complicated				
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm				
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm				
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	One (D7450) per day One (D7451) per day One (D7460) per day One (D7461) per day	No	Pathology Report submitted with Claim and maintained in medical/dental record	Documentation must be submitted with claims and any authorizations. Appropriate code must be put in the number field on the claim form: UR - upper right LR - lower right UL - upper left LL - lower left
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm				
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm				

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	One (D7450) per day One (D7451) per day One (D7460) per day One (D7461) per day	No	Pathology Report submitted with Claim and maintained in medical/ dental record	Documentation must be submitted with claims and any authorizations. Appropriate code must be put in the number field on the claim form: UR - upper right LR - lower right UL - upper left LL - lower left
D7471	Removal of exostosis – per site	One (D7471) per quadrant per lifetime: UL, UR, LL, LR Lateral maxilla or mandibular.	No	Narrative, photographic images maintained in patient record	Use proper coding on claim form: Lower right quadrant (LR)(40), Lower left quadrant (LL)(30) Upper right quadrant (UR)(10), Upper Left quadrant (UL)(20)
D7472	Removal of torus palatinus	One (D7472) per lifetime	No	Narrative, photographic images maintained in patient record	Use proper coding on claim form: Upper Arch (01,UA)
D7473	Removal of torus mandibularis	One (D7473) per mandibular quadrant per lifetime: LL, LR	No	Narrative, photographic images maintained in patient record	Use proper coding on claim form: Lower right quadrant (LR)(40), Lower left quadrant (LL)(30)
D7485	Surgical reduction of osseous tuberosity	Two (D7485) per lifetime	No	Narrative, photographic images maintained in patient record	Use proper coding on claim form: Lower right quadrant (LR)(40), Lower left quadrant (LL)(30) Upper right quadrant (UR)(10), Upper Left quadrant (UL)(20)
D7509	Marsupialization of odontogenic cyst	One per lifetime per tooth	No	Narrative, photographic images maintained in patient record	
D7510	Incision and drainage of abscess - intraoral soft tissue	One (D7510, D7511) per date of service Must include tooth number to receive reimbursement. Teeth Covered: 1-32, 51 - 82, A - T, AS - TS **D7510 Enhanced Benefit HIP Plus**	No	Narrative Operative report maintained in patient record	For benefit purposes, the Operative Report must include a clinical diagnosis, site of incision, instrument used and method of drainage. The benefit for D7510 and D7511 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service by the same Dentist/dentist office
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	Narrative Operative report maintained in patient record	

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7520	Incision and drainage of abscess - extraoral soft tissue	One (D7520, D7521) per date of service Specify area Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS. GS, HS, IS, JS, KS, LS May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.	No	Narrative Operative report maintained in patient record	For benefit purposes, the Operative Report must include a clinical diagnosis, site of incision, instrument used and method of drainage. The benefit for D7510 and D7511 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service by the same Dentist/dentist office
D7521	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	Narrative Operative report maintained in patient record	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	One (D7560) per day	No	Narrative Operative report maintained in patient record	
D7610	Maxilla - open reduction (teeth immobilized, if present)	One (D7610) per day One (D7620) per day One (D7630) per day One (D7640) per day	Post Review	Digital Photos. Narrative/Tx notes. Radiographs	D7610 - D7640 are billed for treatment of fractures (simple and compound) to include acrylic splints, any necessary wiring, office and post- operative visits, radiographs, and suturing. Documentation must be submitted with authorizations and claims for post review
D7620	Maxilla - closed reduction (teeth immobilized, if present)				
D7630	Mandible - open reduction (teeth immobilized, if present)				
D7640	Mandible - closed reduction (teeth immobilized, if present)				
D7650	Malar and/or zygomatic arch - open reduction	One (D7650) per day	Post Review	Radiographs. Narrative/ Tx notes.	Documentation must be submitted with authorizations and claims for post review
D7660	Malar and/or zygomatic arch - closed reduction	One (D7660) per day	Post Review	Radiographs. Narrative/ Tx notes.	Documentation must be submitted with authorizations and claims for post review
D7670	Alveolus - closed reduction may include stabilization of teeth	One (D7670) per day	Post Review	Radiographs. Narrative/ Tx notes.	Documentation must be submitted with authorizations and claims for post review

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7671	Alveolus, open reduction may include stabilization of teeth	One (D7671) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with authorizations and claims for post review
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	One (D7680) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7710	Maxilla open reduction	One (D7710) per day	Post Review	Radiographs. Narrative/Tx notes with claim	Documentation must be submitted with claims for post review
D7720	Maxilla - closed reduction	One (D7720) per day	Post Review	Radiographs. Narrative/Tx notes with claim	Documentation must be submitted with claims for post review
D7730	Mandible - open reduction	One (D7730) per day	Post Review	Radiographs. Narrative/Tx notes with claim	Documentation must be submitted with claims for post review
D7740	Mandible - closed reduction	One (D7740) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7750	Malar and/or zygomatic arch - open reduction	One (D7750) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7760	Malar and/or zygomatic arch - closed reduction	One (D7760) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7770	Alveolus - open reduction stabilization of teeth	One (D7770) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7771	Alveolus, closed reduction stabilization of teeth	One (D7771) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	One (D7780) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7810	Open reduction of dislocation	One (D7810) per day	Post Review	Radiographs. Narrative/Tx notes.	Documentation must be submitted with claims for post review
D7820	Closed reduction of dislocation	Dislocations are billed to include office and post- operative visits, radiographs, and suturing.	Post Review	Radiographs. Narrative/Tx notes.	Joint manipulated into place; no surgical exposure.

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D7910	Suture of recent small wounds up to 5 cm	Traumatic wounds Not to be used in conjunction with extractions	No	Narrative/Operative report	Complicated Suturing (Reconstruction Requiring Delicate Handling of Tissues and Wide Undermining for Meticulous Closure) 1.Specify site in operative report. 2.Repair of traumatic wounds is limited to oral structures. 3.Operative report should include diagnosis and treatment. Documentation should be submitted with clam. Subject to post review.
D7911	Complicated suture - up to 5 cm		No	Narrative/Operative report	
D7912	Complicated suture - greater than 5 cm		No	Photographic image of area and narrative/ operative report.	
D7961	buccal/labial frenectomy (Frenulectomy)	One frenectomy per lifetime per frenum **Frenum** the maxillary midline labial frenum, the mandibular midline labial frenum, the right and left upper and lower labial frenum and the lingual frenum	PA	Narrative/Tx notes. Photographic image(s).	Per IHCP, Medical necessity must be established, which may include breastfeeding issues, ankyloglossia (tongue-tie), tissue pull or diastema
D7962	lingual frenectomy (frenulectomy)		PA	Narrative/Tx notes. Photographic image(s).	Per IHCP, Medical necessity must be established, which may include breastfeeding issues, ankyloglossia (tongue-tie), tissue pull or diastema
D7972	Surgical reduction of fibrous tuberosity	One per maxillary quadrant (UL, UR) per lifetime	Post Review	Narrative, Tx Notes with claim	
D7979	Non-surgical silaolithotomy	One (D7979) per date of service	Post Review	Narrative, Tx/Operative notes, and Pathology/Lab reports as applicable	All salivary gland procedures are subject to prepayment or post payment review. Some services may also be covered under the medical benefit.
D7980	Sialolithotomy	One (D7980) per date of service	No		
D7982	Sialodochoplasty	One (D7982) per date of service	No		
D7983	Closure of salivary fistula	One (D7983) per date of service	No		
D7999	Unspecified oral surgery procedure, by report	By report	PA	Narrative/Tx notes. Photographic image(s).	

7.5.9 Orthodontics D8000-D8999 Coverage Guideline

ORTHODONTICS D8000 - D8999	
Coverage Clinical Guideline	**Medically Necessary Orthodontics**
BACKGROUND **COVERAGE RATIONALE** **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid** - Limitations, Frequencies, Requirements CareSource HLD Scoring Tool

BACKGROUND

Medically necessary orthodontic treatment involves the correction of the dental component of a craniofacial abnormality that results in a handicapping malocclusion and is intended to restore a functional dentition. In order for orthodontics to be considered medically necessary, the case should include the treatment of craniofacial abnormalities, malocclusions caused by trauma, or craniofacial disharmonies. In addition, treatment may be covered when provided in conjunction with other medical issue(s), such as a syndrome, trauma, etc. For example, a severe handicapping malocclusion, which impairs a patient's physical or emotional health, may require medically necessary orthodontic treatment. It is not for orthodontic services for crowded dentitions or crooked teeth, excessive spacing, TMJ conditions and/or vertical/horizontal (overjet/overbite) discrepancies. The American Association of Orthodontists (AAO) most recently promoted a list of auto-qualifiers, conditions such as: overjet and reverse overjet of a given measurement, a posterior crossbite with no functional occlusal contact, defects of cleft lip or palate, congenitally missing teeth, etc., any one of which constitutes medical necessity. Qualification for comprehensive orthodontia treatment, including banding and extended care, requires submission of documentation to support the classification of the malocclusion and the functional concerns as well as the HLD Index scoring Tool. The HLD Index provides an objective and standardized measurement methodology to determine medical necessity for the treatment of a severe physically handicapping malocclusion. The information required to complete the Index is consistent with information providers already collect during the assessment of the patient, and there is no additional examination requirement in order to complete the report. The HLD Index adaptation is universal and one of the most common indexes used.

COVERAGE RATIONALE and CLINICAL CRITERIA

A. Primary Requirements

- All services must be prior approved by the plan
- The member is under the age 21 (through age 20), unless the member specific benefit plan indicates a different age)
- The Member has active coverage with the plan
- The Provider has completed the CareSource HLD Orthodontic Scoring Tool
- The Member meets Clinical Qualifying criteria as indicated per Scoring Tool

B. Provider Requirements:

- All Providers must be in compliance with the applicable state Board of Dentistry Requirements
- Dentists (D.D.S., D.M.D) who provide orthodontic services with CareSource must be credentialed as an orthodontist or as a dentist with orthodontic privileges per qualifications outlined by applicable state board requirements and should include continuing education in orthodontics and completion of at least 5 comprehensive orthodontic cases

C. Clinical Criteria for Approval of D8070, D8080 and D8090 Comprehensive Orthodontic Therapy
Services are related to the treatment of a severe craniofacial deformity that results in a physically Handicapping Malocclusion, including but not limited to the following conditions:

- Cleft Lip and/or Cleft Palate
- Crouzon Syndrome/Craniofacial Dysostosis
- Hemifacial Hypertrophy/Congenital Hemifacial Hyperplasia
- Parry-Romberg Syndrome/Progressive Hemifacial Atrophy
- Pierre-Robin Sequence/Complex
- Treacher-Collins Syndrome/Mandibulofacial Dysostosis

The following conditions and the severity in scoring combination utilizing the HLD Index may also be considered in determining medical necessity for a functional handicapping condition requiring comprehensive therapy:

