pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
October 30, 2019	August 19, 2019	27-19-17

SUBJECT

Medical Assistance Program
Dental Fee Schedule and Dental Provider Handbook Update

BY

Sally A. Kozak,
Deputy Secretary
Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to notify dentists that the Department of Human Services (Department) is issuing updates to the Medical Assistance (MA) Program Dental Fee Schedule and the MA Program Dental Provider Handbook.

SCOPE:

This bulletin applies to dentists enrolled in the MA Program who render services to MA beneficiaries in the Fee-for-Service delivery system. Dentists rendering services to MA beneficiaries in the managed care delivery system should address payment related questions to the appropriate managed care organization.

BACKGROUND/ DISCUSSION:

The Department issued MA Bulletin 99-19-04, titled "2019 Healthcare Common Procedure Coding System (HCPCS) Updates, Fee Adjustments and Other Procedure Code Changes," to announce changes to the MA Program Fee Schedule effective with dates of service on and after August 19, 2019. The 2019 HCPCS updates contain a subset of 2019 Current Dental Terminology (CDT) codes.

As a result, the Department updated the MA Program Dental Fee Schedule to reflect the 2019 CDT procedure codes that were added and deleted, effective with dates of service on and after August 19, 2019. The Department also revised Places of Services and limits for specific procedure codes in the Dental Fee Schedule.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type.

Visit the Office of Medical Assistance Programs Web site at:
http://www.dhs.pa.gov/provider/healthcaremedicalassistance/index.htm.

NOTE: The procedure code updates do not apply to dental services provided in Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC). The Department will continue to pay FQHCs and RHCs their prospective payment rate for dental services provided in the FQHC or RHC.

The Department also updated the format of the Dental Fee Schedule to make it easier to read and to align with other issued fee schedules. Sections 6, 8 and 11 of the MA Program Dental Provider Handbook are updated to reflect the changes in the Dental Fee Schedule.

New Procedure Codes

The Department added the following procedure codes to the MA Program Dental Fee Schedule as a result of the American Dental Association updates and the 2019 HCPCS updates, effective with dates of service on and after August 19, 2019:

Procedure Codes	
D1516	D1517

Dentists are required to provide tooth numbers when billing for procedure codes D1516 and D1517 when submitting claims.

The Department added the following procedure codes to the MA Program Dental Fee Schedule based upon provider requests or clinical review, effective with dates of service on and after August 19, 2019:

Procedure Codes	
D0140	D1320

The Department will limit the use of procedure code D0140 to the following provider specialties: 270 (Endodontist), 272 (Oral/Maxillofacial Surgeon), 273 (Orthodontist/Dentofacial Orthopedist), 275 (Periodontist), 276 (Oral Pathologist) and 277 (Prosthodontist).

NOTE: Dentists who wish to provide tobacco cessation services under procedure code D1320 must be approved by the Department of Health as a Tobacco Cessation Program provider. See MAB 99-18-10, titled “Enrollment of Tobacco Cessation Providers”, effective June 18, 2018.

End-dated Procedure Code

The following procedure code is being end-dated from the MA Program Dental Fee Schedule as a result of the American Dental Association updates and the 2019 HCPCS updates, effective with dates of service on and after August 19, 2019:

Procedure Code
D1515

New authorizations will not be issued for the procedure code being end-dated on and after August 19, 2019. The Department will accept claims with the end-dated procedure codes until August 19, 2020 for those services that were previously prior authorized.

Procedure Code Revisions

The Department is end-dating the following places of service (POS) as a result of clinical review effective with dates of service on and after August 19, 2019, for the following procedure codes:

Procedure Code	End-dated Place of Service
D3320	12 (Patient's Home)
D7999	12 (Patient's Home), 23 (Emergency Room), 99 (Other Unlisted Facility)

The Department is adding the following places of service as a result of clinical review, effective with dates of service on and after August 19, 2019, for the following procedure codes:

Procedure Code	Added Place of Service
D2952	24 (Ambulatory Surgical Center)
D7280	32 (Nursing Facility)
D8210	24 (Ambulatory Surgical Center)
D8220	24 (Ambulatory Surgical Center)

The Department is changing the limitation for the following procedure codes as a result of clinical review, effective with dates of service on and after August 19, 2019:

Procedure Code	Old Limit	New Limit
D0240	6 images per day	2 images per day
D7451	1 unit per day	2 units per day
D9930	3 units per day	1 unit per day

The Department updated the locations where cleft palate services can be performed for children under 21 years of age for procedure codes D0160 and D0170 to include office (POS 11), outpatient hospital (POS 22) and independent clinic (POS 49) for the following provider types and specialties:

Provider Type	Provider Specialty
17 (Therapist)	173 (Speech/Hearing Therapist)
19 (Psychologist)	190 (General Psychologist)
20 (Audiologist)	200 (Audiologist)
21 (Case Manager)	212 (Medical Assistance Case Management for HIV and AIDS), 213 (Early Intervention Case Management)
27 (Dentist)	283 (Cleft Palate)
31 (Physician)	All

PROCEDURE:

Attached is the updated MA Program Dental Fee Schedule, effective for dates of service on and after August 19, 2019. Included in this document are the procedure codes and procedure code descriptions, provider types and specialties, places of services, prior authorization requirements, and limits for the procedure codes discussed in this MA Bulletin. The procedure codes that require prior authorization are identified by a "Yes" under the "Prior Authorization Required" heading.

The Department pays dentists according to the MA Program Dental Fee Schedule, and dentists are to bill the Department using the MA Program Dental Fee Schedule.

Dentists may view the MA Program Dental Fee Schedule by accessing the Department's website at the following link: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_002906.pdf.

Dentists may view the MA Program Dental Provider Handbook by accessing the Department's website at the following link: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_035985.pdf.

ATTACHMENTS:

MA Program Dental Fee Schedule
MA Program Dental Provider Handbook (updated pages of Sections 6, 8 and 11)

Medical Assistance Program Dental Fee Schedule

August 19, 2019

Procedure Code	Provider Type	Provider Specialty	Place of Service	Description	Units of Service	Limits	MA Fee	Prior Authorization
DIAGNOSTIC								
Clinical Oral Evaluation								
D0120	27	All	11, 12, 21, 23, 24, 31, 32, 99	Periodic oral evaluation - established patient	Per visit	1 oral evaluation per 180 days, per patient	$20.00	No
D0140	27	270, 272, 273, 275, 276, 277	11, 12, 21, 23, 31, 32, 99	Limited oral evaluation - problem focused	Per visit	4 per calendar year	$55.22	No
D0145	27	All	11, 12, 21, 23, 24, 31, 32, 99	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Per visit	1 oral evaluation per 180 days, per patient (Under 3 years of age only)	$20.00	No
D0150	27	All	11, 12, 21, 23, 24, 31, 32, 52, 99	Comprehensive oral evaluation - new or established patient	Per visit	1 per patient per dentist per lifetime	$20.00	No
Radiographs/Diagnostic Imaging								
(Maximum allowance for any combination of dental radiographs, per patient per dentist per calendar year is $69.00)								
D0210	27	All	11, 12, 31, 32	Intraoral - complete series of radiographic images	Per series	1 image per 5 years	$45.00	No
D0220	27	All	11, 12, 31, 32	Intraoral - periapical first radiographic image	Per image	1 image per day	$8.00	No
D0230	27	All	11, 12, 31, 32	Intraoral - periapical each additional radiographic image	Per image	10 images per day	$8.00	No
D0240	27	All	11, 12, 31, 32	Intraoral – occlusal radiographic image	Per image	2 images per day	$12.00	No
D0250	27	All	11, 12, 31, 32	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	Per image	1 image per day	$8.00	No
D0251	27	All	11, 12, 31, 32	Extra-oral posterior dental radiographic image	Per image	10 images per day	$8.00	No
D0270	27	All	11, 12, 31, 32	Bitewing – single radiographic image	Per image	1 image per day	$8.00	No
D0272	27	All	11, 12, 31, 32	Bitewings – two radiographic images	Per image pair	1 image per day	$16.00	No

D0273	27	270, 271, 272, 273, 274, 275, 277, 279, 282, 283	11, 12, 31, 32	Bitewings – three radiographic images	Per image set	1 image per day	$22.00	No
D0274	27	All	11, 12, 31, 32	Bitewings – four radiographic images	Per image set	1 image per day	$28.00	No
D0330	27	All	11, 12, 31, 32	Panoramic radiographic image	Per image	1 image per 5 years	$37.00	No
D0340	27	All	11, 31, 32	2D cephalometric radiographic image - acquisition, measurement and analysis	Per image	1 image per day (Under 21 years of age only)	$19.50	No
PREVENTIVE								
Dental Prophylaxis								
D1110	27	All	11, 12, 21, 22, 24, 31, 32, 99	Prophylaxis – adult	Per visit	1 per 180 days, per patient (12 years of age and older only)	$36.00	No
D1120	27	All	11, 12, 21, 24, 31, 32, 99	Prophylaxis – child	Per visit	1 per 180 days, per patient (Under 12 years of age only)	$30.00	No
D1206	27	270, 271, 272, 273, 274, 275, 277, 279, 282, 283	11, 12, 21, 24, 31, 32, 99	Topical application of fluoride varnish	Per procedure	4 per calendar year (16 years of age or under only)	$18.00	No
D1208	27	All	11, 12, 21, 24, 31, 32, 99	Topical application of fluoride - excluding varnish	Per procedure	1 per 180 days, per patient (16 years of age or under only)	$18.72	No
Other Preventive Services								
99407	27	370	11,12, 31, 32, 99	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	Greater than ten minutes; face-to-face encounter	1 unit per day, and a maximum of 70 per calendar year	$19.33	No
D1320	27	370	11, 12, 31, 32, 99	Tobacco counseling for the control and prevention of oral disease	Per visit	1 unit per day, and a maximum of 70 per calendar year	$19.33	No

