B. Outpatient Surgical Services

1. Alveolectomy/Alveoloplasty

   Alveolectomy/alveoplasty services (Procedure Codes **D7310** and **D7320**) are billed *per quadrant.* For MA billing purposes, a quadrant equals 5 – 8 teeth.

   Alveolectomy/alveoplasty services involving less than five teeth are not compensable.

2. Excision of Hyperplastic Tissue

   Procedure Code **D7970**, excision of hyperplastic tissue, per arch, is *not* intended to be used for simple corrective tissue removal associated with extractions. Use of this code is reserved for removal of abnormal, extraneous tissue that is interfering with the normal function of the teeth and/or prosthetic appliances.

C. Medications, Palliative Treatment and Prescriptions

1. Medications and supplies furnished by the dentist during the course of an examination or treatment are *not* paid for by the Department in addition to the regular fees listed in the Medical Assistance Program Fee Schedule.

2. Palliative (emergency) treatment of dental pain (Procedure Code **D9110**) may not be billed in addition to any other treatment or dental service (excluding dental X-rays used to determine appropriate dental care), on the same day.

3. The Department requests that you put your license number on prescriptions/orders for MA recipients. This information is needed to meet federal surveillance and utilization review standards, which require the Department to identify practitioners who order or prescribe goods, services or drugs. Your license number will be submitted to the Department by the provider dispensing the goods, services or drugs that you prescribe.

D. Supernumerary Teeth

Permanent dentition – Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32).

Primary dentition – Supernumerary teeth are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (for example, supernumerary “AS” is adjacent to “A”; supernumerary “TS” is adjacent to “T”).

The appropriate supernumerary tooth number/letters should be placed in the Tooth field (Item 59) of the ADA Claim Form – Version 2000.

E. Homebound, Skilled Nursing/Intermediate Care Facility Services

Dental services are available for eligible clients in the home, skilled nursing facility or intermediate care facility.

When completing the invoice, be certain to indicate the appropriate place of service (Item 49 on the ADA Claim Form – Version 2000).

F. Transportation (Mileage)

Procedure Code **W0500** may be billed when service is provided in the recipient's home, a skilled nursing facility or intermediate care facility outside of the city, borough or unincorporated community in which the dentist's office is located.

Mileage calculation begins at the city, borough or community limits.

When several recipients in the same relative vicinity are visited on a continuous trip, the mileage allowed is for the call to the recipient whose home is the most distant from the defined limit of the community in which the dentist's office is located.

Mileage is paid beginning at the limits defined above, to the farthest destination and return.

G. Dental Procedures for Special Situations

1. Recipient fails to return for completion of service

   When the dentist has received prior authorization for crowns or dentures and the recipient does not return to have the appliance inserted or the work is not completed, the dentist must request payment through the 1150 Administrative Waiver process.

   a. When the item is completed, the dentist must notify the recipient and make an appointment. If the dentist is unable to contact the recipient after thirty (30) days, in spite of repeated attempts which must be documented in the recipient's treatment record, the dentist must send a letter to the recipient and the appropriate County Assistance Office.

   b. If after sixty (60) days neither the dentist nor the County Assistance Office can locate the recipient or the work cannot be completed, the dentist may submit an 1150 Administrative Waiver request to the Department.

2. Recipient loses eligibility

   When billing the Department for a prior authorized custom-made crown or denture for which the impression was taken while the recipient was eligible, but was not inserted in the recipient's mouth before the recipient became ineligible, the dentist must use the date of impression for the date of service. Include the date the appliance was inserted in the Remarks Section of the ADA Claim Form – Version 2000.

H. Inpatient Hospital/Short Procedure Unit (SPU)/Ambulatory Surgical Center (ASC) Dental Care

1. Surgical procedures

   The fee paid by the Department for inpatient surgical services includes all preoperative and postoperative visits. When two or more surgical procedures are performed by the same dentist during the same period of hospitalization, the dentist will be reimbursed for up to 100% of the highest allowable payment for one procedure, and 25% for the second procedure, with no payment for any additional procedures.