- Overjet equal to or greater than 9mm
- Reverse overjet equal to or greater than 3.5 mm
- Lateral or anterior open bite equal to or greater than 4 mm
- Impinging overbite with either palatal trauma or mandibular anterior gingival trauma
- Defects of cleft lip and palate or other craniofacial anomalies or trauma
- Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)
- Full tooth Class II molar malocclusion
- Full tooth Class III molar malocclusion
- Anterior tooth impaction, unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth, which may be malposed but have erupted into the oral cavity and is not a qualifying element
- Excessive anterior crowding
- Anterior open bite that demonstrates that all maxillary and mandibular incisors have no incisal contact
- Posterior open bite shall demonstrate a vertical separation of several posterior teeth and not confused with the delayed natural eruption of a few teeth
- Posterior cross bite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch or a posterior maxillary arch totally lingually malpositioned to the mandibular arch
- Anterior crossbite involving more than two incisors in cross bite and demonstrates gingival inflammation, gingival recession, or severe enamel wear

Orthodontic treatment with a limited objective, or treatment to control harmful habits the following conditions and severity will be considered in determining medical necessity:

D. Note effective 1/1/2022 the CDT nomenclature no longer supports D8050 and D8060 Interceptive Orthodontics.

E. Criteria for Approval D8010 Limited orthodontic treatment of the primary dentition D8020 – Limited Orthodontic Treatment of the Transitional Dentition and D8030 Limited orthodontic treatment of the adolescent dentition: Orthodontic treatment utilizing any therapeutic modality with a limited objective or scale of treatment from section C above. Treatment may occur in any stage of dental development or dentition. For certain appliances and limited treatment:

F. Criteria for Approval D8210 Removable Appliance Therapy and D8220 Fixed Appliance Therapy:
Code D8210 and D8220 is for the use of removable or fixed appliance therapy to correct habits such as tongue thrusting and thumb sucking. Medical necessity consideration may be considered based on the following:

- For correction of thumb sucking habits, models should show evidence of open bite or severe protrusion.
- For correction of tongue thrusting habits, models should show evidence of severe open bite.
- Bite Planes: the patient must show evidence of deep impinging overbite.
- RPE: the submitting orthodontist must provide proof of functional deviation.
- Face Mask: must submit a lateral view radiograph showing the mandibular growth exceeding the growth of the upper jaw. Patient should have a negative ANB difference as determined by a cephalometric x-ray.

DEFINITIONS

Primary Dentition: Teeth developed and erupted first in order of time.
Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.
LIMITED ORTHODONTIC TREATMENT: Orthodontic treatment with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more therapy that is comprehensive.

COMPREHENSIVE ORTHODONTIC TREATMENT: Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or aesthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients.
Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development
MINOR TREATMENT TO CONTROL HARMFUL HABITS: Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting. Fixed appliance therapy - Fixed indicates patient cannot remove appliance; includes appliances for thumb sucking and tongue thrusting.
Parry-Romberg Syndrome/Progressive Hemifacial Atrophy: A rare disorder characterized by slowly progressive deterioration (atrophy) of the skin and soft tissues of half of the face (hemifacial atrophy), usually the left side. (National Institutes of Health)
Pierre-Robin Sequence/Complex: A complex of congenital anomalies including micrognathia and abnormal smallness of the tongue, often with cleft palate, severe myopia, congenital glaucoma, and retinal detachment. (American Cleft Palate-Craniofacial Association)
Treacher-Collins Syndrome/Mandibulofacial Dysostosis: The name given to a birth defect which may affect the size and shape of the ears, eyelids, cheek bones, and upper and lower jaws. The extent of facial deformity varies from one affected individual to another. (American Cleft Palate-Craniofacial Association)
Handicapping Labio-Lingual Deviation (HLD) Index: The HLD Index is an administrative tool used to measure the presence or absence, as well as the degree, of a handicap caused by the components of the Index. It is not used to diagnose malocclusion. The Handicapping Labio-Lingual Deviations Form (HLD) is a quantitative, objective method for measuring malocclusion. The HLD provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Clinical Policies and Coverage Guidelines may apply.

LIMITED ORTHODONTIC TREATMENT

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition

COMPREHENSIVE ORTHODONTIC TREATMENT

D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition

APPLIANCE THERAPY

D8210 Removable appliance therapy
D8220 Fixed appliance therapy

GENERAL DESCRIPTION OF SERVICES

Medically Necessary Services- Orthodontic services to prevent, diagnose, minimize, alleviate, correct, or resolve a malocclusion (including craniofacial abnormalities and traumatic or pathologic anatomical deviations) that cause pain or suffering, physical deformity, significant malfunction, aggravates a condition, or results in further injury or infirmity/

REFERENCES

Understanding Medically Necessary Orthodontic Care. Retrieved From: https://www1.aaoinfo.org/legal-advocacy/understanding-medically-necessary-orthodontic-care/
American Association of Orthodontists. **Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics**. Amended 2017. Retrieved from: https://www.aaoinfo.org/d/apps/get-file?fid=12939
American Association of Orthodontists. **Glossary of Terms**. Retrieved from: https://www.aaoinfo.org/blog/parent-s-guide-post/glossary-of-terms/
Baik, Hyoung-Seon DDS, MS, PhD **Presurgical and Postsurgical Orthodontics in Patients With Cleft Lip and Palate**, Journal of Craniofacial Surgery: September 2009 - Volume 20 - Issue 8 - p 1771-1775 doi: 10.1097/SCS.0b013e3181b5d644

Orthodontics D8000-D8999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20* (EPSDT/HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Orthodontic	D8010 D8070 D8220 D8020 D8080 D8030 D8090 D8040 D8210	N/A	D8010* D8070* D8220* D8020* D8080* D8030* D8090* D8040* D8210*	N/A	N/A

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
All orthodontic treatment services are payable to correct a severe functional condition and not payable to correct physical appearance or crowded dentitions. Complete guidelines for medically necessary orthodontics, scoring methodology and forms are available in the updated Provider manual. Covers orthodontic services for patients with documentation of one or more of the diagnoses for craniofacial and malocclusion. Cleft palate and craniofacial specialists helped develop the criteria. The diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Orthodontic procedures only for members younger than 21 years old. Appliances and retainers as included in the fee for the comprehensive treatment, and providers cannot separately bill for them when rendering comprehensive treatment. **Note Effective 1/1/2022 Interceptive Orthodontics Codes D8050, D8060 have been terminated by the American Dental Association Code on Nomenclature.**					
D8010	Limited orthodontic treatment of the **primary dentition**	One (D8010) per lifetime	Yes	1. Narrative describing member's condition, compliance with and need for treatment 2. Estimated treatment time 3. Radiographs-Panoramic and cephalometric images 4. Oral/facial photographic images	**Transitional/Mixed dentition:** From approximately age six to 13, primary and permanent teeth are present in the mouth. **Adolescent dentition:** All primary teeth have exfoliated, second permanent molars may be erupted or erupting, and third molars have not erupted.
D8020	Limited orthodontic treatment of the **transitional dentition**	One (D8020) per lifetime	Yes		
D8030	Limited orthodontic treatment of the **adolescent dentition**	One (D8030) per lifetime	Yes		
D8040	Limited orthodontic treatment of the **adult dentition**	One (D8040) per lifetime	Yes		
D8070	Comprehensive orthodontic treatment of the **transitional dentition**	Only one of the following per lifetime: D8070, D8080, D8090.	Yes		
D8080	Comprehensive orthodontic treatment of the **adolescent dentition**		Yes		
D8090	Comprehensive orthodontic treatment of the **adult dentition**		Yes		
D8210	Removable appliance therapy	One (D8210) per lifetime	Yes		

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D8220	Fixed appliance therapy	One (D8220) per lifetime	Yes	5. Images of diagnostic models or digital models (Requested) 6. Completion of the ***Evaluation for Orthodontic Treatment Form/ Scoring Tool or handicapping labio-lingual deviations (HLD) form***	

7.5.10 Adjunctive Services D9000-D9999 Coverage Guidelines

ADJUNCTIVE SERVICES D9000 - D9999	
Coverage Clinical Guideline GENERAL ANESTHESIA AND CONSCIOUS SEDATION SERVICES	
BACKGROUND **COVERAGE RATIONALE** **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid** - Limitations, Frequencies, Requirements CareSource Sedation Scoring Tool Therapeutic Parenteral Drug Administration Dental Procedures in a Hospital, Outpatient Facility or Ambulatory Surgery Center – IN MCD

BACKGROUND

Sedation or general anesthesia services may be required to receive comprehensive dental care for some patients who have special challenges related to their age, behavior, developmental disabilities, medical status, intellectual limitations, or special needs. Oral conditions, such as caries and periodontal diseases, if left untreated, can result in loss of function, infection, and pain (American Academy of Pediatric Dentistry [AAPD], 2005). Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and subject to Educational Requirements as required by those state laws, rules and/or regulations. Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established. Guidelines are supported by both the American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures as well as the Guidelines for the Use of Sedation and General Anesthesia by Dentists published by the American Dental Association.

COVERAGE RATIONALE and CLINICAL CRITERIA

A carefully obtained and reviewed preoperative medical history, physical examination, and laboratory tests (as necessary), designed to identify high-risk patients with potential medical contraindications to office-based anesthesia, is recommended to prevent anesthetic emergencies by applying strict inclusion criteria (AAPD, 2006; Perrott, et al., 2003; D'eramo, et al., 2003; Iverson, 2002; Hoeffllin, et al., 2001). Office-based facilities must ensure timely access to the healthcare system for complications that may occur during, or days after, the surgery (AAPD, 2012b; ASA, 2014b; Fleisher, et al., 2004). Different types of sedation are used in dentistry and are proven to decrease anxiety, diminish fear and increase tolerance for dental procedures. It may also be the only way to provide safe and comprehensive dental treatment for individuals of certain criteria. CareSource determines medical necessity of these adjunctive services. The CareSource Sedation Justification Scoring Tool must be completed and submitted for all Moderate, Deep Sedation and General Anesthesia requests in either hospital, ASC, or Office-based settings. The corresponding benefit grids notate specific plan coverage, age, frequency, limitations, etc.

Anxiolysis/ Sedation/General Anesthesia/Blocks

I. Nitrous Oxide (Anxiolysis)

Nitrous oxide inhalation analgesia is only payable to providers who possess a personal permit for its administration from the applicable State Board of Dentistry and administer it in a State Board approved facility if permit required by the applicable state.

Nitrous oxide may be indicated for the following:

- Ineffective Local Anesthesia
- Anticipatory or Situational Anxiety
- Apprehensive/frightened child
- Individuals with special needs
- Extensive and/or complex services
- Behaviorally challenged or uncooperative individuals
- Management of a severe gag reflex

Nitrous oxide is contraindicated for, but not limited to, the following situations:

- Nasal Obstruction
- Severe underlying medical conditions
- Upper respiratory tract infections or other acute respiratory conditions
- Severe emotional disturbances or severe behavioral disorders
- Chemical dependencies
- Claustrophobia
- Pregnancy –not recommended electively, especially in the first trimester
- Treatment with bleomycin sulfate (injection used in cancer patients)
- Methlenetetrahydropfolate reductase (MTHFR) deficiency
- Vitamin B12 deficiency

Nitrous Oxide will not be considered strictly for member or dentist convenience.
Nitrous is not reimbursable when used in conjunction with sedation or general anesthesia service codes

II. Moderate/Conscious Sedation

Note: Per IHCP intravenous sedation in a dental office is reimbursable when provided for oral surgery services only.

