INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Dental Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: Aug. 9, 2016	Correction	FSSA and HPE
1.3	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: March 21, 2017	*Core*MMIS update	FSSA and HPE
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6.0	Policies and procedures as of July 1, 2021 Published: Oct. 14, 2021	Scheduled update	FSSA and Gainwell
7.0	Policies and procedures as of Sept. 15, 2023 Published: April 25, 2024	Scheduled update: • Edited and reorganized text as needed for clarity • Added a reference to the FQHC/RHC module in the *Introduction* section • Replaced IVR system references with GABBY in the *Member Eligibility Verification and Benefit Limit Information* section • Updated *Table 1 – Dental Limits Returned by the EVS and the EOBs for Related Claim Denials*	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Updated the *Prior Authorization for Dental Services* section • Moved and updated the *Patient Record Requirements* section to encompass all dental services • Updated the *Behavior Management Services* section • Added the *COVID-19 Vaccine Administration* section • Updated the *Dentures – Complete and Partial* section and subsections • Updated the *Extractions* section • Updated the age for D1206 in the *Fluoride Treatment (Topical)* section • Updated the *Medicament Application/Silver Diamine Fluoride* section • Updated the *Frenulectomy (Frenectomy or Frenotomy)* section • Updated the *Maxillofacial Prosthesis/Sleep Apnea Appliance* section • Updated the *Oral Evaluations* section • Updated the *Orthodontics* section and *Prior Authorization Requirements for Orthodontics* subsection • Updated the *Periodontal Maintenance* section • Updated the limits in the *Periodontal Scaling and Root Planing,* and *Full-Mouth Debridement or Scaling* section • Updated the *Prophylaxis* section • Updated the *Restorations* section	

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Bulletins, available at in.gov/medicaid/providers.*

Introduction

Dental services are provided to Indiana Health Coverage Programs (IHCP) members as described in this module, subject to limits established for certain benefit packages. Dental services include diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist in the practice of the dental profession. These services include treatment of the teeth and associated structures of the oral cavity as needed to prevent or treat disease, injury or impairment that may affect the oral or general health of the individual. Dental services may be provided by general dentistry practitioners or by dental specialists, such as endodontists, oral surgeons, orthodontists, pediatric dentists and periodontists.

Dental providers must bill for services as a dental claim, using the appropriate Current Dental Terminology (CDT®[1]) procedure codes, as described in the *Billing and Reimbursement for Dental Services* section.

This module also includes information about physician-administered fluoride varnish billed as a professional claim; see the *Physician-Administered Topical Fluoride Varnish* section.

See the *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services* module for information about EPSDT-related dental screening services. For information about billing and reimbursement for dental services provided in a federally qualified health center (FQHC) or rural health clinic (RHC), see the *Federally Qualified Health Centers and Rural Health Clinics* module.

Member Eligibility Verification and Benefit Limit Information

Providers must verify eligibility at the time a member makes an appointment and again on the day of the appointment, before rendering the service. Providers can verify member eligibility through the Eligibility Verification System (EVS) options:

- IHCP Provider Healthcare Portal (IHCP Portal), accessible from the homepage at in.gov/medicaid/providers
- Virtual assistant (GABBY) at 800-457-4584, option 2
- 270/271 Eligibility Benefit Inquiry and Response electronic transaction using approved vendor software

These methods provide basic enrollment information for all IHCP members, including those enrolled through a managed care program, such as Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise. For members enrolled in a fee-for-service (FFS) program, such as Traditional Medicaid, the EVS options provide additional information. See the *Member Eligibility and Benefit Coverage* module for details.

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Benefit Limits

IHCP coverage for specific dental services is subject to the benefit limits described in the *Coverage, Limits and Billing for Specific Dental Services* section.

To avoid claim denials, providers should verify that the member has not exhausted benefit limits before rendering services. For FFS members, the EVS options indicate whether the member has reached certain benefit limits, including limits related to the following dental services:

- Fluoride treatment
- Full mouth debridement
- Oral evaluations
- Prophylaxis
- Periodontal maintenance
- Periodontal scaling and root planing
- Sealant treatments
- Full-mouth or panoramic X-rays

Table 1 lists the specific benefit limit responses returned by the EVS, as well as the related explanation of benefits (EOBs) for claims that exceed those limits.

For benefit limit information that is **not** returned by the EVS, providers can contact the Written Correspondence Unit to request research of a member's fee-for-service (FFS) claim history for a given service. This request can be sent by secure correspondence as described in the *Provider Healthcare Portal* module.

Table 1 – Dental Limits Returned by the EVS and the EOBs for Related Claim Denials

EVS Limit Description	Corresponding EOB
6209 FULL MOUTH OR PANORAMIC X-RAYS LIMIT ONCE /3 YRS	Full-mouth or panorex X-rays limited to once every three years.
6211 PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6 MONTHS	Periodic or limited oral evaluations are limited to one every 6 months.
6212 FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTHS	Indiana Health Coverage Program benefits allow payment for one topical application of fluoride every six (6) months. Fluoride treatments are limited to recipients 0 through 20 years of age.
6221 PERIODONTAL ROOT PLAN/SCAL 4 TX/2YRS NON-INSTITUTI	Reimbursement limited to four treatments of periodontal root planing/scaling every two (2) years for non-institutionalized recipients between the ages of three (3) and twenty (20) years.
6222 PERIODONTAL ROOT PLAN/SCALING, 4 TX PER 2 YRS INST	Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-INST	Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.
6225 ONE SEALANT PER TOOTH PER LIFETIME	Indiana Health Coverage Program benefits allow payment for one sealant treatment per premolars and molars per lifetime.

EVS Limit Description	Corresponding EOB
6232 PROPHY & PERIODTL MAINT INSTIT AGE 3> LIM 1/3 MOS*	Prophylaxis and periodontal maintenance is limited to one treatment every 3 months for members age 3 yrs & older.*
6235 PROPHY & PERIODTL MAINT NON-INSTI AGE 3> LIM 1/3 MOS*	Prophylaxis and periodontal maintenance is limited to one treatment every 3 months for members age 3 years & older.*
6244 D4355/D4346 LIMITED TO ONCE EVERY 3 YEARS (DTL)**	D4355/D4346 limited to once every 3 years(dtl)**
6310 PROPHY AGE 1-2 YRS LIM 1/6 MOS*	Prophylaxis limited to one treatment every six months for members age one to two years.*

Notes:

* *For dates of service on or after Sept. 15, 2023, the IHCP changed its policy to limit reimbursement to one unit of either periodontal maintenance (D4910) or prophylaxis (D1110 or D1120) every three months (whole mouth) for members age 3 years and older, regardless of institutional status. For members ages 1–2 years, the limit remains one prophylaxis treatment every six months; periodontal maintenance is not covered for members under age 3.*

** *For dates of service on or after Sept. 15, 2023, the IHCP changed its policy to limit reimbursement for full-mouth debridement (D4355) and full-mouth scaling (D4346) to once per **24 months**. Full-mouth debridement cannot be performed within six months of CDT codes D1110, D1120, D4341, D4342, D4346 or D4910. Full-mouth scaling services cannot be performed in six months of CDT codes D1110, D1120, D4341, D4342, D4355 or D4910. System updates enforcing these changes (as well as updates to the corresponding EVS limit and EOB descriptions) are forthcoming at a later date.*

Emergency Dental Services Covered Under Package E and Package B

The *Package E* benefit plan provides **emergency services only** (ESO) coverage for lawful permanent residents who meet eligibility guidelines. The *ESO Coverage with Pregnancy Coverage* benefit plan (also known as Package B) provides the same coverage as Package E, plus pregnancy benefits.

