



**CHAPTER 505– COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
DENTAL SERVICES
CHANGE LOG**

Replace	Title	Change Date	Effective Date
505.6	Covered Services for Members less than 21 Years of Age	February 3, 2010	April 5, 2010
505.14.2	Children’s Dental Services	February 3, 2010	April 5, 2010
Attachment 1	Covered Dental Services Procedure Codes	3/10/05	1/01/05

February 3, 2010

Section 505.6, Covered Services for Members less than 21 Years of Age

Introduction: Section 505.6, Covered Services for Members less than 21 Years of Age

Old Policy: N/A

New Policy: add bullet at end of section: Dental service limits can be exceeded as a result of an EPSDT exam based on medical necessity (Refer to EPSDT billing information at www.wvdhhr.org/bms)

Section 505.14.2, Children’s Dental Services

Introduction: Section 505.14.2, Children’s Dental Services

Old Policy: Most dental services for children (ages less than 21 years) are excluded from the (HMO) Mountain Health Trust program. In general, the Managed Care Organizations are not responsible for dental procedures, but are required to cover most costs associated with dental services provided in an inpatient or outpatient hospital setting. Dental service limits can be exceeded as a result of an EPSDT exam based on medical necessity (Refer to EPSDT billing information at www.wvdhhr.org/bms)



New Policy: Most dental services for children (ages less than 21 years) are excluded from the (HMO) Mountain Health Trust program. In general, the Managed Care Organizations are not responsible for dental procedures, but are required to cover most costs associated with dental services provided in an inpatient or outpatient hospital setting. Dental services provided as a result of an EPSDT exam can be exceeded based on medical necessity. Refer to EPSDT Billing Information at www.wvdhhr.org/bms.

JANUARY 1, 2005

Section – Attachment 1

Introduction: The following changes have been made to the procedure code listing found in Attachment 1:

D0501 Listed in error and has been deleted.

D1351 Service limit of 1 every 3 years inadvertently omitted has now been added.

D7281 Code has been deleted.

D7283 Replacement code for D7281.

Directions: Replace previous Attachment 1 with this update.

Change: The procedure codes listed in the update supersede codes previously listed.



**CHAPTER 505—COVERED SERVICES, LIMITATIONS AND
EXCLUSIONS FOR DENTAL SERVICES
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CHAPTER 505—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services in writing.

WV Medicaid covers comprehensive dental services for members under 21 years of age and limited dental services for older members. Highest priority is placed on the preventive and maintenance dental health care of all Medicaid children in order to provide them with access to necessary treatment. Certain dental services are covered without any prior approval requirements. Other covered services must be approved in advance in order to receive payment from WV Medicaid.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV. The BMS in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program.

505.1 QUALIFIED DENTISTS

A qualified dentist is an individual licensed to provide dental services in the State in which he or she practices. Dental providers must comply with all applicable Federal and State laws, regulations, and licensing and certification requirements.

505.2 MEDICAID ENROLLMENT REQUIREMENTS

Dental providers in private practice who wish to participate in the WV Medicaid Program must meet the general requirements in Chapter 300, as well as the specific requirements outlined below.

Answers to questions about the enrollment application can be obtained by calling the Provider Enrollment Unit at 304-348-3360 or 1-888-483-0793. Providers must meet all of the provider requirements and their practices must be fully operational before they may enroll as Medicaid providers.

A dentist must be enrolled in the WV Medicaid Program in order to be paid for covered services furnished to Medicaid members.

505.3 RECORD KEEPING REQUIREMENTS

Participating dental providers must maintain dental treatment records that contain at least the following information about the member:

- Current medical history
- Results of clinical examinations and diagnostic tests, including oral pathology or disease
- X-ray results
- Proposed treatment plan



- Treatment Provided

All services provided must be documented in the member's record. Documentation must include a description of the service provided, the date the service was provided, the outcome of the service, and include the signature and title of the person providing the service.

The Bureau for Medical Services conducts post payment review of services to assure they are documented correctly and provided within the definition of covered services as defined in the Dental Services Manual. This criteria includes, but is not limited to, those specified in the CDT Manual.

505.4 COVERED DENTAL SERVICES

WV Medicaid covers medically necessary services that do not duplicate another provider's services. Covered dental services must meet all of the following criteria:

- Services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs
- Services must not be experimental, investigational, or for research purposes
- Services must reflect the level of treatment that can be safely furnished, and for which no equally effective, more conservative, or less costly treatment is available statewide
- Services must not be for the convenience of the member, the member's caretaker, or the provider of service.

Attachment 1 identifies the dental services that WV Medicaid covers. Some of the procedures have service limits for defined time periods. A service may be covered only for members under 21 years of age or for all members regardless of their age.

All covered services for members less than 21 years of age must be started before the member's twenty-first birthday. Services initiated on or after the birth date are not covered even if the member's eligibility extends to the end of the month in which the birth date occurs.

IMPORTANT: The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided, even for prior authorized services.

505.5 PLACE OF SERVICE

WV Medicaid covers dental services provided in a dentist's office, hospital setting, or ambulatory surgical center. It is especially important that the medical need for dental treatment in a hospital setting or ambulatory surgical center be documented clearly and thoroughly in the member's medical record. Inpatient hospitalization requires prior authorization for the hospital.