Moderate/Conscious Sedation administered intravenously may be indicated for the following situations:

- Anxiety and fear when other techniques have proven inadequate
- Pain control when other techniques have proven inadequate
- Management of gag reflex if nitrous oxide is ineffective or not suitable
- Individuals that are medically compromised or those with special needs
- Lengthy restoration procedures for pediatric members
- Allergy or sensitivity to local anesthesia

Moderate/Conscious Sedation administered intravenously is contraindicated for, but not limited to, the following:

- Allergy to intravenous medications
- In any individual where intravenous sedation presents increased risk of adverse outcome or complications

See General Description of Services below for additional guideline/indications

III. Non-Intravenous Sedation

May be indicated for the following situations:

- Anxiety
- Individuals that are uncooperative or unmanageable with complex dental needs

Non-intravenous sedation is contraindicated for individuals with, but not limited to, the following:

- Member or dentist convenience

IV. Deep Sedation/General Anesthesia ***Not reimbursable for Age 21 and older in the Dental Office Setting***

Per IHCP Deep Sedation/General Anesthesia criteria for medical necessity coverage includes:

- Mental incapacitation (such that the member's ability to cooperate with procedures is impaired), including intellectual disability, organic brain disease and behavioral problems associated with uncooperative but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication

Deep Sedation/General Anesthesia is contraindicated for, but not limited to, the following situations:

- Individuals with predisposing medical and/or physical conditions that potentially make Deep Sedation/General Anesthesia unsafe
- Cooperative individuals with minimal dental needs
- Choice of an alternative option for treatment
- A very young patient with minimal dental needs that can be addressed with therapeutic interventions (e.g., ITR, fluoride varnish) and/or treatment deferral
- Language or cultural barriers
- **Parental objection or for patient/practitioner convenience**

V. Nerve Blocks

Nerve blocks are not covered for dental services. Please refer to the appropriate Medical Policy for specifics regarding coverage for nerve blocks.

DEFINITIONS

Situational anxiety is a specific type of anxiety that occurs during unfamiliar situations or events that makes an individual so nervous that they lose control of their ability to stay calm.

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Monitored Anesthesia Care ("MAC") does not describe the continuum of depth of sedation; rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue*** patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue*** patients who enter a state of General Anesthesia.

*** Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D9222 Deep sedation/general anesthesia – first 15 minutes

D9223 Deep sedation/general anesthesia – each subsequent 15-minute increment

D9230 Inhalation of nitrous oxide/analgesia, anxiolysis

D9239 Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes

D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment

D9248 Nonintravenous conscious sedation

Per IHCP, when the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form, Portal professional claim, or 837P transaction).

00170 Anesthesia for intraoral procedures, including biopsy; not otherwise specified

99151 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age

99152 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness an physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

99153 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time

GENERAL DESCRIPTION OF SERVICES

The administration of local anesthetic is common and used for most routine dental procedures. For some patients, Moderate/Conscious Sedation, non-intravenous sedation, and Deep Sedation/General Anesthesia may be necessary to safely provide dental care. These procedures generally are safe when administered by trained, certified providers in the appropriate setting, but are not without risk. According to the American Dental Association (ADA), dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and follow the educational and training requirements for the level of sedation intended. The ADA maintains clinical guidelines and educational/training requirements for all levels of sedation and includes specific information for the following:

- Patient history and evaluation
- Personnel and equipment requirements
- Monitoring and documentation (including consciousness, oxygenation, ventilation, and circulation)
- Recovery and discharge
- Emergency management

This guideline can be found at: https://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements.

According to the American Academy of Pediatric Dentistry (AAPD), the sedation of children is different from the sedation of adults, and the in-office use of deep sedation or general anesthesia may be appropriate on select pediatric dental patients administered in appropriately equipped and staffed facilities. The Guideline for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures addresses pediatric specific considerations and was developed in conjunction with the American Academy of Pediatrics (AAP). The AAPD guideline highlights the higher risks of adverse outcomes associated with sedation of pediatric patients and emphasizes the steps and actions needed to minimize the risks. This guideline can be found at: https://www.aapd.org/globalassets/media/policies_guidelines/bp_monitoringsedation.pdf

The following are some of the recommendations from the American Society of Anesthesiologists focusing on appropriate patient selection, quality anesthesia care and patient safety in the dental office:

- Pediatric patients and adults with major medical problems (ASA Physical Status III and above) are at higher risk of adverse events than other patients. For these high-risk patients and younger pediatric patients, ASA recommends evaluation by a primary care physician or physician anesthesiologist prior to scheduling a procedure.
- Prolonged and extensive procedures with longer periods of sedation and anesthesia care are of concern in the office-based setting and qualified anesthesia providers, in consultation with such patients, should consider more suitable facilities for the procedure.
- Personnel with training in advanced resuscitative techniques (e.g., ACLS, PALS) should be immediately available until all patients are discharged home. A designated individual, other than the individual performing the procedure, should be present to monitor the patient throughout procedures performed with sedation. During deep sedation and/or general anesthesia, this individual should have no other responsibilities.
- At a minimum, all facilities should have a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.
- Ensure there is a protocol for accessing emergency medical services, managing life-threatening complications, and maintaining emergency life support/rescue services.

This guideline can be found at: https://www.asahq.org (December 2019)

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ADJUNCTIVE SERVICES D9000 - D9999

Sedation and Anesthesia Administration
AMBULATORY SURGICAL CENTER HOSPITAL SETTINGS DENTAL OFFICE BASED SETTINGS

BACKGROUND
COVERAGE RATIONALE
DEFINITIONS
APPLICABLE CODES
DESCRIPTION OF SERVICES
REFERENCES

Related Policies or Information

Covered Benefit Grid - Limitations, Frequencies, Requirements

CareSource Sedation Scoring Tool

GENERAL ANESTHESIA AND CONSCIOUS SEDATION SERVICES

Dental Procedures in a Hospital, Outpatient Facility or Ambulatory Surgery Center - IN MCD

BACKGROUND

Most dental care can be provided in a traditional dental office setting with local anesthesia and if medically necessary, a continuum of behavior guidance strategies, ranging from simple communicative techniques to nitrous oxide, enteral or parenteral sedation. Monitored Anesthesia Care or Sedation (Minimal, Moderate or Deep) may be a requirement of some patients including those with challenges related to age, behavior or developmental disabilities, medical status, intellectual limitations, or other special needs. As an increasing number of patients of all ages and complexity seek sedation and anesthesia for dental procedures in office-based settings, it is important to keep patient safety central to the delivery of sedation and anesthesia services. Sedation and anesthesia safety in an office-based setting is dependent on patient selection, sedation and anesthesia goals, techniques, vigilant patient monitoring, as well as the skills and competencies of the patient-centered care team.

As noted by the American Academy of Pediatric Dentistry (AAPD) and the American Society of Anesthesiologists (ASA), there are certain situations where appropriate candidates may require General Anesthesia in a healthcare facility such as an Ambulatory Surgical Center or Outpatient Hospital facility.

COVERAGE RATIONALE and CLINICAL CRITERIA

ASC/Hospital Facility

The provision of dental care under general anesthesia in a hospital operating room (OR), Short procedure unit (SPU) or ambulatory surgery center (ASC) may be medically necessary for select individuals. All requests for ASC or Hospital settings Place of Service require a Prior authorization for non-emergency cases and the completion of the CareSource Sedation/General Anesthesia scoring Tool (located in the Appendix of this manual or available from Skygen Provider Portal account under “Documents tab.”

I. QUALIFYING CRITERIA OUTPATIENT HOSPITAL OR ASC

Providers should seek to request care approval in ASC versus outpatient facility. Requests for approval for OUTPATIENT/ASC are limited to those cases which cannot be handled in the dental office setting due to the existence of one or more of the following conditions or situations:

- extremely young Member, (extremely young is considered four (4) years old or younger) requiring multiple restorative or oral surgery procedures
- individual who is severely psychologically impaired or developmentally disabled (specific disability or special need should be stated) requiring multiple restorative or oral surgery procedures
- individual with American Society of Anesthesiologists (ASA) Physical Status Classification* of P3 or greater requiring multiple restorative or oral surgery procedures
- individual who has one or more significant medical conditions for which careful monitoring is required during and immediately following the planned procedure due to medical complexity (specific condition, illness, syndrome, etc. should be stated)
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication
- Only Restorative, Endodontic, Periodontal Surgical Procedures and Oral Surgical Procedures are qualifying procedures for hospital/ASC settings.

Only Restorative, Endodontic, Periodontal Surgical Procedures and Oral Surgical Procedures are qualifying procedures for hospital/ASC settings.

II. QUALIFYING CRITERIA INPATIENT

The use of hospital inpatient facility services may be medically necessary when providing dental care or oral surgery in the following situations:

- Complex oral surgical procedures with a greater than average incidence of life-threatening complications, such as excessive bleeding or airway obstruction.
- Concomitant, non-dental systemic conditions for which the patient is under current medical management such as respiratory illness, cardiac conditions, or bleeding disorders and which currently are not in optimal control and, therefore, may increase the risk of serious complications.
- Postoperative complications following outpatient dental/oral surgery.

Prior authorization is required for all dental admissions.

III. ASC/OUTPATIENT FACILITY APPROVAL PROCESS

The review for dental services to be performed in a Hospital Inpatient or Outpatient Facility or Ambulatory Surgery Center Facility under general anesthesia is a two-step process. The first step is completed by a request of the treating dentist to Dental Utilization Management (UM-DM) team to review the authorization for the requested dental services to ensure the services need to be completed in an outpatient setting under general anesthesia services. The second step is completed by the Facility to Medical Utilization Management (UM-MM) team.

Step 1: The Treating Dentist to UM-DM Team

The treating dentist is responsible for obtaining prior authorization from CareSource and is responsible for providing the prior authorization confirmation number/information to the Hospital/ASC facility and Anesthesiologist (if separate entity from facility)

A. For eligible CareSource members, dentist submits authorization request for dental services to be performed under General Anesthesia in a Hospital short procedure unit (SPU) or ambulatory surgery unit (either hospital-based or free-standing) to the Dental Medical Management team. Requests should include the SPU name and address location. The CareSource Scoring Tool must be submitted, the provider should list each planned dental service (CDT code) and number of units for that code as a separate line item. If the actual treatment rendered differs from the initial treatment approved, the provider can submit a Change Request for additional codes and units.

The changes must be submitted within thirty (30) days of the date of service.

Authorization Requests can be submitted online https://pwp.sciondental.com/PWP/Landing or via mail at:

CareSource: Authorization
P.O. Box 474
Milwaukee, WI 53201

B. If the request is for services to be performed in a Hospital or ASC setting, Place of Service (POS) on the authorization must be designated as: (21) Inpatient Hospital, (22) On Campus-Outpatient Hospital, (19) Off-campus Outpatient Hospital or (24) Ambulatory Surgical Center. This must be designated on the authorization. The facility must be in network with CareSource as pre-verified by dental provider. The Facility Name, Address and Contact Number should be included in the Authorization notes section.

