PART II

POLICIES AND PROCEDURES
for
DENTAL SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: April 1, 2025

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Policy Revision Record

[October 2024 to January 2025[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
04/01/2025	802.2.4.3	Denture codes was added	M	
01/01/2025	900	Sedation units' clarification	M	
10/01/2024	Entire Manual	Entire manual was updated to include coverage related to Adult Dental Services. Coverage effective 7/1/2024.	A	Legislation
10/01/2024	Entire Manual	General Policy clarification, and editing Continued from quarter 1 ,2, 3 version edits	M	
10/01/2024	Chapter 800	Identification and clarification of services requiring prior approval or post review and document requirements	M	
10//01/2024	Section 900	Clarification and updates of benefit limits and frequencies for covered services	M	
10/01/2024	Appendix H	Consolidation of NEMT and GA Families to one appendix and addition of links to the document	M	
10/01/2024	Appendix B	Maximum Allowance FFS Schedule updated to include adult benefits	M	Legislation
10/01/2024	Appendix B1	Pregnant Women Only Benefits Updated to Coverage 12 months post-partum	M	Regulation
10/01/2024	Appendix C	Updated to Current Guidelines for Dental Records	M	
10/01/2024	Appendix I	HLD Index for Ortho	A	

[1] The revisions outlined in this Table are from 2024 to current. For revisions prior to 2024, please see prior versions of the policy.

601. Conditions

In addition to the conditions for participation outlined in Part I, dental providers must:

601.1. Hold a current, valid license to practice dentistry pursuant to Chapter 150-3. License requirement of the Rules and Regulations of the State of Georgia and must be enrolled, credentialed and re-credentialed by the centralized Credentialing Verification Organization (CVO) of the Georgia Department of Community Health. Provider Participation can include other license types.

601.1.1. Public Health License - holding a current valid Public Health Dentistry license, in accordance with the Georgia Board of Dentistry Rules, Chapter 150-7-01 and O.C.G.A., Sections (§§ 43-11-40 — 43-11-53, may be enrolled to render services as described below:

Providers enrolled under the Public Health license may render services within an official state or a local health department and their associated settings such as school-based health centers (SBHC); or in state-operated eleemosynary institutions as Medicaid applicable. The Public Health License enrollment status may not be used to render or bill for services rendered outside of the respective assigned Public Health entity setting.

601.1.2. Faculty License holding a current valid Faculty License, in accordance with the Georgia Board of Dentistry Rules, Chapter 150-7-02, may be enrolled for Medicaid participation.

Faculty License enrollment status is for the sole purpose to render services as described below:

For the sole purpose of teaching or instructing, in an accredited dental college or training clinic in this state, those procedures and services recognized in this state to be within the scope of practice of such person's professional license. Refer to Section 602 for service conditions.

601.1.3. Sedation Permits No dentist shall administer conscious sedation at the moderate level in Georgia in accordance with the definition of conscious sedation as defined by O.C.G.A. 43-11-1unless such dentist possesses a permit based on a credentials review.

Per Rule 150-13-.02 Deep Sedation/General Anesthesia Permits, when administration of deep sedation/general anesthesia is provided by another qualified dentist holding a current (Georgia) deep sedation/general anesthesia permit or by a physician anesthesiologist, the operating dentist and the staff must be

certified in cardiopulmonary resuscitation at the basic life support level given by a board-approved sponsor with an update not to exceed two years per board Rules 150-3-.08, 150-3-.09, 150-5-.04, and 150-5-.05. When a certified Registered Nurse Anesthetist (CRNA) is permitted to function under the direction and responsibility of a dentist, administration of deep sedation/general anesthesia by a CRNA shall require the operating dentist to have completed training in deep sedation/general anesthesia, commensurate with these guidelines.

601.2. The dentist agrees to bill the Division the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date(s) of service, or the lowest price charged to other third-party payers for the procedure code most closely reflecting the service rendered.

601.3. Providers must bill the Medicaid Program at the same usual and customary rate as charged to the general public and not at the published Medicaid fee schedule rate. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medicaid. Payment to providers will not exceed the maximum reimbursement rate of the Medicaid Program.

601.4. Agree to bill the Division for only those services rendered personally by the dentist, or by a dental hygienist under the dentist's direct or general supervision as outlined in Georgia Board of Dentistry Rule 150-5-.03 Supervision of Dental Hygienists and Georgia Code, Title 43, Chapter 11, Article3. Under no circumstances may a dental provider bill for services rendered by another dental practitioner or physician who is enrolled or eligible to enroll as a provider of services in the Medical Assistance program. except in the instance of locum tenens (Refer to section 602). Also, a dental provider may bill for covered services rendered by a dental auxiliary individual (i.e., dental school student, dental assistant, etc.) only when services performed by that individual is within the scope of delegated duties pursuant to Rules of the Georgia Board of Dentistry Chapter 150-9 Delegated Duties.

601.5. Maintain copies of submitted claims and all corresponding radiographs for a minimum of five (5) years from the date(s) the service(s).

601.6. Agree to notify the Division's Provider Enrollment Unit via the MMIS web portal should any change in enrollment status occur such as: new address or telephone number; additional practice or office locations; change in payee; close of any individual practice; dissolution of a group practice causing any change in the Division's records; and voluntary termination from the Medical Assistance program. Each notice of change must include the date on which the change is to become effective. (See Section 105.8 of Part I Policies and Procedures.)

601.7. Agree to bill the Division the procedure code(s) which best describes the service rendered and not to bill under separate procedure codes for services which are included under a single procedure code.

601.8. Agree to maintain accurate and contemporaneous dental records of all Medicaid Members of the practice and their corresponding dental visits and/or communication available timely upon request.

601.9. A proper and valid record must at a minimum include:

601.9.1. Patient's name and Medicaid number

601.9.2. Date of birth and address

601.9.3. Medical and dental histories, notes, and updates

601.9.4. Progress, operative and treatment notes (including dosage, type, route administration of any medication)

601.9.5. Diagnostic records, including charts, labeled radiographs, photographs, scans as applicable.

601.9.6. Medication prescriptions, including types, dose, amount direction for use and number of refills.

601.9.7. Referral letters and consultation with referring dentists and/or physicians

601.9.8. Patient noncompliance and missed appointment notes

601.9.9. Postoperative or home instructions, or a notation about any pamphlets or reference materials provided

601.9.10. Informed consent/refusal forms

601.9.11. Correspondence, including a dismissal letter; if appropriate

602. Locum Tenens

It is a long-standing practice for a dentist to retain a substitute dentist to take over his/her professional practice when the regular dentist is absent for reasons such as illness, pregnancy, vacation, or continuing dental education. The regular dentist will be able to bill and receive payment for the substitute dentist as though he/she performed the services himself/herself. The substitute dentist is generally called 'locum tenens' dentist.

Conditions for locum tenens arrangements:

602.1. The regular dentist (the dentist that is normally scheduled to see a patient) submits the claim under his/her NPI, using the appropriate CDT procedure codes.

602.2. The regular dentist, not the locum tenens dentist, receives any Medicaid payment for the service.

602.3. The regular dentist pays the locum tenens dentist for his/her services on a per diem or similar fee for-time basis (the locum-tenens dentist cannot be an

employee of the regular dentist or group practice).

602.4. The Medicaid Member is advised treatment being provided by locum tenens.

602.5. The locum tenens dentist provides the visit services to Medicaid patients over a continuous period of no longer than sixty (60) days.

602.6. The covering dentist must be an enrolled Medicaid provider. The locum tenens should have a valid Medicaid number in the State of Georgia.

602.7. Reimbursements will be for services which the regular dentist (or group) is entitled to submit. A dentist or other person who falsely certifies any of the above requirements may be subject to possible civil and criminal penalties for fraud.

602.8. Documentation by and of the locum tenens provider should be identified in the Member's dental record held by the regular dentist, which should be available for inspection upon request, and if using ADA Claim form 2024, mark box 53a if the treating dentist is providing services in a locum tenens capacity.

603. Faculty Licenses Dental Providers Reimbursement

Services provided by a Faculty License Dentist are eligible for reimbursement when the Faculty Dentist personally renders the services, or the services are rendered by a dental student in the presence of a Faculty Dentist.

These services must be rendered on the premises of an accredited School of Dentistry or training clinic, where the teaching dentist is employed within the scope of their position as a faculty member for the sole purpose of teaching and/or instructing.