D1351	27	All	11, 12, 21, 24, 31, 32, 99	Sealant - per tooth	Per tooth	1 application per indicated 1st and 2nd premolars – 1 application per permanent 1st and 2nd molars per lifetime. Includes 1st and 2nd molars where a buccal restoration may exist (Under 21 years of age only)	$25.00	No
D1354	27	All	11, 12, 21, 24, 31, 32, 99	Interim caries arresting medicament application - per tooth	Per tooth	10 units per day (Under 21 years of age only)	$25.00	No
Space Maintenance (Passive Appliances)								
D1510	27	All	11, 12, 21, 24, 31, 32	Space maintainer – fixed, unilateral	Per appliance	1 per quadrant (Under 21 years of age only; 4 per lifetime)	$120.00	No
D1516	27	All	11, 12, 21, 24, 31, 32	Space maintainer – fixed - bilateral, maxillary	Per appliance	1 per arch (Under 21 years of age only; 1 per lifetime)	$190.00	No
D1517	27	All	11, 12, 21, 24, 31, 32	Space maintainer – fixed - bilateral, mandibular	Per appliance	1 per arch (Under 21 years of age only; 1 per lifetime)	$190.00	No
D1550	27	All	11, 12, 21, 24, 31, 32	Re-cement or re-bond space maintainer	Per procedure	1 unit per day (Under 21 years of age only)	$30.00	No
D1555	27	270, 271, 272, 273, 274, 275, 277, 279, 282, 283	11, 12, 31, 32	Removal of fixed space maintainer	Per procedure	4 units per day (Under 21 years of age only)	$25.00	No

Medical Assistance Program Dental Fee Schedule

August 19, 2019

RESTORATIVE								
Amalgam Restoration (Including Polishing)								
D2140	27	All	11, 12, 21, 24, 31, 32	Amalgam – one surface, primary or permanent	Per procedure	1 unit per day	$45.00	No
D2150	27	All	11, 12, 21, 24, 31, 32	Amalgam – two surfaces, primary or permanent	Per procedure	1 unit per day	$55.00	No
D2160	27	All	11, 12, 21, 24, 31, 32	Amalgam – three surfaces, primary or permanent	Per procedure	1 unit per day	$65.00	No
D2161	27	All	11, 12, 21, 24, 31, 32	Amalgam – four or more surfaces, primary or permanent	Per procedure	1 unit per day	$65.00	No
Resin-based Composite Restorations								
D2330	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – one surface, anterior	Per procedure	1 unit per day	$50.00	No
D2331	27	All	11, 12, 21, 22, 24, 31, 32, 49	Resin-based composite – two surfaces, anterior	Per procedure	1 unit per day	$60.00	No
D2332	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – three surfaces, anterior	Per procedure	1 unit per day	$65.00	No
D2335	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	Per procedure	1 unit per day	$65.00	No
D2390	27	All	11, 12, 21, 24, 31, 32	Resin-based composite crown, anterior	Per procedure	1 unit per day (Under 21 years of age only)	$150.00	No
D2391	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – one surface, posterior	Per procedure	1 unit per day	$50.00	No
D2392	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – two surfaces, posterior	Per procedure	1 unit per day	$60.00	No
D2393	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – three surfaces, posterior	Per procedure	1 unit per day	$65.00	No
D2394	27	All	11, 12, 21, 24, 31, 32	Resin-based composite – four or more surfaces, posterior	Per procedure	1 unit per day	$65.00	No
Crowns - Single Restoration Only								
* D2710	27	All	11, 12, 21, 24, 31, 32	Crown - resin-based composite (indirect)	Per tooth	1 per 3 years	$150.00	Yes
* D2721	27	All	11, 12, 21, 24, 31, 32	Crown – resin with predominantly base metal	Per tooth	1 per 5 years	$200.00	Yes
* D2740	27	All	11, 12, 21, 24, 31, 32	Crown – porcelain/ceramic	Per tooth	1 per 5 years	$500.00	Yes
* D2751	27	All	11, 12, 21, 24, 31, 32	Crown – porcelain fused to predominantly base metal	Per tooth	1 per 5 years	$500.00	Yes

* Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

* D2791	27	All	11, 12, 21, 24, 31, 32	Crown – full cast predominantly base metal	Per tooth	1 per 5 years	$475.00	Yes
Other Restorative Services								
D2910	27	All	11, 12, 21, 24, 31, 32	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Per tooth	1 unit per day	$25.00	No
D2915	27	All	11, 12, 21, 24, 31, 32	Re-cement or re-bond indirectly fabricated or prefabricated post and core	Per tooth	1 unit per day	$25.00	No
D2920	27	All	11, 12, 21, 24, 31, 32	Re-cement or re-bond crown	Per tooth	1 unit per day	$25.00	No
D2930	27	All	11, 12, 21, 24, 31, 32	Prefabricated stainless steel crown - primary tooth	Per tooth	1 unit per day (Under 21 years of age only)	$99.00	No
D2931	27	All	11, 12, 21, 24, 31, 32	Prefabricated stainless steel crown - permanent tooth	Per tooth	1 unit per day (Under 21 years of age only)	$110.00	No
D2932	27	All	11, 12, 21, 24, 31, 32	Prefabricated resin crown	Per tooth	1 unit per day (Under 21 years of age only)	$50.00	No
D2933	27	All	11, 12, 21, 24, 31, 32	Prefabricated stainless steel crown with resin window	Per tooth	1 unit per day (Under 21 years of age only)	$145.00	No
D2934	27	All	11, 12, 21, 24, 31, 32	Prefabricated esthetic coated stainless steel crown - primary tooth	Per tooth	1 unit per day (Under 21 years of age only)	$145.00	No
D2952	27	All	11, 12, 24, 31, 32	Post and core in addition to crown, indirectly fabricated	Per tooth	1 unit per day	$80.00	No
D2954	27	All	11, 12, 21, 24, 31, 32	Prefabricated post and core in addition to crown	Per tooth	1 unit per day	$80.00	No
D2980	27	All	11, 12, 21, 24, 31, 32	Crown repair necessitated by restorative material failure	Per tooth	1 unit per day	$42.00	No
ENDODONTICS								
Pulpotomy								
D3220	27	All	11, 12, 21, 24, 31, 32	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	Per tooth	6 units per day (Under 21 years of age only)	$75.00	No

D3230	27	All	11, 12, 21, 24, 31, 32	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Per tooth	1 unit per day (Under 21 years of age only)	$150.00	No
D3240	27	All	11, 12, 21, 24, 31, 32	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	Per tooth	1 unit per day (Under 21 years of age only)	$180.00	No
* D3310	27	All	11, 21, 24, 31, 32	Endodontic therapy, anterior tooth (excluding final restoration)	Per tooth	1 unit per day	$275.00	No
* D3320	27	All	11, 21, 24, 31, 32	Endodontic therapy, premolar tooth (excluding final restoration)	Per tooth	1 unit per day	$375.00	No
* D3330	27	All	11, 21, 24, 31, 32	Endodontic therapy, molar tooth (excluding final restoration)	Per tooth	1 unit per day	$500.00	No
Apicoectomy/ Periradicular Services								
* D3410	27	All	11, 21, 24, 31, 32	Apicoectomy - anterior	Per tooth	2 units per day	$70.00	No
* D3421	27	All	11, 21, 24, 31, 32	Apicoectomy - premolar (first root)	Per tooth	2 units per day	$70.00	No
* D3425	27	All	11, 21, 24, 31, 32	Apicoectomy - molar (first root)	Per tooth	2 units per day	$70.00	No
* D3426	27	All	11, 21, 24, 31, 32	Apicoectomy (each additional root)	Per root	2 units per day	$70.00	No
PERIODONTICS								
Surgical Services (Including Usual Post- Operative Care)								
* D4210	27	All	11, 12, 21, 24, 31, 32	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Per quadrant	4 quadrants per 24 months	$125.00	Yes
Non-Surgical Periodontal Services								
* D4341	27	All	11, 12, 21, 24, 31, 32	Periodontal scaling and root planing – four or more teeth per quadrant	Per quadrant	1 - 2 quadrants per day; 4 quadrants per 24 months	$75.00	Yes
* D4355	27	All	11, 12, 21, 24, 31, 32	Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	Per procedure	1 per 365 days	$60.00	No - requires post operative review.

* Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

Other Periodontal Services								
* D4910	27	All	11, 12, 21, 24, 31, 32	Periodontal maintenance	Per procedure	Any combination of routine prophylaxis and periodontal maintenance totaling 3 per year	$44.00	Yes
PROSTHODONTICS								
Complete Dentures (Including Routine Post-Delivery Care)								
* D5110	27	All	11, 12, 31, 32	Complete denture – maxillary	Per appliance	1 per arch (upper and lower) per lifetime	$525.00	Yes
* D5120	27	All	11, 12, 31, 32	Complete denture – mandibular	Per appliance	1 per arch (upper and lower) per lifetime	$525.00	Yes
* D5130	27	All	11, 12, 21, 24, 31, 32	Immediate denture – maxillary	Per appliance	1 per arch (upper and lower) per lifetime	$525.00	Yes
* D5140	27	All	11, 12, 21, 24, 31, 32	Immediate denture – mandibular	Per appliance	1 per arch (upper and lower) per lifetime	$525.00	Yes
Partial Dentures (Including Routine Post-Delivery Care)								
* D5211	27	All	11, 12, 31, 32	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Per appliance	1 per arch (upper and lower) per lifetime	$375.00	Yes
* D5212	27	All	11, 12, 31, 32	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Per appliance	1 per arch (upper and lower) per lifetime	$375.00	Yes
* D5213	27	All	11, 12, 31, 32	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, resin and teeth)	Per appliance	1 per arch (upper and lower) per lifetime (6-120 years of age only)	$550.00	Yes