Preventive treatments such as sealants, prophylaxis and fluoride treatments do not meet the definition of an emergency medical condition and are not covered under either benefit plan. Package E and Package B members who seek nonemergency dental services are responsible for the payment of services not covered under their benefit plan. IHCP providers can bill the member for these services within the guidelines described in the *Charging Members for Noncovered Services* section of the *Provider Enrollment* module.

The *Omnibus Budget Reconciliation Act of 1990* (OBRA) defines an emergency medical condition as follows:

> *A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of an organ or part.*

With the assistance of the Dental Advisory Panel (DAP), the IHCP created a table of the CDT codes that are allowed for reimbursement under Package E and Package B. These codes are listed in the *Dental Procedure Codes Allowed for Package E and Package B Members* table in *Dental Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. The listing of a code in this table does not eliminate the need for providers to maintain supporting documentation in the patient's records.

Radiographs are reimbursed under Package E and Package B only when the member presents with symptoms that warrant the diagnostic service.

For reimbursement under Package E or Package B, dental claims must include the following:

- On the *ADA 2012* paper claim form*:*
  - In field 2: Predetermination/Preauthorization Number, enter the word **Emergency** to indicate that the claim is for an emergency situation.
  - In field 29: Procedure Code, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services.
  - If applicable, in field 45: Treatment Resulting From, indicate if the treatment is the result of an occupational illness or injury, an auto accident, or other accident.
- On the IHCP Portal dental claim:
  - In the C*laim Information* section of the *Submit Dental Claim: Step 1* panel, select the **Emergency** box to indicate that the claim is for an emergency situation.
  - Also in the *Claim Information* section of *Submit Dental Claim: Step 1*, if the treatment is a result of an occupational illness or injury, auto accident, or other accident, select the appropriate option from the drop-down menu in the Accident Related field.
  - In the *Service Details* panel under *Submit Dental Claim: Step 3*, in the Procedure Code field, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services.

Prior Authorization for Dental Services

The following dental services are subject to prior authorization (PA) for medical necessity:

- Periodontal surgery
- Space maintenance for children under 3 years of age or if permanent teeth are missing
- Orthodontics
- Dentures (complete and partial)
  - For dates of service on or after Sept. 15, 2023, PA is required for members of all ages. For prior dates, PA was not required for members under 21 years of age.
- Repairs and relines of dentures (complete and partial)
  - For dates of service on or after Sept. 15, 2023, PA is required for members of all ages. For prior dates, PA was not required for members under 21 years of age.
- Frenulectomy (buccal/labial or lingual frenectomy procedures) for members 1 year of age or older
  - For dates of service on or after Sept. 15, 2023, PA is not required for members under 1 year of age. For prior dates, PA was required for members of all ages.
- General anesthesia for members 21 years of age or older
- Intravenous (IV) sedation for members 21 years of age or older

The IHCP returns PA requests to the provider if the requests are submitted for any other dental services. Prior authorization **does not override** a noncovered status on a dental code; therefore, a dental provider should **not** submit a PA request for a noncovered procedure code. The IHCP provides no reimbursement for ineligible members or for noncovered services. PA does not guarantee payment.

For questions about dental PA, contact the appropriate PA contractor: the IHCP fee-for-service (FFS) prior authorization and utilization management (PA-UM) contractor or the applicable managed care entity (MCE) dental PA contractor. See the *IHCP Quick Reference Guide* for contact information.

PA requests for dental services may be submitted to the PA contractor using their provider portal, or by mailing or faxing them the appropriate PA request form, available on the *Forms* page at in.gov/medicaid/providers:

- For orthodontic PA requests, use the *IHCP Prior Authorization Request Form* (universal PA form).
- For all other dental PA requests, use the *IHCP Prior Authorization Dental Request Form*.

For detailed information about completing and submitting PA requests, see the *Prior Authorization* module.

Patient Record Requirements

Providers must maintain documentation for dental services in the patient's dental or medical record, as required by *405 IAC 1-1.4-2*, which includes:

- Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving Medicaid assistance.
- Medicaid records must be documented at the time the services are provided or rendered, and prior to associated claim submission.
- All providers shall maintain, for a period of seven years from the date Medicaid services are provided to a member, such medical and/or other records, including X-rays, as are necessary to fully disclose and document the extent of the services provided. A copy of the claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement.

Billing and Reimbursement for Dental Services

The IHCP reimburses dental services using a combination of a maximum fee pricing methodology and manual pricing methodology. Providers must use CDT procedure codes to bill dental services. Providers must submit dental claims on the dental claim (*American Dental Association 2012 Dental Claim Form [ADA 2012]*, IHCP Portal dental claim or 837D transaction). See the *Claim Submission and Processing* module for instructions for completing and submitting a dental claim. CDT codes and related reimbursement information are included in the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

For information about billing and reimbursement related to dental procedures performed in a hospital or ambulatory surgical center (ASC), see the *Services Provided Outside the Dental Office* section.

> *Note: If a member wants a service that is noncovered by the IHCP, such as a type of denture that does not meet coverage guidelines, IHCP providers can bill the member for the services within the guidelines described in the Charging Members for Noncovered Services section of the Provider Enrollment module.*

Area of Oral Cavity

The Area of Oral Cavity field on the dental claim is evaluated for duplication when providers bill CDT codes that are based on dental quadrants. For example, providers should indicate the appropriate dental quadrant for each line item when billing multiple units of D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant.* If a provider bills multiple units of D4341 with the same area of oral cavity, or without identifying the area of oral cavity, the IHCP pays the first line item and denies the second and all subsequent D4341 line items with the EOB 5000 or 5001– *This is a duplicate of another claim*.

Table 2 indicates the two-digit codes for each area. If the CDT code does not refer to a quadrant or arch, or if the specific quadrant or arch in question is already identified by the CDT code itself, the Area of Oral Cavity field should be left blank.

Table 2 – Area of Oral Cavity Codes

Code	Area
L	Left
R	Right
00	Entire oral cavity
01	Maxillary area
02	Mandibular area
09	Other area of oral cavity
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

Tooth Numbering System

For certain CDT procedure codes, the IHCP requires that the tooth number (or letter) be entered in the service line. For a list of applicable CDT codes, see *Dental Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. The IHCP accepts only one tooth number per service line.

The IHCP recognizes the Universal/National Tooth Designation System (1–32 for permanent dentition and A–T for primary dentition), as described in the CDT reference manual.

Supernumerary Tooth Designations

The IHCP has adopted the ADA tooth designations for supernumerary teeth.

For 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.

Table 3 – Supernumerary Tooth Designations for Permanent Dentition

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

For primary dentition, supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (supernumerary "AS" is adjacent to "A").

Table 4 – Supernumerary Tooth Designations for Primary Dentition

Tooth #	A	B	C	D	E	F	G	H	I	J
"Super" #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Tooth #	T	S	R	Q	P	O	N	M	L	K
"Super" #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

Supernumerary tooth services, such as extractions, are billed using the appropriate CDT procedure code with the appropriate supernumerary tooth number or letters. No attachment is required.

Tooth Surface Codes

For any claim detail billed using a procedure code that requires a tooth surface, as indicated in the CDT description of the code, providers must bill using the appropriate number of valid tooth surface codes. Table 5 provides valid tooth surface codes.