Medicaid dental reimbursement is made only when:

603.1. The Faculty Dentist is present during the key portion of any exam, surgery or procedure for which payment is sought.

603.2. In the case of surgery, a dangerous or complex procedure, the Faculty Dentist must be present during all critical portions of the procedure and immediately available.

603.3. The Faculty Dentist must be present for the portion of the service that determines the level of service(s) billed.

603.4. The Faculty Dentist must personally document his/her presence and participation in the services in the patient's medical/dental record. Refer to the Georgia Board of Dentistry Rules, Chapter 150-7-02(2) and O.C.G.A. Secs. 43-1-42, 43-11-7, 43-11-8 and 43-11-52 for specific guidelines

Chapter 700: Member Eligibility Conditions

701. General

Under the Georgia Medicaid/PeachCare for Kids program, there are four (4) separate components of dental coverage: the HEALTH CHECK Program for Members under twenty-one years old (eligibility ends at the end of the month in which they turn twenty-one), PeachCare for Kids®, the State Children's Health Insurance Program (S-CHIP), the Adult Dental Program for Members twenty-one and older, and Dental Services for Pregnant Women.

The state's newest program, Georgia Pathways to Coverage™ members are eligible to receive the same State Plan benefits as other Medicaid groups, members ages 19 and 20 under Pathways receive the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) HEALTH CHECK benefits.

702. Health Check (Under 21) Dental Program

702.1. In the Health Check (COS 450) program, all children in Medicaid programs are covered by a provision called EPSDT (Early and Periodic Screening, Diagnosis, and Treatment). This provision includes the standard package of comprehensive and preventive health care services the state Medicaid plan offers all children from birth through age 20, who are enrolled in Medicaid through the categorically needy pathway, and any medically necessary nonstandard EPSDT requests.

702.2. Per the Federal EPSDT policy guidelines, per periodicity guidelines medically necessary, dental services must be provided to eligible members under twenty-one years of age.

702.3. Dental services required under the Health Check/EPSDT benefit include:

702.3.1. Dental care needed for relief of pain, infection, restoration of teeth, and maintenance of dental health (provided at as early an age as necessary); and

702.3.2. Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems, or cause irreversible damage to the teeth or supporting structures; and

702.3.3. Medically necessary oral health and dental services, including those identified during an oral screening or oral evaluation, are covered under the Health Check/EPSDT benefit.

The Member's proposed dental treatment plan must be completed within the scope of dental policies and procedures as outlined in this manual. Refer to Chapter 902—Covered Services and Appendix B.

702.3.4. DCH uses the American Academy of Pediatric Dentistry (AAPD) – Oral Health Policies & Recommendations (The Reference Manual of Pediatric Dentistry), dental providers should refer to the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents for best practice recommendations about anticipatory guidance and timing of other clinical modalities which promote oral health during infancy, childhood, and adolescence.

703. PeachCare for Kids Benefit Plan

703.1. PeachCare for Kids® is the State Children's Health Insurance Program (S-CHIP). Each child in the program has a Georgia Families Care Management Organization (CMO) who is responsible for coordinating the child's care.

703.2. Although EPSDT is not required in separate CHIP programs, Georgia provides Medicaid-based Secretary-approved coverage, which includes the EPSDT, Medicaid-based benefit package, available to PeachCare for Kids® members 18 and under (eligible until end of their 19th birthday). Refer to Chapter 902—Covered Services and Appendix B

703.3. Unless otherwise specified, all services approved for PeachCare for Kids® are subject to the same coverage limitation and reimbursement guidelines as outlined in this manual.

704. Adult Dental Program

704.1. Adult dental coverage begins on the first day following the end of the month the Member turned twenty-one.

704.2. Effective July 1, 2024, individuals over age 21and older will receive the following medically necessary dental services: diagnostic, preventive, restorative, periodontal, prosthodontic, orthodontic, endodontic, emergency dental services, and oral surgery (inpatient and outpatient).

705. Pregnant Women

705.1. Pregnant Women receive all the benefits as their applicable nonpregnant age category Health Check or Adults (new adult benefit effective July 1, 2024), to the extent of their eligibility period.

705.2. There are some additional services for pregnant women only, these services begin on the date of service following verification of pregnancy and extend 12 months post-partum. These are outlined in Covered Services Section 900 and Appendix B1 of this manual and identified as Pregnant Women Only.

705.3. Providers are required to validate eligibility and obtain written verification of pregnancy prior to rendering service (Refer to Appendix B 2, DMA Form 635—Attestation of Pregnancy Form).

C**hapter 800: Prior Approval**

801. General

As a condition of reimbursement, the Division requires Prior approval (PA) of certain services or procedures, to verify documentation of medical necessity and appropriateness of treatment plan, before being rendered to a member. Prior approval does not guarantee payment of submitted fees, ensure beneficiary eligibility on the date of service, or guarantee that a pre or post payment review of clinical documentation will not be conducted to determine whether a service or drug was medically necessary and covered under the member's benefit plan. The Member must be eligible for Medicaid and for the specific services at the time the services are rendered. (Members should be required to show their Medical Assistance Eligibility Certification at each appointment.)

To ensure that problems or questions are directed to the proper individual or unit, please keep the following information in mind:

801.1. The role of the fiscal agent includes claims processing, maintenance and printing of billing manuals, and all aspects of training in provider billing. Contact with the fiscal agent should be relative to these items. The fiscal agent can be contacted by phone 1-800-766-4456 or by selecting "Contact Us" on the electronic claim.

801.2. The role of Alliant Health Solutions (AHS) includes processing dental approval requests. The decision status for an authorization can be viewed on the MMIS Web Portal. Questions regarding an authorization should be directed to AHS 1-800-766-4456 option 5 or by selecting "Contact Us" on the authorization.

801.3. The role of the Medicaid Program Specialist for Dental Services includes interpretation of state or federal policies pertinent to dental services, training providers in policy matters, revising the Medicaid Dental Policies and Procedures Manual, assisting providers with complex or unusual policy problems, serving as liaison between the dental community and the Division and analysis and review relative to program utilization. Contact with the Program Specialist should be related to these items.

801.4. The role of the Dental Peer Reviewer is to review treatment plans for requested services and to determine medical necessity. The Peer Reviewer will consider all supporting documentation to render a decision for approval or denial. Any questions regarding Peer Review decisions may be directed to AHS at 1-800-766-4456 Option 5 or Contact Us on the authorization.

801.5. The role of the fiscal agent is to answer claim inquiries concerning billing problems and the status of claims submitted for payment (e.g., status of submitted claim, the reason a claim was denied or is in process, and how to complete a claim). If there are questions concerning the status of a claim or billing problems needing to be resolved, Gainwell Technologies can be contacted by phone at 1-800-766-4456 or by selecting "Contact Us" on the electronic claim.

For denied claims with explanation of benefit (EOB) code (for example

timeliness and conflict with another claim), the provider can request assistance with resolution by selecting the DMA-520 form, a link on the actual claim. The DMA-520 can be submitted for review by Gainwell Technologies of the claim's denial.

Please reference Part I Policies & Procedures for Medicaid/PeachCare for Kids, Chapter 200 for additional information to address a denied claim for any reason other than medical necessity.

For denied claims with denial reason code for medical necessity, (for example one extraction per tooth) the provider can submit a DMA-520A form, found on the MMIS Web Portal, Prior Authorization, Medical Review Portal. AHS will review the inquiry to determine if the claims denial is appropriate.

802. Services Requiring Prior Approval

Services, as described in 802.2, require Prior Approval before services are rendered unless otherwise noted below. Coverage guidelines including frequencies and limits for these services are included in **Chapter 900 Covered Services**. Failure to obtain the required prior approval prohibits reimbursement Services that require prior approval but are rendered in an emergency are exempt from prior approval but MUST be submitted **for post treatment review within thirty (30) calendar days from the date of service**. This process for post treatment review is also used for non-emergency services requiring post authorization or where post approval is allowed. An authorization request with supporting documentation (documentation requirements noted below), must be submitted on the MMIS Web Portal within thirty (30) calendar days from the date of service.

802.1. With all service requests, in determining approval as "Medically Necessary" or "Medical Necessity" which means health care services that a dentist, exercising prudent clinical judgment, would provide to a patient. See DCH Part I Policies and Procedures for general definitions including "prudent buyer" policy. In general services must be:

802.1.1. For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.

802.1.2. In accordance with the generally accepted standards of dental practice.

802.1.3. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease.