505.6 COVERED SERVICES - MEMBERS LESS THAN 21 YEARS OF AGE

For members less than 21 years of age, WV Medicaid covers certain diagnostic and preventive services, restorative, endodontic, and periodontal treatment, surgical procedures, extractions, orthodontic treatment, and complete or partial dentures. Specifically, WV Medicaid covers the following medically necessary dental services for members less than 21 years of age:

- Regular visits for prophylaxis, bitewings, treatment planning, restorations, and other routine service



- Emergency dental care to relieve pain, eliminate infection, or reduce fractures
- Restorations to preserve the dentition of the teeth. Restorative materials are limited to composite resin, acrylic, plastic, or silicate for anterior teeth and composite or amalgams for posterior teeth
- Prefabricated stainless steel or prefabricated resin crowns
- Root canal treatments
- Treatment for periodontal disease
- Extractions if teeth cannot be restored
- Repairs, relines, and duplications (rebase) of existing prosthetic appliances
- X-rays needed for diagnosis; (x-rays must justify extensive dental work requiring emergency treatment)
- Removal of cysts or tumors; biopsies; repair of traumatic wounds
- Treatment of fractures of maxilla and mandible
- Space maintainers
- Dental surgery that requires inpatient hospitalization. All inpatient care must be pre-authorized by the BMS contracted agency. See section 505.10.
- Hospital outpatient dental surgery.
- Tobacco Cessation Services
- Dental service limits can be exceeded as a result of an EPSDT exam based on medical necessity (Refer to EPSDT billing information at www.wvdhhr.org/bms)

Under certain circumstances, service limitations and prior authorization requirements may apply to the preceding services for members less than 21 years of age. For instance, admission to a hospital for dental surgery requires prior approval.

505.7 COVERED SERVICES - MEMBERS 21 YEARS OR OLDER

For all members, including those 21 years of age or older, WV Medicaid covers the following dental services:

- Removal of cysts or tumors; biopsies; repair of traumatic wounds
- Treatment of fractures of maxilla and mandible
- Emergency tooth extraction – with documentation of the emergency in member's chart
- Certain x-ray procedures. Tobacco Cessation Services

Under certain circumstances, service limitations and prior authorization requirements may apply to the preceding services for members 21 years or older. These limits and prior authorizations are detailed in attachment 1.

505.8 PRIOR AUTHORIZATION - ORTHODONTIC SERVICES

Orthodontic services are covered on a limited basis for Medicaid members less than 21 years of



age, whose malocclusion creates a disability and impairs their physical development. Medicaid coverage for orthodontic services is provided based on medical necessity. However, because a member meets criteria submitted for consideration, does not mean that coverage is automatic. All requests for treatment are subject to prior approval review by the Bureau's contracting agency. Treatment is routinely accomplished through fixed appliance therapy and maintenance visits.

NOTE: Orthognathic surgical procedures associated with orthodontic treatment will be covered even if the member exceeds 21 years of age if the needed surgery is documented in the original orthodontic request and is requested before the member becomes 21 years of age.

Medically necessary orthodontic coverage is limited to services for dento-facial anomalies. This excludes impacted teeth, crowding, and cross bites. The following situations, with supporting documentation, will be considered for coverage:

- Member with syndromes or craniofacial anomalies such as cleft palate, Alperst Syndrome or craniofacial dyplasia
- Severe malocclusion associated with dento-facial deformity. (e.g., a patient with a full cusp Class II malocclusion with a demonstrable impinging overbite into the palate).

Attachment 2 contains the form to request prior authorization for orthodontic services. This form is different from the authorization form for general dentistry. Supporting documentation must be submitted with the treatment request. Failure to submit any of the following information will result in a denial of the request for prior approval of orthodontic services:

- Panoramic Film
- Cephalometric Tracing
- Cephalometric X-ray
- Photographs - Intra and Extra Oral
- Treatment Plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment
- Upper and lower study casts trimmed to the correct occlusion. Failure to trim study casts to correct occlusion will delay decision.

The completed form and any supporting documentation must be sent to the BMS contracted agency.

Comprehensive orthodontic treatment is reimbursable only once in the member's lifetime. If treatment is discontinued or the patient transfers before completion of orthodontics, payment for the uncompleted portion must be returned to the BMS. A provider who accepts a transfer patient must complete a prior authorization request for continuing the previously initiated orthodontic treatment, and submit it to the BMS contracted agency.

If an eligible member under 21 years of age moves to WV from another State while undergoing active orthodontic treatment, a WV provider may request prior authorization to provide the balance of the treatment.

WV Medicaid does not cover orthodontic services for cosmetic purposes.



505.9 PRESCRIPTIONS

Covered drugs are allowed upon the written prescription of a physician or dentist as allowed within the scope of their practice. The member may present the prescription at a participating pharmacy. The pharmacy bills WV Medicaid for prescription services. Certain limitations and prior approval criteria may apply.

505.10 PRIOR AUTHORIZATION – GENERAL DENTISTRY

Attachment 3 contains the form to request prior authorization for general dentistry. Any service that requires prior authorization must be identified in the treatment section of the authorization form. The completed form and any supporting x-rays must be sent to the BMS contracted agency.

Prior authorization numbers will not be issued over the telephone. Services that require authorization must not be provided until an authorization number is received in writing. Prior authorizations will not be back-dated. Special consideration may be given when a member's Medicaid eligibility is determined retroactively.

All inpatient hospitalization for dental care requires prior approval through BMS' utilization management contracted agent. A separate approval is required if the procedure that will be performed also requires prior approval. In other words, two distinct approvals are required—one for the hospital admission and one for the dental service.