C. Providers should submit request using **ADA code D9420** (used as code to designate hospital procedure only, not reimbursed) and include all services that are requested to be performed on the ADA Claim form in addition to the following documents:

- Treatment plan
- Diagnostic, pre-operative radiographs (Must show areas of treatment requests)
- Relevant chart notes/narrative of medical necessity/rationale
- Intraoral photos, if requested
- Completed scoring tool **"CareSource Sedation/General Anesthesia Scoring Tool***
- A copy of Provider's current PERMIT TO ADMINISTER ANESTHESIA AND SEDATION. -Or- LIGHT PARENTERAL CONSCIOUS SEDATION PERMIT (828 IAC 3-1-1),

D. The Dental Director or Dental Consultant reviews for medical necessity of the requested dental procedures that require authorization and reviews for the medical necessity of the procedures to be performed in applicable POS Surgical setting under general anesthesia care.

E. CareSource will notify the treating dentist of the determination via a Prior Authorization/Medical Necessity Determination (PA/MND) letter. The determination can also be viewed in the dental vendor provider portal. The treating dentist would then confirm appointment with facility and provide a copy of the Authorization to the facility and anesthesiologist. **The approval of D9420** indicates the CareSource approval determination for (21) Inpatient Hospital, (22) On Campus-Outpatient Hospital, (19) Off-campus Outpatient Hospital or (24) Ambulatory Surgical Center and General Anesthesia Services

F. Upon completion of the approved services, the treating dentist via claim will submit dental therapeutic services rendered with any required documentation (per dental manual guidelines) to the dental vendor-Skygen for claims adjudication.

Step 2: The Facility to UM-MM Team

A. The facility Is responsible for submitting prior authorization request for any facility services other than (anesthesia, ancillary and radiology) to CareSource Medical Management (UM-MM) team along with the approved Prior Authorization Determination letter (approved authorization #) from Dental UM.

B. The Medical UM team reviews submitted documentation from Dental UM. Anesthesia CPT Code 00170 does not require a separate prior authorization approval if Dental Authorization (D9420 shows services have been approved to be performed in hospital/ASC setting). CPT code 41899 (used as facility fee code) is reviewed by the Medical Management team and any other CPT/HCPCS codes. All **in-patient** facility services must be pre-certified by Medical Utilization Management. CareSource Medical UM will notify the facility via fax of determination and/or facility precertification verification.

C. Upon completion of the approved services, Dental services provided to members in an inpatient hospital, outpatient hospital, or ambulatory surgical center (ASC) setting (after obtaining authorization) must be billed as follows:

- Dental-related **facility charges** must be billed on an institutional claim (UB-04 claim form, Portal institutional claim, 837I transaction). (Submitted to CareSource)

- **Dental services** provided in hospital or ASC setting can be billed with CDT codes on the ADA dental claim form or electronic equivalent. (Submitted to Dental Vendor- Skygen)
- All other **associated professional services, such as radiology and anesthesia, as well as ancillary services** related to the dental services, must be billed on a professional claim (CMS-1500 claim form or electronic equivalent). (Submitted to CareSource)

Please remember that the provider who submits the authorization for the dental therapeutic services must be the provider that performs the services. If the authorized provider does not perform the service, claims will deny. In the event the authorized provider is unable to perform the services or the location changes, CareSource must be notified to update the authorization prior to the services being performed.

Office-Based Settings

An office setting will be the required location for conscious sedation therapeutic management modalities when there are appropriately trained and licensed personnel to administer and monitor these services and office facilities are properly equipped and safe per federal and state regulatory requirements. See indications and clinical criteria for sedation in **GENERAL ANESTHESIA AND CONSCIOUS SEDATION SERVICES** Guideline. The CareSource Justification Scoring Tool for Sedation/Anesthesia Services must be completed and submitted with prior authorization (as applicable per PA requirements of codes) and kept in patient/member chart available per request.

Office Based Requirements

A. Anesthesia Provider and Team

The individual providing sedation and/or anesthesia care in the dental office-based setting should have approved formal education, whether incorporated in the core curriculum or as post-graduate education, consistent and equivalent with the level of sedation and anesthesia required for credentialing and privileging in non-office-based facilities where similar procedures are routinely performed. Additionally, any required state sedation/anesthesia permits must be current and in good standing with the Board of Dentistry. There should be enough appropriately trained staff to both carry out the procedure and monitor the patient, before, during and a staffed recovery area.

B. Office Facility

The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. A protocol for immediate access to back-up emergency services shall be clearly outlined. For nonhospital facilities, a protocol for the immediate activation of the EMS system for life-threatening complications must be established and maintained. The availability of EMS does not replace the practitioner's responsibility to provide initial rescue for life-threatening complications.

C. Monitoring and Patient Safety

Sedation is a continuum that includes minimal sedation to general anesthesia. Each patient has a unique response to medications utilized for sedation and anesthesia. Therefore, moderate sedation may quickly transition to deep sedation and general anesthesia, affecting spontaneous ventilation and oxygenation requiring immediate intervention. When an anesthesia professional is available to continuously monitor the patient, he or she can focus on changes in the patient's condition and intervene as necessary in emergent situations.

Equipment used to monitor the patient during sedation and anesthesia should be consistent with AANA Standards for Office Based Anesthesia Practice and other nationally recognized standards and guidelines. The AAPD Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures should be followed as a guide for patient safety and any applicable state requirements.

- An emergency cart or kit must be immediately accessible. This cart or kit must contain the necessary age- and size-appropriate equipment (oral and nasal airways, bag-valve-mask device, LMAs or other supraglottic devices, laryngoscope blades, tracheal tubes, face masks, blood pressure cuffs, intravenous catheters, etc.) to resuscitate a nonbreathing and unconscious child.
- Monitoring devices, such as electrocardiography (ECG) machines, pulse oximeters with size-appropriate probes, end-tidal carbon dioxide monitors, and defibrillators with size-appropriate patches/paddles, must have a safety and function check on a regular basis as required by local or state regulation.

- Documentation prior to and during sedation shall include, but not be limited to, the following recommendations: 1) health evaluation 2) Informed consent, 3) Anesthesia documentation time 4)Treatment Documentation

The Provider location owner must complete the facility safety attestation, located on the sedation scoring tool.

DEFINITIONS

Ambulatory Surgical Treatment Centers - means any institution, building, or facility, or part thereof, devoted primarily to the provision of surgical treatment to patients not requiring hospitalization.

Outpatient is defined as a patient who is receiving professional same day services at a participating hospital SPU—Short procedure unit or an Ambulatory Surgical Center (ASC), free standing (satellite) clinics, which are not operated as part of a hospital, and does not include individual or group practice offices of private physicians or dentists,

Inpatient is defined as a patient who is receiving professional services at a hospital, requires room and board admission, and longer stay services.

SPU—Short procedure unit—A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic, or medical services.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

ASC/Hospital Facility
D0100 -D9999 Professional Dental Services
41899 Other Procedures on the Dentoalveolar Structures
00170 Anesthesia for Procedures on the Head

Office Based Facility
D0100- D9999 Dental Services

GENERAL DESCRIPTION OF SERVICES

Benefits may vary between plans. Please refer to the appropriate plan details for applicable Dental and Inpatient/Outpatient/Free Standing Ambulatory Surgery benefits/coverage. Prior authorization for the acute hospital setting or SPU setting does not automatically include coverage for dental procedures. Facility charges (e.g., operating room, anesthesia, medical consults) are eligible for coverage under the member's medical benefit when the above medical criteria are met. Coverage for services performed by the oral surgeon/dentist may be provided through the dental benefit. Office facilities approved by the state agency as an Ambulatory Surgical Treatment Centers or regulated facility may be applicable for facility fee. A Managed Care Organization cannot approve a facility as an official ASC, or "Sedation Center" as defined and provided under provisions of IAC. A "permit" or 'license, is granted by the State of Indiana to an applicant to operate an ambulatory surgical treatment center with the administration of general anesthesia/sedation. If there is lack of availably of Ambulatory Surgical Treatment Centers in provider's geographic region, contact CareSource Provider Relations.

REFERENCES

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ADJUNCTIVE SERVICES D9000 - D9999

Coverage Clinical Guideline **BEHAVIOR MANAGEMENT**

BACKGROUND **COVERAGE RATIONALE** **DEFINITIONS** **APPLICABLE CODES** **DESCRIPTION OF SERVICES** **REFERENCES**	Related Policies or Information **Covered Benefit Grid** - Limitations, Frequencies, Requirements

BACKGROUND

A dentist who treats children should be able to accurately assess the child's developmental level, dental attitudes, and temperament and to anticipate the child's reaction to care. The response to the demands of oral health care is complex and determined by many factors. Developmental delay, physical/ mental disability, and acute or chronic disease are potential reasons for noncompliance during the dental appointment it is important that dentists have a wide range of behavior guidance techniques to meet the needs of the individual child and be tolerant and flexible in their implementation.

COVERAGE RATIONALE AND CLINICAL CRITERIA

Indications for Behavior Management

In these instances, dental providers often must provide additional time, skill, and/or staff assistance to such patients to render treatment properly.

- Young Children (Age 3 or less)
- Special needs patients (defined as those patients who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform a dental visit.)

DEFINITIONS

Dental anxiety is defined as a feeling of fretfulness about dental treatment that is not essentially connected to a particular external stimulus

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

D9920 Behavior Management

GENERAL DESCRIPTION OF SERVICES

PEDIATRIC DENTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of young patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements.

The more frequently used pediatric dentistry behavior management techniques are as follows:

- **Tell-Show-Do:** The doctor or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

- **Positive reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.
- **Voice Control:** Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
- **Immobilization by the doctor:** The doctor controls the child from movement by gently holding down the child's hands or upper body, stabilizing the child's head between the dentist 's arm and body.
- **Protective Stabilization or Immobilization** by the assistant or parent: The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements
- **Modeling** - Assessing another parallel aged child or elder siblings having dental treatment fruitfully can have an encouraging influence on an anxious child. This technique is more helpful in those aged between 3 and 5 years.

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ADJUNCTIVE SERVICES D9000 - D9999

Coverage Clinical Guideline **Sleep Apnea Oral Appliance (formerly Maxillofacial Prosthesis)**

BACKGROUND
COVERAGE RATIONALE
DEFINITIONS
APPLICABLE CODES
DESCRIPTION OF SERVICES
REFERENCES

Related Policies or Information

Covered Benefit Grid - Limitations, Frequencies, Requirements

BACKGROUND

Sleep-related breathing disorders comprise a variety of diagnoses, including simple snoring, hypopnea, upper airway resistance syndrome, central sleep apnea, and obstructive sleep apnea (OSA). OSA is the most prevalent form of sleep apnea, accounting for over 80% of sleep-disordered breathing cases in the U.S. (ADA, 2020). People with OSA stop breathing multiple times throughout the night due to physical blockages of the airway. As a result, they often experience daytime tiredness, headaches, trouble concentrating, and other symptoms. These symptoms may interfere with their work life, relationships, and ability to drive safely. OSA has numerous health consequences, ranging from sleep fragmentation and excessive daytime sleepiness to chronic hypertension, coronary heart failure, neurocognitive dysfunction, and ischemic stroke. Central Sleep Apnea (CSA) is distinguished by a temporary interruption of neural output from the respiratory control center, resulting in loss of respiratory stimulation and airflow cessation. The underlying pathophysiology of central sleep apnea is due to either post hyperventilation central apnea, which may be triggered by a variety of clinical conditions or central apnea secondary to hypoventilation, which has been described with opioid use hypoventilation. Currently available treatments for central sleep apnea are not widely accepted because of sparse effectiveness data, poor patient adherence, and potential safety risks.