802.1.4. Not primarily for the convenience of the patient, health care provider.

802.1.5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

802.2. Specifically, designated services listed below require a Prior Approval before services are rendered or if allowed for post treatment review (post approval).

802.2.1. Prefabricated porcelain/ceramic crown- permanent tooth (D2928); Prefabricated stainless-steel crown-permanent tooth (D2931); Prefabricated resin crown primary or permanent (D2932); these codes require post approval.

Medical necessity is not indicated: 1) when a primary tooth is close to exfoliation, with more than half the root(s) resorbed; 2) when a more conservative restoration is indicated; 3) when solely provided for cosmetic purposes; 4) excessive tooth crown loss resulting in the inability for mechanical retention; 5) as a preventive measure for teeth with no evidence of pathology.

Preoperative radiographs (to include bitewings and periapicals), treatment plan, clinical notes as indicated should be submitted with requests. Documentation for other prefabricated crowns including D2930, D2934 should be kept in record and available upon request, if indicated.

802.2.2. Root Canal Therapy D3310, D3320 and Apicectomies D3410, D3426; prior approval required; post authorization allowed for emergency treatment but does not guarantee approval. Medical necessity considerations include:

802.2.2.1. Tooth must have adequate (50% bone or greater) periodontal support and adequate sound coronal structure for restoration.

802.2.2.2. Medical necessity indications include presence of irreversible pulpitis; pulpal necrosis; apical periodontitis; or frank vital carious pulpal exposure.

802.2.2.3. When the general oral condition indicates a poor and or uncertain periodontal, restorative, or endodontic outcome case may be denied due to the unfavorable prognosis of the involved tooth/teeth.

802.2.2.4. Surgical endodontics may be indicated when: 1) failed retreatment of endodontic therapy, 2) when the apex of tooth cannot be accessed due to calcification or other anomaly, 3) where visualization of the periradicular tissues and tooth root is required when perforation or root fracture is suspected.

802.2.2.5. Molar Root Canal Therapy D3330 is not a covered benefit under the standard Medicaid

program.

Sufficient and appropriate radiographs to evaluate the entire area of interest, including the full length of the root and at least 3 mm of periapical bone and visibility for periodontal attachment level, should be included. This includes periapical preoperative radiographs, bitewings, and any other supporting radiographic documentation. A treatment plan and indication of overall oral health condition should be included. **Section 802.1.5** is applicable in medical necessity determination. If endodontic treatment is done on an emergency basis the same documentation is required plus a post-op periapical radiograph. American Association of Endodontists White Paper for treatment standards https://www.aae.org/specialty/wp content/uploads/sites/2/2018/04/TreatmentStandards_Whitepaper.pdf

802.2.3. All Periodontal Services; prior approval only

802.2.3.1. Scaling and Root Planning (D4341, D4342) is indicated for the treatment of the following: 1) stage II-stage IV periodontitis with grade B or grade C progression (see American Academy of Periodontics (AAP) staging; or 2) periodontal abscess. (https://www.perio.org/wp-content/uploads/2019/08/staging-and-grading-periodontitis.pdf).

802.2.3.2. Gingivectomy procedures (D4210) is indicated for the following: 1) Elimination of suprabony pockets, exceeding 3mm, if the pocket wall is fibrous and firm and there is an adequate zone of keratinized tissue; 2) Elimination of gingival enlargements/overgrowth; 3) Elimination of suprabony periodontal abscesses; 4) Exposure of soft tissue impacted teeth to aid in eruption; 5) To reestablish gingival contour following an episode of acute necrotizing ulcerative gingivitis; 6) To allow restorative access, including root surface caries.

802.2.3.3. Gingival Flap (D4240, D4241) may be indicated 1) in the presence of moderate to deep probing depths; 2) moderate/severe gingival enlargement or extensive areas of overgrowth; 3) loss of attachment; 4) the need for increased access to

root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful; 5) the diagnosis of a cracked tooth, fractured root, or external root resorption when this cannot be accomplished by noninvasive methods.

802.2.3.4. Osseus Surgery(D4260) may be indicated for diagnosis of Stage III or Stage IV periodontal disease and/or when less invasive therapy (i.e., non-surgical periodontal therapy, Flap procedures) has failed to eliminate disease.

802.2.3.5. Pedicle Soft Tissue Graft (D4270) may be indicated for covering exposed tooth roots due to sensitivity or thickening existing gum tissue to halt further tissue loss; it is not reimbursable strictly for cosmetic reasons.

When requesting prior approval for procedure codes D4210, D4240, D4241, D4260, D4341, D4342, and D4910 the codes should be listed as separate line items for each quadrant needed (on the prior authorization) or each quadrant rendered (when filing for reimbursement on a dental claim). For example, if two quads of procedure code D4210 are being requested, list the code, D4210 on two separate line items and the quadrant coding scheme for the appropriate area of the mouth in the quadrant field. Separate fees assigned to each quadrant.

Pre-operative comprehensive radiographs (D0210 or Bitewings and periapicals); Complete periodontal charting and notation of periodontal diagnosis; a narrative documenting medical necessity are required. Photographic images may be applicable for services such as D4270.

802.2.4. Prosthodontic services: All Dentures, Partial Dentures and Medically Necessary Fixed Prosthodontic: prior approval only

802.2.4.1. Prosthodontics, Fixed, D6240 and D6750; have limited coverage available only for members whose medical or mental condition precludes the use of removable prosthodontics and must be documented by physician, included with submission notes, along with treatment plan, radiographs, clinical notes, and prognosis. All approvals for these procedures must be medically necessary as determined by AHS.

802.2.4.2. For the edentulous patient, an individualized radiographic examination, based on clinical signs, symptoms, and treatment plan is recommended. A panoramic radiograph should be submitted. If this radiograph is not available a full series of periapical radiographs and combination of occlusal, or other extraoral radiographs that may be used to achieve diagnostic goals should be submitted with request.

802.2.4.3. Removable Complete D5110, D5120, D5130, and D5140 or Partial Dentures D5211 and D5212 (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury.

802.2.4.4. Treatment plans and clinical notes for partials that indicate members with chronic poor oral hygiene, or abutment teeth that are in poor condition due to periodontal disease or extensive caries may not be considered for approval.

802.2.4.5. Treatment plans and clinical notes for dentures that indicate there has been extensive bone atrophy resulting in an inadequate edentulous ridge, poor neuro-muscular control; or unresolved soft tissue concerns (e.g., lack of vestibular depth, hypertrophy, hyperplasia, stomatitis may not be considered for approval.

Include treatment plan, treatment notes, radiographic documentation, and images of study models as applicable with request. Be sure to include tooth numbers being replaced for partial dentures.

802.2.4.6. Denture adjustment, repair relines- More than two denture adjustments, D5410, D5411, D5421, D5422: two laboratories reline, or two-tissue conditioning rendered to a member per calendar year; require prior approval.

Narrative or treatment plan notes should be submitted with request.

802.2.5. Oral & Maxillofacial Surgery: prophylactic removal of asymptomatic 3rd molars other than due to an underlying medical condition or orthodontics, is not covered. **The following services require prior approval:**

802.2.5.1. Surgical removal of erupted tooth D7210 (post approval allowed*

Indications include: 1) The fracture of a tooth or roots during a non-surgical extraction procedure (post approval allowed only in these instances)* 2) Erupted teeth with unusual root morphology (dilacerations, cementosis); 3) Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm; 4) When fused to an adjacent tooth; 5) In the presence of periapical lesions; 6) For maxillary posterior teeth whose roots extend into the maxillary sinus; 7) When tooth has been crowned or been treated endodontically.

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

802.2.5.2. Removal of impacted tooth – soft tissue D7220

802.2.5.3. Removal of impacted tooth – partially bony D7230

802.2.5.4. Removal of Impacted Tooth Complete Bony D7240

For impacted teeth determination is based on the definitions as noted:

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. (D7220)

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal (D7230)

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal (D7240)

802.2.5.5. Surgical removal of residual tooth roots (cutting) D7250

D7250 nomenclature this is a cutting procedure, which involves cutting soft tissue and/or hard tissue (bone). If the crown of the tooth is not present and the removal of the root is performed, no (cutting) is involved (i.e., elevator and/or

forceps removal), the appropriate ADA code should be used (i.e., D7140 - extraction, erupted tooth, or exposed root).