Prior authorization does not necessarily mean that WV Medicaid will pay for the services e.g. an individual who is not Medicaid eligible, the service is not a covered service, or a service that is not medically necessary.

505.11 SERVICE LIMITATIONS

The last column of **Attachment 1** indicates the service limitations that apply to specific covered dental services. Typically, the limitation is expressed in terms of the number of times that a service may be provided to a member during one or more years.

505.12 BILLING AND REIMBURSEMENT

All dental services billed to WV Medicaid must be medically necessary; documentation in the patient's record must substantiate the medical necessity and all records must be made available for post-payment reviews. All providers, **including oral surgeons** must bill on ADA claim forms or electronically on the 837 dental format, using D codes.

If there is no "D" procedure code which describes the service performed, an unlisted "D" code such as D9999 must be used. If there is a CPT code which describes the service, list this CPT code on the prior authorization request form with the unlisted "D" code. Payment for this unlisted "D" code will be based on the CPT code amount.

WV Medicaid's Dental Fee Schedule is used to pay for dental services. In all cases, the payment amount is based on the lower of the provider's usual and customary charge or the Medicaid fee less any applicable insurance reimbursement.

505.13 TOBACCO CESSATION PROGRAM

Dental practitioners enrolled in the WV Medicaid Program may participate in the Tobacco Cessation Program. Dentists may bill for the counseling component of the tobacco cessation service. See attachment 1 for correct code. Documentation in the patient's chart must indicate



that the dentist has performed each of the required elements of the counseling service in order to be reimbursed.

WV Medicaid covers pharmaceutical products and behavioral modification services to help Medicaid members discontinue the use of tobacco products. Dentists should ask about and record the tobacco-use status of every patient. Minimal counseling is considered part of dental care provided and is not reimbursed separately. Separate Medicaid payment is made for intensive counseling services with a primary diagnosis code of 305.1 (tobacco use disorder).

Behavioral modification through the tobacco-quit line must be included in any combination of treatment. Tobacco cessation behavioral modification services are provided through Partners for Corporate Health's tobacco-quit line, 1-877-YNOTQUIT (1-877-966-8784).

Payment for dentist counseling services for Medicaid members enrolled in managed care plans is reimbursed by the HMO and will not be reimbursed by Medicaid.

505.13.1 TOBACCO CESSATION PRODUCTS

Medicaid reimbursement for tobacco cessation pharmacological products is available for one 12-week course of treatment per member per calendar year. The member has to be enrolled in a smoking cessation program before these drugs are covered. Pregnant females are eligible for additional courses of treatment, if appropriate.

WV Medicaid covers tobacco cessation products for members, including those enrolled in Medicaid managed care plans. Members must agree to stop tobacco use completely either with the start of nicotine replacement therapy or one week after starting bupropion (Zyban®). Tobacco quit-line staff refers members to dentists, physicians, or other qualified providers to obtain a prescription for an appropriate cessation medication.

Tobacco cessation products covered by WV Medicaid include, but are not limited to:

- Sustained release bupropion products
- Nicotine replacement drug products both over-the-counter and legend, such as patch, gum, inhaler, and nasal spray.

Members must notify the quit line of the tobacco cessation product that they will use. If the member is unable to provide the information to quit-line personnel, the dentist may fax the information, or a copy of the prescription, to the quit line at 304-599-5507 for prior authorization.

A licensed dentist must write a prescription for over-the-counter tobacco cessation products for Medicaid to reimburse the pharmacy. Over-the-counter nicotine replacement therapy for members residing in long-term care facilities is included in the per diem rate paid to nursing facilities.

Prior authorization is required for tobacco cessation medications and is coordinated through the tobacco-quit line. Medicaid-covered tobacco cessation products are subject to the following services limitations:

- Nicotine gum - 720 pieces per 30 days
- Nicotine patches - 30 patches per 30 days
- Nicotine inhaler - 30 per 30 days
- Nicotine Lozenge – 600 per 30 days



- Bupropion - 60 tablets (150mg) per 30 days
- Nicotine nasal spray – case-by-case basis. Because nicotine nasal spray products are the most addictive of the available products, the nasal spray is reserved for patients who have unsuccessfully used other forms of nicotine replacement therapy.

Members less than 18 years of age will be offered phone coaching services and printed materials only, unless a dentist or other practitioner specifically writes an order for a pharmacological product. This documentation should be faxed to the quit line.

Many tobacco cessation products are contraindicated in pregnant women. The prescribing dentist should determine the appropriateness of these products for these members.

505.13.2 DENTIST COUNSELING FOR TOBACCO CESSATION

At every office visit, dentists should encourage every person who uses tobacco to stop. Clinicians should ask about and record the tobacco-use status of every patient. Cessation counseling even as brief as 3-minutes per visit is effective. Medicaid payment for minimal counseling is included in the normal charge and fee paid for the service provided.

Dentists may provide more intensive counseling services to Medicaid members for tobacco cessation with the intent to promote the discontinuation of the member's tobacco use. Medicaid payment for counseling services will be made for the diagnosis of 305.1.