* D5214	27	All	11, 12, 31, 32	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Per appliance	1 per arch (upper and lower) per lifetime (6-120 years of age only)	$550.00	Yes
Adjustments to Dentures								
D5410	27	All	11, 12, 21, 24, 31, 32	Adjust complete denture – maxillary	Per procedure	1 unit per day	$20.00	No
D5411	27	All	11, 12, 21, 24, 31, 32	Adjust complete denture – mandibular	Per procedure	1 unit per day	$20.00	No
D5421	27	All	11, 12, 21, 24, 31, 32	Adjust partial denture – maxillary	Per procedure	1 unit per day	$20.00	No
D5422	27	All	11, 12, 21, 24, 31, 32	Adjust partial denture – mandibular	Per procedure	1 unit per day	$20.00	No
Repairs to Complete Dentures								
D5511	27	All	11, 12, 21, 24, 31, 32	Repair broken complete denture base, mandibular	Per appliance	1 unit per day (6-120 years of age only)	$50.00	No
D5512	27	All	11, 12, 21, 24, 31, 32	Repair broken complete denture base, maxillary	Per appliance	1 unit per day (6-120 years of age only)	$50.00	No
D5520	27	All	11, 12, 21, 24, 31, 32	Replace missing or broken teeth – complete denture (each tooth)	Per tooth	3 teeth per day	$45.00	No
Repairs to Partial Dentures								
D5611	27	All	11, 12, 21, 24, 31, 32	Repair resin partial denture base, mandibular	Per appliance	1 unit per day	$50.00	No
D5612	27	All	11, 12, 21, 24, 31, 32	Repair resin partial denture base, maxillary	Per appliance	1 unit per day	$50.00	No
D5621	27	All	11, 12, 21, 24, 31, 32	Repair cast partial framework, mandibular	Per appliance	1 unit per day	$60.00	No
D5622	27	All	11, 12, 21, 24, 31, 32	Repair cast partial framework, maxillary	Per appliance	1 unit per day	$60.00	No
D5630	27	All	11, 12, 21, 24, 31, 32	Repair or replace broken retentive/clasping materials - per tooth	Per tooth	1 clasp per tooth, total of 4 clasps per day	$60.00	No
D5640	27	All	11, 12, 21, 24, 31, 32	Replace broken teeth – per tooth	Per tooth	3 teeth per day	$45.00	No
D5650	27	All	11, 12, 21, 24, 31, 32	Add tooth to existing partial denture	Per tooth	2 teeth per day	$50.00	No

D5660	27	All	11, 12, 21, 24, 31, 32	Add clasp to existing partial denture - per tooth	Per tooth	1 clasp per tooth, total of 2 clasps per day	$50.00	No
Denture Reline Procedures								
D5730	27	All	11, 12, 21, 24, 31, 32	Reline complete maxillary denture (chairside)	Per appliance	1 unit per day	$70.00	No
D5731	27	All	11, 12, 21, 24, 31, 32	Reline complete mandibular denture (chairside)	Per appliance	1 unit per day	$70.00	No
D5740	27	All	11, 12, 21, 24, 31, 32	Reline maxillary partial denture (chairside)	Per appliance	1 unit per day	$70.00	No
D5741	27	All	11, 12, 21, 24, 31, 32	Reline mandibular partial denture (chairside)	Per appliance	1 unit per day	$70.00	No
D5750	27	All	11, 12, 21, 24, 31, 32	Reline complete maxillary denture (laboratory)	Per appliance	1 unit per day	$100.00	No
D5751	27	All	11, 12, 21, 24, 31, 32	Reline complete mandibular denture (laboratory)	Per appliance	1 unit per day	$100.00	No
D5760	27	All	11, 12, 21, 24, 31, 32	Reline maxillary partial denture (laboratory)	Per appliance	1 unit per day	$100.00	No
D5761	27	All	11, 12, 21, 24, 31, 32	Reline mandibular partial denture (laboratory)	Per appliance	1 unit per day	$100.00	No
PROSTHODONTICS, FIXED								
Other Fixed Partial Denture Service								
D6930	27	All	11, 12, 21, 24, 31, 32	Re-cement or re-bond fixed partial denture	Per appliance	1 unit per day	$30.00	No
D6980	27	All	11, 12, 21, 24, 31, 32	Fixed partial denture repair necessitated by restorative material failure	Per appliance	1 unit per day	$35.00	No
ORAL AND MAXILLOFACIAL SURGERY								
Extractions (Includes Local Anesthesia, Suturing If Needed, and Routine Postoperative Care)								
D7140	27	All	11, 12, 21, 23, 24, 31, 32	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Per tooth	1 per tooth per lifetime	$65.00	No
D7210	27	All	11, 12, 21, 23, 24, 31, 32	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Per tooth	1 per tooth per lifetime	$65.00	No
D7220	27	All	11, 21, 23, 24, 31, 32	Removal of impacted tooth – soft tissue	Per tooth	1 per tooth per lifetime	$90.00	Yes

D7230	27	All	11, 21, 23, 24, 31, 32	Removal of impacted tooth – partially bony	Per tooth	1 per tooth per lifetime	$170.00	Yes
D7240	27	All	11, 21, 24, 31, 32	Removal of impacted tooth – completely bony	Per tooth	1 per tooth per lifetime	$200.00	Yes
D7250	27	All	11, 21, 22, 24, 31, 32, 49	Removal of residual tooth roots (cutting procedure)	Per tooth	1 per tooth per lifetime	$100.00	Yes
Other Surgical Proceduress								
D7260	27	All	11, 21, 24, 31, 32	Oroantral fistula closure	Per procedure	1 unit per day	$75.00	No
D7270	27	All	11, 12, 21, 23, 24, 31, 32	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Per tooth	1 unit per day (Under 21 years of age only)	$320.00	No
D7280	27	All	11, 12, 21, 24, 31, 32	Exposure of an unerupted tooth	Per tooth	1 per tooth per lifetime (Under 24 years of age only	$80.00	Yes
D7283	27	All	11, 12, 21, 24, 31, 32	Placement of device to facilitate eruption of impacted tooth	Per tooth	1 unit per day (Under 24 years of age only)	$35.00	Yes
D7288	27	All	11, 12, 21, 24, 31, 32, 49	Brush biopsy – transephithelial sample collection	Per procedure	2 units per day	$34.50	No
Alveoplasty - Preparation of Ridge								
D7310	27	All	11, 21, 24, 31, 32	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Per quadrant	4 units per day	$ 30.00 1st quadrant $ 15.00 each, 2nd – 4th quadrant	No
D7320	27	All	11, 21, 24, 31, 32	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Per quadrant	4 units per day	$ 30.00 1st quadrant $ 15.00 each, 2nd – 4th quadrant	No

* Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

Excision of Intraosseous Lesions								
D7450	27	All	11, 21, 24, 31, 32	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Per lesion	2 units per day	$40.00	No
D7451	27	All	11, 21, 24, 31, 32	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Per lesion	2 units per day	$80.00	No
D7460	27	All	11, 12, 21, 24, 31, 32	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	Per lesion	2 units per day	$40.00	No
D7461	27	All	11, 21, 24, 31, 32	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Per lesion	2 units per day	$80.00	No
Excision of Bone Tissue								
D7471	27	All	11, 21, 22, 24, 31, 32	Removal of lateral exostosis – (maxilla or mandible)	Per procedure	2 units per day	$60.00	No
D7472	27	All	11, 12, 21, 24, 31, 32	Removal of torus palatinus	Per procedure	2 units per day	$60.00	No
D7473	27	All	11, 12, 21, 24, 31, 32	Removal of torus mandibularis	Per procedure	2 units per day	$60.00	No
D7485	27	All	11, 12, 21, 24, 31, 32	Reduction of osseous tuberosity	Per procedure	2 units per day	$60.00	No
Surgical Incision								
D7510	27	All	11, 12, 21, 24, 31, 32	Incision and drainage of abscess – intraoral soft tissue	Per procedure	2 units per day	$25.50	No
D7511	27	All	11, 12, 21, 24, 31, 32	Incision and drainage of abscess – intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Per procedure	2 units per day	$88.50	No

D7520	27	All	11, 12, 21, 24, 31, 32	Incision and drainage of abscess – extraoral soft tissue	Per procedure	2 units per day	$38.50	No
D7521	27	All	11, 12, 21, 24, 31, 32	Incision and drainage of abscess – extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Per procedure	2 units per day	$88.50	No
Other Repair Procedures								
D7871	27	All	11, 21, 24	Non-arthroscopic lysis and lavage	Per procedure	1 unit per day	$64.50	No
D7960	27	All	11, 12, 21, 24, 31, 32	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	Per procedure	2 units per day	$80.00	No
D7970	27	All	11, 12, 21, 24, 31, 32	Excision of hyperplastic tissue – per arch	Per arch	2 units per day	$80.00	No
D7999	27	All	11, 21, 24	Unspecified oral surgery procedure, by report	Per procedure	1 unit per day	$80.00	No
ORTHODONTICS								
Comprehensive Orthodontic Treatment								
D8080	27	273, 283	11	Comprehensive orthodontic treatment of the adolescent dentition	Per treatment	1 unit per day (Under 23 years of age only)	$1,000.00	Yes
Other Orthodontic Services								
D8660	27	273	11	Pre-orthodontic treatment examination to monitor growth and development	Per visit	1 per 365 days per provider (Under 21 years of age only)	$35.00	No
D8670	27	273, 283	11	Periodic orthodontic treatment visit	Per visit	1 unit per day (Under 23 years of age only)	$350.00	Yes