When tooth roots or fragments of tooth roots remain in bone following a previous incomplete tooth extraction by another provider or provider group. Not covered when the removal of residual tooth root(s) is performed by the same provider or within the same provider group that attempted the original failed extraction.

802.2.5.6. Surgical access of unerupted tooth D7280

Documentation should support indications of when a normally developing permanent tooth is unable to erupt into a functional position, or for labially impacted teeth if there will be 2-3 mm of gingival cuff present after eruption.

D7283 Placement of device to facilitate eruption of impacted tooth is not a covered benefit under the state program, as the approval of D7280 should be used in combination with orthodontic cases already approved or in treatment.

802.2.5.7. Excisional biopsy of minor salivary glands D7284

Narrative of medical necessity, other supporting info as indicated to support medical necessity.

802.2.5.8. Removal of exostosis D7471

Indications include: 1) if a partial or complete denture cannot be adapted successfully; 2) when causing soft tissue trauma with existing removable appliances; 3) for unusually large protuberances that are prone to recurrent traumatic injury; 4) when there is a functional disturbance, including, but not limited to mastication, swallowing and speech.

Radiographic and/or intraoral photographic image as indicated and narrative to support medical necessity.

802.2.5.9. All Alveoloplasty services, D7310, D7311, D7320, D7321

Indications for coverage of Alveoplasty: 1) For

bone recontouring and smoothing as part of the tooth extraction process or as a standalone procedure prior to fixed or removable prosthetic construction; 2) When removal or reshaping of irregular alveolar bone is necessary to prepare for radiation therapy or transplant surgery; 3) When it is necessary to remove alveolar bone arising from a pathologic condition.

802.2.5.10. Frenulectomy (Frenectomy), D7961, D7962

May be indicated: 1) When the frenum attachment causes gingival defects and/or loss of alveolar bone leading to a present or future detriment of the involved dento-alveolar complex; 2) When the position attachment of the Frenum is interfering with proper oral hygiene; 3) Prior to the construction of a removable denture replacing teeth in the area of aberrant frenal attachment; 4) When there is a functional disturbance, including, but not limited to mastication, swallowing, and speech; 5) For Ankyloglossia or papillary penetrating attachment of maxillary labial Frenum in newborns when there is interference with feeding.

802.2.5.11. Excision of hyperplastic tissue – per arch D7970

May be indicated when the presence of excess tissue interferes with the fit of a partial or complete denture

802.2.5.12. Excision of pericoronal gingiva D7971

May be indicated 1) For recurrent infections of the operculum around impacted or partially erupted lower third molars; 2) When an erupted maxillary third molar is traumatizing soft tissue around opposing tooth; 3) When the presence interferes with the fit of a partial or complete denture

Applicable preoperative radiographs should be submitted with request of any above bone and extraction procedures; a narrative and intraoral image(s) for D7961/D7962, D7970, D7971.

802.2.6. Medically Necessary Orthodontic Services (General Criteria)

Banding (D8080) and periodic visits (D8670) require prior

approval. D8670 is auto approved upon an approved or in treatment case of D8080 (for any eligible remaining D8670 units). The D8660 - Pre-Orthodontic Treatment Examination To Monitor Growth And Development, but must only be initiated on Members that present with probable medically necessary likelihood that there is a severe functionally handicapping malocclusion as defined in this section and any benefit plan policy documents.

The American Academy of Orthodontics (AAO) has led efforts to standardize criteria for determining which orthodontic cases are medically necessary. The Handicapping Labio-Lingual Deviation (HLD) Index is a quantitative method for measuring malocclusion and identifying dento-facial handicaps. The HLD Index is intended to measure the degree of handicap caused by these components, rather than to diagnose malocclusion.

Comprehensive orthodontic services will be authorized for the correction of severe functionally handicapping malocclusions on a case-by-case basis. As defined by the AAO services to alleviate, correct, or resolve a handicapping malocclusion (including craniofacial abnormalities and traumatic or pathologic anatomical deviations) that cause pain or suffering, physical deformity, significant malfunction, aggravates a condition, or results in further injury or infirmity may be considered medically necessary.

Guidelines used by AHS orthodontic consultants to determine medical necessity for orthodontic services are as follows:

802.2.6.1. Cleft Lip/Palate deformities and other significant craniofacial anomalies.

802.2.6.2. Deep impinging overbite that shows palatal impingement of the majority of lower incisors.

802.2.6.3. Severe Traumatic Deviations (e.g., accidental loss of premaxilla, gross pathology)

802.2.6.4. True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).

802.2.6.5. Anterior or posterior crossbite. (Involves three or more teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).

802.2.6.6. Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where

incisors or canines are going to erupt ectopically).

802.2.6.7. Overjet greater than 9 mm with incompetent lips

802.2.6.8. Reverse Overjet greater than 3.5mm.

802.2.6.9. Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.

Adult Orthodontic Coverage (Age 21 and older) is only for Members that present with one of the above auto qualifiers.

When none of the auto qualifiers apply but a Health Check member's condition results in an AHS verified score of 28 points or greater on the AHS version of the Handicapping Labial-Lingual Deviation Index form (Appendix I}, medical necessity may be indicated.

Prior authorization requests submitted for orthodontic services to improve physical appearance (cosmetic) and crowded dentition will not be approved.

The dental provider is responsible for evaluating the attitude of the patient and parent or guardian toward orthodontic treatment and their ability and willingness to follow treatment instructions and meet appointments, patients, or caregiver's ability to maintain an acceptable level of oral hygiene which is vital to success of orthodontic treatment during the treatment period. This evaluation should precede the taking of orthodontic records. And documented in notes with authorization submission.

802.2.7. Prior Authorization Request Procedures for Orthodontic Services

If after initial screening and evaluation the provider determines that the case might qualify as medically necessary, the provider should:

802.2.7.1. Submit an authorization request on the MMIS Web Portal. The provider should request procedure code D8080 for the banding, orthodontic appliance, and procedure code D8670, twelve (12) units, for the monthly maintenance visits. The authorization request

should be submitted with the actual DOS when the records were taken for D8660.

802.2.7.2. Attach the following as supporting documentation:

A panoramic, cephalometric image, or comprehensive series of intra-oral radiographic images

Digital Scan as indicated

Intraoral and extraoral facial photograph composite

A detailed narrative describing the patient's condition, medical necessity for orthodontics, anticipated compliance with treatment, estimated treatment period.

A completed Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet

802.2.7.3. Attachments can be added online once the prior authorization request is submitted, and a pending request ID has been generated. The 'create an attachment' link will be available for downloading the documents. If mailed for review, hardcopy documentation and orthodontic records will be returned to the provider.

802.2.7.4. If the case is denied, the provider may request a second clinical review by submitting a Reconsideration for the initial request via the MMIS Web Portal/Prior Authorization/ Medical Review Portal/Reconsideration (See Section 803.3) with additional information and/or documentation to support the medical necessity of this treatment. A narrative of rationale for this appeal can be attached or included in the reconsideration. When the second clinical review is completed, the decision can be viewed by the provider online.

802.2.8. Hospital Admissions (Inpatient and Outpatient)

802.2.8.1. The provision of dental care in a hospital operating room (OR) or ambulatory surgery center (ASC) requires prior approval.

802.2.8.2. All CDT codes to be rendered in the hospital setting must be on the dental authorization request. The treatment plan can be submitted prior to admission and the codes and units adjusted to actual treatment rendered by submitting a Change Request within 30 days of admit date.

802.2.8.3. The correct Place of Service must be noted on the authorization Request (POS 19 Off Campus-Outpatient Hospital, POS 22 On Campus-Outpatient Hospital, POS 21 Inpatient Hospital, POS 24 Ambulatory Surgical Center)

802.2.8.4. Hospital Call D9420 Requires Prior approval; include number of units as calculated.

*(Refer to Section 804 for Hospital/ASC request process and document requirements)

802.2.9. Consultation – D9310 Covered for Hospital Setting Only – post approval allowed

Narrative of medical necessity

802.2.10. D9110 Palliative (Emergency) Treatment of Dental Pain - Per Visit (post approval allowed

Narrative of medical necessity

802.2.11. Sedation/Anesthesia/Adjunctive Services

802.2.11.1. General Anesthesia; D9222; prior approval; D9223 post approval allowed up to seven units same member, same provider, same calendar year.