To be reimbursed by Medicaid, dental counseling services must include at least the following items

- Ask about tobacco use.
 - Include tobacco use in vital signs data collection
 - Place tobacco-use status stickers on all patient charts or indicate tobacco-use status using computer reminder systems.
- Advise tobacco users to quit.
 - Be clear. (“I think it is important for you to quit smoking or using smokeless tobacco now and I will help you.”)
 - Speak strongly. (“As your clinician, I need you to know that quitting smoking or smokeless tobacco is the most important thing you can do to protect your current and future health.”)
 - Personalize your advice. (“You’ve already had one heart attack.”) Mention the impact of tobacco use on children or others in the household. (“You know your children need you.”)
- Assist the patient with a quit plan.
- Advise the tobacco user to:
 - Set a quit date, ideally within 2 weeks.
 - Inform friends, family, and co-workers of plans to quit, and ask for support



- Remove cigarettes or other tobacco products from home, car, and workplace and avoid using tobacco products in these places.
- Review previous quit attempts - what helped, what led to relapse.
- Anticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal.
- Give advice on successful quitting:
 - Total abstinence is essential - not even a single puff
 - Drinking alcohol is strongly associated with relapse
 - Having other tobacco users in the household hinders successful quitting.
- Encourage use of pharmacological therapy for appropriate patients. Inform the member that pharmacological agents are available only after he or she registers with the tobacco-quit line. Members who request medication prior to registering may receive a prescription, but must be registered before Medicaid will pay for a prescription.
- Encourage use of the tobacco-quit line.

If the member does not want to quit, the clinician should ask questions at each visit to help the member identify reasons to quit and barriers to quitting.

Dentists are not entitled to Medicaid payments for any service that they provide to the general public at no charge, including tobacco cessation counseling services. Sufficient documentation must be maintained to substantiate the medical necessity of the services provided.

Additional information may be obtained at www.ynotquit.com or by calling the Quit Line at 1-877-966-8784.

505.14 MANAGED CARE

If the Medicaid recipient is a member of an HMO, authorization for services should be obtained according to HMO's authorization requirements for inpatient and outpatient services. The following information outlines services included and excluded under HMO coverage.

505.14.1 ADULT DENTAL SERVICES

Emergency dental services for adults (age 21 years and older) outlined in Attachment I are covered under Mountain Health Trust and should be paid by the Managed Care Organization. No part of the adult emergency dental benefit is carved out and covered under Fee for Service Medicaid.

505.14.2 CHILDREN'S DENTAL SERVICES

Most dental services for children (ages less than 21 years) are excluded from the (HMO) Mountain Health Trust program. In general, the Managed Care Organizations are not responsible for dental procedures, but are required to cover most costs associated with dental services provided in an inpatient or outpatient hospital setting. Dental service limits can be exceeded as a result of an EPSDT exam based on medical necessity (Refer to EPSDT billing information at www.wvdhhr.org/bms).

CHAPTER 505
DENTAL SERVICES
JULY 1, 2004

ATTACHMENT 1
COVERED DENTAL SERVICES PROCEDURE CODES
PAGE 1 OF 23
REVISED JANUARY 1, 2005

DENTAL PROCEDURE CODES

CATEGORY OF SERVICE		CODE SERIES
I.	Diagnostic	D0100 - D0999
II.	Preventive	D1000 - D1999
III.	Restorative	D2000 - D2999
IV.	Endodontics	D3000 - D3999
V.	Periodontics	D4000 - D4999
VI.	Prosthodontics, removable	D5000 - D5899
VII.	Maxillofacial Prosthetics	D5900 - D5999
VIII.	Prosthodontics, fixed	D6200 - D6999
IX.	Oral Surgery	D7000 - D7999
X.	Orthodontics	D8000 - D8999
XI.	Adjunctive General Services	D9000 - D9999

- 1 This document is a comprehensive list of Medicaid covered services. If the procedure is not on the list, it is considered a non-covered service.
- 2 Those procedure codes which are followed by an asterisk (*) require prior approval by the Dental Consultant, at West Virginia Medical Institute (WVMI), or Bureau's designated representative.
- 3 Written prior authorization must be given by the Bureau for Medical Services' designated representative (WVMI) before the dental work is started.
- 4 When submitting a treatment plan for prior authorization, please include all necessary supporting documentation such as x-ray, study notes, etc. (A prior authorization number will be issued for each procedure.)
- 5 Prior authorization can not be backed-dated. Verbal or phone authorization will not be given. Special consideration may be given when a member's eligibility is determined retroactive.
- 6 Should a patient have an emergency that requires prior authorization for dental services, please call WVMI immediately. If the emergency occurs during the evening or on weekends, please contact WVMI on the next business day. The number to call is (304) 1-800-982-6334.
- 7 An "X" beside the procedure code indicates coverage group for which it may be billed - children (through age 20) or adults, age 21+ and /or both.
- 8 All covered services for children, must be started prior to their 21st birthday. Services offered on or after the actual birth date are not reimbursable even if eligibility extends to the end of the month.
- 9 Please note that coverage for adults is limited to emergency procedures only, i.e. emergency examination along with emergency radiographs and emergency incision and drainage, or emergency extraction.