D8680	27	273	11	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Per visit	1 unit per day (Under 23 years of age only)	$150.00	Yes
Minor Treatment to Control Harmful Habits								
D8210	27	All	11, 24	Removable appliance therapy	Per procedure	1 per lifetime per arch (Under 21 years of age only)	$200.00	Yes
D8220	27	All	11, 24	Fixed appliance therapy	Per procedure	1 per lifetime per arch (Under 21 years of age only)	$200.00	Yes
CLEFT PALATE SERVICES The Department will pay one member of the Cleft Palate Treatment Team, and payment is inclusive of all providers.								
Ancillary Services for Provider Type 17,19, 20, 21, 27, 31								
D0160	17	173	11, 22, 49	Detailed and extensive oral evaluation – problem focused, by report.	Per visit	Complete initial examination at a Cleft Palate Clinic only involving all licensed staff	$120.00	No
	19	190	11, 22, 49					
	20	200	11, 22, 49					
	21	212,213	11, 22, 49					
	27	283	11, 22, 49					
	31	All	11, 22, 49					
D0170	17	173	11, 22, 49	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	Per visit	1 unit per day	$25.00	No
	19	190	11, 22, 49					
	20	200	11, 22, 49					
	21	212,213	11, 22, 49					

	27	283	11, 22, 49					
	31	All	11, 22, 49					
ADJUNCTIVE GENERAL SERVICES								
Unclassified Treatment								
D9110	27	All	11, 12, 23, 31, 32	Palliative (emergency) treatment of dental pain – minor procedure	Per visit	1 unit per day	$ 30.00	No
Anesthesia								
D9222	27	284	11	Deep sedation/general anesthesia – first 15 minutes	15 minutes	1 unit of service per day	$122.00	No
D9223	27	284	11	Deep sedation/general anesthesia – each subsequent 15 minute increment	15 minutes	2 units of service per day	$122.00	No
D9230	27	284, 285, 286	11	Inhalation of nitrous oxide/analgesia, anxiolysis	Per procedure	1 unit per day (Under 21 years of age only)	$44.00	No
D9239	27	284, 285	11	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	15 minutes	1 unit of service per day	$128.50	No
D9243	27	284, 285	11	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	15 minutes	2 units of service per day	$128.50	No
D9248	27	284, 285	11	Non-intravenous conscious sedation	Per procedure	1 unit per day	$184.00	No
Miscellaneous Services								
D9920	27	All	11, 12, 31, 32	Behavior Management Fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability – a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	per visit	1 unit per day; maximum 4 per calendar year	$125.00	No
D9930	27	All	11, 12, 23, 31, 32	Treatment of complications (post-surgical) – unusual circumstances, by report	Per procedure	1 unit per day	$15.00	No

S0215	27	271	12, 31, 32	Mileage - additional allowance for home, skilled nursing facility and ICF visits	Per mile	300 miles per day	$0.10	No
Maxillofacial Prosthetics								
21076	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation; surgical obturator prosthesis	Per appliance	1 unit per day	$387.00	No
21079	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: Interim obturator prosthesis	Per appliance	1 unit per day	$387.00	No
21080	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: definitive obturator prosthesis	Per appliance	1 unit per day	$387.00	No
21081	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: mandibular resection prosthesis	Per appliance	1 unit per day	$387.00	No
21082	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: palatal augmentation prosthesis	Per appliance	1 unit per day	$387.00	No
21083	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: palatal lift prosthesis	Per appliance	1 unit per day	$387.00	No
21084	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: speech aid prosthesis	Per appliance	1 unit per day	$387.00	No
21085	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: oral surgical splint	Per appliance	1 unit per day	$387.00	No
21086	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: auricular prosthesis	Per appliance	1 unit per day	$387.00	No
21087	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: nasal prosthesis	Per appliance	1 unit per day	$387.00	No
21088	27	All	11, 21, 22, 24, 49, 99	Impression and custom preparation: facial prosthesis	Per appliance	1 unit per day	$387.00	No

6 Prior Authorization

The Prior Authorization process for dental providers is described in this section. Along with the general information, this section includes the services that require prior authorization as well as the procedures to obtain prior authorization. Special guidelines for specific services are outlined here, as well as instructions on how to complete the ADA Claim Form – Version 2012 to obtain prior authorization. The final sections detail the procedure to transfer previously approved dental treatment to another MA enrolled dentist and examples of completed dental prior authorization requests.

6.1 General Information

Services and procedures that require prior authorization are identified in the Medical Assistance Program Fee Schedule with the suffix "**PA**" following the MA fee.

6.1.1 DENTAL FEE SCHEDULE AND BENEFITS

The Department limits the following dental services for beneficiaries 21 years of age and older, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC:

- Periodic oral evaluation will be limited to one (1) per 180 days, per beneficiary. Additional oral evaluations will require a Department approved BLE request.

  NOTE: Comprehensive oral evaluation will not be paid if rendered within the same 180-day time period.

- Prophylaxis, adult will be limited to one (1) per 180 days, per beneficiary. Additional prophylaxis will require a Department approved BLE request.

- Dentures will be limited to one per upper arch, regardless of procedure code) (full or partial denture) and one per lower arch, regardless of procedure code (full or partial denture) **per lifetime**. The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015. Additional dentures will require a Department approved BLE request.

Beneficiaries over 21 years of age, **who do not reside** in a nursing facility, an ICF/ID or ICF/ORC, will only be eligible for the following services if the Department approves a Benefit Limit Exception (BLE) request.

- Crowns and adjunctive services
- Periodontic services
- Endodontic services

Services requiring prior authorization include:

1. Orthodontics,
2. Complete and partial dentures,
3. Surgical extractions,

4. Placement of device to facilitate eruption of impacted tooth,
5. Crowns, and
6. Periodontal services except full mouth debridement, which requires post-operative review.

(See Section 6.3 for a comprehensive listing of services requiring prior authorization by category and procedure code.)

This section of the handbook explains the process for obtaining prior authorization for the above services. Orthodontic prior authorization is explained in Section 7 of this handbook.

NOTE: An approved prior authorization request means only that the "service" was determined medically necessary. The prior authorization is for the service only, not for the place of service. If providing service in an inpatient hospital, hospital short procedure unit or free-standing ambulatory surgical center, payment is dependent upon the Department's authorization approval of the admission.

An approved request does not guarantee the beneficiary's continued MA eligibility. **It is the responsibility of the provider to verify the beneficiary's eligibility; not only on the date the service is requested, but also on the date the service is performed.**

MA does not cover restorations, procedures or appliances done to alter vertical dimension. Such procedures include, but are not limited to, those done primarily for replacement of tooth structure lost by attrition, realignment of teeth, splinting, equilibration, full mouth rehabilitation, and treatment of temporal mandibular joint syndrome. The beneficiary must be informed prior to service delivery that the Department does not cover the service. If performed, the service must be done with agreement from the beneficiary to assume all costs of same.

6.2 Authorization Process

Described briefly, the process for obtaining Department authorization for services is as follows:

Request – The dentist completes the ADA Claim Form - Version 2012, for any services that require prior authorization.

The dentist submits the ADA claim form, all required radiographs and information to justify medical necessity for the requested service(s) in the ENV 320 envelope or an envelope large enough to accommodate all of the required documentation without folding to:

Department of Human Services
Office of Medical Assistance Programs
P.O. Box 8050
Harrisburg, PA 17105-8187

All radiographs should be placed in the X-ray envelope (ENV 98) prior to mailing.

Determination - Upon receipt of the required documents, the Department will either approve or disapprove the request for prior authorization. The dentist is notified of the approval or denial on the "Prior Authorization Notice" (MA 328).

Payment - After the service is approved and rendered, the provider may bill the Department. The ADA Claim Form - Version 2012 is completed in accordance with the instructions for completing claim forms in this handbook.

6.3 Services Requiring Prior Authorization

The following procedures require prior authorization.

Services Requiring Prior Authorization			
Procedure	Procedure Code	Procedure	Procedure Code
Crowns	D2710 D2721 D2740 D2751 D2791	Surgical Extractions	D7220 D7230 D7240 D7250
Periodontics	D4210 D4341 D4355 ** D4910	Other Surgical Procedures	D7280
Complete Dentures	D5110 D5120 D5130 D5140	Partial Dentures	D5211 D5212 D5213 D5214
Placement of device to facilitate eruption of impacted tooth.	D7283	Orthodontics	D8080 D8210 D8220 D8670 D8680

The above services must be accompanied by a full mouth periapical or a panorex and current radiograph(s) of the affected area(s). Exceptions to this rule are noted in Section 6.4, Special Guidelines, which follows.

******The Department requires the dentist to secure post-operative review approval for procedure code D4355. The dentist is to submit for post-operative review through the prior authorization program. The procedure name and procedure code must match and accurately describe the requested service(s).

6.4 Special Guidelines

6.4.1 Crowns

a. Radiological films for proposed crowns or abutment teeth must have acceptable views of adjacent and opposing teeth.

b. Molars must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps.

   Anterior teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge.

   Bicuspids (premolars) must have pathological destruction to the tooth by caries or trauma and must involve three (3) or more surfaces and one (1) cusp.

c. When submitting a request for a crown following a root canal, the following conditions must be met:

   1. a one month period of time must elapse between the date a root canal is completed and the date that the request for a crown is submitted;
   2. a periapical film must be taken and submitted to show the root and crown of the natural tooth;
   3. the tooth is filled within two millimeters of the radiological apex; and
   4. the root canal filling material is not filled beyond the radiographical apex.

d. The beneficiary must be free from active and advanced periodontal disease.

e. Crowns must be opposed by teeth in the opposite jaw or be a support for a partial.

f. Crowns for primary teeth will not be covered if the radiograph indicates imminent exfoliation.

g. Crowns will not be approved when lesser means of restoration is possible.

h. The dentist should impress upon the beneficiary the importance of taking care of a crown. Crowns that are dislodged, broken, or lost are not sufficient justification for replacement.