802.2.11.2. D9239 and D9243 – 8 units combined (120 minutes) can be provided without prior approval and billed upon completion of the treatment, same member, same provider, same calendar year. (D9239 first unit) (D9243 seven units). Intravenous Sedation, D9243 greater than seven units; post approval allowed.

Written narrative detailing the type of anesthesia/sedation to be used and rationale of medical necessity; radiographs; treatment plan; sedation scorecard as indicated.

Anesthesia/Sedation records should be submitted with the request if greater than 120 minutes submitted for approval.

All other anesthesia/sedation records should be available upon request.

802.2.11.3. Non-Intravenous Conscious Sedation, D9248; post approval allowed.

Submit narrative of rationale for medical necessity

802.2.11.4. Nitrous Oxide, D9230; review for age 13 and older post approval allowed.

Submit narrative of rationale for medical necessity

802.2.12. Therapeutic Parenteral Drug, single administration, D9610; post approval allowed

Narrative or chart notes with name of drug, dosage, quantity, and route of administration submitted with claim.

802.2.13. Other Drugs and Medications, D9630; post approval allowed.

Narrative is required to identify the type, dosage, and the technique for administering the drug or preventive product.

See section 902 for additional info

802.2.14. Behavior Management, D9920; only post approval is required.

Narrative describing the highest level of behavior management technique used for the member. Notation such as “additional staff and time” or “protective stabilization” should be documented.

802.2.15. Catastrophic Procedures Prior approval.

802.2.16. EPSDT medically necessary service, such as a service to correct or ameliorate (make tolerable) an identified condition, if that service otherwise would not be covered by the Medicaid program; prior approval required. All Health Check medically necessary limit exception requests; prior approval,

The Dental Peer Reviewer will consider all supporting documentation to render a decision for approval or denial and makes the final determination of medical necessity pursuant to O.C.G.A. 33-20A-31, and it is determined on a case-by-case basis. Services cannot be primarily for the convenience of the patient, health care provider, or other physicians or health care providers and is not costlier than an alternative service or sequence of services at least as likely to produce equivalent

therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

803. Prior Authorization Request Procedures

The procedures for submitting a prior approval request include:

803.1. Routine Prior Authorization Request

803.1.1. Submit an authorization request via the MMIS Web Portal for only those services which require pre or post approval. Diagnostic services (exams, prophylaxes, sealants, and x-rays) DO NOT require prior approval.

803.1.2. Submit any x-rays, charting and narrative necessary to support medical necessity and, circumstances, or services as listed in Section 802.1.

803.1.3. Post approvals requests must be submitted within thirty (30) days of date of service.

803.1.4. Authorization/Approvals are valid for twelve months from the date of determination. Providers must submit claims for services using the authorization number/request ID assigned when PA was submitted.

803.1.5. To be considered timely, claims must be submitted within six (6) months from the month of the actual date of services.

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

803.1.7. X-Ray film must be properly mounted, or digital film must be adequately printed, clearly readable, and free from defect. All clinical crowns and root tips must be observable on periapical x-rays. Bite wing x-rays should have reduced overlap. Panoramic x-rays should be free of errors.

803.1.8. The density and clarity must be such that interpretation can be made without difficulty. Defective or illegible radiographs will not be considered for review and must be remade without additional cost to the Division or the Member.

803.1.9. Digital x-rays should be attached to the authorization when submitted via the Medical Review Portal. Attachment can be added after submitting the request. Select "Create Attachment" on Pending Request ID Screen.

803.1.10. Hard copy x-ray film should be labeled with the patient's name,

Medicaid ID number and date of the x-ray. When it is necessary to send hard copy film, an authorization request should be submitted online, and the x-ray attached to a printed copy of the authorization.

803.1.11. Incomplete or unclear proposed treatment plan or treatment rendered, non-diagnostic x-rays for review or authorization requests submitted with missing information may be denied, additional information required. The requesting provider can submit an online reconsideration to include appropriate x-rays, additional information, or clarification.

803.1.12. The review process is resumed upon receipt of additional information. In some cases, questions related to an authorization may be directed to AHS at 1-800-766- 4456 option 5 or by selecting "Contact Us" on the authorization.

803.1.13. Once approved, an authorization number is valid for **12 (twelve) months**. The expiration date for rendering treatment is the end of the twelfth month following the month of the approval. Example: If the treatment is approved October 1, the expiration date will be October 30 of the following year.

803.1.14. All treatment must be completed by the expiration date. Extensions are not granted except for Orthodontic services on a case-by-case basis. Where the provider is unable to complete the approved treatment by the expiration date, a new prior authorization request with supporting documentation must be submitted via the MMIS Web Portal.

803.1.15. A provider should not begin the treatment until after the prior approval is received. When the services are rendered, the provider may submit to the fiscal agent for reimbursement (electronic or MMIS Web Portal; see Dental Billing Manual for specific billing procedures).

803.1.16. Each claim submitted for payment must be received by the Division's fiscal agent within six months of the actual month of service to be considered a timely submission. (See Section 202.2 Policy Part I).

803.1.17. The six-month law pertaining to claims submission and the authorization twelve months expiration date are two separate and distinct requirements.

803.2. Change or Addition to a Prior Approval (Change Request)

803.2.1. In some cases, a change or addition to an approved prior authorization may be necessary. A Change Request, for a specific authorization, may be submitted via the MMIS Web Portal/Prior Authorization/Medical Review Portal/Change

Request. When the changes have been processed, updates to the authorization can be viewed by the provider online.

803.2.2. After the change request has been processed, the provider must submit a new claim for the additional treatment approved. To be considered a timely submission for payment, the claim must be received within six months from the month service was rendered.

803.3. Reconsideration for Adverse Determination

Providers not in agreement with an adverse determination may request a second clinical review by submitting a reconsideration via the MMIS Web Portal/Prior Authorization/Medical Review Portal/Reconsideration. An explanation of medical necessity, supporting documentation and related radiographs should be attached. When the second clinical review is completed, the provider can view the decision online.

803.4. Emergency Services

803.4.1. Emergency services are such that the Member needs immediate attention for relief of pain or needs repair due to a severe injury. Because of the Member's condition, the services must be rendered immediately, thereby causing the normal prior approval procedures to be impractical.

803.4.2. Emergency services may be rendered in a dental office or hospital setting. In emergency situations, the services may be rendered without prior approval but must be submitted via the MMIS Web Portal to AHS for post-treatment review. Attach all necessary clinical information that explains why the services rendered were deemed to be emergent. The request for authorization should be submitted immediately after the services are rendered. If the authorization request for emergency services is not received within thirty (30) days of date of service, post approval will not be granted.

803.4.3. Services the Division does not consider emergent treatment include but may not be limited to crowns, dentures, periodontal services, periodontal scaling, and root planning or asymptomatic third molars.

804. Non-Emergency Hospital/Ambulatory Surgical Center Admission Pre-certification

All dental services rendered as an inpatient or outpatient admission must be Prior Approved and/or Pre-certified for Medicaid members regardless of age and service being performed. It is the responsibility of the attending dentist to obtain prior approval and/or precertification by submitting a request via the MMIS Web Portal using the Hospital Admissions and Outpatient Procedures (Form Number: GMCF form PA81/100). All planned dental services should be included on the request. Complete documentation and clinical information should be given to warrant dental services in the hospital setting. As stated in the Ambulatory Surgical Center Policy and Procedure Manual section 903.10: medically necessary dental

surgeries can be performed in an Ambulatory Surgical Center. Whether hospital or ASC, the correct Place of Service Code (POS) should be used.

Procedures for submitting a prior authorization request and obtaining pre-certification for the hospital request are as follows:

804.1. Hospitalization for non-emergency dental procedures requires prior approval and pre-certification for all eligible members, regardless of age. Hospitalization may be either on an inpatient or outpatient basis.

804.2. An "inpatient" is defined as a patient who has been admitted to a participating hospital on recommendation of a licensed practitioner and is receiving room, board, and professional services in the hospital on a continuous twenty-four hour a day basis. A length of stay less than twenty-four hours may be considered inpatient if the service can only be provided on an inpatient basis.