Non-surgical oral appliances, worn during sleep, can be an effective treatment option for OSA. **This appliance has traditionally been covered under medical benefits as a Durable Medical Equipment (DME) E0486. Effective May 14, 2020, the Indiana Health Coverage Programs (IHCP) begin covering Healthcare Common Procedure Coding System (HCPCS) code D5999 – Unspecified maxillofacial prosthesis for the use of oral appliances for sleep apnea. Effective beginning January 1, 2022, the ADA Council on Benefits instituted the CDT nomenclature code D9947 for the purposes of reporting oral appliances for sleep apnea.**

COVERAGE RATIONALE and CLINICAL CRITERIA

Indications for Medical Necessity as outlined by IHCP are as follows:

Removable Oral Appliances are proven and medically necessary for treating Obstructive Sleep Apnea (OSA) as documented by a sleep study (e.g., polysomnography or Home Sleep Apnea Testing).

Medical necessity for the coverage of oral appliance therapy is subject to the following:

- There is a face-to-face evaluation by a provider before a sleep test, to assess the member for obstructive sleep apnea.

When taking patient health histories and conducting oral clinical examinations, dentists can screen patients for OSA-related risk factors or common presenting features, such as: large tongue or tonsils; mandibular retrognathia or micrognathia; large neck circumference; nocturnal choking or gasping; obesity; loud or irregular snoring; or breathing pauses during sleep (if reported by bed partner). Individuals presenting with these symptoms or features may be referred to a primary care physician or sleep medicine specialist for further evaluation.

The sleep test must meet one of the following:

- An apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) that is equal to 5 or less than 14 events per hour
- AHI or RDI is greater than or equal to 15 events per hour with a minimum of 30 events and;
- Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine
- AHI or RDI is equal to or greater than 30 events per hour and;
- Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine
- The patient has confirmed obstructive sleep apnea.

The device must be ordered by a provider following review of the report of the sleep test.

- Referral must be from a physician to the dentist.
- The device is provided and billed by a dentist.

Pricing: Code D9947 used in place of D5999 will pay 90% of billed charges. A cost invoice or manufacturer's suggested retail price (MSRP) must be submitted with the claim. If a Provider submits as a medical claim, the HCPCS DME code (E0486) should be used.

DEFINITIONS

Obstructive Sleep Apnea (OSA) is characterized by recurrent narrowing or collapse of the upper airway during sleep, resulting in partial or complete cessation of airflow despite continued respiratory effort.

APPLICABLE COVERED CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.

E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment
D9947	Custom sleep appliance fabrication and placement (fitting and adjustment is not reimbursed separately)
D9948	Adjust sleep apnea appliance
D9949	Repair sleep apnea appliance

GENERAL DESCRIPTION OF SERVICES

Oral appliances are devices put in the mouth to help keep a person's airway open as they sleep. Dentists working collaboratively with primary care physicians and sleep specialists, as part of a multidisciplinary care team, can assist in providing optimal long-term care for patients with OSA, including periodic dental and periodontal assessment, as well as fabrication and maintenance of properly fitted oral appliances that can be used safely over time.

A **mandibular advancement device (MAD)** is an oral appliance that connects to both the upper and lower teeth in order to advance or move the jaw forward. Sometimes called mandibular advancement splints (MAS), or a mandibular protrusion device, this type of device helps open the upper airway by moving the base of the tongue forward. This oral appliance is designed to be inserted before sleep, then removed in the morning. MADs look similar to a mouthguard and can be customized to fit the individual.

Tongue-stabilizing devices (TSDs), also called tongue-retaining devices, pull the tongue forward using suction. The tip of the tongue then sits in a plastic bulb, protruding through the lips. Moving the tongue forward is intended to help keep the tongue base from blocking the airway. These are usually stock, one-size-fits-all devices, but some may be customized to an individual's mouth. Research suggests they reduce lapses in breathing and improve daytime tiredness.

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ADJUNCTIVE SERVICES D9000 - D9999

Coverage Clinical Guideline Teledentistry

BACKGROUND
COVERAGE RATIONALE
DEFINITIONS
APPLICABLE CODES
DESCRIPTION OF SERVICES
REFERENCES

Related Policies or Information

Covered Benefit Grid - Limitations, Frequencies, Requirements

BACKGROUND

Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery. Teledentistry refers to the use of telehealth systems and methodologies in dentistry. While traditionally used in public health settings such as school based centers, nursing homes and other facilities utilizing dental hygienists and other expanded function personnel, modifications and guidance are provided per state practice acts and the Centers for Medicare & Medicaid Services (CMS),the Office for Civil Rights (OCR) and Drug Enforcement Administration (DEA) for public health emergencies (such as the Coronavirus 2019 COVID-19 pandemic), where Teledentistry may better assess "urgent and emergency" needs via two-way provider- patient communication, services requiring immediate care in the dental office and to help prevent overwhelming hospital emergency departments, telecommunication technology can be leveraged.

COVERAGE RATIONALE and CLINICAL CRITERIA

Indications for Teledentistry may include:

- Hygienists can perform offsite preventive care or screenings in schools, nursing homes, satellite facilities
- Dentists can assess other needs and additional care needed for onsite follow- up appointments
- Specialists real - time collaboration and referrals
- Providers can connect with patient touchpoints, such as external providers like pediatricians, physicians, and skilled nursing facilities.

Indications for Teledentistry During Public Health Emergencies may include:

- To assess 'Urgent and emergent" dental needs
- To reduce risk of disease outbreak
- To help prevent unneeded hospital ER visits

Please visit CareSource.com for additional information on Teledentistry Policies and Resources

Requirements

- IHCP allows for the following services via teledentistry, and they must be performed in real time Oral Evaluation (D0140) and Counseling Services (Tobacco D1320) and Caresource offers expanded benefit (Substance Use D1321). When these services are delivered as telehealth, claims require POS code 02 or 10
- Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.(ADA, 2015)
- Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.(ADA, 2015)
- Licensure: Dentists and allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state in which the patient receives service. The delivery of services via teledentistry must comply with the state's scope of practice laws, regulations, or rules. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry(ADA, 2015)
- HIPPA – Although some modifications of HIPPA policy form the Office of Civil Rights, CMS and Drug Enforcement Administration during Public Health Emergency Orders, providers should seek to incorporate HIPPA- compliant technology platforms to protect patient Personal health information

DEFINITIONS

Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual (video conferencing) telecommunications technology.

Store-and-forward (asynchronous): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions, and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real- time or live interaction.

Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

APPLICABLE COVERED CODES
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all-inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service for all benefit categories. The member specific benefit plan document and applicable laws that may require coverage for a specific service determine benefit coverage for health services. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. See corresponding benefit grid for limitation, exclusions, and benefit categories.
D9995 Teledentistry – synchronous; real-time encounter (Used as encounter code) Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.
GENERAL DESCRIPTION OF SERVICES
See Definitions
REFERENCES
American Dental Association ADA Policy on Teledentistry. 2015.Retrieved from: https://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/statement-on-teledentistry N. D. Jampani, R. Nutalapati,1 B. S. K. Dontula,2 and R. Boyapati3. **Applications of Teledentistry:** A literature review and update. J Int Soc Prev Community Dent. 2011 Jul-Dec; 1(2): 37–44. doi: 10.4103/2231-0762.97695: 10.4103/2231-0762.97695 American Dental Association. **ADA Guide to Understanding and Documenting** Teledentistry Events. Revised March 2020.Retrieved from: https://www.ada.org/~/media/ADA/Publications/Files/CDT_D9995D9996-GuideTo_v1_2017Jul17.pdf

Adjunctive Services D9000-D9999 Benefit Grid

Service Category by CDT codes	HOOSIER HEALTHWISE (HHW) Package A Children (Age 0-20) Package C (CHIP) Children (Age 0-18)	HOOSIER HEALTHWISE (HHW) Package A (Age 21- 25) Package A Pregnant Women (Age ≥ 21)	HIP State Plan Basic HIP State Plan Plus HIP Pregnancy/Maternity (Age 19-64)	HIP BASIC Age 19 or 20* (EPSDT/ HealthWatch)*	HIP PLUS (Age 19-64)
			Some HIP Plan Services may be limited to Age 19-20*		
Adjunctive Services	D9120 D9230 D9248 D9948 D9222 D9239 D9920 D9949 D9223 D9243 D9947 D9953	D9120 D9243 D9948 D9239 D9947 D9949 D9953	D9120 D9230* D9248* D9948 D9222* D9239 D9920* D9949 D9223* D9243 D9947 D9953	EPSDT as Medically Necessary	**D9230***

CareSource Teledentistry Policy and program, Only HHW and HIP State Plans eligible. D9995 is used as an encounter code with D0140 or D1320/D1321 (only teledentistry services per IHCP), to denote real - time encounter by providers as applicable by state practice acts and ADA guidelines. See the Teledentistry Policy in CareSource Provider ORM.

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
Complete guidelines for adjunctive services are in the Provider manual. Please follow these guidelines closely. CareSource may elect to perform chart audits on these services. After review by the CareSource Dental Director/Consultant, any reimbursement already made for an inadequate service or inappropriate billing is subject to recoupment.					
Requests for sedation or general anesthesia are reviewed on a case-by-case basis. A case will be eligible when medical necessity has been established. Please see the Provider Office Reference manual for complete guideline indications. **The IHCP restricts reimbursement for dental anesthesia to one type of sedation per member per date of service. For example, general anesthesia may not be billed and reimbursed for the same date of service as inhalation of nitrous oxide, intravenous conscious sedation or nonintravenous conscious sedation.**					
Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non- invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration. The attested anesthesia record with procedural time, pharmacology used method of delivery and anesthesia time should be kept in the patient's record and available upon chart request.					
D9120	Fixed partial denture sectioning	One (D9120) per day(s)	Post Review	Narrative and Radiographs	
D9222	Deep sedation/ general anesthesia - **first 15 minutes**	One (1) of D9222 per date of service Dental Office Setting **Age 0-20 only** ASC/Hospital Facility* Age 0 - 64	PA	1. Written narrative detailing the type of anesthesia to be used 2. Rationale of medical necessity 3. Radiographs 4. Tx plan 5. Recorded treatment time documented in record 6. CareSource 7. Sedation/General Anesthesia Scoring Tool* 8. Sedation Record included with claims	Prior approval must be obtained to render this service except in **emergencies**. D9230, D9239, D9243, D9248, D9920 are not payable on the same date of service as D9222, D9223 General anesthesia provided in the dentist's office reimbursed only for members younger than 21 years old. The IHCP covers general anesthesia for members 21 years old and older only if the procedure is performed in an inpatient or outpatient hospital setting, or in an ambulatory surgical center (ASC). **When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate CPT code must be billed on a professional claim (CMS-1500 claim form),**
D9223	Deep sedation/ general anesthesia - each subsequent **15 minutes**	Five (5) units of D9223 per date of service . A maximum of 6 units (1 ½ hrs.) are payable per date of service. Additional units beyond six for D9222/ D9223 per date of service (greater than 1 ½ hrs. Anesthesia time) are subject to prepayment review for medical necessity. Dental Office Setting Age 0-20 only ASC/Hospital Facility* Age 0 - 64	PA Prepayment if greater than 6 units used and no PA		

Nitrous oxide, if provided, should be billed on the same claim form as the restorative and/or surgical service (s). If a claim for payment is received for nitrous oxide and there are no restorative and/or surgical service (s) listed on the claim form or no Medicaid claims history record indicating that a restorative and/or surgical service was previously reimbursed for the same date of service as the nitrous oxide, the payment for nitrous oxide will be denied.