CHILD / ADULT

I. DIAGNOSTIC

CLINICAL ORAL EXAMINATIONS

X		D0120	Periodic oral examination	1 Per 6 Months
X	X	D0140	Limited oral evaluation -- problem focused	Emergency
X		D0150	Comprehensive oral evaluation-new or established patient	1 Per Year
X		D0210	Intraoral complete series (including bitewings)	1 Every 2 Years
X	X	D0220	Intraoral periapical - first film	
X	X	D0230	Intraoral periapical each additional film	8 Every 3 Months
X		D0240	Intraoral occlusal film	1 Every 6 Months
X		D0250	Extraoral - first film	1 Every 3 Years
X		D0260	Extraoral - each additional film	3 Every 3 Years
X		D0270	Bitewings - single film	4 Per Year
X		D0272	Bitewings - two films	1 Per Year
X		D0290	Posterior/anterior or lateral skull and facial bone survey film.	2 Per Year
X		D0310	Sialography	
X		D0320	Temporomandibular joint, arthrogram, including injection.	
X		D0321	Other temporomandibular joint films, by report	
CHILD /ADULT		D0322	Tomographic survey	
X	X	D0330	Panoramic film	1 Every 3 Years
X		D0340	Cephalometric film	2 Per Year

X D0350 Oral/facial images (includes intra and extraoral images)
For orthodontics only

X D0470 Diagnostic casts 2 Per Year

X D0502* Other oral pathology procedure, by report

II. PREVENTIVE

D1120 Prophylaxis - child 1 Every 6 Months

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

X D1203 Topical application of fluoride
(prophylaxis not included) – child 1 Every 6 Months

OTHER PREVENTIVE SERVICES

X X D1320 Tobacco counseling 2 Per Year

SEALANTS CAN ONLY BE DONE ON THE OCCLUSAL SURFACE OF POSTERIOR PERMANENT TEETH

X D1351 Sealant - per tooth (posterior teeth) 1 Every 3 Years

CHILD /ADULT

**SPACE MAINTENANCE (PASSIVE APPLIANCES)
(Space maintenance for children through 20 years age)**

X D1510 Space maintainer - fixed unilateral 4 Per Year

X D1515 Space maintainer - fixed - bilateral 2 Per Year

X D1520 Space maintainer - removable - unilateral 4 Per Year

X	D1525 Space maintainer - removable - bilateral	2 Per Year
X	D1550 Re-cementation of space maintainer (limited to one per year after first year)	2 Per Year

III. RESTORATIVE

AMALGAM RESTORATIONS (INCLUDING POLISHING)

If a surface filling has previously been billed for on the same tooth, on the same day, Medicaid will not reimburse for duplication of services.

X	D2140 Amalgam - one surface, primary or permanent	1 Every 3 Years
X	D2150 Amalgam - two surfaces, primary or permanent	1 Every 3 Years
X	D2160 Amalgam - three surfaces, primary or permanent	1 Every 3 Years
X	D2161 Amalgam - four or more surfaces, primary or permanent	1 Every 3 Years

The codes above include any necessary base and local anesthesia.

CHILD /ADULT

RESIN RESTORATIONS

X	D2330 Resin - based composite - one surface, anterior	1 Every 3 Years
X	D2331 Resin - based composite - two surfaces, anterior	1 Every 3 Years
X	D2332 Resin - based composite - three surfaces, anterior	1 Every 3 Years
X	D2335 Resin - based composite - four or more surfaces or involving incisal angle (anterior)	1 Every 3 Years
X	D2390 Resin-based composite crown, anterior	1 Every 3 Years

X	D2391 Resin-based composite - one surface, posterior	1 Every 3 Years
X	D2392 Resin-based composite - two surfaces, posterior	1 Every 3 Years
X	D2393 Resin-based composite - three surfaces, posterior	1 Every 3 Years
X	D2394 Resin-based composite - four or more surfaces, posterior	1 Every 3 Years

The codes above include any necessary base, local anesthesia and acid etching

CROWNS - SINGLE RESTORATION ONLY

X	D2751* Crown - porcelain fused to predominantly based metal	1 Every 5 Years
X	D2791* Crown - full cast predominantly base metal	1 Every 5 Years

CHILD / ADULT

OTHER RESTORATIVE SERVICES

X	D2920 Re-cement crown	1 Per Year
X	D2930 Prefabricated stainless steel crown - primary tooth	1 Per Year
X	D2931 Prefabricated stainless steel crown, permanent tooth	1 Per Year
X	D2932 Prefabricated resin crown	1 Per Year
X	D2940 Sedative filling	1 In 6 Months
X	D2950 Core build-up, including any pins For permanent teeth only	1 In 3 Years
X	D2951 Pin retention - per tooth, in addition to restoration	1 In 3 Years
X	D2952 Cast post and core in addition to crown	1 In 3 Years
X	D2954 Prefabricated post and core in addition to crown	1 In 3 Years

**IV. ENDODONTICS
PULPOTOMY**

X D3220 Therapeutic pulpotomy (excluding final restoration) 1 In 3 Years

ROOT CANAL THERAPY

X D3310 Anterior (excluding final restoration)

X D3320 Bicuspid (excluding final restoration)

X D3330 Molar (excluding final restoration)

X D3346 Retreatment of previous root canal therapy - anterior

X D3347 Retreatment of previous root canal therapy - bicuspid

X D3348 Retreatment of previous root canal therapy - molar

X D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

X D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

X D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)

All diagnostic tests, evaluations, radiographs and post-operative treatment are included in the payment made for these procedures.