804.3. An "outpatient" is defined as a patient who is receiving professional services at a participating hospital or ASC. Free standing (satellite) clinics, which are not operated as part of a hospital, are considered doctors' offices. Services provided in these clinics and other away-from-hospital settings are not covered in the Hospital Program. If the condition of the Member allows, use of the outpatient ambulatory facility is preferable to an inpatient admission.

804.4. Requests for approval for hospitalization or ASC are limited to those cases which cannot be managed in the dental office setting due to the existence of one or more of the following conditions or situations:

804.4.1. Members that are medically compromised or those with special needs, (specific diagnosis or problem(s) should be stated)

804.4.2. Members with physical, cognitive, or developmental disabilities, (Document specific disability or special need)

804.4.3. Extremely young Member, (extremely young is considered by the Division to be three (3) years old or younger)

804.4.4. Complex or extensive dental rehabilitation procedure(s) performed on a Member who requires monitored anesthesia (e.g., general, intravenous sedation, monitored anesthesia care) and use of an operating room

804.5. When submitting a precertification request on the MMIS Web Portal for hospital/ASC admission, the prior approval procedures should be followed.

804.5.1. The provider should select the Hospital Admissions and Outpatient Procedures (Form Number: AHS form PA81/100).

804.5.2. The provider should include the facility Reference ID using 'REF' and the 9-digit number.

804.5.3. A detailed narrative of medical necessity must be included in the

request for approval of precertification, along with radiographs, scorecards, and any other supporting documentation of medical necessity. All reasonable effort must be exercised to complete the treatment in the office.

804.5.4. The provider should list each planned dental service (CDT code) and number of units for that code as a separate line item. If the actual treatment rendered differs from the initial treatment approved, the provider can submit a Change Request for additional codes and units. The changes must be submitted within thirty (30) days of the admit date.

804.5.5. The provider may schedule the hospital admission once the authorization has been approved. An authorization request cannot be expedited to accommodate dental surgeries scheduled prior to the completion of the review by AHS.

804.5.6. The provider has the right to request a Reconsideration for second clinical review of a denied pre-certification request.

804.5.7. The provider is responsible for obtaining the pre-certification approval. The pre-certification number should be made available to the hospital prior to admission.

804.5.8. Telephone requests for hospital pre-certification are granted only in emergency situations. In non-emergency situations a provider should not admit a member to the hospital prior to receiving approval for hospital dental services.

804.5.9. The attending dentist must provide the dental precertification/authorization number to the hospital/ASC for the facility to obtain medical administrative review approval.

804.5.10. The dentist's failure to obtain a dental authorization will result in denial of payment for services rendered and any facility fees.

804.5.11. Coordination of services – every attempt should be made to complete all treatment necessary during one hospital stay. Surgeries between OMFS, general dentist and/or physician should be submitted under one authorization request to include all services planned by each provider. Only one pre-cert is allowed per admission.

804.5.12. The pre-certification number is valid for 90 days from the date of approval. If the pre-certification number effective dates become invalid, the dental provider must submit a Change Request to AHS via the MMIS Web Portal/Prior authorization/ Medical Review Portal /Change Request to edit for new admission date. If a Change Request is not possible, provider should submit the new admit date via the 'Contact Us' link on the initial authorization.

805. Emergency Hospital Admission - Health Check and Adult Program

805.1. Situations that require emergency hospital admission do not require prior approval. These cases are subject to post-treatment review and a hospital pre-certification must be submitted on the MMIS Web Portal within thirty (30) days of admit date. All emergent dental treatment and surgical procedures rendered must be on the request. Operative notes, x-rays, and narrative of medical necessity should be included. As noted above, it is the dental provider's responsibility to obtain the pre-certification number and give it to the hospital/ambulatory surgery center.

805.2. Certification acknowledges only the medical necessity and appropriateness of the setting. Services approved should be billed by the rendering provider using the authorization number/request ID assigned.

805.3. If an emergency hospital admission is determined as not medically necessary, the services may be denied retrospectively. The provider can submit a reconsideration with additional information for second clinical review.

806. Facility Precertification and Billing

The Provider/treating dentist should submit for the professional component of the dental services rendered using the appropriate Current Dental Terminology (CDT) codes as provided on the precertification request. At least one unit of D9420 should be included on precertification request. Procedure code D9420 is to be used by the ASC/hospital to bill for the facility fee. No other dental procedure code should be used by the ASC/hospital to bill for the technical component of the dental or surgical services being performed. The Division does not allow precertification and billing for facility fee for dental office setting (POS 11).

The appropriate anesthesia code should be used, for general anesthesia in a hospital/ASC facility, CPT code 00170 should be used and does not require prior approval.

Chapter 900: Scope of Services

901. General

Dental services are defined as any diagnostic, preventive, or corrective procedures administered by or under the direct or general supervision of a licensed dentist. These services may include treatment of teeth and associated structures of the oral cavity and treatment of disease, injury, or impairment that may affect the oral or general health of the individual. Services are subject to the limitations established under the Georgia Medicaid program.

The Division of Medical Assistance statewide maximum allowable payment for each procedure is listed in Appendix B. This is not a fee schedule. As required by this Policy Manual and the Statement of Participation, dentists must bill the Division no more or less than their usual and customary fees. "Usual and customary" is defined as the fee charged to private paying patients for the same procedure or service during the same period. Dentists must not change their fees to reflect those listed in this schedule, even if fees are higher than the maximum allowable payments for the services rendered. Usual, Customary, and Reasonable (UCR)" refers to the UCR, a term used in healthcare to determine the fair and reasonable pricing for medical or dental services in a particular geographic area. Providers' usual and customary submitted fees are recorded and are used when the maximum allowable payments are updated.

901.1. Coding of Claims

The Code on Dental Procedures and Nomenclature- Current Dental Terminology (CDT) (including procedure codes, nomenclatures, descriptors, and other data contained herein), has been obtained from the American Dental Association. CDT is copyright of the American Dental Association. Providers are required to bill for services using the appropriate CDT codes that best describes the level and complexity of the services rendered or proposed.

901.1.1. Terminated CDT codes are not eligible for reimbursement.

901.1.2. Unspecified or unlisted" procedures codes are not payable by the Division.

901.1.3. Updates to the ADA CDT codes nomenclature are effective the first day of January following the month of ADA official publication or as indicated

901.1.4. Providers will be notified of the effective date of related changes. The provider is responsible to remain current on the updates and maintain current ADA CDT publications.

901.1.5. The most current iteration of the ADA claim should be used. (ADA 2019, ADA 2024)

The ADA Dental Claim Data Recommendation Guideline Reporting Area of the Oral Cavity and Tooth Anatomy by CDT

Code should be used for which codes per standard require a tooth number, quadrant, surface, etc. unless already noted with the CDT code.

902. Covered Services

This program is intended to assist eligible Medicaid and PeachCare for Kids eligible members in obtaining dental screenings, diagnostic, preventive, and treatment services which decrease the chance of future more complex oral and overall health problems.

Effective July 1, 2024, all procedure codes indicated in Appendix B are available to Members regardless of age.

Pregnant Women dental coverage has been extended to the duration of the member's eligibility. A completed DMA 635 "Attestation Pregnancy Form" from their PCP, OB/GYN or other appropriate licensed health care provider must be presented for pregnancy only benefits.

902.1. Diagnostic (Clinical Oral Evaluations)

Clinical oral evaluations are reimbursable depending on the type of evaluation completed and the age of the Member. The evaluations covered are comprehensive oral evaluation (initial and periodic), limited oral evaluation (examination during office hours), periodontal evaluations (for pregnant women), and office visit after regularly scheduled hours (emergency evaluation). The evaluations are described in subsequent paragraphs.

902.1.1. D0120 Periodic Oral Evaluation – established patient (Health Check and Adults)

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures.

Benefit is one (1) periodic oral evaluation (D0120) per 6 months.

The periodic oral evaluation may not occur in combination with the comprehensive oral evaluation (D0150) until at least 180 days after the comprehensive oral evaluation. Not payable same date of service as D0140 or D9440.

902.1.2. D0140 Limited Oral Evaluation-problem focused, (Health Check and Adults)

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. The comprehensive or the periodic exam my not occur in conjunction with a limited oral evaluation, D0140, or examination after

office hours, D9440. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date of service as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

Use of this service may not exceed two (2) times per Member, per calendar year.