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Age 0 – 20 One (D9230) per date of service. Not payable in conjunction with D9222, D9223, D9239, D9243, D9248, D9920 same date of service Enhanced Benefit HIP Plus age 19 – 20 used as noted in additional information column	No	A written narrative detailing the rationale of need, treatment planned, or treatment rendered if submitted with claims Radiographs required with claims (Age 13 and older).	(Age 6 - 12). Payable for dates of service on which restorative and/or surgical services (codes D2140 - D7997) are performed unless there is documentation from the member's physician that identifies the member as mental or physical special needs detailing medical necessity. Age (13 - 18) requests for nitrous D9230 are primarily considered when surgical services are performed. Other services must necessitate medical necessity. Age 19 and older, D9230 is a covered service for CareSource members who are mentally or physically challenged or otherwise present with special management needs with established medical necessity, physician documented. Authorization for D9230 is not required but only claims with documented medical necessity will be considered for payment. All claims subject to post review.
D9239	Intravenous (IV) moderate (conscious) sedation/ analgesia-first 15 minutes	One (D9239) per date of service Five (5) units of D9243 per date of service A maximum of 6 units of D9239 (1) and D9243 (5) (1 ½ hours) are payable per date of service. Additional units beyond six for D9239/ D9243 per date of service (greater than 1 ½ hrs. sedation time) are subject to prepayment review for medical necessity.	PA Age 21 and older Prepayment if greater than 6 units used and no PA	1. Rationale of medical necessity 2. Pre-Operative Radiographs 3. Treatment rendered or treatment plan if submitted as Prior auth* 4. Anesthesia/Sedation Provider attested **anesthesia record** 5. CareSource Sedation Scoring Tool* Documents should be submitted with PA and claims if post review applicable	D9239 and D9243 do not require Prior authorization up to the 6 units per date of service, however it is subject to post review and or chart audit if indicated. Treatment rendered on same date of service should be included on same claim as D9239 D9243. If billed by separate provider (i.e. Anesthesia Provider) claims should be submitted congruently or claims history should reflect treatment services on same date of service as D9239/D9243 procedures. D9230, D9222, D9223, D9248, D9920 are not reimbursable on the same date of service as D9239, D9243
D9243	Intravenous (IV) moderate (conscious) sedation/ analgesia-each additional 15 minutes				
D9248	Nonintravenous conscious sedation	One (1) unit of D9248 per date of service. Covered for Age 0- 20	No	A written narrative detailing the rationale of need, treatment rendered, or treatment planned, and radiographs required.	It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. Document sedative agent and administration route used in member's record.

Code	Service Description	Benefit Limitations/ Frequency	Prior Auth (PA) or Post Review	Required Documents	Additional Information
D9920	Behavior management, by report	D9920 – One (1) unit per date of service, D9920 - one unit equals 15 minutes. Covered for Age 0 20	No* Subject to post payment review in accordance with IHCP	Narrative describing the highest level of behavior management technique used for the member in the **comments field of your claim**. Comments such as "additional staff and time" or "protective stabilization" will be sufficient. This service is payable when the assistance of at least one additional dental professional staff is needed to protect the client and staff from injury while treatment is rendered	You must include any narratives as required and all procedures provided in conjunction with these services. Approval is subject to professional review. D9920 is not payable in conjunction with D9230 or D9248 Monitored and subject to prepayment and post payment Management time is calculated by determining the additional time to be spent beyond the normal time required to complete the service. The minutes or time requested must be only for the additional time - Not for the full appointment
D9947	Custom sleep apnea appliance fabrication and placement	One sleep apnea appliance per lifetime reimbursed	PA	• Referral must be from a physician to the dentist. • Letter must note patient has confirmed obstructive sleep apnea • The dental provider should maintain sleep study results in the patient's file. • A cost invoice or manufacturer's suggested retail price (MSRP) must be submitted with the claim.	A face-to-face evaluation must be completed by a physician before a sleep test, to assess the member for obstructive sleep apnea. The sleep test must meet one of the following: • An apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) that is equal to or greater than 5 and less than 15 events per hour • AHI or RDI is greater than or equal to 15 and less than 30 events per hour and: Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine • AHI or RDI is equal to or greater than 30 events per hour and; Patient experiencing trial and failure of a CPAP machine • The device must be ordered by a provider following review of the report of the sleep test
D9948	Adjustment of custom sleep apnea appliance	One per 12 months(s). Not covered within 6 months of placement	No	NONE	
D9949	Repair of custom sleep apnea appliance	One per 12 months(s). Not covered within 6 months of placement	No	NONE	
D9953	reline custom sleep apnea appliance (indirect)	One per 12 months(s). Not covered within 6 months of placement	No	NONE	
D9995	teledentistry – synchronous; real-time encounter	Used as an encounter code with D0140 or D1320/D1321 (only teledentistry services per IHCP to denote real- time encounter	No	NONE	D9995 not reimbursed, used only as encounter code to denote real- time encounter

*All Scoring Tools and Forms can be accessed via the Scion Provider web portal.

The Code on Dental Procedures and Nomenclature- Current Dental Terminology (CDT Code) (including procedure codes, nomenclatures, descriptors, and other data contained therein) ("CDT") has been obtained from the American Dental Association. CDT is copyright © 2022 – 2023 American Dental Association. All rights reserved.

This content has been reviewed; however, changes and/or revisions occur frequently. Health partners should check our website at CareSource.com for the most current version of this QRG and the Indiana Dental Provider Office Reference Manual (ORM) for more up to date details and network notifications. Unintentional typographical mistakes requiring correction will be communicated to health partners on our website or in writing when needed. Significant policy or procedure changes will be communicated in writing with a minimum of 30 days' notification.

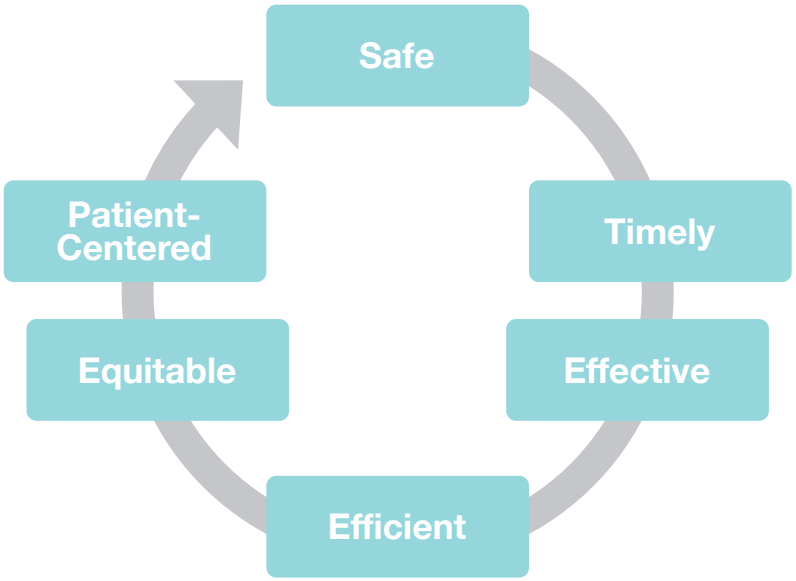
CHAPTER 8: QUALITY MANAGEMENT PROGRAM

Program Description

CareSource's Oral Health Quality Management and Improvement (QMI) Program is organized to ensure the highest quality oral healthcare for CareSource members in a cost-effective manner. The scope of the QMI Program activities includes continuous monitoring and evaluation of adherence to practice guidelines in clinical and non-clinical aspects of dental care delivery. In addition, the scope includes systematic processes for evaluating and monitoring essential elements including quality of care, accessibility, availability, continuity of care and patient safety as well as quality of service.

The CareSource Oral Health Program in collaboration with its delegated dental vendors, structures its quality model around the principles of the National Committee for Quality Assurance (NCQA) and the defined theorem of the Institute of Medicine (IOM). (IOM) defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The IOM further describes the following six domains as essential standards for the provision of quality health care services:

STEEEP



Safe	Avoiding harm to patients from the care that is intended to help
Timely	Reducing waits and sometimes harmful delays for both those who receive and
Effective	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and missue, respectively
Efficient	Avoiding waste, including waste of equipment, supplies, ideas and
Equitable	Providing care that does not vary in quality because of personal characteristics
Patient-centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring the patient values guide all clinical decisions.

The CareSource Quality Improvement Program includes but is not limited to:

- Quality Metrics Monitoring (such as HEDIS and EPSDT measures) and provider performance
- Policy, standards, and clinical criteria development
- Problem and trend identification and assessment
- Development and implementation of QMI Program studies, performance, measure monitoring and member/provider surveys
- Infection control monitoring and patient safety protocols
- Facility and medical/dental record review audits
- Medical -Dental Integration
- Utilization management and monitoring
- Monitoring of member and provider grievance/appeals and follow-up
- Dental Home disenrollment, enrollment, and transfer request tracking, care coordination
- Access and Availability monitoring
- Prescription Drug Monitoring Program Compliance
- Provider/member education
- CareSource Performance Improvement Plans/Corrective Action Plans

Value – Based Care Programs

Value- Based Care is a person or patient-centered approach to health care delivery designed to achieve the triple aim of providing better care for patients and better health for populations at efficient cost. It focuses on access to care and care coordination that ensures the right provider gives patients the right care at the right time. Our providers are critical to the success of our oral health programs. CareSource's periodic value-based reimbursement (VBR), pay-for performance (P4P) and rewards programs recognize the everyday work of providers to improve patients' health, experiences, and care quality outcomes. Contact CareSource Provider Relations or visit CareSource.com, to learn more about our Quality initiatives such as our Dental Home is Where the Heart Is™ and CareSource MEDDental ™ Partnership for Whole Person Health programs.

CHAPTER 9: UTILIZATION MANAGEMENT PROGRAM

The CareSource Utilization Management (UM) Program in partnership with our contracted dental administrator provides a structure to monitor and facilitate the delivery of high quality, individualized care to program participants. The Program offers a portfolio of best practice UM services and products designed to improve the individual member experience, improve oral and population health, and improve the provider experience while reducing the costs of health care. Under the auspices of a utilization review committee, Utilization Review (UR) activities are supported by objective, evidence–based, nationally recognized clinical policies, clinical guidelines, and criteria. These policies, guidelines and criteria promote delivery of appropriate care to CareSource members in the most appropriate setting at the appropriate time. Dental Directors, Consultants and CareSource team members work closely with health care providers to optimize health care outcomes. The CareSource UM Clinical Team bases their decisions on appropriateness of care, service, and existence of coverage.