6.4.2 Complete Dentures

a. A Prior Authorization Request for a denture(s) should be based on:

   1. the total condition of the mouth;
   2. the ability of the beneficiary to adjust to a denture(s); and
   3. the desire of the beneficiary to wear a denture(s).

b. Where essential preparatory services of any type are a part of an approved complete or partial denture treatment plan, those services must be completed before the denture service itself is initiated, including prior authorization of any teeth requiring extraction.

c. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.

d. Dentures must be fabricated for a specific beneficiary with individually positioned teeth, wax up of the entire denture body and conventional laboratory processing.

NOTE: Complete dentures for nursing facility beneficiaries - This procedure is to be used for requesting complete denture only:

When a beneficiary is a resident of a nursing facility and the medical condition is such that the beneficiary cannot be moved from a room of the facility to obtain the needed radiographs, a Dental Services Certification form (available through the nursing facility) can be submitted, in lieu of radiographs, with the ADA Claim Form - Version 2012. When submitting a request with a certification form, the treatment plan should contain sufficient detail for a thorough diagnostic review. The Dental Certification form must be completed and signed. Enter the statement "DENTAL CERTIFICATION FORM SUBMITTED IN LIEU OF RADIOGRAPHS" in the Remarks section of the ADA Claim Form - Version 2012.

6.4.3 Partial Dentures

a. The treatment plan must identify all teeth that are going to be placed on the partial denture.

b. Abutment teeth must be at least 50% supported by bone.

c. The dentist should impress upon the beneficiary the importance of taking care of dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.

6.4.4 Extractions

a. Surgical

   1. The surgical extraction is not a simple extraction. Surgical extractions require an incision of overlaying soft tissue, elevation of flap, and/or removal of bone, the removal of teeth, and possibly sectioning of the teeth.

   2. Surgical extraction will be for fully developed permanent teeth causing or threatening to cause irreversible damage.

3. Routine removal of impacted or unerupted teeth must be supported by pathology.

   A. Lesions associated with impaction

   B. Threat of resorption of root of permanent adjacent tooth

b. Procedure Code Identification

1. Refer to the following illustrations to determine the appropriate MA Procedure Code for prior authorization.

   A. Complete Bony Impaction

   The occlusal surface of the crown of the tooth is completely encased in bone, and requires bone removal and/or sectioning of the tooth in order to remove the tooth.

   B. Partial Bony Impaction

   The occlusal surface of the crown of the tooth is sufficiently covered with bone to require removal of bone and/or sectioning to remove it from its bony crypt. In this case, the crown is partially covered by bone.

   C. Soft Tissue Impaction

   The occlusal surface of the crown of the tooth is partially or completely covered by soft tissue, which is incised and/or retracted from bone to remove the tooth.

   D. Root Recovery

   Surgical removal of a residual root completely covered by bone. A root remains with bony tissue grown over the space, which was once occupied by the coronal portion of the tooth.

NOTE: If a fee for tooth extraction was previously paid, no additional payment will be made for a subsequent root recovery involving the same tooth.

6.4.5 Periodontal Services

a. Gingivectomy or Gingivoplasty - per quadrant

1. The procedure is medically necessary for the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Severe gingival hyperplasia interferes with or restricts the ability to perform effective daily oral hygiene procedures.
2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:

A. Comprehensive periodontal evaluation (e.g., description of periodontal tissues, pocket depth chart, tooth mobility, mucogingival relationships), and

B. Pertinent medical and dental history (e.g., medications), and

C. Objective evidence of severe gingival hyperplasia restricting the ability to perform effective daily oral hygiene procedures, or

D. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.

E. Exceptions to established limits may be granted if documentation presented indicates recurrence of severe gingival hyperplasia within a two-year period due to inability to alter medications.

b. Periodontal scaling and root planing - per quadrant

1. The procedure is medically necessary to:

A. Reduce clinical inflammation as evidenced by edema, erythema of the gingival, generalized bleeding on probing, spontaneous bleeding reported by beneficiary, or by purulent gingival discharge;

B. Effectuate microbial shifts to a less pathogenic, subgingival flora;

C. Reduce probing depths when pocket depth is equal to or greater than 5mm or in the presence of clinical inflammation (see a above) following routine prophylaxis; and/or

D. Gain clinical attachment.

2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:

A. Comprehensive periodontal evaluation (e.g., description of periodontal tissue, pocket depth chart, tooth mobility, mucogingival relationships), and

B. Current diagnostic radiographs demonstrating evidence of bone loss, and

C. Narrative/documentation of clinical information, including pocket depth(s) of 5mm or greater except in cases of medication related gingival hyperplasia or persistent inflammation characterized by generalized bleeding on probing (multiple bleeding points present per tooth on at least ½ of remaining dentition per quadrant), or

D. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.

E. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene.

c. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis **the dentist is required to secure post-operative review and approval from the Department through the prior authorization program.**

1. The procedure is medically necessary for removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an oral evaluation. A preliminary procedure that does not preclude need for other procedures.

2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:

A. Radiographs for diagnostic purposes demonstrating evidence of gross calculus buildup (radiographically visible calculus involving at least 75% of remaining dentition), or

B. In lieu of radiographs, documentation is presented indicating treatment was provided under general anesthesia or intravenous sedation, or radiographs were not obtainable due to the beneficiary's medical status, or

C. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.

D. Exception to established limitations may be granted if objective evidence is presented indicating beneficiary is unable to perform effective daily oral hygiene procedures due to medical status.

d. Periodontal maintenance procedures following active treatment (this excludes full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit)

1. The procedure is medically necessary to:

A. Prevent or minimize the recurrence and progression of periodontal disease in beneficiaries who have been previously treated for periodontitis;

B. Prevent or reduce the incidence of tooth loss by monitoring the dentition and any prosthetic replacements of the natural teeth; and

C. Increase the probability of locating and treating, in a timely manner, other diseases or conditions found within the oral cavity.

2. If the following criteria are met in the professional judgment of the reviewer, this service will be approved:

   A. Documentation of previous periodontal treatment, and

   B. Continuous documentation of significant hard and soft tissue changes (e.g., changes in pocket depth greater than or equal to 2mm), or

   C. Other documentation of objective evidence of clinical condition whose severity is consistent with above criteria.

   D. Exceptions to established limitations will not be granted due to lack of beneficiary compliance and/or continued poor oral hygiene.

6.4.6 Endodontic Therapy (Root Canals)

a. Payment for root canals no longer requires post-operative review for prior authorization approval.

b. Root canals are not covered in the following situations:

   1. Intentional (elective) endodontics;

   2. Third molar (unless it is an abutment tooth);

   3. Teeth with advanced periodontal disease;

   4. Teeth with subosseous and/or furcation carious involvement;

   5. Teeth which cannot be restored with conventional methods (i.e., amalgam, composite or crowns); or

   6. Teeth, which have received prior endodontics treatment.

6.5 How to Complete the ADA Claim Form - Version 2012 for a Prior Authorization and a Dental BLE Request

Please click the following link for detailed instructions on completing the ADA Claim Form – Version 2012 for Prior Authorization and a Dental BLE Request:

http://www.dhs.pa.gov/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm

6.6 Administrative Waiver (Program Exception)

The Department, under extraordinary circumstances, will pay for a medical service or item that is not one for which the MA Program has an established fee, or will expand the limits for services or items that are listed on the MA Program Fee Schedule. If a provider concludes that lack of the service or item would impair the beneficiary's health, the provider may request an 1150 Administrative Waiver or Program Exception (PE).

6.6.1 Services and Items Requiring 1150 Administrative Waiver

Services and items not listed on the MA Program Fee Schedule require an 1150 Administrative Waiver. An 1150 Administrative Waiver is also required for the expansion of the limits for services and items that are listed on the MA Program Fee Schedule.

6.6.2 Procedure for Obtaining 1150 Administrative Waiver

When an MA beneficiary has the need for a service(s) or item(s) requiring an 1150 Administrative Waiver, the dentist completes the 1150 Waiver section of the Outpatient Service Authorization Request (MA 97).

The dentist submits the MA-97 form, all required radiographs and information to justify medical necessity for the services in an envelope large enough to accommodate all of the required documentation without folding to:

Outpatient
PA/1150 Waiver Services
P.O. Box 8187
Harrisburg, PA 17105-8187

All radiographs should be placed in the X-ray envelope (ENV 98) prior to mailing.

Upon receipt of the required documentation, the Department will either approve or disapprove the request for a program exception. The dentist is notified of the approval or denial on the "Program Exception Notice" (MA 481).

If the request is approved, the dentist may bill the Department after the service is rendered. The ADA Claim Form - Version 2012 is completed in accordance with the instructions for completing claim forms in this handbook.

6.7 How to Complete the Outpatient Service Authorization Request Form (MA 97) for an 1150 Administrative Waiver

The MA 97 is a snapset form. The original (Department Copy) is to be submitted for processing, while the copy (Provider Copy) is to be retained in the beneficiary's dental record. Instructions for completing the form can also be found on the back of the MA 97 cover page.

Item 1. Prior Authorization (LEAVE BLANK)

Item 2. 1150 Waiver (Program Exception) (MUST) Place a checkmark in this block.

PATIENT INFORMATION

Items 3 through 6 are to be completed using information obtained from the Eligibility Verification System (EVS)

Item 3. Beneficiary Number (MUST)

Enter the 10-digit beneficiary identification number.

Item 4. Patient's Name (Last, First, MI) (MUST)

Enter the beneficiary's last name, first name, and middle initial.

Item 5. Birthdate (MMDDCCYY) (MUST)

Enter the beneficiary's birthdate in an 8-digit format.

Item 6. Sex (OPTIONAL)

Check the appropriate box, "M" (male) or "F" (female)

PROVIDER/PRESCRIBER INFORMATION

Items 7 through 10 are to be completed using the information found on the provider's Medical Assistance "Provider Notice Information Form".

Item 7. Provider Name (MUST)

Enter the provider's last name, first name, and middle initial.

Item 8. Provider Number/Service Location (MUST)

Enter the provider's 9-digit Provider Identification Number and 4-digit Service Location.