2. Inpatient visit(s)

   Payment may be made to dentists for daily inpatient medical care under the following conditions:

a. Dentist is responsible for care:

The recipient was hospitalized in anticipation of dental surgery that was not performed because medical treatment was successful. In addition, a physician was not responsible for the daily medical care of the recipient. Finally, the condition of the recipient required hospitalization.

b. Another practitioner is responsible for the care:

The dentist must provide care for a condition or diagnosis unrelated to any daily medical care provided by the primary physician.

c. Inpatient consultation(s)

Any professional consultation requested for any recipient is limited to one such consultation per hospital admission. The consultation must be requested by the primary dentist or physician and must be provided by a dental or medical specialist other than the dentist providing the treatment. A consultation report must be made in writing and is considered to be a part of the recipient's dental treatment and hospital records.

d. Limited compensable services

All dental procedures listed in the Medical Assistance Program Fee Schedule are considered outpatient procedures. Outpatient procedures are not compensable on an inpatient basis unless there is medical justification documented in the recipient's medical record and on the invoice.

Generally, the following services are compensable on an inpatient basis when properly invoiced:

1) Oral surgery procedures when the condition of the recipient and/or the nature of the oral surgery may entail undue risk to the recipient if performed on an outpatient basis.

2) Extractions of teeth only when:

   a) The teeth are impacted (i.e., soft tissue, complete bony and partial bony impactions where the surgical procedure would constitute undue risk to the recipient without hospitalization); or

   b) A recipient presents a medically compromising condition that would endanger the physical health of the recipient without hospitalization; or

   c) A recipient is unmanageable in a dental office because of a severe mental and/or physical condition and requires general anesthesia.

3) The procedure is a secondary, necessary procedure.

4) Dental restorative services performed for a recipient who is unmanageable in a dental office because of a severe physical and/or mental condition that necessitates the use of general anesthesia. (Payment for the administration of general anesthesia will be made to the anesthesiologist, *not* the dentist.)

NOTE: ALL REQUESTS FOR REIMBURSEMENT FOR COMPENSABLE DENTAL SERVICES PERFORMED ON AN INPATIENT/SPU/ASC BASIS MUST BE DOCUMENTED BY SUBSTANTIATING INFORMATION IN THE "REMARKS" SECTION OF THE INVOICE.

I. Consultations

A referral to another practitioner does not constitute a consultation. For example, when a dentist refers a recipient to the oral surgeon who then performs oral surgery, the oral surgeon would bill for the surgical procedure(s). A consultation will not be reimbursed in this case. When a recipient is referred to another practitioner, the medical record must indicate the name of the practitioner and the reason for the referral.

1. Procedure codes

   Consultation procedure codes **99241** through **99275** are located in the Medical Assistance Program Fee Schedule.

2. Payment limitations

   a) Payment will not be made for a self-referred consultation. A consultation must be requested by another practitioner.

   b) A practitioner will not be reimbursed for a consultation and an oral examination on the same date of service.

   c) Payment will not be made for a consultation when it is performed by a surgeon or assistant surgeon regarding the advisability of definitive surgery and surgery subsequently is performed by that surgeon.

   d) Payment will not be made for a consultation if the consultation occurs between members of the same group, shared facility, or providers sharing common records.

   e) Payment will not be made for a dental consultation in a long term care facility when provided by a dentist who has a contract or agreement to provide dental exams and follow-up care to residents of the facility. A dentist may bill for an initial or periodic oral exam for these services.

   f) Payment for an inpatient consultation includes payment for follow-up care. Therefore, the consultant is not eligible to bill for daily medical care. Only the attending practitioner is entitled to bill for daily medical care.

J. Assistant Surgeon Services

The maximum payment to an assistant surgeon will be an amount equal to 20% of the maximum allowable payment made to the surgeon for the surgery performed.

The assistant surgeon should bill using procedure code **D7999**. This code should be placed under "Procedure Code" on the ADA Claim Form – Version 2000. The letters **"ASST SURG"** and the **procedure code indicating the actual surgery performed** *must* be entered in the "Remarks" section of the ADA Claim Form – Version 2000.