Community Practice Patterns

To ensure fair and appropriate reimbursement, the CareSource Utilization Management in collaboration with our administrator vendor partners, adopts the philosophy that recognizes the relationships between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships are typically influenced by community practice patterns. Our Utilization Management guidelines are designed to ensure healthcare dollars are distributed fairly and appropriately, as defined by the regionally based community practice patterns of local dentists and their peers.

All Utilization Management analysis, evaluations, and outcomes are related to these community practice patterns. CareSource Utilization Management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. To ensure fair comparisons within peer groups, our Utilization Management evaluates specialty dentists as a separate group and not with general dentists, since the types and nature of treatment may differ.

Evaluation

CareSource's Utilization Management evaluates claims submission patterns, prior authorization requests, medical/dental records (as indicated), and utilization patterns, reported and reviewed, at a minimum, monthly. in such areas as:

- Diagnostic and preventive treatment.
- Patient treatment planning and sequencing.
- Types of treatment.
- Treatment outcomes.
- Treatment cost effectiveness.

Results

With the objective of ensuring fair and appropriate reimbursement to providers, CareSource via coordinated dental vendor analytics helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers. CareSource administrative personnel or a clinical representative may speak or meet with the Provider to address aberrant billing practices or significant deviations and help develop a program to resolve the issue. CareSource is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to the Indiana Family and Social Services Administration.

Fraud, Waste & Abuse

CareSource and contracted dental administrator partners, conduct our business operations in compliance with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules. We are committed to detecting, reporting, and preventing potential fraud, waste, and abuse, and we look to our providers to assist us. We expect our dental network partners to share this same commitment, conduct their businesses similarly, and report suspected noncompliance, fraud, waste, or abuse.

Definitions

Fraud, waste, and abuse are defined as:

Fraud. Fraud is intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act, which constitutes fraud under federal or state law. (Examples- billing for procedures not provided to Member, billing for the same services twice)

Provider Fraud. Provider fraud is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity to receive benefits or funds to which they are not entitled. This may include deception by improper coding, upcoding or other false statements by providers seeking reimbursement or false representations or other violations of federal healthcare program requirements, its associates, or contractors.

Waste. Waste is the unintentional, thoughtless, or careless expenditures, consumption, mismanagement, use, or squandering of federal or state resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls.

Abuse. Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and that result in the unnecessary cost to the government healthcare program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts, or omissions, unreasonable confinement, sexual abuse, or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Provider Self-Disclosure

The provider has an obligation to ensure that claims are submitted accurately. Section 1128J(d) of the Social Security Act requires providers to report and return overpayments to CareSource within 60 days from the date the overpayment is identified.

Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim. The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person suing may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

For more information about the False Claims Act visit www.TAF.org.

Whistleblower Protection- The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA.

Notes

APPENDIX

- **General Anesthesia/Sedation Scoring Tool**
- **Orthodontic Scoring Tool and Instructions**
- **Orthodontic Continuity of Care Submission Form**
- **Non-Covered Services Disclosure Form**

CareSource

CARESOURCE PRIOR AUTHORIZATION

Sedation/General Anesthesia Justification Scoring Tool

Member's Name:	Member's DOB:
Member ID #:	Date of Request:
	Tentative Service Date:

Type of Sedation Requested	**Place of Service for Administration of Sedation or General Anesthesia**
Choose one: • Moderate sedation (drug-induced depression of consciousness) _____ (D9239,D9243,99151-99157) -or- • Deep Sedation/General Anesthesia (state of unconsciousness or depressed consciousness inability to independently maintain an airway) _____ (D9222,D9223,00170)	Choose one: • Private dental office location _____ -or- • Hospital/ambulatory surgical center location _____

Provider Permits for Sedation/General Anesthesia in Private Dental Office	
• Does the requesting dental provider have a sedation/ general anesthesia permit issued by the Indiana Board of Dentistry (IBD)	Yes No If YES, please enter permit number: _____
• If the requesting dental provider does not have a sedation/general anesthesia permit/license issued by IBD, does the rendering general anesthesia or sedation provider have a permit/license issued by appropriate state board/agency	Yes No If YES, please enter permit/license number and provider name: _____ _____

THE FOLLOWING INFORMATION MUST BE SUBMITTED ALONG WITH THIS JUSTIFICATION SCORING TOOL IN ORDER FOR A MEDICAL NECESSITY REVIEW TO BE CONDUCTED FOR SEDATION/GENERAL ANESTHESIA IN AN OUTPATIENT HOSPITAL/SURGICAL CENTER SETTING OR PRIVATE DENTAL OFFICE:

- Readable Pre-Operative X-rays
- Dental Treatment Plan
- All Relevant Office Chart Notes
- Completed Scoring Tool (Below)

Documented Previous Behavior Management Attempted and Outcome

	Attempted		**Outcome**	
Tell/Show/Do	Yes	No	Pos	Neg
Voice Control	Yes	No	Pos	Neg
Oral Sedation	Yes	No	Pos	Neg
Nitrous Oxide	Yes	No	Pos	Neg
Restraints	Yes	No	Pos	Neg
IV Sedation	Yes	No	Pos	Neg

SCORING TOOL FOR QUALIFICATION	
Scoring Parameters	**Points**
Age (Age of Patient on Date of Service)	
Less than five years old (age 0-4)	8
Five or six years old	6
Seven or eight years old	3
Nine years old	1
Ten years old or older	0
Behavioral Score (Based upon Documented Previous Management Attempts)	
Definitely negative	6
Somewhat negative	4
Somewhat positive	2
Definitely positive	0
Ten years old or older	0
Planned Treatment	
10 or more teeth or 4 quadrants (Moderate restorative or surgical procedures)	8
6-9 teeth or 3 quadrants (Moderate restorative or surgical procedures)	6
3-5 teeth or 2 quadrants (Moderate restorative or surgical procedures)	4
1-2 teeth or 1 quadrant (Moderate restorative or surgical procedures)	0
Other Factors	
Oral/Peri-oral abnormality limiting ability to treat	7
Oral pathology limiting ability to treat	7
Invasive or complex surgical procedure (e.g., impacted wisdom teeth)	12
Documented Medically Compromised or Handicapping Condition	
Hemodynamically significant congenital heart defects or prosthetic heart valve that requires strict anticoagulation	10
Neuromuscular disease, including spastic paralysis, muscular dystonias and cerebral palsy	10
Cognitively Disabled complicated by seizures	10
Serious bleeding disorders	10
Moderate to severe asthma with medication adherence	6
Behavioral disorders (e.g., autism), severe emotional disturbance, severe anxiety documented by physician (**Must provide Physician letter**)	6
Severe Situational Anxiety	3
Other please specify:	TBD
	Total Points:

Attestation of Sedation/General Anesthesia of Medical Necessity and Appropriateness in a Hospital/Ambulatory Surgical Setting	
I attest that the information regarding the patient's condition requires the use of moderate sedation or general anesthesia in a hospital/ambulatory setting. I certify that the medical necessity information contained in this Justification Scoring Tool and all supporting documentation is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of any material fact or statement may subject me to contractual, civil, and/or criminal liability.	
Provider's Signature:	Date:

Attestation of Sedation/General Anesthesia of Medical Necessity and Appropriateness in a Private Dental Office Setting	
I attest that the information regarding the patient's condition requires the use of parenteral sedation or general anesthesia in a private dental office setting. I attest and certify that the medical necessity information contained in this Justification Scoring Tool and all supporting documentation is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of any material fact or statement may subject me to contractual, civil, and/or criminal liability. I further attest and certify that: (1) the dental office setting where the general anesthesia, deep, moderate or light parenteral conscious sedation will be performed is a safe and medically appropriate environment with required emergency equipment in accordance with Indiana Code §828 IAC 3-1-10 and §828 IAC 3-1-11 for the administration of parenteral sedation or general anesthesia; (2) the administration of parenteral sedation or general anesthesia will be performed by qualified individuals, training and permits in accordance with Indiana Code. § 828 IAC 3-1-2 828, §828 IAC 3-1-3, §828 IAC 3-1-4, §828 IAC 3-1-5; and (3) the standard of care for administration of general anesthesia, deep, moderate, or light parenteral conscious sedation will comply with basic minimum requirements for patient protection in accordance with Indiana Code. § 828 IAC 3-1-6.1 828, IAC 3-1-6.5, and all other applicable Indiana applicable Law; and (4) the administration of parenteral sedation or general anesthesia will follow all applicable guidelines from the American Dental Association (ADA), American Association of Pediatric Dentistry (AAPD) and the American Society of Anesthesiologists (ASA). Further, I understand and agree that CareSource may conduct in office site visits, with or without cause, with reasonable advance notice.	
Provider's Signature:	Date:

For Dental Consultant use only: ☐ Medical exceptions with score total less than 23 (check one) ___ Oral Surgery ___ Medical Comorbidity ___ Clinical significance for Sedation/Anesthesia	**APPROVED** ☐ **EXCEPTION** ☐ **DENIED** ☐
☐ Medical exceptions with score total less than 25 (check one) for ASC/Hospital Setting	**APPROVED** ☐ **EXCEPTION** ☐ **DENIED** ☐

Sedation Scoring Tool
CareSource.com | CareSource Health Partner Services: : 1--844-607-2831

CARESOURCE HANDICAPPING LABIO-LINGUAL DEVIATIONS FORM (CARESOURCE HLD INDEX)

The Handicapping Labio-Lingual Deviations Form (HLD) is a quantitative, objective method for measuring the presence or **absence, as well as the degree** of a handicap malocclusion caused by the components of the index. It is not used to diagnose malocclusion. The HLD provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion. Deciduous teeth and teeth not fully erupted should not be scored. Please follow the scoring instructions attached and include the required documentation.