Item 9. Provider's Own Reference No. (OPTIONAL)

Enter your own reference number or beneficiary's name to comply with the provider's filing system.

Items 10 and 11 will only be completed if the payment for services will be sent to someone other than the dentist providing the services. A group/payee must be enrolled with the Department.

Item 10. Group Name (IF APPLICABLE)

Enter the name of the person, group, or organization designated to receive payment.

Item 11. Group Number/Service Location (IF APPLICABLE)

Enter the group/payee's 9-digit Provider Identification Number and 4-digit Service Location.

Items 12 through 16 refer to the Referring Practitioner, if applicable.

Item 12. Name of Referring Practitioner or Prescriber (IF APPLICABLE)

Enter the name of the referring practitioner, if applicable. Enter the first name, middle initial and last name, followed by degree.

Item 13. License Number (IF APPLICABLE)

Enter the referring practitioner's professional license number.

Item 14. Specialty (IF APPLICABLE)

Enter the referring practitioner's area of professional specialty.

Item 15. Telephone Number (IF APPLICABLE)

Enter the referring practitioner's telephone number, including area code. The referring practitioner may be contacted if additional information is needed by the Department.

Item 16. Practitioner's/Prescribing Physician's Street Address (IF APPLICABLE)

Enter the referring practitioner's street address to which the approval or denial notice is to be mailed. Make sure the address is correct and complete.

Item 17. Primary Diagnosis (LEAVE BLANK)

Item 18. ICD-10-CM Diagnosis (LEAVE BLANK)

Item 19. Secondary Diagnosis (LEAVE BLANK)

Item 20. ICD-10-CM Diagnosis (LEAVE BLANK)

REQUESTED SERVICES (Items 21A through 26G)

Item 21A Description of Services/Supplies Requested (MUST)

Enter a description of the service or item or use CDT-4 procedure name terminology. If a CDT-4 procedure code is available, please include it in the description.

Item 21B Procedure Code (LEAVE BLANK)

Item 21C Modifier (LEAVE BLANK)

Item 21D Quantity (LEAVE BLANK)

Item 21E Amount Per Unit (MUST)

Enter the exact dollar amount requested for each service.

Item 21F Quantity per Month (MUST)

Enter the exact quantity of services requested.

Item 21G Number of Months (LEAVE BLANK)

Related items 22A through 26G MUST be completed when additional services are requested. Complete as described in Items 21A through 21G.

Item 27A Estimated Length of Need (No. of Months) (IF APPLICABLE) If the service will be needed over a period of months, enter the number of months the beneficiary is expected to need the service (Enter 1-99; 99=Lifetime).

Item 27B Initial Date of Service (MMDDCCYY) (LEAVE BLANK)

Item 27C Beginning Date of Service for This Request (MMDDCCYY) (MUST)

Enter the date that the service being requested is scheduled to begin using an 8-digit format. If the service will be provided only once, enter the date the service will be provided.

Item 28 What Other Alternatives Have Been Tried or Used to Meet This Patient's Needs? (MUST)

Attach documentation of alternatives which have been tried and justify the need for the service(s) requested in Items 21A through 26G. If no alternatives have been tried or used, indicate "N/A".

Item 29 Check the Box Which Applies to This Patient's Current Residential Status (MUST) Check the appropriate box to indicate where the beneficiary resides.

Item 30 Justification Needed for the Evaluation of This Request (MUST)

Give a narrative description of the specific symptoms or abnormalities the services/equipment/supplies are intended to alleviate.

This item must contain sufficient documentation to justify the medical necessity for all requested services. If additional space is needed, please attach additional sheets of paper. The additional pages should be 8 ½" X 11".

The Program Exception request for dental services must be performed as part of a complete dental treatment program and must be accompanied by a detailed treatment plan. The treatment plan must include all of the following:

- 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;
- 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.

Note: For those Service Programs where dental services are limited to services provided in an inpatient hospital, hospital short procedure unit or ambulatory surgical center, please include a statement identifying where the service will be provided.

Item 31. Number of Attachments (IF APPLICABLE)

Indicate the number of attachments, including radiographs that are being submitted with the MA 97. For example, if you attached two additional pages to include additional treatment plan information and a Panorex, you would enter a "3".

Item 32. Resubmission of Previously Denied Request (IF APPLICABLE)

If this is a resubmission of a previously denied request, enter an "X" in this field and the previously denied Program Exception (PE) Reference Number from the "Program Exception Notice" (MA 481) in the space provided.

Item 33. Initial Request (IF APPLICABLE)

If this is the initial request, enter an "X" in this field.

Item 34. Signature of Patient/Authorized Representative (MUST)

The patient or authorized representative MUST sign the MA 97.

Item 35. Date (MMDDCCYY) (MUST)

The patient or authorized representation must enter the date the MA 97 was signed in 8-digit format.

Item 36. Practitioner's/Prescriber's Signature (MUST)

It is essential that the practitioner requesting the service/item sign or use his/her signature stamp on the MA 97.

Item 37. Date (MMDDCCYY) (MUST)

The practitioner must enter the date the MA 97 was completed in 8-digit format.

6.8 Dental Benefit Limit Exception (BLE) Request

6.8.1 Services and Items Requiring a BLE Request

The Department limits the following dental services for beneficiaries 21 years of age and older, **who do not reside** in a nursing facility, an Intermediate Care Facilities for individuals with intellectual disability (ICF/ID) or ICF/ORC:

- Periodic oral evaluation is limited to one (1) per 180 days, per beneficiary. Additional oral evaluations will require a Department approved BLE request.
- Prophylaxis, adult is limited to one (1) per 180 days, per beneficiary. Additional prophylaxis will require a Department approved BLE request.
- Dentures will be limited to one per upper arch, regardless of procedure code (full or partial denture) and one per lower arch, regardless of procedure code (full or partial denture) **per lifetime**. The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015. Additional dentures will require a Department approved BLE request.

Beneficiaries over 21 years of age, **who do not reside** in a nursing facility, an Intermediate Care Facilities for individuals with intellectual disability (ICF/ID) or ICF/ORC, will only be eligible for the following services if the Department approves a BLE request.

- Dentures (when the limit has been exceeded)
- Crowns and adjunctive services
- Periodontic services
- Endodontic services

The Department will approve a BLE request to any of the dental limits described above when one of the following circumstances applies:

- The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the beneficiary;
- The Department determines the beneficiary has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the beneficiary;
- The Department determines that approving a specific exception is a cost-effective alternative for the MA Program; or,
- The Department determines that approving an exception is necessary in order to comply with Federal law.

Services provided beyond a recipient's benefit limits are not covered, unless a BLE is requested and approved by the Department.

6.8.2 Procedure for Obtaining Benefit Limit Exception

The provider must submit an ADA Claim Form completed in compliance with the instructions in Section 6.5, as the provider would when requesting prior authorization, and attach a completed Dental Benefit Limit Exception (BLE) Request Form (MA 549)

The provider must indicate "Dental BLE Attached" in Box 35 - Remarks Section.

The request must include documentation supporting the need for the service, including but not limited to chart/record documentation, diagnostic study results, radiographs (if applicable), comprehensive medical and dental history. The Department will notify the provider and beneficiary of its decision within 21 days after receiving a prospective BLE request, or within 30 days after receipt of a retrospective BLE request. A retrospective request for a dental benefit limit exception must be submitted no later than 60 days from the date the Department rejects the claim because the service is over the benefit limit. Retrospective exception requests made after 60 days from the claim rejection date will be denied.

Providers must submit the completed forms and supporting documentation by mail to the Department at:

Office of Medical Assistance Programs
Fee-for-Service Program
Dental Benefit Exception Review
P.O. Box 8187
Harrisburg, PA 17105

Dental providers MUST INCLUDE the BLE authorization number in the appropriate field of the application claim submission modality.

NOTE: The provider may not seek payment from the MA beneficiary for a service that is over a benefit limit unless:

- The provider informed the beneficiary before providing the service that the service may be above the benefit limit, in which case it would not be covered unless the Department grants an exception;
- The provider submitted a request for an exception to the benefit limit; and,
- The Department denied the BLE request.

6.8.3 APPEALS PROCESS

The Department will issue a written Notice of Decision for BLE requests to the beneficiary and provider. Providers may only appeal the Department's denial of a retrospective BLE request. Providers may file an appeal of a denial of a retrospective BLE request within 30 days from the date of the denial notice to the address listed on the notice of decision.

6.9 Transfer of Previously Approved Dental Treatment

- Within a Group Practice

  If a dental service has been approved for one provider in a group and now another provider within the same group wants to perform the service, the new provider must submit a new ADA Claim Form - Version 2012, including the prior authorization number of the previously approved request and stating the reason for the requested transfer. X-rays are not required when requesting the exact services previously approved. Enter the statement "TRANSFER OF PREVIOUSLY APPROVED DENTAL TREATMENT" in the Remarks section of the ADA Claim Form - Version 2012.

- Transfer Between Unrelated Providers

  If a dental service has been approved for one provider and beneficiary goes to a new provider for the service, the new provider must submit a new ADA Claim Form - Version 2012, stating the reason for the new request. Include the previous provider's name, if known, and the previous prior authorization number. X-rays are not required when requesting the exact service previously approved. Enter the statement "TRANSFER OF PREVIOUSLY APPROVED DENTAL TREATMENT" in the Remarks section of the ADA Claim Form - Version 2012.

Important - Please Note:

If new services, in addition to those previously approved are being requested as part of a transfer, a treatment plan justifying all requested services and radiographs must be submitted.

If more than 180 days has passed from the date of the original approval and/or the original approval has expired, the new request must include an updated treatment plan and the required radiographs.