Table 5 – Valid Tooth Surface Codes

Anterior Teeth		**Posterior Teeth**	
D	(Distal)	B	(Buccal)
F	(Facial)	D	(Distal)
I	(Incisal)	L	(Lingual)
L	(Lingual)	M	(Mesial)
M	(Mesial)	O	(Occlusal)

For a list of all procedure codes that require a tooth surface code for billing, as well as the minimum number of tooth surface codes required for each procedure code, see *Dental Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Coverage, Limits and Billing for Specific Dental Services

This section provides coverage, limits and billing procedures for the more commonly used dental services. IHCP coverage for any particular service is subject to limits established for certain benefit plans. For age restrictions attached to certain dental procedure codes, see the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers.

Behavior Management Services

Behavior management services that fall under CDT code D9920 – *Behavior management, by report* are to be administered according to national clinical guidelines. For dates of service on or after Sept. 15, 2023, the IHCP expanded coverage of CDT code D9920 to members of all ages with developmental disability or significant mental illness, or who are otherwise uncooperative. (For prior dates of services, coverage was limited to members under 21 years of age.) The IHCP limits reimbursement of CDT code D9920 to once per member, per date of service. Documentation supporting the medical necessity, type and appropriateness of dental behavior management services must be retained in the member's chart and is subject to postpayment review.

COVID-19 Vaccine Administration

The IHCP reimburses dentists for the administration of coronavirus disease 2019 (COVID-19) vaccines. For all covered codes, as well as age restrictions, see the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. A table of covered CDT codes for billing COVID-19 vaccination on a dental claim is included in *Dental Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Dentures – Complete and Partial

The IHCP covers complete dentures (D5110 and D5120) and partial dentures (see *Table 6 – Covered Partial Dentures*) for eligible members of all ages, subject to medical necessity and prior authorization.

For immediate dentures (D5130, D5140, D5227 and D5228), IHCP coverage is limited to members 21 years of age and older with prior authorization. See the *Immediate Dentures* section for more information.

The IHCP provides reimbursement for dentures once every six years, if medically necessary and prior authorized. (See the *Prior Authorization and Medical Necessity for Dentures* section for special circumstances where earlier replacement may be authorized.) For research of a member's FFS claim history to determine the age of a denture, contact the Written Correspondence Unit as described in the *Benefit Limits* section.

The IHCP can require the member to use the most cost-effective treatment instead of the specifically requested treatment, as long as the cost-effective procedures meet the medically necessary needs of the member.

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The provider must bill the IHCP according to when the services are rendered.

The IHCP requires that provider records be maintained in accordance with *405 IAC 1-1.4-2*. Per *405 IAC 1-1.4-2(b)(4)*, the medical record must contain the date when the service was rendered.

Prior Authorization and Medical Necessity for Dentures

Effective for dates of services on or after Sept. 15, 2023, the IHCP requires PA for dentures for *all* members, regardless of age (for prior dates, PA was required only for members 21 years of age and older). Requests are reviewed for medical necessity. Documentation of medical necessity should also be maintained by the provider in the patient chart.

The IHCP considers eight posterior teeth in occlusion – four maxillary and four mandibular teeth in functional contact with each other – to be adequate for functional purposes. Effective for dates of service on or after Sept. 15, 2023, the IHCP covers partial dentures that replace posterior and/or anterior teeth if medically necessary (for prior dates, partial dentures that replaced only anterior teeth were noncovered).

A service is "medically necessary" when it meets the definition of "medically reasonable and necessary service" as defined in *405 IAC 5-2-17*. The IHCP determines medical necessity by reviewing documentation submitted by the provider to support the functional and medical needs of the patient. When submitting the PA request (either via the PA contractor's provider portal or using the *IHCP Prior Authorization Dental Request Form*), the dentist should complete all applicable information and include all descriptions necessary to create a complete clinical picture of the patient and the need for the request. The denture PA request should include any information about bone or tissue changes due to shrinkage, recent tooth loss, weight loss, bone loss in the upper or lower jaw, recent sickness or disease, or changes due to physiological aging. If the request is for a repair or reline of a prosthesis, dentists should indicate on the PA request whether the useful life of the existing prosthesis can be extended by the repair or a reline. Dentists must also include their office telephone number on the PA request, in case the PA analyst has questions.

The dental provider must submit documentation supporting the need for dentures (full or partial), including the following:

- The member is edentulous and unable to masticate properly (fewer than eight posterior teeth are in occlusion). *(Note: This requirement does not apply to requests for anterior-only dentures.)*
  - If a member has been edentulous for three or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time. The documentation must include a favorable prognosis, an analysis of the oral tissue status (such as muscle tone, ridge height and muscle attachments), and justification of the reason the patient has been without a prosthesis.
  - If the provider's request indicates that the member has not worn an existing prosthesis for three or more years and the provider documents no mitigating circumstances warranting the authorization of a new prosthesis, the IHCP denies the PA request.
- The member is physically and psychologically able to wear and maintain the prosthesis.
- If the member's primary source of nutrition is parenteral or enteral nutritional supplements, a plan of care to wean the member from the nutritional supplements must be included with the request.

For **replacement** dentures, in addition to the preceding items, the provider must also submit documentation that the existing prosthesis requires replacement due to one of the following reasons:

- The existing prosthesis is six years old or older, beyond repair, and cannot be relined.
- The base is ill-fitting, the teeth are worn, and the prosthesis cannot be relined.
- There is severe loss of vertical dimension, and the prosthesis cannot be relined.
- The prosthesis has been lost, destroyed or stolen. (Providers must submit an explanation of the circumstances; otherwise, the IHCP denies the request.)

Covered Partial Denture Types

Table 6 outlines coverage and PA guidelines for partial dentures. For information about immediate dentures (both partial and complete), see the *Immediate Dentures* section.

Table 6 – Covered Partial Dentures

Type of Denture	Procedure Codes	Coverage Guidelines
Resin partial dentures	D5211 and D5212	Covered. Prior authorization is required for members of all ages.
Cast-metal partial dentures	D5213 and D5214	Covered only for members with facial deformity due to congenital, developmental or acquired defects. The need for a cast-metal partial must be documented in the member's medical record for all members who require this type of denture. Prior authorization is required for members of all ages, and the PA request must include specific reasons for the request.

Type of Denture	Procedure Codes	Coverage Guidelines
Flexible-base partial dentures	D5225 and D5226	Covered only for members with one of the following: • A documented allergic reaction to other denture materials • A facial deformity due to congenital, developmental or acquired defects (such as cleft palate conditions) that require the use of a flexible-base partial instead of an acrylic or cast-metal partial The need for a flexible-base partial must be documented in the member's medical record for all members who require this type of denture. Prior authorization is required for members of all ages, and the PA request must include specific reasons for the request.
Immediate flexible-base partial dentures	D5227 and D5228	Covered. Limited to members 21 years of age and older. Prior authorization is required for members of all ages.
Removable unilateral partial dentures, one-piece cast metal	D5282 and D5283	Covered. Prior authorization is required for members of all ages.
Removable unilateral partial dentures, one-piece flexible base	D5284	Covered. Prior authorization is required for members of all ages.
Removable unilateral partial denture, one-piece resin	D5286	Covered. Prior authorization is required for members of all ages.

Immediate Dentures

The IHCP covers immediate dentures (complete [D5130, D5140] and partial [D5227, D5228]) only for members 21 years of age and older. Prior authorization is required.