PERIAPICAL SERVICES

X D3410* Apicoectomy/Periradicular surgery - anterior

X D3421* Apicoectomy/Periradicular surgery - bicuspid (first root)

OTHER ENDODONTIC PROCEDURES

CHILD / ADULT

X D3999* Unspecified endodontic procedure, by report

CHILD / ADULT

V. PERIODONTICS

SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES)

X	D4210* Gingivectomy or gingivoplasty -four or more contiguous teeth or bounded teeth spaces, per quadrant.	1 Per Quad. Per Year
X	D4211* Gingivectomy or gingivoplasty - one to three teeth,	1 Per Quad. Per Year per quadrant
X	D4260* Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces, per quadrant	1 Per Quad. Per Year
X	D4261* Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	1 Per Quad. Per Year

ADJUNCTIVE PERIODONTAL SERVICES

X	D4341* Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant	1 Per Quad. Per Year
X	D4342* Periodontal scaling and root planing - one to three teeth, per quadrant	1 Per Quad. Per Year
X	D4355* Full mouth debridement to enable comprehensive evaluation and diagnosis	1 Every 6 Months

X D4999* Unspecified periodontal procedure, by report

CHILD / ADULT

VI. PROSTHODONTICS - REMOVABLE

COMPLETE DENTURES (INCLUDING ROUTINE POST DELIVERY CARE FOR UP TO 6 MONTHS)

X	D5110* Complete denture - maxillary	1 in 5 Years
X	D5120* Complete denture - mandibular	1 in 5 Years
X	D5130* Immediate denture - maxillary	
X	D5140* Immediate denture - mandibular	
X	D5213* Maxillary partial denture - case metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 In 5 Years
X	D5214* Mandibular partial denture - cast metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 In 5 Years
X	D5281* Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	

Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction (except for immediate dentures.)

CHILD / ADULT**ADJUSTMENTS TO REMOVABLE PROSTHESES**

X	D5410	Adjust complete denture - maxillary	3 Per Year
X	D5411	Adjust complete denture - mandibular	3 Per Year
X	D5421	Adjust partial denture - maxillary	3 Per Year
X	D5422	Adjust partial denture - mandibular	3 Per Year

REPAIRS TO COMPLETE DENTURES

X	D5510	Repair broken complete denture base	2 Per Year
X	D5520	Replace missing or broken teeth complete denture (each tooth)	2 Per Year

REPAIRS TO PARTIAL DENTURES

X	D5610	Repair resin denture base	2 Per Year
X	D5620	Repair cast framework	2 Per Year
X	D5630	Repair or replace broken clasp	2 Per Year
X	D5640	Replace broken teeth per tooth	3 Per Year
X	D5650	Add tooth to existing partial denture	2 Per Year
X	D5660	Add clasp to existing partial denture	

CHILD / ADULT

DENTURE REBASE PROCEDURES

X	D5710	Rebase complete maxillary denture	1 In 5 Years
X	D5711	Rebase complete mandibular denture	1 In 5 Years
X	D5720	Rebase maxillary partial denture	1 In 5 Years
X	D5721	Rebase mandibular partial denture	1 In 5 Years

DENTURE RELINE PROCEDURES

X	D5730	Reline complete maxillary denture (chairside)	1 In 2 Years
X	D5731	Reline complete mandibular denture (chairside)	1 In 2 Years
X	D5740	Reline maxillary partial denture (chairside)	1 In 2 Years
X	D5741	Reline mandibular partial denture (chairside)	1 In 2 Years
X	D5750	Reline complete maxillary denture (laboratory)	1 In 2 Years
X	D5751	Reline complete mandibular denture (laboratory)	1 In 2 Years
X	D5760	Reline maxillary partial denture (laboratory)	1 In 2 Years
X	D5761	Reline mandibular partial denture (laboratory)	1 In 2 Years

OTHER REMOVABLE PROSTHETIC SERVICES

X	D5899*	Unspecified removable prosthodontic procedure, by report	
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CHILD /ADULT

VII. MAXILLOFACIAL PROSTHETICS

X	D5911*	Facial moulage (sectional)	
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X	D5912* Facial moulage (complete)
X	D5913* Nasal prosthesis
X	D5914* Auricular prosthesis
X	D5915* Orbital prosthesis
X	D5916* Ocular prosthesis
X	D5919* Composite facial prosthesis
X	D5924* Cranial Prosthesis
X	D5925* Facial augmentation implant prothesis
X	D5931* Obturator prosthesis, surgical
X	D5932* Obturator prosthesis, definitive
X	D5933* Obturator prosthesis, modification
X	D5934* Mandibular resection prosthesis with guide flange
X	D5935* Mandibular resection prosthesis without guide flange
X	D5937* Trismus appliance (not for TMD treatment)
X	D5951* Feeding aid
X	D5952* Speech aid prosthesis, pediatric
CHILD /ADULT	
X	D5954* Palatal augmentation prosthesis
X	D5955* Palatal lift prosthesis, definitive
X	D5982* Surgical stent

- X D5983* Radiation carrier
- X D5984* Radiation shield
- X D5985* Radiation cone locator
- X D5986* Fluoride gel carrier
- X D5987* Commissure splint
- X D5999* Unspecified maxillofacial prosthesis, by report

IX. PROSTHODONTICS, FIXED

Each abutment and each pontic constitute a unit in a bridge.