6.9.1 Treatment

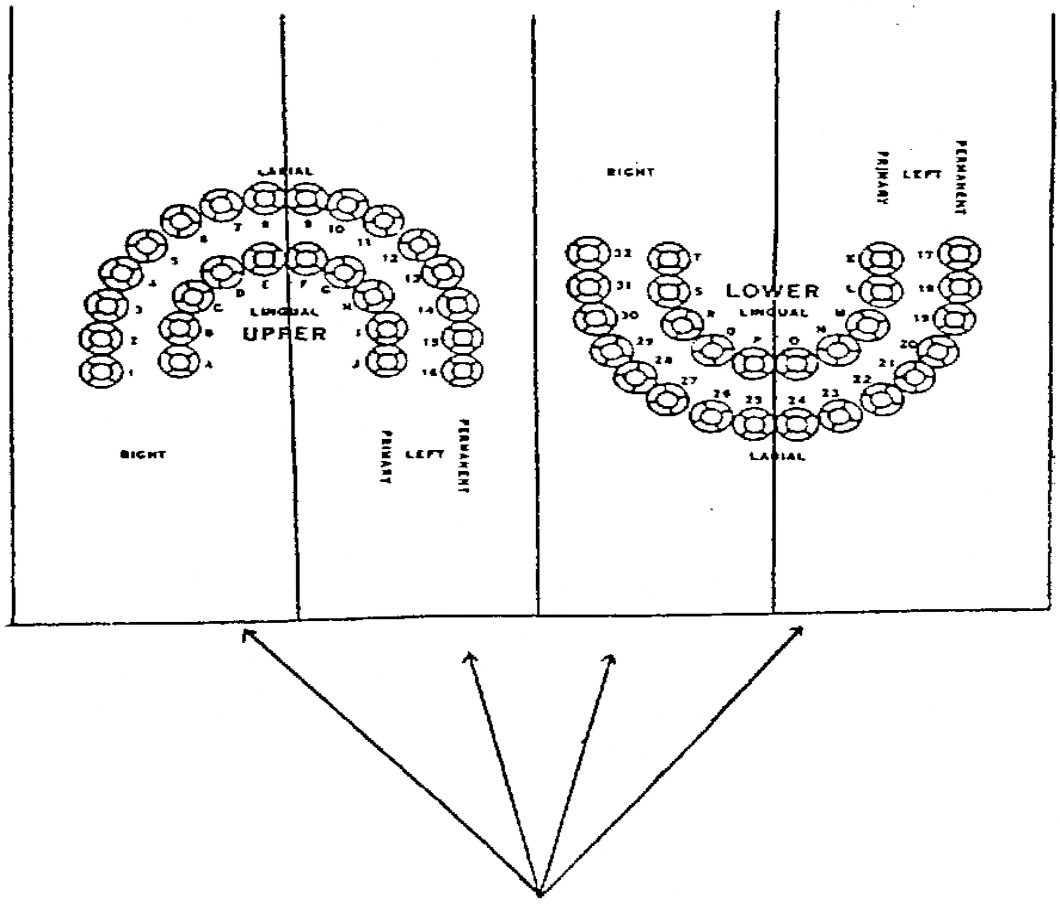
For each approved quarter of orthodontic treatment, the orthodontist must submit an original ADA Claim Form - Version 2012 for payment. Providers should retain a copy of the submitted claim form for their records.

6.9.2 Diagnostic Aids

An orthodontist can bill for diagnostic aids (Procedure Code D8999) *only if* the beneficiary meets all of the requirements for orthodontic treatment listed on page 81, but the Department determined the beneficiary is ineligible for orthodontic treatment.

Bill for diagnostic aids *after* receiving the denial notification. When billing for diagnostic aids, **enter the Prior Authorization Reference Number from the MA 328 in the "Remarks" section of the ADA Claim Form - Version 2012**. 2.3

HOW TO IDENTIFY QUADRANTS



EACH AREA EQUALS 1 QUADRANT

8 Special Billing Information

8.1 Dental Anesthesia/Sedation

A dentist is eligible for payment only for deep sedation general anesthesia), intravenous (I.V.) conscious sedation/analgesia, non-intravenous conscious sedation and analgesia, anxiolysis, inhalation of nitrous oxide provided in the dentist's office or a dental clinic in conjunction with a compensable surgical procedure.

Inhalation of nitrous oxide and non-intravenous conscious sedation are only compensable for eligible beneficiaries under 21 years of age. These procedure codes are compensable in conjunction with the dental treatment of the mentally, physically, or medically compromised beneficiary or those whose psychological or emotional maturity limits the ability to undergo successful dental treatment.

The person responsible for the administration of the deep sedation general anesthesia, inhalation of nitrous oxide, conscious I.V. sedation/analgesia and non-intravenous conscious sedation must be in compliance with all rules, regulations, certifications and licensure as indicated by the Pennsylvania State Board of Dentistry. **A current copy of the dentist's anesthesia permit must be on file with the Department**.

8.1.1 Inpatient Anesthesia/Sedation

A dentist is not eligible for payment for anesthesia/sedation services provided in a hospital short procedure unit, a hospital emergency room, an ambulatory surgical center or on an inpatient basis.

The Department will pay a physician for anesthesia services when dental services are provided in a hospital short procedure unit, ambulatory surgical center, emergency room or inpatient hospital.

8.1.2 Outpatient Anesthesia/Sedation

Payment of the management fee precludes payment for outpatient deep sedation/general anesthesia, intravenous conscious sedation, non-intravenous conscious sedation, or analgesia, anxiolysis, inhalation of nitrous oxide on the same date of service.

8.1.2.1 General Information

Payment for outpatient anesthesia/sedation is made to the dental provider or the dental clinic only if:

a. The condition of the beneficiary and/or the nature of the oral surgery is such that the use of local anesthesia is not practical;

b. It is medically necessary;

c. The qualifications of the dentist and the office facilities are such that the administration of anesthesia/sedation will not cause undue risk to the beneficiary; *and*

d. The general anesthesia was administered by a properly supervised Certified Registered Nurse Anesthetist.

8.1.2.2 Documentation

A statement must be included in the Remarks section of the invoice justifying the use of anesthesia/sedation on the basis of the beneficiary's condition and/or the nature of the oral surgery plus medical necessity. If the procedure performed is one of the surgical procedures identified in the MA Program Fee Schedule, medical necessity does not have to be documented.

The following procedures are considered "surgical procedures" in the MA Program Fee Schedule:

- D3410 through D3426
- D7450 through D7970
- 10060 through 10140
- 11010 through 11012
- 11310 through 20150
- 20520 through 20525
- 20661 through 21088
- 21116 through 21510
- 21555 through 23930
- 29804 through 30020
- 30110 through 31267
- 40500 through 40805

- 40810 through 41018
- 41110 through 42000
- 42104 through 42340
- 42408 through 42510
- 42600 through 42955
- 64600 through 64872
- 67840 through 67966

Pedodontists and Oral Surgeons must also adhere to the guidelines specified above. However, the only documentation required is a statement in the Remarks section, explaining that the dentist is a Pedodontist or Oral Surgeon.

8.1.2.3 What constitutes acceptable documentation for the condition of the beneficiary or the nature of the oral surgery to justify anesthesia/sedation?

a. Child is under 5 years of age and more than one simple extraction or surgical extraction is performed.

b. Beneficiary has medical conditions that preclude the use of local anesthesia.

c. Severe infection at the injection site.

d. Beneficiaries with intellectual disability, other mental health or physical conditions and who are unmanageable using local anesthesia.

e. Multiple extractions in more than one quadrant. If the treatment is simple or surgical extractions, two or more quadrants must have had at least two teeth extracted per quadrant *or* three or more quadrants had at least one tooth extracted per quadrant. Medical Assistance uses the diagram on page 89 to identify quadrants.

8.1.2.4 What constitutes acceptable documentation to justify medical necessity?

a. Severe infection at the injection site.

b. Severe cerebral palsy, unmanageable.

c. Severe intellectual disability, unmanageable.

NOTE: A DEFINITIVE DIAGNOSIS AND SECONDARY DIAGNOSIS ALONG WITH DOCUMENTATION OF THE STATEMENTS UNDER THE REMARKS SECTION MUST BE SUBSTANTIATED IN THE BENEFICIARY'S MEDICAL RECORD. THESE CLAIMS ARE SUBJECT TO REVIEW FOR MEDICAL NECESSITY.

8.1.2.5 Examples of unacceptable documentation:

a. Beneficiary unable to tolerate the procedure.

b. Beneficiary prefers or requests general anesthesia.

c. Beneficiary wants to be asleep.

d. Additional invoicing requirements

Dental practitioners who administer and bill the Department for anesthesia/sedation when performing outpatient surgical procedures or tooth extractions (warranting anesthesia/ sedation) *must* bill for the surgical extractions and the anesthesia/sedation on the same invoice.

Any substantiating documentation to justify payment for the anesthesia must be included in the Remarks section of the claim form.

8.2 Outpatient Surgical Services

8.2.1 Alveolectomy/Alveoloplasty

Alveolectomy/alveoplasty services) 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.

8.2.2 Excision of Hyperplastic Tissue

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.

8.3 Medications, Palliative Treatment and Prescriptions

a. 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.

b. Palliative (emergency) treatment of dental pain may not be billed in addition to any other treatment or dental service (excluding dental radiographs used to determine appropriate dental care), on the same day.

c. The Department requests that you put your license number on prescriptions/orders for MA beneficiaries. 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.

8.4 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 Number or Letter(s) field (Item 27) of the ADA Claim Form - Version 2012.

8.5 Homebound, Nursing Facilities

Dental services are available for eligible beneficiaries in the home or nursing facility.

When completing the claim form, be certain to indicate the appropriate place of service (Item 38 on the ADA Claim Form - Version 2012).

8.6 Transportation (Mileage)

Procedure Code S0215 may be billed when service is provided in the beneficiary's home or a nursing 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 beneficiaries in the same relative vicinity are visited on a continuous trip, the mileage allowed is for the call to the beneficiary 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.