The IHCP *does not* reimburse an additional amount for immediate dentures beyond the current denture allowance.

The IHCP waives the 60-day waiting period between the date of the last extraction and the date of the initial impression. The IHCP does not reimburse for additional charges related to furnishing the dentures before the 60-day waiting period. Providers can hold the patient responsible for these additional charges if the provider gives the patient advance notice and documents this in the record as described previously.

Repairs, Relines and Rebases of Dentures

The IHCP covers laboratory relines, chairside relines and repairs to complete or partial dentures only when the reline or repair extends the useful life of a medically necessary denture. The IHCP does not cover rebases (D5710–D5721).

Effective for dates of service on or after Sept. 15, 2023, providers must obtain PA for members of all ages for relines and repairs to complete or partial dentures (for prior dates, PA was required only for members 21 years of age and older). To be approved, the provider should indicate on the PA request that a repair or reline will extend the useful life of the existing prosthesis. Providers must use the following codes for claims and PA requests for relines and repairs:

- Repairs to dentures – D5511, D5512 and D5520
- Repairs to partial dentures – D5611, D5612, D5621, D5622, D5630, D5640, D5650 and D5660
- Chairside relines – D5730, D5731, D5740 and D5741
- Laboratory relines – D5750, D5751, D5760 and D5761

Documentation to support medical necessity must be maintained by the provider in the medical record.

Extractions

The IHCP covers extraction of teeth when the procedure is medically necessary and the diagnosis supports the extraction.

The IHCP allows only one tooth number per service line for dental extractions. A provider submitting a claim for CDT codes D7140 – *Extraction, erupted tooth or exposed root (elevation and/or forceps removal)* or D7111 – *Extraction coronal remnants – deciduous tooth* must indicate the tooth number for each tooth extracted on a separate service line in field 27 on the *ADA 2012* claim form or in the equivalent field of the electronic dental claim.

The IHCP pays 100% of the maximum allowed amount or the billed amount, whichever is less, for the initial extraction. For multiple extractions within the same quadrant on the same date of service, the IHCP pays 90% of the maximum allowed amount for procedure code D7140 or the billed amount, whichever is less.

D7111 will also cut back to 90% of the allowed amount when billed with multiple units or with D7140.

> *Note: Sutures are considered a part of a general extraction. Therefore, D7910–D7912 (sutures) should not be billed for the same date of service as D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250 or D7251 (extractions), except when sutures are needed* ***unrelated*** *to the extraction. If this situation occurs, sutures are payable separately from the extraction. Providers must submit written documentation with the claim to support that the suture is unrelated to the extraction being billed (for example, the suture is in another part of the mouth).*

Fluoride Treatment (Topical)

According to *405 IAC 5-14-4*, reimbursement is available for one topical application of fluoride every six months for members from first tooth eruption through 20 years of age. Topical applications are not covered for members 21 years of age or older. Table 7 summarizes these reimbursement limits.

Table 7 – Topical Fluoride Treatment Benefit Limits

Age	Limit
From first tooth eruption until 21st birthday	One application every six months
21 years of age or older	No coverage for fluoride

Topical fluoride includes gel, foam or varnish. The IHCP reimburses for the following CDT codes as indicated:

- D1208 – *Topical application of fluoride – excluding varnish* is reimbursed once per six months for members under 21 years of age.
- D1206 – *Topical application of fluoride varnish* is reimbursed once per six months for members under 21 years of age, effective for dates of service on or after Sept. 15, 2023 (for prior dates of service, coverage was limited to members age 1 through 20 years with a moderate to high risk of dental caries).

For information about fluoride varnish administered by a physician and billed on the professional claim, see the *Physician-Administered Topical Fluoride Varnish* section.

Medicament Application/Silver Diamine Fluoride

The IHCP covers CDT code D1354 – *Interim caries arresting medicament application – per tooth* for silver diamine fluoride (SDF). Prior authorization is required for members 21 years of age or older.

Reimbursement for D1354 is limited to once per tooth per three months. The tooth number is required. Ten teeth are allowed per date of service, with one application per three months per tooth number.

The IHCP will be removing coverage of caries preventive medicament application (D1355) effective retroactively for dates of service on or after Sept. 15, 2023.

Frenulectomy (Frenectomy or Frenotomy)

A frenulectomy (frenectomy or frenotomy) in the dental setting is a covered IHCP service.

The following procedures are each limited to two units per day, per member:

- D7961 – *Buccal/labial frenectomy (frenulectomy)*
- D7962 – *Lingual frenectomy (frenulectomy)*

Prior authorization is required for a frenulectomy in members 1 year of age or older. For dates of service on or after Sept. 11, 2023, PA is not required for buccal/labial or lingual frenectomy procedures for members under 1 year of age.

For members of all ages, coverage of this service requires that medical necessity be established within the patient's file, including a referral from the member's provider documenting significant feeding challenges as a condition and photos.

Maxillofacial Surgery

Prior authorization is required for maxillofacial surgery. IHCP providers may be required, based on the facts of the case, to obtain a second or third opinion substantiating the medical necessity or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as ambulatory surgical center, hospital or clinic.

Maxillofacial Prosthesis/Obstructive Sleep Apnea Appliance

The IHCP covers CDT code D5999 – *Unspecified maxillofacial prosthesis* and D9947 – *Custom sleep apnea appliance fabrication and placement*. Prior authorization is required.

Prior authorization for the coverage of oral appliance therapy is subject to the following:

- A face-to-face evaluation must be completed by a provider before a sleep test, to assess the member for obstructive sleep apnea.
- The sleep test must meet one of the following:
  - An apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) that is equal to or greater than 5 and less than 15 events per hour
  - AHI or RDI is greater than or equal to 15 and less than 30 events per hour and:
    - Patient experiencing trial and failure of a continuous positive airway pressure (CPAP) machine
  - AHI or RDI is equal to or greater than 30 events per hour and:
    - Patient experiencing trial and failure of a CPAP machine
- The patient has confirmed obstructive sleep apnea.
- The device must be ordered by a provider following review of the report of the sleep test.
- Referral must be from a physician to the dentist.
- The device is provided and billed by a dentist.

The dental provider should maintain sleep study results in the patient's file.

Prior authorization is not required for adjustment (D9948) or repair (D9949) of the custom sleep apnea appliance.

Oral Evaluations

The IHCP limits reimbursement of procedure codes D0150 – *Comprehensive oral evaluation – New or established patient* and D0160 – *Detailed and extensive oral evaluation – Problem focused, by report* to one unit of either D0150 or D0160 per provider per member lifetime. In addition, members are limited to a total of two units per year for any combination of these two codes when rendered by different providers.

The IHCP limits procedure code D0145 – *Oral evaluation for a patient under three years of age and counseling with primary caregiver* to one per year, per member, any provider.

The IHCP limits procedure code D0120 – *Periodic oral evaluation – Established patient* to one every six months, per member, any provider.

The IHCP does not subject procedure code D0140 – *Limited oral evaluation – Problem focused* to unit limits; however, providers should use the code as defined in the CDT reference manual. This type of evaluation is for patients who have been referred for a specific problem, such as dental emergencies, trauma, acute infections, conditions requiring immediate medical attention and so forth. Providers should not use D0140 for periodic oral evaluations or other types of evaluations.

Table 8 summarizes these reimbursement limits for oral evaluation codes.