902.1.3. D0150 Comprehensive Oral Evaluation - new or established patient (Health Check and Adults)

Applies to new patients being evaluated comprehensively by a general dentist and/or specialist servicing provider group or payable once per thirty-six (36) months per servicing provider group for established patients who have been absent from active treatment for three or more years. Established patients who have had a significant change in health condition or other unusual circumstances by report less than 36 months, approval required.

Only one of (D0120, D0150) per 6 months per provider group. Not payable same date of service as D0140 or D9440.

902.1.4. D0180 Comprehensive Periodontal Evaluation - new or established patient (Pregnant Women only)

Reimbursable once every three calendar years per servicing provider/group unless medical necessity can be documented for additional service. Not payable on same date of service with D0150, D0120.

902.1.5. D9440 Office Visit - After Regularly Scheduled Hours (Health Check and Adults)

This examination is reimbursable for emergency situations, which occur after regularly scheduled office hours. This examination may be completed in either an office or hospital setting. The location and time should be indicated in the chart and listed as Place of Service on the electronic claim.

Scheduled appointments cannot be billed as an emergency exam, D9440.

An examination after office hours, D9440, cannot occur in conjunction with the comprehensive periodic or limited exam.

If D9440 is rendered in a hospital setting, a precertification must be submitted, or the code must be added to an existing precertification for the date of service.

Use of this service is not to exceed two (2) times per Member,

per calendar year.

902.2. Diagnostic (Imaging)

Radiographs (Excluding Panoramic Films) are subject to $100 calendar year maximum reimbursement for all Medicaid Members

All teeth or areas involved in the treatment request must be visible. Radiographs presented for review must meet the following specific criteria:

X-Ray film must be properly mounted, or digital film must be adequately printed, clearly readable, and free from defect.
The density and clarity must be such that interpretation can be made without difficulty.

Hard copy x-ray film should be labeled with the patient's name, Medicaid ID number and date of the x-ray. When it is necessary to send hard copy film, an authorization request should be submitted online, and the x-ray attached to a printed copy of the authorization.

Digital x-rays should be attached to the authorization when submitted via the Medical Review Portal. Attachment can be added after submitting the request. Select "Create Attachment" on Pending Request ID Screen.

All clinical crowns and root tips must be observable on periapical x-rays. Bitewing x-rays should have reduced overlap. Panoramic x-rays should be free of errors.

Defective, non-diagnostic or illegible radiographs will not be considered for review and must be remade without additional cost to the Division or the Member.
Radiographs must be maintained by the provider for a period of five years.

902.2.1. Comprehensive Radiographic Images

The two types of comprehensive radiographs, reimbursable under this program are intraoral – comprehensive ser of radiographic images including bitewings (D0210) and Panoramic radiographic image (D0330).

These two types of full mouth radiographs are mutually exclusive within a three (3) calendar year time frame.

902.2.1.1. D0210 Intraoral-comprehensive set of radiographic images including bitewings (Health Check and Adults)

A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas, and alveolar bone including edentulous areas. The

radiographs must comply with the conditions in Section 902.1.

902.2.1.2. D0330 Panoramic radiographic image (Health Check and Adults)

Panoramic radiograph is limited to once every three calendar years and is not included in the $100 per calendar year limit allowed for x-rays. Panoramic option is limited to members (5) five years of age and older.

A panoramic radiograph may be used in lieu of the comprehensive set of radiographs, but as a diagnostic tool, may not be sufficient to allow the appropriate quality review of treatment plans. If the dentist elects to submit a panoramic x-ray, periapical frames, occlusal x-rays and/or bitewings for the appropriate treatment areas, that are taken the same date of service, x-rays are reimbursable up to an amount equal to that of a comprehensive series.

902.2.2. Individual Periapical Radiographs (Health Check and Adults)

Periapical are not considered reimbursable when part of the procedure. The total number of individual periapical images taken per date of service is reimbursable up to the amount of a comprehensive series.

902.2.2.1. D0220 Intraoral-periapical, first film

902.2.2.2. D0230 Intraoral-periapical each additional film Procedure code D0230 is reimbursable up to six times per date of service) amount reimbursable to comprehensive series. When billing for this service, list the total number of films taken for D0230.

902.2.3. Occlusal film (Health Check and Adults)

D0240 Intraoral Occlusal film - When billing for this service, list the total number of films taken for D0240, limited to two per calendar year.

902.2.4. Individual Bitewing Radiographs (Health Check and Adults)

902.2.4.1. D0270 Bitewing, single radiographic image

902.2.4.2. D0272 Bitewings, two radiographic images

902.2.4.3. D0274 Bitewings, four radiographic images

When billing for three (3) bitewings, procedure codes D0270 and D0272 must be used.

902.3. Laboratory/Pathology (Health Check and Adults)

902.3.1. D0604 antigen testing for a public health related pathogen, including coronavirus (1 per date of service)

902.3.2. D0605 antibody testing for a public health related pathogen, including coronavirus (1 per date of service)

902.4. Preventive (Prophylaxis) (Health Check and Adults)

Prophylaxis and fluoride are reimbursable as separate services.

Prophylaxis includes the necessary scaling of the teeth to remove calculus deposits and the polishing of the teeth. The application of topical fluoride is considered a separate part of the prophylaxis treatment and should not be included in the prophylaxis charge.

902.4.1. D1110 Prophylaxis-adult

To be used for permanent dentition. (Reimbursable only age 13 and older)

Removal of plaque, calculus, and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irrigational factors.

902.4.2. D1120 Prophylaxis-child

Refers to a dental prophylaxis performed on primary or transitional dentition

One (1) prophylaxis (one of D1110, D1120) per six-month period

902.5. Preventive (Topical Fluoride) (Health Check and Adults)

902.5.1. D1206 Topical application of fluoride varnish

Therapeutic application for moderate to high caries risk patients

902.5.2. D1208 Topical application of fluoride

Only two fluoride treatments (i.e.., two of D1206 or one D1206 and one D1208 or two of D1208) are reimbursable per member, per calendar year (12 months).

902.6. Other Preventive Services (Health Check and Adults)

902.6.1. D1351 Sealant-per tooth

Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are covered for adults only if narrative documented with claim notes high caries risk (due to conditions such as xerostomia, medical condition, etc.)

Topical application of sealants is covered once per tooth in a four calendar-year (48-month) period.

Sealants are reimbursable for permanent first and second molars only (teeth numbers 2, 3, 14, 15, 18, 19, 30 and 31).

No reimbursement will be made for sealants replaced within the four-calendar year period or for sealants placed on premolars or deciduous teeth. No reimbursement for D2940 as a sealant treatment.
Teeth to be sealed must be free of proximal caries and there can be no restorations on the tooth to be sealed. Sealant material to be used must be ADA approved.

902.6.2. D1354 Application of caries arresting medicament – per tooth

Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

One application per tooth per date of service. Two per tooth per lifetime.

902.6.3. D1355 Caries preventive medicament application – per tooth

For primary prevention or remineralization. Medicaments applied do not include topical fluoride.

One application per tooth per date of service. Two per tooth per lifetime.

902.7. Space Management Therapy (Health Check and Adults)

Space maintainers are to be considered after the premature loss of a deciduous tooth when there is an indeterminate time before the eruption of the permanent tooth or teeth.

Space management therapy and palliative treatment no longer require prior approval.
The coding scheme for the fixed band, unilateral space maintainers is as

follows:

10 = upper right
20 = upper left
30 = lower left
40 = lower right

902.7.1. D1510 Space maintainer: fixed-unilateral, per quadrant

902.7.2. D1516 Space maintainer: fixed-bilateral, maxillary

902.7.3. D1517 Space maintainer: fixed-bilateral, mandibular

902.7.4. D1526 Space maintainer: removable-bilateral, maxillary

902.7.5. D1527 Space maintainer: removable-bilateral, mandibular

Covered when indicated per EPSDT due to premature loss of posterior primary teeth. However, general parameters:

One (D1510) per quadrant per lifetime
One (D1516) per maxillary arch per lifetime
One (D1517) per mandibular arch per lifetime
One (D1526) per maxillary arch per lifetime
One (D1527) per mandibular arch per lifetime

902.7.6. D1551 Re-cement/re-bond bilateral space maintainer Maxillary

902.7.7. D1552 Re-cement/ re-bond bilateral space maintainer Mandibular

902.7.8. D1553 Re cement/re-bond unilateral space maintainer per Quadrant

Not covered within six (6) months of initial placement by same provider group

The coding scheme for the fixed bilateral and removable-acrylic bilateral space maintainer, re-cementation of space maintainer and appliance removal of space maintainer is as follows:
01 = upper 02 = lower

When billing for procedure codes D1510, D1516, D1517, D1526, and D1527, the appropriate code must be put in the tooth number field on the claim form. For example, if the treatment plan includes a maxillary acrylic removable bilateral space maintainer, put “01” in the tooth number field and procedure code D1526 in the procedure code field. Indicate the fee in the fee field on the claim form.