8.7 Dental Procedures for Special Situations

8.7.1 Beneficiary fails to return for completion of service

When the dentist has received prior authorization for crowns or dentures and the beneficiary 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 beneficiary and make an appointment. If the dentist is unable to contact the beneficiary after thirty (30) days, in spite of repeated attempts, which must be documented in the beneficiary's treatment record, the dentist must send a letter to the beneficiary and the appropriate County Assistance Office.

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

8.7.2 Beneficiary loses eligibility

When billing the Department for a prior authorized custom-made crown or denture for which the impression was taken while the beneficiary was eligible, but was not inserted in the beneficiary's mouth before the beneficiary 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 2012.

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

8.8.1 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.

8.8.2 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 beneficiary 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 beneficiary. Finally, the condition of the beneficiary 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 beneficiary 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 beneficiary'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 beneficiary'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 beneficiary and/or the nature of the oral surgery may entail undue risk to the beneficiary 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 beneficiary without hospitalization); or

   B. A beneficiary presents a medically compromising condition that would endanger the physical health of the beneficiary without hospitalization; or

   C. Beneficiary 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 beneficiary 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 CLAIM FORM.

8.9 Consultations

A referral to another practitioner does not constitute a consultation. For example, when a dentist refers a beneficiary 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 beneficiary is referred to another practitioner, the medical record must indicate the name of the practitioner and the reason for the referral.

8.9.1 Procedure codes

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

8.9.2 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 nursing 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.

8.10 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" (Field 29) on the ADA Claim Form - Version 2012. The letters **"ASST SURG"** and the **procedure code indicating the actual surgery performed** *must* be entered in the "Remarks" (Field 35) section of the ADA Claim Form - Version 2012.

8.11 Other Billing Information

8.11.1 General Policies

Children under 21 years of age are eligible for all medically necessary dental services. For children under 21 years of age who require medically necessary dental services beyond the fee schedule limits, the dentist should request a waiver of the limits, as applicable, through the 1150 Administrative Waiver (Program Exception) process.

8.11.2 Preventive Services

Treatment guidelines for "Interim Caries arresting medicament application – per tooth" are as follows:

- High caries-risk patients with anterior or posterior active cavitated lesions;
- Cavitated caries lesions in individuals presenting with behavioral or medical management challenges;
- Patients with multiple cavitated caries lesions that may not all be treated in one visit;
- Difficult to treat cavitated dental caries lesions; or
- Active cavitated caries lesions with no clinical signs of pulp involvement.

The number of teeth treated should be based on the clinical evaluation. The presence of an active cavitated carious lesion in the tooth is required for treatment.

Re-evaluation and retreatment is allowed once within a 6 month period for the same patient without prior authorization. The second visit should occur at least two weeks after the initial visit.

Further retreatment of the same teeth after the second treatment visit is limited to after 12 months from the initial visit.

8.11.3 Restorations

The Department considers two or more restorations on the same surface of a tooth to be one restoration. Providers are to bill for only one restoration per tooth.

The Department's payment for restoration and filling include local anesthesia, polishing, bonding agents, cement bases, acid etch, light cured material and the necessary medications when indicated.

8.11.4 Sealants

The Department limits sealants to children under 21 years of age as follows:

(1) 1st premolars (tooth numbers 5, 12, 21, 28) and 2nd premolars (tooth numbers 4, 13, 20, 29);

(2) permanent first molar (tooth numbers 3, 14, 19, 30) and permanent second molars (tooth numbers 2, 15, 18, 31).

NOTE: Application of sealants includes the occlusal surface of 1st and 2nd molars where a buccal restoration may exist.

Payment is limited to one application per caries-free and restoration-free permanent molar, per

lifetime.

8.11.5 Space Maintainers

Space maintainers are passive appliances designed to prevent tooth movement for posterior teeth only. A bilateral space maintainer must maintain spaces for permanent successors to prematurely lost posterior deciduous teeth occurring bilaterally in the maxillary or mandibular arch.

8.11.6 Tobacco Cessation Counseling

In order to provide tobacco cessation counseling services, a dentist must be pre-approved by the Department of Health (DOH) as a Tobacco Cessation Program. The Fee Schedule defines one unit of a tobacco cessation counseling session as greater than 10 minutes, limited to one visit (unit of service) per day and a maximum of 70 units per individual, per calendar year. Providers must provide a full 10-minute counseling session in order to submit a claim for one unit of service. Providers are not permitted to round the unit of service to the next higher unit when providing a partial unit of time. Providers are not permitted to combine partial time units to equal a full unit of service.

Additional information on pre-approval by the Department of Health may be found Medical Assistance Bulletin, 99-18-10, titled "Enrollment of Tobacco Cessation Providers," effective June 18, 2018.

8.11.7 Cleft Palate Services

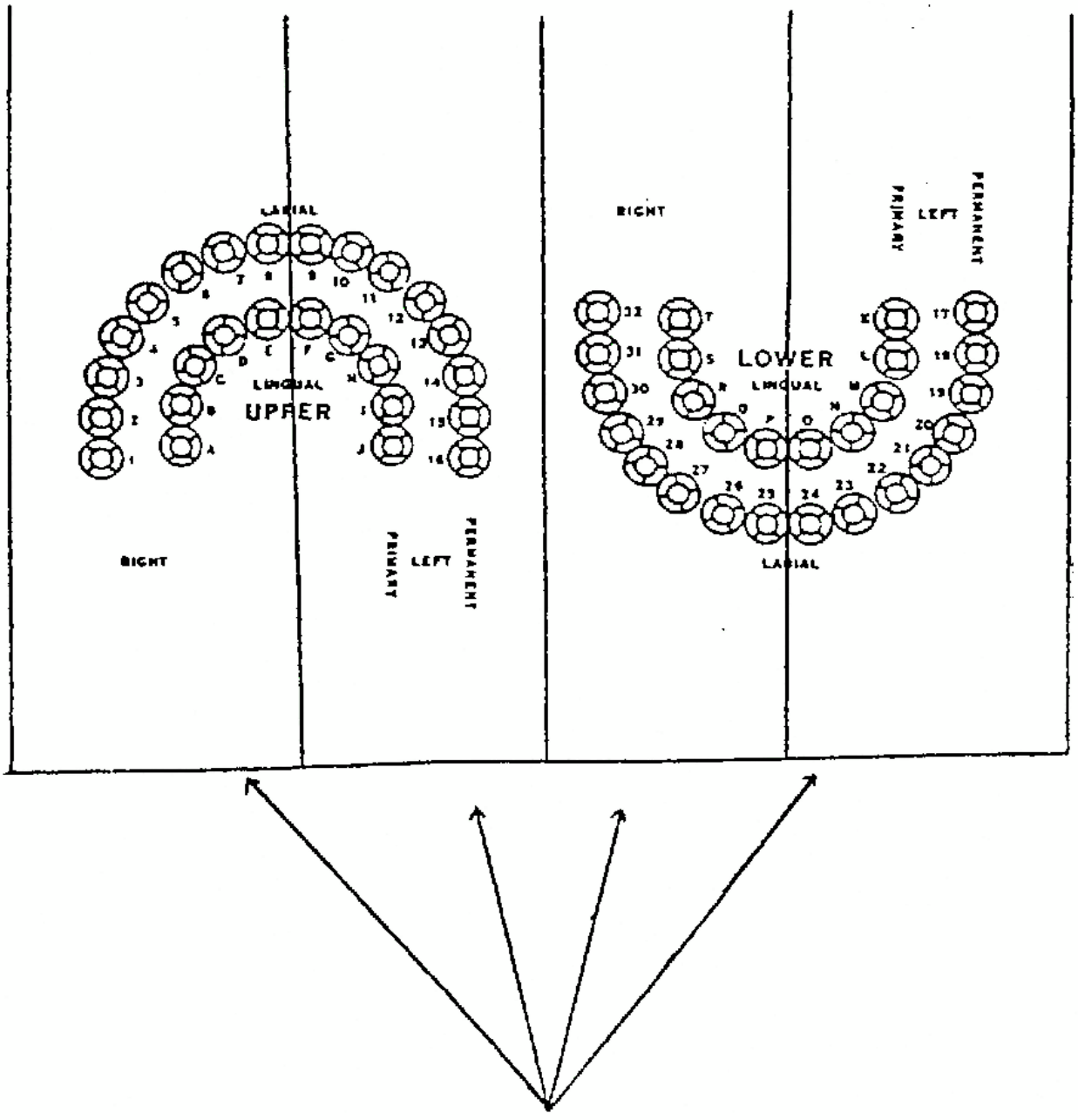
(Beneficiaries 20 Years of Age and Under)

Evaluations -

Cleft Palate Clinic providers are to submit a copy of the completed initial evaluation to the address below for prior authorization for cleft palate services. The evaluation must be updated on a yearly basis as long as the beneficiary is covered by the Medical Assistance Cleft Palate Program.

Orthodontic services covered under this program must not be done solely for cosmetic purposes, but must be done in conjunction with craniofacial reconstruction and/or the correction of a severe handicapping malocclusion. Orthodontic services will not be limited to eight quarters of treatment and/or permanent dentition only for Cleft Palate Treatment.

Department of Human Services
Office of Medical Assistance Programs/Bureau of Fee-for-Service Programs
Cleft Palate Services
P.O. Box 8050



EACH AREA EQUALS 1 QUADRANT

11 Medical Assistance Program Dental Fee Schedule

The Medical Assistance (MA) Program Dental Fee Schedule is posted on the Department of Human Services website at the following website link: http://www.dhs.pa.gov/publications/forproviders/schedules/mafeeschedules/outpatientfeeschedule/index.htm

Providers should refer to the MA Program Dental Fee Schedule for information on specific provider types, provider specialties, places of service, limits and prior authorization requirements. The procedure codes that require prior authorization are identified by a "Yes" under the "Prior Authorization" heading.