Table 8 – Oral Evaluation Benefit Limits

Dental Code	Code Description	Unit Limit
D0120	Periodic oral evaluation – Established patient	One every six months, per member
D0140	Limited oral evaluation – Problem focused	None
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	One per year, per member
D0150	Comprehensive oral evaluation – New or established patient	One per lifetime, per member, per provider*
D0160	Detailed and extensive oral evaluation – Problem focused, by report	One per lifetime, per member, per provider*

*Note: *The IHCP allows members up to two units per year for any combination of procedure codes D0150 and D0160, but the two units cannot be from the same provider. A particular provider can bill either D0150 or D0160 only one time per member per lifetime.*

Dental evaluations are closely monitored by the IHCP and are subject to recoupment. Documentation in the dental and medical records must support that the provider rendered the oral evaluation in compliance with the procedure definition for the dental code being used.

Note: Oral exams and routine cleanings for residents of state-operated group homes are included in the per diem rate when performed at the group home.

Orthodontics

The IHCP covers orthodontic procedures only for members 20 years old and younger and only for cases of craniofacial deformities, whether congenital or acquired. Prior authorization is required for all orthodontic services. Providers must maintain documentation for orthodontic services in the patient's dental or medical record, as described in the *Patient Record Requirements* section.

The IHCP reimburses for a maximum of two phases of orthodontic treatment: one limited treatment and one comprehensive treatment, as follows:

- **Limited orthodontic treatment** is defined as treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive treatment. Limited orthodontic treatment codes are as follows:
  - D8010 – *Limited orthodontic treatment of the primary dentition*
  - D8020 – *Limited orthodontic treatment of the transitional dentition*
  - D8030 – *Limited orthodontic treatment of the adolescent dentition*
  - D8040 – *Limited orthodontic treatment of the adult dentition*
- **Comprehensive orthodontic treatment** is defined as treatment of the dentition as a whole. Treatment usually, but not always, uses fixed orthodontic appliances or braces. Comprehensive treatment includes appliances, retainers, and repair or replacement of retainers; these may not be separately billed if comprehensive treatment is rendered. Comprehensive orthodontics may incorporate treatments focusing on specific objectives at various stages of dentofacial development. Comprehensive orthodontic treatment codes are as follows:
  - D8070 – *Comprehensive orthodontic treatment of the transitional dentition*
  - D8080 – *Comprehensive orthodontic treatment of the adolescent dentition*
  - D8090 – *Comprehensive orthodontic treatment of the adult dentition*

Prior Authorization Requirements for Orthodontics

PA is required for all orthodontic services. When submitting a PA request for orthodontic services by mail or fax, providers must use the *Indiana Health Coverage Programs Prior Authorization Request Form* (universal PA form), available on the *Forms* page at in.gov/medicaid/providers. The dental PA request form should ***not*** be used for submitting orthodontic PA requests.

PA requests for limited and/or comprehensive orthodontic treatment are reviewed on a case-by-case basis, and must include a treatment plan detailing time frames and expectations. A PA request for removable or fixed-appliance therapy must show that the patient meets the criteria outlined in this policy and has a harmful habit in need of correction.

Phased Orthodontic Treatment

The IHCP accepts PA requests for **phased orthodontic treatment** that includes **one limited** orthodontic treatment (D8010, D8020, D8030 or D8040) and **one comprehensive** orthodontic treatment (D8070, D8080 or D8090). All PA requests for phased orthodontic treatment must include a step-by-step treatment plan detailing time frames and expectations for each phase of the treatment. One PA is issued per treatment phase, and the PA lasts for the length of the treatment specified.

Medical Necessity Requirements for Orthodontic PA

Members meet the criteria for medical necessity for orthodontic care when it is part of a case involving treatment of craniofacial anomalies, malocclusion caused as the result of trauma, or a severe malocclusion or craniofacial disharmony that includes, but is not limited to:

- Overjet equal to or greater than 9 mm
- Reverse overjet equal to or greater than 3.5 mm
- Posterior crossbite with no functional occlusal contact
- Lateral or anterior open bite equal to or greater than 4 mm
- Impinging overbite with either palatal trauma or mandibular anterior gingival trauma
- One or more impacted teeth with eruption that is impeded (excluding third molars)
- Defects of cleft lip and palate or other craniofacial anomalies or trauma
- Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)

The member's diagnosis must include information descriptive of facial and soft tissue, skeletal, dental/occlusal, functional, and applicable medical or other conditions. Diagnostic records required to establish medical necessity include:

- Panoramic radiograph
- Cephalometric radiograph
- Intraoral and extraoral photos

Members with malocclusions associated with a craniofacial anomaly must be diagnosed by a member of a craniofacial anomalies team recognized and endorsed by the American Cleft Palate-Craniofacial Association (ACPA), presumably an orthodontist, and treated by an orthodontist who may or may not be a member of a recognized craniofacial anomalies team.

Members with malocclusions not associated with a craniofacial anomaly may be diagnosed and treated by any orthodontist, whether a member of a recognized craniofacial anomalies team or not. The treating provider is not required to be associated with a recognized craniofacial anomalies team.

Billing and Reimbursement

The IHCP ***does not reimburse*** for the following procedure codes; these services are included in the reimbursement for orthodontic treatment and are not separately reimbursed:

- D8660 – *Pre-orthodontic treatment examination to monitor growth and development*
- D8670 – *Periodic orthodontic treatment visit*
- D8680 – *Orthodontic retention (Removal of appliances, construction and placement of retainer(s))*
- D8681 – *Removable orthodontic retainer adjustment*
- D8696 – *Repair of orthodontic appliance - maxillary*
- D8697 – *Repair of orthodontic appliance - mandibular*
- D8698 – *Re-cement or re-bond fixed retainer - maxillary*
- D8699 – *Re-cement or re-bond fixed retainer - mandibular*
- D8701 – *Repair of fixed retainers, includes reattachment - maxillary*
- D8702 – *Repair of fixed retainer, includes reattachment - mandibular*
- D8703 – *Replacement of lost or broken retainer - maxillary*
- D8704 – *Replacement of lost or broken retainer - mandibular*
- D8999 – *Unspecified orthodontic procedure, by report*

The IHCP expects patients to continue treatment with the same practitioner for the period of treatment time that is prior authorized. In the unlikely event that the patient must discontinue treatment with one practitioner and begin treatment with another practitioner, the practitioner continuing the treatment must submit a new PA request. The first practitioner must refund part of the reimbursement to the IHCP. Generally, one-third of the reimbursement is for the evaluation and treatment plan, and two-thirds of the reimbursement is for the actual treatment. Based on the time remaining in the treatment rendered by a new practitioner, the first practitioner must prorate the amount to be refunded to the program.

Palliative Treatment of Facial Pain for Emergency Dental Services

405 IAC 5-14-13 limits palliative treatment of facial pain, such as an abscess, incision and drainage, to emergency treatment only. Providers can bill CDT code D0140 – *Limited oral evaluation – problem focused* for the emergency exam. If the specific procedure performed for the palliative care has a corresponding CDT code, providers should also bill that code, rather than billing the code for palliative care. The IHCP does not cover CDT code D9110 – *Palliative (emergency) treatment of dental pain – Minor procedure*.

For example, if a provider performs an emergency incision and drainage of an abscess or intraoral soft tissue procedure, the provider should bill code D7510 for the procedure with code D0140 for the exam.