- X D6211* Pontic - cast predominantly base metal 1 In 5 Years
- X D6241* Pontic - porcelain fused to predominantly based metal 1 in 5 Years
- X D6545* Retainer - cast metal for resin bonded fixed prosthesis 1 In 5 Years

OTHER FIXED PROSTHETIC SERVICES

- X D6930 Recement fixed partial bridge 1 Per Year
- X D6999* Unspecified fixed prosthodontic procedure, by report

CHILD /ADULT

X. ORAL SURGERY

Extractions - includes local anesthesia and post operative care (including adults)

- X X D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

SURGICAL EXTRACTIONS - Includes local anesthesia and routine postoperative care

X	X	D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
X	X	D7220	Removal of impacted tooth - soft tissue
X	X	D7230	Removal of impacted tooth - partially bony
X	X	D7240	Removal of impacted tooth - completely bony

Any necessary suture included in fee for extraction

OTHER SURGICAL PROCEDURES

X	X	D7260*	Oral antral fistula closure
X		D7270	Tooth reimplantation and/or stabilization of accidental avulsed or displaced tooth
X		D7280	Surgical access of an unerupted tooth
X		D7283	Placement of device to facilitate eruption of impacted tooth
X	X	D7285	Biopsy of oral tissue - hard (bone, tooth)
X	X	D7286	Biopsy of oral tissue - soft (all others)

CHILD /ADULT

ALVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

X		D7310	Alveoplasty in conjunction with extractions per quadrant
X		D7320	Alveoplasty not in conjunction with extractions, per quadrant

VESTIBULOPLASTY

X		D7340*	Vestibuloplasty - ridge extension (secondary epithelization)
X		D7350*	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

REMOVAL OF TUMORS, CYSTS AND NEOPLASMS (INCLUDES ADULTS)

X	X	D7410	Excision of benign lesion up to 1.25 cm
X	X	D7411	Excision of benign lesion greater than 1.25 cm
X	X	D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
X	X	D7441*	Excision of malignant tumor - lesion diameter greater than 1.25 cm
X	X	D7450*	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
X	X	D7451*	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
X	X	D7460	Removal of benign nonodontogenic cyst or tumor lesion diameter up to 1.25 cm
X	X	D7461	Removal of benign nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm

CHILD /ADULT

EXCISION OF BONE TISSUE

X		D7471	Removal of lateral exostosis (maxilla or mandible)
X		D7472	Removal of torus palatinus
X		D7473	Removal of torus mandibularis
X		D7485	Surgical reduction of osseous tuberosity
X		D7490*	Radical resection of mandible with bone graft

SURGICAL INCISION (Procedure codes D7510 and D7520 covered for adults)

X	X	D7510	Incision and drainage of abscess - intraoral soft tissue
X	X	D7520	Incision and drainage of abscess - extraoral soft tissue

X	X	D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
X		D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
X		D7560	Maxillary sinusotomy for removal of tooth fragment of foreign body

TREATMENT OF FRACTURE - SIMPLE (These procedures are covered for adults)

X	X	D7610	Maxilla - open reduction (teeth immobilized if present)
X	X	D7620	Maxilla - closed reduction (teeth immobilized if present)
X	X	D7630	Mandible - open reduction (teeth immobilized if present)
X	X	D7640	Mandible - closed reduction (teeth immobilized if present)

CHILD /ADULT

X	X	D7671	Alveolus - open reduction, may include stabilization of teeth
X	X	D7680*	Facial bones - complicated reduction with fixation and multiple surgical approaches

TREATMENT OF FRACTURES - COMPOUND (These procedures covered for adults)

X	X	D7710	Maxilla - open reduction
X	X	D7720	Maxilla - closed reduction
X	X	D7730	Mandible - open reduction
X	X	D7740	Mandible - closed reduction
X	X	D7750	Malar and/or zygomatic arch - open reduction
X	X	D7770	Alveolus - open reduction, stabilization of teeth
X	X	D7780*	Facial bones - complicated reduction with fixation and multiple surgical approaches.

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

- X D7810* Open reduction of dislocation
 - X D7820* Closed reduction of dislocation
 - X D7830* Manipulation under anesthesia
 - X D7850* Surgical discectomy, with/without implant
- CHILD /ADULT**
- X D7852* Disc repair - (cannot bill D7850 and D7852 with same date of service.)
 - X D7858* Joint reconstruction
 - X D7865* Arthroplasty
 - X D7870* Arthrocentesis
 - X D7872* Arthroscopy - diagnosis, with or without biopsy
 - X D7873* Arthroscopy - surgical lavage and lysis of adhesions
 - X D7874* Arthroscopy - surgical: disc repositioning and stabilization
 - X D7876* Arthroscopy - surgical - discectomy
 - X D7877* Arthroscopy - surgical - debridement
 - X D7880* Occlusal orthotic device, by report
 - X D7899* Unspecified TMD therapy, by report

REPAIR OF TRAUMATIC WOUNDS (COVERED FOR ADULTS)

- X X D7910 Suture of recent small wounds up to 5 cm (not for recent extractions)

Complicated suturing (Reconstruction requiring delicate handling of tissues and wide undermining or meticulous closure) Covered by adults

- X X D7911 Complicated suture up to 5 cm, by report
- X X D7912 Complicated suture - over 5 cm, by report

When billing for the above code, please write number of centimeters on claim.