Conditions Observed	HLD Score	
THE FOLLOWING IF DETERMINED BY CLINICAL REVIEW, MAY BE AUTOMATIC QUALIFYING CONDITIONS IIf any condition #1 through #7 applies, please indicate with an "X" in the column and submit the form.		
1. Cleft Palate or other Cranio-facial Anomaly or Syndrome (See instructions or Clinical Guidelines)		
2. Severe Traumatic Deviations (e.g. accidental loss of premaxilla, gross pathology)		
3. Facial discrepancy requiring combined orthodontics and Orthognathic surgery		
4. Overjet greater than 9 mm with incompetent lips		
5. Reverse overjet greater than 3.5 mm		
6. Deep Impinging Overbite (with evidence of occlusal contact into the opposing soft tissue resulting in tissue damage; tissue damage must be visible on photographic images)		
7. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present		
Continue to score below if there are no qualifying conditions checked above, the remaining conditions require a minimum score of "28" to qualify for comprehensive treatment. Score each condition that applies according to examination findings using the HLD Index Scoring Instructions. Limited Orthodontics is scored on a subset of the below.		
8. Overjet in mm	mm x1	
9. Reverse Overjet (Mandibular Protrusion) in mm – see scoring instructions	mm x5	
10. Overbite in mm	mm x1	
11. Open Bite in mm	mm x4	
12. Ectopic Eruption, (Number of teeth, excluding third molars) (Do not double score with crowding	# x3	
13. Anterior Crowding: __Maxilla __ Mandible Add 5 points for each arch if applicable.	pts x1:	
14. Labio-Lingual Spread in mm (anterior spacing) – see scoring instructions	mm x1	
15. Posterior Unilateral Crossbite (must involve two or more adjacent teeth)	Score 4	
16. Bilateral Crossbite (Must involve two or more teeth including a molar on both sides)	Score 8	
17. Impacted **anterior or posterior** teeth required for function that will not erupt without surgical intervention or congenitally missing **anterior** or **posterior** teeth (excluding third molars) required for function	# x3:	
18. Psychosocial factors require detailed documentation letter by mental health provider as described per mental health clinical criteria of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.	TBD per review of documentation	
Total		

I certify under the pains and penalties of perjury that I am the treating dentist identified on this form. I certify that the medical necessity information on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of treating Dentist: _____ **Date:**_____

Printed name of treating Dentist: _____

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

For Dental Consultant use only: ☐ Medical exceptions with score total less than 28 (check one) ___ Dental diagnosis ___ Medical diagnosis ___ Clinical significance or functional impairment	**APPROVED** ☐ **EXCEPTION** ☐ **DENIED** ☐

Handicapping Labio-Lingual Deviation Index Scoring Instructions

The Handicapping Labio-Lingual Deviations Form (HLD) is a quantitative, objective method for measuring the presence or absence, as well as the degree of a handicap, malocclusion caused by the components of the index. It is not used to diagnose malocclusion. The HLD provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion. Deciduous teeth and teeth not fully erupted should not be scored. Please follow the **scoring instructions** outlined when completing the attached form and include the required documentation with authorization request.

The following documentation is required to be submitted. Any authorization request submitted without complete documentation will be noted as "incomplete documentation received" denial exclusion.

- ☐ The completed CareSource HLD Scoring Index Form
- ☐ A narrative describing the nature of the severe physically handicapping malocclusion, along with any documentation relevant to determining the nature and extent of the handicap.
- ☐ Orthodontic Treatment plan
- ☐ A panoramic and/or full mouth series of intra-oral X-rays.
- ☐ A cephalometric X-ray with teeth in centric occlusion and cephalometric analysis/tracing.
- ☐ Facial photographs of frontal and profile views.
- ☐ Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view.
- ☐ Maxillary and mandibular occlusal photographs.
- ☐ Photos of articulated models or 3D scans can be submitted optionally (Do NOT send stone casts).
- ☐ Requests where there is significant disparity between the evaluation and narrative and objective documentation (e.g., photographs and / or X-rays) will be returned for clarification without review.
- ☐ All x-rays, photographs and other required documents should be dated and labeled with the patient's name, Date of Birth (DOB).

The following information provides definition and guidelines for the categories on the HLD Index: (Acceptable clinical documentation must include all the above noted clinical information and any specific documentation noted below). All measurements are scaled in millimeters. Entering "0" must record absence of any conditions.

1. **Cleft Palate or other craniofacial anomalies:** REQUIRES CERTIFICATION (Attach report from the "diagnosing specialist" indicating the diagnosis, the severity and scope of diagnosis, and the resulting complications including effect of the diagnosis on occlusion, oral health, and oral function.) Examples of cranio-facial anomalies include cleft lip, cleft palate, hemifacial microsomia, deformational plagiocephaly. These would not include normal or skeletal malocclusion. Indicate with an "X" on the score form, attach documentation of condition, and do not score any further. This condition is considered a handicapping malocclusion.
2. **Severe Traumatic Deviations:** Traumatic deviations include for example, loss of a premaxilla segment due to burns or an accident, the result of osteomyelitis or other gross pathology. Supporting documentation explaining and illustrating the deviation resulting from trauma or damage from gross

pathology must be attached for consideration of this condition. Indicate with an "X" on the score form, attach documentation of condition, and do not score any further. This condition is considered a handicapping malocclusion.

3. **Facial Discrepancies requiring Surgical Malocclusion with Orthognathic surgery:** (This does not include extractions for spacing. Examples include B.S.S.O., S.A.R.P.E., and Lefort Osteotomy) Attach report indicating surgical treatment plan, and orthodontic plan to manage surgical malocclusion. Indicate with an "X" on the score form, attach documentation of condition, and do not score any further. This condition is considered a handicapping malocclusion.

4. **Overjet greater than 9 mm** Indicate an "X" on the form. This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form. This condition is considered a handicapping malocclusion.

5. **Reverse overjet greater than 3.5 mm**: Indicate an "X" on the form. This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. This condition is considered handicapping malocclusion.

6. **Deep Impinging Overbite:** Indicate an "X" on the form when lower incisors are destroying, (tissue destruction of the palate must be clearly visible in mouth and reproducible and visible. The lower teeth must be clearly touching the palate and there must be clear evidence of damage visible on the submitted documentation; touching or slight indentations do not qualify.) (Indicate an "X" if present and score no further. This condition is considered handicapping malocclusion.

7. **Crossbite of individual anterior teeth** -When clinical attachment loss and recession of the gingival margin are present. Gingival recession must be at least 2 mm deeper than the adjacent teeth. In the case of a canine, the amount of gingival recession should be compared to the opposite canine. Indicate an "X" on the score sheet when destruction of soft tissue is present and do not score any further. This condition is considered to be a handicapping malocclusion

8. **Overjet in millimeters:** Indicate an "X" on the form. This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form.

9. **Mandibular Protrusion (Reverse Overjet) in Millimeters:** Score exactly as measured from the buccal groove of the first mandibular molar to the MB cusp of the first maxillary molar. The measurement in millimeters is entered on the form and multiplied by 5.

10. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

11. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge in millimeters. This measurement is entered on the form and multiplied by 4. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

12. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of ectopic teeth on the form and multiply by 3. If Condition No. 13, Anterior Crowding, is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.

13. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points for maxillary and mandibular anterior crowding. If Condition No. 12, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition**. Do not score both conditions.**

14. **Labio-Lingual Spread:** The measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio- lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.

15. Additionally, anterior spacing may be measured as the total score in mm from the mesial of cuspid to the mesial of cuspid, totaling both arches.

    Only score the greater score attained by either of these two methods.

16. **Posterior Unilateral Crossbite:** Posterior Unilateral - This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth.

17. **Bilateral Posterior Crossbite:** This condition involves two or more adjacent teeth on both sides including a molar. The presence of a bilateral crossbite is indicated by a score of 8 on the form.

18. **Impacted anterior or posterior teeth or congenitally missing anterior or posterior teeth (excluding third molars) required for function:** Total the number of anterior or posterior teeth, excluding third molars that meet this criterion and multiply by 3.

HLD Orthodontic Scoring Tool
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CARESOURCE ORTHODONTIC CONTINUATION OF CARE SUBMISSION FORM

For orthodontia services, there are two critical steps — obtaining payment history and treatment plan information. CareSource will apply this information to the participants' lifetime Medicaid state orthodontic benefit — and issue benefits from the effective date forward, as determined medically necessary. This process ensures the total benefit paid between the two organizations does not exceed the lifetime orthodontia maximum under the state Medicaid program. Please submit the following form with any prior authorization requests for continued orthodontic services under new Provider/TIN.

Patient Information		
Name (First & Last):	Date of Birth:	SS or ID#:
Address:	City, State, Zip:	Area Code & Phone number:
Group Name:	Plan Type:	

Provider Information		
Dentist Name:	Provider NPI #:	Location ID #:
Address:	City, State, Zip:	Area Code & Phone number:

Name of Previous Vendor that issued original approval:	
Banding Date:	**Case Rate Approved by Previous Vendor:**
Amount paid for dates of service that occurred prior to CareSource:	
Amount owed for dates of service that occurred prior to CareSource:	
Balance expected for future dates of service:	
Numbers of adjustments remaining:	

Additional information required:

- ☐ If the member is transferring from an existing Medicaid Managed Care Organization or state FFS program: A copy of the original orthodontic approval is required with the authorization request for continued service.
- ☐ If the member is private pay or transferring from a commercial insurance program: Original diagnostic photos or ortho scans equivalent, radiographs as well as status records should be submitted with authorization

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CARESOURCE NON-COVERED SERVICES DISCLOSURE AND TREATMENT CONSENT FORM ("CONSENT FORM")

This Consent Form must be presented to the member before any non-covered services are rendered, kept as part of the member's medical record, and be made available to CareSource upon request.

Health Partner Information

Indiana Medicaid ID	Health Partner Address	Health Partner Phone
Health Partner Name	Date Consent Form Presented	

I, the undersigned Health Partner, understand and acknowledge, in accordance with the terms of my contract with CareSource, I am only permitted to bill CareSource members for non-covered services when such members have, in writing, prior to the time services are rendered, agreed to assume full financial responsibility for the non-covered services. I confirm and attest I have reviewed the below health care services with the undersigned CareSource member or parent/guardian and that such services are not covered by CareSource and have not been denied by CareSource on the basis of lack of medical necessity or my failure to comply with the terms and conditions of my contract or any applicable CareSource

health partner manuals or policies ("Non-Covered Services"). I attest I have offered the below Non-Covered Services, in good faith, to the undersigned CareSource member or parent/guardian based on my assessment of the undersigned member's needs and I have discussed the relevant health care services that CareSource does cover that can safely and effectively treat the undersigned member's health condition, if any, with the undersigned member or parent/guardian.

Non-Covered Services

CDT/CPT Code	Procedure(s)	Cost ($)

I, the undersigned, do hereby affirm that all statements made by me on this Consent Form are true, accurate, and correct to the best of my knowledge and belief.

Health Partner Signature	Date

Member Information		
Medicaid ID	Name	DOB
Phone Number	Address	Parent/Guardian Name

I understand AND agree to what was presented. Answer YES or NO to each statement below and enter your initials.	**YES**	**NO**	**Initial**
I have been advised that the Non-Covered Services I am electing or that have been recommended are not covered health care services through CareSource, but I am electing to have these Non-Covered Services anyway and understand I am assuming full financial responsibility for the Non-Covered Services listed on this Consent Form.			
I understand by assuming full financial responsibility for the Non-Covered Services that CareSource will not be responsible for providing any payment to my doctor for the Non-Covered Services.			
I understand that CareSource may cover other health care services that can safely and effectively treat my heath condition and I may call CareSource, at any time, to determine what other health care services CareSource does cover to treat my health condition, if any.			

I, the undersigned, understand the acceptance of the Non-Covered Service(s) listed on this Consent Form is voluntary and that I may refuse the Non-Covered Service(s). I acknowledge I have been informed in advance of receiving the Non-Covered Services as to what my financial responsibility is and agree to make financial arrangements with my doctor to pay for the Non-Covered Services.	
Member Name (Print)	
If applicable, Authorized Representative Name (Print) and relationship to member:	
Member Signature (leave blank if member has an Authorized Representative):	Date
If applicable, Authorized Representative Signature:	Date

CareSource®

RR2022-IN-MED-P-1410150a; Issued Date: 1/10/2023

OMPP Approved: 1/10/2023

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