To specify that the services performed were for emergency care, providers must write the word "Emergency" in field 2 of the *ADA 2012 Dental Claim Form* dental claim form or select the Emergency box in the *Claim Information* panel in Step 1 of the IHCP Portal dental claim submission. All services are subject to postpayment review, and documentation must support medical necessity for the services performed.

Periodontal Maintenance

The IHCP covers HCPCS code D4910 – *Periodontal maintenance* for members 3 years of age and older. For dates of service on or after Sept. 15, 2023, the IHCP expanded coverage for all eligible members age 3 years and older to allow either one periodontal maintenance service (D4910) or one prophylaxis service (D1110 or D1120) once every three months for the whole mouth.

> *Note: For prior dates of service, members 3–20 years of age and all institutionalized members were limited to one periodontal maintenance or prophylaxis service every six months, and noninstitutionalized members 21 years of age and older were limited to one periodontal maintenance or prophylaxis service every 12 months.*

Table 9 summarizes the current reimbursement limits for periodontal maintenance. For more information about prophylaxis services, the *Prophylaxis* section.

Table 9 – Periodontal Maintenance Benefit Limits

Age	Limits
Under 3 years old	No coverage for periodontal maintenance
3 years old and older	One periodontal maintenance **or** prophylaxis service every three months (whole mouth)

For reimbursement of D4910, at least one unit of a qualifying service must have been previously provided to the member. For a list of applicable codes, see the *Qualifying Dental Service Required Before Periodontal Maintenance* table on *Dental Services Codes,* accessible from the *Codes Sets* page at in.gov/medicaid/providers. The date of service for the most recent qualifying service must be at least six months before the date of service for the periodontal maintenance.

If a claim for D4910 denies with EOB 6305 – *Periodontal maintenance (D4910) not allowed without a periodontal service paid in history*, and a qualifying service was performed before the member's enrollment, providers may request an administrative review of the claim's adjudication. The review request should include medical and/or dental records verifying that a qualifying service was performed before the member was enrolled and that the service was rendered at least six months before the date of the periodontal maintenance.

Periodontal Scaling and Root Planing, and Full-Mouth Debridement or Scaling

The IHCP covers periodontal scaling and root planing for members 3 years of age and older. For members at least 3 years old and under 21 years old, and for all institutionalized members, coverage is limited to four units every two years. For noninstitutionalized members 21 years old and older, the IHCP limits periodontal scaling and root planing to four units per lifetime. Providers can perform the service for all four quadrants on the same date of service.

Table 10 summarizes these reimbursement limits for periodontal scaling and root planing services.

Table 10 – Periodontal Scaling and Root Planing Benefit Limits

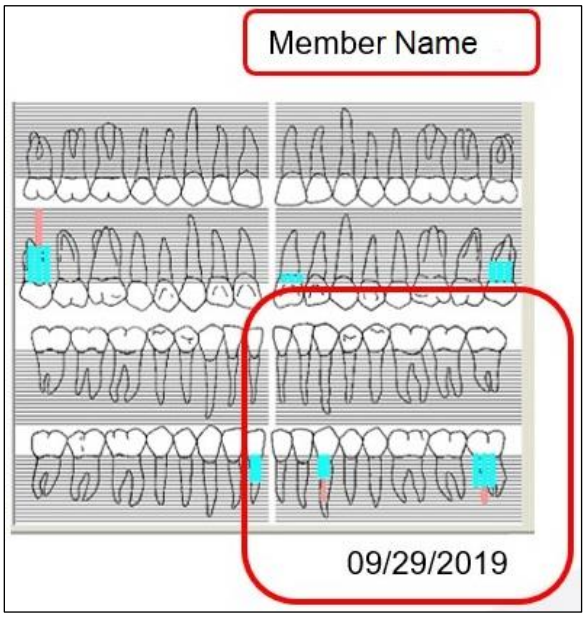
Age	Limits
Under 3 years old	No coverage for root planing and scaling
At least 3 years old but under 21 years old	Four units every two years
21 years and older	Four units per lifetime
Institutionalized members (all ages)	Four units every two years

When IHCP providers submit claims for D4341 – *Periodontal scaling and root planing – four or more teeth per quadrant* or D4342 – *Periodontal scaling and root planing – one to three teeth per quadrant*, they must submit documentation (periodontal charting) supporting the medical necessity of providing this service. The following requirements apply:

- Documentation must indicate that the member has periodontal disease by showing pocket markings or evidence of attachment loss and showing that the procedure was necessary for the removal of cementum and dentin that is rough, permeated by calculus, or contaminated with toxins or microorganisms.
- **The date of the scaling and root planing must be written on the periodontal chart next to the quadrant** (see Figure 1).
- **The attachment must also include the member's name** (see Figure 1). If the member's name and date of service are not on the attachment, the claim will deny for EOB 4019 – *Attachment required for service rendered. Please verify and resubmit*.
- The IHCP does not require radiographs documenting the periodontal disease with the claim submission, but radiographs must be part of the dental record and maintained in the dentist's office.

When billing for multiple units of D4341 or D4342, the quadrants must be indicated for each service line, as described in the *Area of Oral Cavity* section.

Figure 1 – Documenting Date of Service and Member Name on Periodontal Chart Attachment



Full-mouth debridement and full-mouth scaling services are intended for patients with excessive plaque or calculus that inhibits the dental professional's ability to perform comprehensive oral evaluations. Either service is indicated only in situations when the patient has not had a dental visit for several years. For dates of service on or after September 15, 2023, the IHCP limits coverage of D4355 – *Full mouth debridement to enable comprehensive evaluation and diagnosis* and D4346 – *Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation* as follows:

- Full-mouth debridement (D4355):
  - Limited to one treatment per 24 months per member
  - Limited to one unit per date of service
  - Cannot be performed within six months of prophylaxis (D1110, D1120), periodontal scaling and root planing (D4341, D4342), periodontal maintenance (D4910), or full-mouth scaling (D4346)

- Full-mouth scaling (D4346):
  - Limited to one treatment per 24 months per member
  - Limited to one unit per date of service
  - Cannot be performed within six months of prophylaxis (D1110, D1120), periodontal scaling and root planing (D4341, D4342), periodontal maintenance (D4910), or full-mouth debridement (D4345)

> *Note: For dates of service **prior to** Sept. 15, 2023, full-mouth debridement (D4355) and full-mouth scaling (D4346) were limited to one treatment per three years, and could not be billed for the same date of service as prophylaxis (D1110 or D1120) or periodontal root scaling and planing (D4341 or D4342). System updates reflecting the new policy for these services, as described in this section, are in progress. Affected claims with dates of service on or after Sept. 15, 2023, will be reprocessed retroactively.*

Periodontal Surgery

Periodontal surgery is a covered IHCP service for cases of drug-induced periodontal hyperplasia. Documentation in the patient's record must substantiate that the service was provided for drug-induced periodontal hyperplasia.

Prophylaxis

The IHCP covers prophylaxis for members 12 months of age and older. For dates of service on or after Sept. 15, 2023, the IHCP expanded coverage to allow one prophylaxis service (D1110 or D1120) once every three months for the whole mouth, for members 3 years of age or older. For members 1–2 years of age, the limit for prophylaxis remains once per six months. Members under 12 months of age are not eligible for prophylaxis unless medical necessity can be established.

> *Note: For dates of service **prior to** Sept. 15, 2023, prophylaxis coverage for members from 12 months of age to their 21st birthday, and for institutionalized members of all ages, was limited to once every six months. For noninstitutionalized members 21 years old and older, coverage was limited to once every 12 months.*

Table 11 summarizes these reimbursement limits for prophylaxis.