CHILD /ADULT

OTHER REPAIR PROCEDURES

- X D7920* Skin grafts (identify defect covered, location and type of graft)
- X D7941* Osteotomy - mandibular rami
- X D7943* Osteotomy - mandibular rami with bone graft: includes obtaining graft
- X D7944* Osteotomy - segmented or subapical per sextant or quadrant
- X D7946* LeFort I (maxilla - total)
- X D7947* LeFort I (maxilla - segmented)
- X D7948* LeFort II or LeFort III (osteoplasty of facial bone for midface hypoplasia or retrusion without bone graft)
- X D7949* LeFort II or LeFort III - with bone graft
- X D7950* Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous
- X D7955* Repair of maxillofacial soft and hard tissue defects
- X D7960 Frenulectomy (frenectomy or frenotomy) separate procedure
- X D7970* Excision of hyperplastic tissue - per arch
- X D7980 Sialolithotomy
- X D7981* Excision of salivary gland
- X D7982* Sialodochoplasty

X	D7991* Coronoidectomy
X X	D7999* Unspecified oral surgery procedure, by report

CHILD /ADULT

XI. ORTHODONTICS -- 08000-08999

DENTITION

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 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 comprehensive therapy.

X	D8010* Limited Orthodontic treatment of the primary dentition	2 Per Year
X	D8020* Limited orthodontic treatment of the transitional dentition	2 Per Year
X	D8030* Limited orthodontic treatment of the adolescent dentition	2 Per Year
X	D8040* Limited orthodontic treatment of the adult dentition	2 Per Year

INTERCEPTIVE ORTHODONTIC TREATMENT

X	D8050* Interceptive orthodontic treatment of the primary dentition	2 Per Year
X	D8060* Interceptive orthodontic treatment of the transitional dentition	2 Per Year

CHILD /ADULT

MINOR TREATMENT TO CONTROL HARMFUL HABITS

- X D8210* Removable appliance therapy 2 Per Year
- X D8220* Fixed appliance therapy 2 Per Year

Orthodontic appliances for children through 20 years of age

COMPREHENSIVE ORTHODONTIC TREATMENT

- X D8070* Comprehensive orthodontic treatment of the transitional dentition
- X D8080* Comprehensive orthodontic treatment of the adolescent dentition
- X D8090* Comprehensive orthodontic treatment of the adult dentition

OTHER ORTHODONTIC DEVICES

- X D8680* Orthodontic retention (removal of appliances construction and placement of retainer.)
- X D8692 Replacement of lost or broken retainer 2 Per Lifetime
- X D8999* Unspecified orthodontic procedure, by report

Comprehensive orthodontic treatment for children through 20 years of age.

XII. ADJUNCTIVE GENERAL SERVICES

ANESTHESIA

- X X D9220 Deep sedation/general anesthesia - First 30 minutes
- X X D9221 Deep sedation/general anesthesia - Each additional 15 minute unit, up to 2 additional units.

CHILD /ADULT

- X X D9230 Analgesia,anxiolysis, inhalation of nitrous oxide

- X X D9241 Intravenous conscious sedation/analgesia - First 30 minutes
- X X D9242 Intravenous conscious sedation/analgesia - Each additional 15 minute unit

PROFESSIONAL CONSULTATION

- X D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

PROFESSIONAL VISITS

- X D9420 Hospital call

DRUGS

- X D9630 Other drugs and/or medicaments by report

MISCELLANEOUS SERVICES

- X D9940* Occlusal guards, by report
- X D9951* Occlusal adjustments - limited
- X D9952* Occlusal adjustments - complete
- X D9999* Unspecified adjunctive procedures, by report

**CHAPTER 505
DENTAL SERVICES
JULY 1, 2004**

**ATTACHMENT 2
PRIOR AUTHORIZATION FORM FOR ORTHODONTIC SERVICES
PAGE 1 OF 3**

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
PRIOR AUTHORIZATION FOR ORTHODONTIC SERVICES**

PATIENT NAME: _____

I.D. NUMBER: _____

INFORMATION REQUIRED FOR ASSESSING HANDICAPPING MALOCCLUSION

1. OVER JET _____ 2. OVER SIZE _____

3. MOLAR RELATIONSHIP R _____ L _____

4. SKELETAL RELATIONSHIP I _____ II _____ III _____

5. MISSING TEETH _____

6. IMPACTED TEETH _____

7. CROWDING _____

8. CLEFT PALATE YES _____ NO _____

9. CROSS BITE

A - ANTERIOR TEETH _____

B - POSTERIOR TEETH L _____

C - POSTERIOR TEETH R _____

10. OPEN BITE

A - ANTERIOR TEETH _____

B - POSTERIOR TEETH L _____

C - POSTERIOR TEETH R _____

11. COMMENTS: _____

Form Number: DNTL-ORTHO 501 02/03TW



Confidential

Request for Prior Authorization for Comprehensive Orthodontic Treatment

Phone: 1-800-982-6334; Opt. 5 Fax: 1-877-762-4338 or 1-304-346-8185

Date: ___/___/___ Patient Name: _____ DOB: _____

Patient Address: _____ Street _____ City _____ State _____ Zip _____

Medicaid #: _____ Examined On _____

Provider Name: _____ Provider Phone: _____

Provider Address: _____

Provider Fax: _____ Medicaid Provider #: _____

Complete Diagnosis _____

Current Treatment Status _____

Recommendations for Comprehensive Orthodontic Treatment _____

Comprehensive Orthodontic Treatment - Procedure Code _____

Post Treatment Stabilization - Procedure Code D8680 _____

Total Fee (Your usual and customary charge) _____

Doctor's Signature Date

PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT
It is the providers responsibility to verify eligibility by the Medicaid card or calling
ACS/Consultec at 1-800-688-5810.

CHAPTER 505
DENTAL SERVICES
JULY 1, 2004

ATTACHMENT 3
GENERAL DENTISTRY PRIOR AUTHORIZATION
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