Table 11 – Prophylaxis Benefit Limits

Age	Limits
Under 12 months	No coverage for prophylaxis service unless medical necessity can be established
12 months through 24 months	One unit every six months
3 years or older	One unit every three months

If an adult prophylaxis is supplied, the provider can bill CDT code D1110 – *Prophylaxis, adult* for members 12 years old and up. Providers use code D1120 – *Prophylaxis, child* to bill for child prophylaxis for members under age 12.

Prophylaxis is considered a preventive procedure for healthy tissue, whereas periodontal services are therapeutic procedures. Adult or child prophylaxis services (D1110 or D1120) will not be reimbursed if provided within the same six-month period as periodontal services (D4341, D4342, D4355 or D4346).

Additionally, providers are not allowed to bill for prophylaxis (D1110 or D1120) and periodontal maintenance (D4910) for a member within the same three-month period.

> *Note: For residents of a nursing home or a group home, the IHCP will pay for prophylaxis only once every six months. Oral exams and routine cleanings for residents of state-operated group homes are included in the per diem rate when performed at the group home.*

Radiographs

The IHCP limits reimbursement of a full-mouth radiograph series (D0210) or panoramic X-rays (D0330) to one set per member every three years.

Bitewing radiographs are limited to one set per member every 12 months. The IHCP defines one set of bitewings as four horizontal films (D0274 or appropriate combinations of D0270, D0272 and D0273) or seven to eight vertical films (D0277).

405 IAC 5-14-3(3) limits intraoral radiographs to one first film (D0220) and seven additional films (D0230) per member every 12 months. Claims billing more than one first film in a 12-month period will be denied with EOB 6243 – *D0220 is limited to one film every twelve months*. Claims billing more than seven additional films in a 12-month period will be denied with EOB 6231 – *D0230 Intraoral-periapical-each additional film is limited to seven films per twelve months.*

Bitewing and intraoral-periapical radiographs are not covered for the same date of service as a full-mouth complete series of radiograph images. The complete series is inclusive of bitewing and intraoral-periapical radiographs.

Table 12 summarizes these reimbursement limits for radiograph services.

Table 12 – Radiograph Unit Benefit Limits

Age	Unit Limits
Full-mouth radiographs/panoramic X-rays	One set per member every three years
Bitewing radiographs	One set (four horizontal films or seven to eight vertical films) per member every 12 months
Intraoral-periapical radiographs	One first film and seven additional films per member every 12 months

Note: Bitewing and/or intraoral-periapical radiographs are not reimbursed for the same date of service as a full-mouth complete series of radiograph images. The complete series is inclusive of bitewings and intraoral-periapical radiographs.

The IHCP limits reimbursement of procedure code D0240 – *Intraoral – Occlusal radiographic image* to two units per member per day. Each occlusal film provides a more extensive view of the maxilla and mandible and reveals the entire arch of teeth in either the upper or lower jaw.

The IHCP covers procedure code D0340 – *2D cephalometric image – acquisition, measurement and analysis* only for orthodontic services and limits it to provider specialty 273 – *Orthodontists.*

Temporomandibular joint (TMJ) arthrograms, other temporomandibular films, tomographic surveys and cephalometric films are not covered in a dental office.

Restorations

Treatment of dental caries with amalgam restorations, resin-based composite restorations or stainless-steel crowns is a covered IHCP service. The use of pit sealants on permanent molars and premolars only is a covered service for members under 21 years of age; there is a limit of one treatment per tooth, per lifetime.

The IHCP covers anterior and posterior resin restorations. IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant (see the *Sealants* section). Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

> *Note: Margination of restorations and occlusal adjustments are not separately reimbursed.*

Multiple Restorations on the Same Surface

For multiple restorations on the same tooth, using the same material on the same surface of a tooth, without involvement of a second surface, on the same date and by the same dentist, the IHCP processes the restorations as a single-surface restoration. The IHCP reimburses for multiple restorations involving only one surface as a single-surface restoration.

For example, for a one-surface amalgam restoration (D2140) billed multiple times for tooth number **14** for the same surface **O**, the same date of service and by the same provider, the IHCP reimburses once at the *lower* of the submitted charge or the maximum fee allowable for that procedure.

Multiple Restorations on Different Surfaces of the Same Tooth

When billing for restorations performed by the same dentist, on the same date, on the same tooth, using the same material, the dentist must use the single CDT code that appropriately identifies the total number of unique surfaces restored. For example, for an amalgam restoration of a tooth, the dentist would bill either D2140, D2150, D2160 or D2161, depending on whether the restoration was for one, two, three, or four or more surfaces of the tooth. The claim detail must identify the tooth number and list all affected surfaces.

Providers can count each surface only once when selecting the code identifying the total number of unique surfaces. Reimbursement can never exceed the maximum fee for a restoration of four or more surfaces when providers use the same material.

For example, if a dentist performs an amalgam restoration on two surfaces of the same tooth on the same date, and bills the restorations as two separate line items, each using D2140 – *Amalgam-one surface* for tooth number **30** (the first for surface **D**, and the second for surface **O**), the IHCP pays the first line item only. The second detail of D2140 for tooth 30 (surface O) is denied with EOB 5000 or 5001 – *This is a duplicate of another claim*. For reimbursement of *both* restorations, the provider must submit an adjustment to the paid detail line, correcting the restoration code from D2140 – *Amalgam-one surface* to D2150 – *Amalgam-two surfaces* and listing both surfaces **D** and **O** within the single detail line. The IHCP reimburses the claim at the *lower* of the submitted charge or the maximum fee for a two-surface amalgam restoration (D2150).

Multiple Restorations Using Different Materials

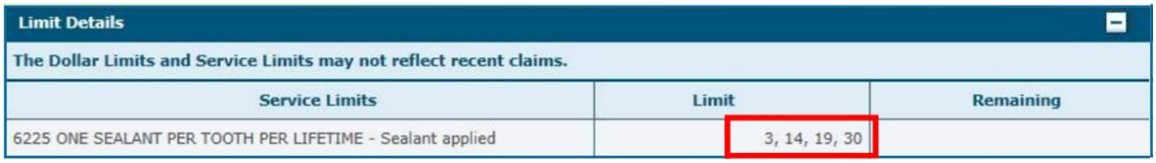
For multiple restorations on the same tooth, using different materials, which involve the same surface without involvement of a second surface, on the same date by the same dentist, the IHCP processes the restorations as a single surface restoration for *each material*. **Providers should rarely experience situations requiring multiple restorations using different materials on the same tooth, and the IHCP may review such claims for medical necessity because of the use of the different materials**.

For example, for tooth number **30**, if the provider bills a one-surface amalgam restoration (D2140) for the **B** surface and bills a one-surface resin-based composite restoration (D2391) for the **B** surface, the IHCP reimburses once for D2140 and once for D2391.

Sealants

Pursuant to *405 IAC 5-14-5*, the IHCP covers sealants for molars and premolars for members less than 21 years old, and limited to one per tooth, per member, per lifetime. The IHCP does not cover sealants for members 21 years old and older. Benefit limit information is available on the eligibility verification system, indicating tooth numbers to which sealants have already been applied (see Figure 2).

Figure 2 – Sealant Benefit Limits Displayed on the IHCP Portal Eligibility Verification



The *American Dental Association Current Dental Terminology* is the current coding reference for dental providers. The ADA distinguishes a **sealant** from a **preventive resin restoration** as follows:

> *"If the care is limited to the enamel, it is still considered a sealant. If the decay penetrates the dentin, then this is considered a restorative procedure."*

IHCP providers should bill for resin restorations only when decay has penetrated the dentin. If only the enamel is affected, providers should bill the procedure as a sealant. Dental providers are responsible for maintaining documentation that supports the level of dental decay and the procedure performed when billing these services.

Sedation for Dental Procedures (Dental Anesthesia)

The following sections provide information about IHCP coverage of the following types of sedation for dental procedures:

- General anesthesia
- Inhalation of nitrous oxide
- Intravenous (IV) moderate (conscious) sedation
- Nonintravenous conscious sedation (monitored sedation for children)

The IHCP restricts reimbursement for dental anesthesia to **one type of sedation** per member per date of service. For example, general anesthesia may not be billed and reimbursed for the same date of service as inhalation of nitrous oxide, intravenous conscious sedation or nonintravenous conscious sedation.

The CDT dental anesthesia codes associated with each type of sedation are included in Table 13. Note that the reimbursement restriction to one type of sedation per date of service does not apply to codes billed for the same type of sedation:

- D9222 and D9223 may be reimbursed for a member on the same date of service.
- D9239 and D9243 may be reimbursed for a member on the same date of service.

Additionally, as indicated by the asterisks in Table 13, reimbursement for dental anesthesia codes D9222, D9230, D9239 and D9248 is limited to **one unit** per member per date of service.

Table 13 – Types of Dental Sedation (Limit One Type per Date of Service)

Type of Sedation	Procedure Code	Description
General anesthesia	D9222* and D9223	Deep sedation/general anesthesia – first 15 minutes Deep sedation/general anesthesia – each subsequent 15 minute increment
Inhalation of nitrous oxide	D9230*	Inhalation of nitrous oxide/anxiolysis, analgesia
Intravenous conscious sedation	D9239* and D9243	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment
Nonintravenous conscious sedation	D9248*	Non-intravenous conscious sedation
** Dental anesthesia codes limited to one unit per date of service per member.*		

General Anesthesia for Dental Procedures

The IHCP reimburses for general anesthesia provided in the dentist's office only for members younger than 21 years old.

The IHCP covers general anesthesia for members 21 years old and older only if the procedure is performed in an inpatient or outpatient hospital setting, or in an ambulatory surgical center (ASC). When the service is performed in a hospital or ASC setting, providers may not bill the CDT procedure code. Instead, the appropriate Current Procedural Terminology (CPT®[2]) code must be billed on a professional claim (*CMS-1500* claim form, IHCP Portal professional claim or 837P transaction). Prior authorization is required for general anesthesia for members 21 years of age or older.

Documentation for general anesthesia for adults or children should include why the individual cannot receive necessary dental services unless a provider administers general anesthesia. The provider must retain documentation in the member's file for at least three years.

The criteria for coverage of general anesthesia for dental services are as follows:

- Mental incapacitation (such that the member's ability to cooperate with procedures is impaired), including intellectual disability, organic brain disease and behavioral problems associated with uncooperative but otherwise healthy children
- Severe physical disorders affecting the tongue or jaw movements
- Seizure disorders
- Significant psychiatric disorders resulting in impairment of the member's ability to cooperate with procedures
- Previously demonstrated idiosyncratic or severe reactions to IV sedation medication

For more information about anesthesia, see the *Anesthesia Services* module.

Nitrous Oxide

The IHCP covers nitrous oxide analgesia only for members younger than 21 years old.

[2] *CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Intravenous (IV) Conscious Sedation

The IHCP provides medical reimbursement for intravenous sedation in a dental office when provided for oral surgery services only.

Prior authorization is required for IV sedation for members 21 years of age or older.

Nonintravenous Conscious Sedation (Monitored Sedation for Children)

The IHCP reimburses for monitored sedation for children, provided in the dentist's office, for members younger than 21 years old. Monitored sedation is the administration of subcutaneous, intramuscular or oral sedation, in combination with monitoring the patient's vital signs.

Providers should bill this service using service code D9248 – *Non-intravenous conscious sedation*. The IHCP does not cover nonintravenous conscious sedation for members aged 21 years or older.

Services Provided Outside the Dental Office

Per *405 IAC 5-14-14*, the IHCP reimburses covered services provided outside the dental office at the amount allowed for the same service provided in the office. It is not appropriate for providers to bill the IHCP or the IHCP member (or member's family) an *additional* charge for performing covered dental services in a hospital or surgery center setting.

Dental services provided to members in an inpatient hospital, outpatient hospital or ambulatory surgical center (ASC) setting (after obtaining authorization) must be billed as follows:

- **Dental-related facility charges** must be billed on an institutional claim (*UB-04* claim form, IHCP Portal institutional claim, 837I transaction).
- **Dental-related services** provided in an inpatient, outpatient or ASC setting can be billed with CDT codes on the *ADA 2012* dental claim form or electronic equivalent.
- All other associated **professional services**, such as radiology and anesthesia, as well as ancillary services related to the dental services, must be billed on a professional claim (*CMS-1500* claim form or electronic equivalent).

> *Note: An exception to this guidance is that physician-administered fluoride varnish (procedure code 99188) is allowed in the outpatient facility setting when billed with the appropriate revenue code on the institutional claim. See the Physician-Administered Topical Fluoride Varnish section.*

Physician-Administered Topical Fluoride Varnish

The IHCP covers physician-administered topical fluoride varnish for members from the time of first tooth eruption until the age of 4 years. Coverage requires the service be provided by or under the supervision of a physician. The IHCP recognizes the following provider types as eligible to render the service:

- Physicians
- Physician assistants
- Advanced practice registered nurses

Before performing and billing for this service, eligible providers are required to complete a certified training course.

Physician-administered topical fluoride varnish should be billed using CPT code 99188 – *Application of topical fluoride varnish by a physician or other qualified health care professional*. This service must be

billed on a professional claim form or, if the service is performed in a hospital or other outpatient facility setting, on an institutional claim form in conjunction with the appropriate revenue code.

Reimbursement is available for one physician-administered topical application of fluoride every six months per member. Billing for CPT code 99188 will not affect dental benefit limits.

Space Maintenance

Space maintenance in children with deciduous molar teeth is a covered IHCP service. Space maintenance for children under 3 years of age requires PA. Space maintenance for missing permanent teeth requires PA. Adjustment to space maintainers, bands and all other appliances included in the reimbursement for the service and may not be billed separately. All requests for PA will be reviewed on a case-by-case basis.

For all bridge devices and space maintainers, providers must indicate the tooth number for the tooth to which the device or appliance is cemented (the abutment tooth) on the *ADA 2012* claim form or its electronic equivalent.

Tobacco Dependence Counseling

The IHCP covers CDT code D1320 – *Tobacco counseling for the control and prevention of oral disease*. For IHCP reimbursement of D1320, the counseling must be rendered by the dentist.

The IHCP also covers the following CPT codes for tobacco dependence counseling:

- 99406 – *Smoking and tobacco use intermediate counseling, greater than 3 minutes up to 10 minutes*
- 99407 – *Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*

For more information on tobacco dependence counseling provided by practitioners other than dentists, see the *Behavioral Health Services* module.

> *Note: When providers furnish a service to the general public at no charge, including smoking cessation counseling services, they cannot receive IHCP reimbursement for that service. The Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) Program Integrity staff closely monitors adherence to this program limitation.*