When billing for procedure code (D1551, D1552, D1553) the

appropriate code must be put in the tooth number field on your claim. For example, if the treatment plan includes a fixed band unilateral space maintainer for the upper left quadrant, put "20" in the tooth number field and the proper CDT in the procedure code field. For the lower right, put "40" in the tooth number field, and the proper CDT on the next line in the procedure code field. Separate fees for these services must be indicated for each line item in the fee field on the claim.

902.7.9. D7997 Appliance Removal (not by dentist who placed appliance), includes removal of arch bar.

The reimbursement for the removal of a space maintainer (D7997) is only reimbursable to the provider that did not originally insert the space maintainer. This service does not require approval. You MUST use the appropriate coding scheme for the unilateral (10, 20, 30, 40) or bilateral space maintainer (01 for maxillary and 02 for mandibular).

902.8. Restorative (Health Check and Adults)

Only one (1) restorative (filling) procedure code is reimbursable per tooth, per surface per 12 months.

All surfaces must be identified on the claim form to receive reimbursement.

The coding scheme for surfaces is as follows:

M – Mesial D - Distal

L – Lingual B – Buccal F – Facial

O – Occlusal I – Incisal

No reimbursement will be allowed for permanent restorations placed on primary teeth where an early loss of teeth is expected.

902.8.1. Amalgam Restorations

All adhesives, liners and bases are included as part of the restoration

902.8.1.1. D2140 Amalgam-one surface, primary or permanent

902.8.1.2. D2150 Amalgam-two surfaces, primary or permanent

902.8.1.3. D2160 Amalgam-three surfaces, primary or permanent

902.8.1.4. D2161 Amalgam-four surfaces, primary or permanent

902.8.2. Resin-Based Composite Restorations – Direct

Tooth preparation, acid etching, adhesives, liners, bases, and curing are included as part of the restoration.

902.8.2.1. D2330 Resin–based composite; one surface, anterior

902.8.2.2. D2331 Resin-based composite; two surfaces, anterior

902.8.2.3. D2332 Resin-based composite; three surfaces, anterior

902.8.2.4. D2335 Resin-based composite; 4 or more surfaces, anterior

902.8.2.5. D2391 Resin based composite-one surface posterior

902.8.2.6. D2392 Resin based composite-two surfaces, posterior

902.8.2.7. D2393 Resin based composite-three surfaces posterior

902.8.2.8. D2394 Resin based composite-four or more surfaces posterior

Posterior composite and amalgam restorations are reimbursable based upon total number of restored surfaces. For example, non- contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three-surface restoration.

Anterior composite restorations, non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three-surface restoration.

902.9. Restorative (Crowns – Prefabricated) (Health Check and Adults)

902.9.1. D2928 Prefabricated Porcelain Ceramic crown-permanent tooth

902.9.2. D2930 Prefabricated stainless steel crown-primary tooth.

902.9.3. D2931 Prefabricated stainless steel crown-permanent tooth.

902.9.4. D2932 Prefabricated resin crown primary or permanent

D2932 limited to anterior teeth from cuspid to cuspid-maxillary to mandibular. Anterior teeth numbers are 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27; and C - H, M -R.

902.9.5. D2934 Prefabricated esthetic coated stainless-steel crown - primary tooth.

D2934 payable only for anterior teeth from cuspid to cuspid-maxillary to mandibular. Teeth C - H, M – R

A member may have one (1) Prefabricated crown, per tooth per lifetime.

902.10. Other Restorative Services (Health Check and Adults)

902.10.1. D2920 Re-cement or re-bond crown

One per tooth per 12 months; not payable within 6 months to provider group that placed crown

902.10.2. D2940 Placement of interim direct restoration

Used to protect tooth and or tissue form, relieve pain, promote healing, manage caries

One per tooth per 12 months

902.10.3. D2951 Pin Retention per tooth, in addition to restoration.

902.10.4. D2954 Prefabricated post and core in addition to crown

Core is built around a prefabricated post. This procedure includes the core material.

Once per tooth per lifetime.

902.10.5. D2991 Application of hydroxyapatite regeneration medicament per-tooth.

Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration.
One application per tooth per 12 months. Up to four payable per date of service. Narrative should be submitted with claim.

902.11. Endodontics (Pulpotomy) (Health Check and Adults)

902.11.1. D3220 Therapeutic pulpotomy (excluding final restoration); removal of pulp coronal to the dentin cemental junction and application of medication.

Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

To be performed on primary and permanent teeth. This is not to be construed as the first stage of root canal therapy

Once per tooth per lifetime. More than eight per date of service subject to post payment review.

902.11.2. D3221 Pulpal Debridement, primary and permanent teeth.

Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

Once per tooth per lifetime

902.12. Endodontics (Endodontic Therapy) (Health Check and Adults)

902.12.1. D3310 Anterior tooth (excluding final restoration)

Procedure code D3310 can be used for either a deciduous (per tooth) root canal or a one canal, permanent root canal.

902.12.2. D3320 Bicuspid tooth (excluding final restoration)

The Division will reimburse for either root canal therapy (codes D3310 or D3320) or Emergency - Open Pulp Chamber (code D3221—pulpal debridement, primary and permanent teeth), but not both.

To be consistent when billing root canal services, the date the canal is completed should be used as the date of service.

Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, x-rays during treatment, and post-operative x-rays

(Refer to Appendix E for instructions on billing procedures for open pulp-chamber to establish drainage and partially completed endodontic therapy).

Endodontic therapy is once per tooth per lifetime. Retreatment is not a covered benefit under program.

902.13. Periradicular Services

902.13.1. D3410 Apicoectomy/periradicular surgery-anterior for surgery on root of anterior tooth. Does not include placement of retrograde filling material.

Teeth covered 6 – 11; 22 – 27

One per tooth per lifetime

902.13.2. D3426 Apicoectomy/periradicular surgery (each additional root)

Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. Does not include retrograde filling material placement. Teeth covered; 2 - 5, 12 - 21, 28 – 32

One per tooth per lifetime (regardless number of roots per tooth)

902.14. Periodontal Services (Health Check and Adults)

All periodontal services must be prior approved. These services are not considered emergency procedures and must be submitted as prior approvals.

902.14.1. D4210 Gingivectomy or Gingivoplasty four or more contiguous teeth or bounded teeth spaces, per quadrant

Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal level. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, and to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.

One per quadrant per 12 month(s)

902.14.2. D4240 Gingival flap procedure, including root planning, four or more contiguous teeth or bonded teeth spaces, per quadrant.

902.14.3. D4241 Gingival flap procedure, including root planning, one to three contiguous teeth or bonded teeth spaces per quadrant. (Pregnant Women Only)

902.14.4. D4260 Osseous Surgery (including flap entry and closure)-four or more contiguous teeth or bounded teeth spaces, per quadrant

D4240, D4241, D4260 one per quadrant per 12 month(s)

902.14.5. D4341 Periodontal Scaling and Root Planning, four or more teeth per quadrant. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces

902.14.6. D4342 Periodontal Scaling and Root Planning, one to three teeth per quadrant. This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and

calculus from these surfaces. (Pregnant Women Only)

The coding scheme for gingivectomy- D4210, gingival flap- D4240, D4241, osseous surgery- D4260, periodontal scaling and root planning- D4341, D4342 is as follows:

10 = upper right 20= upper left
30 = lower right 40 = lower left

One (D4341, D4342) per 12 month(s) per quadrant

902.14.7. D4910 Periodontal Maintenance –

This procedure is instituted following periodontal therapy and continues at varying intervals for the life of the dentition. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planning where indicated, and polishing the teeth. (Pregnant Women Only)

Once per 4 month(s) in combination with D1110, D1120 cannot exceed four times per 12 month(s)

902.15. Prosthodontic Services, Removable (Dentures)

902.15.1. D5110 Complete denture - maxillary

902.15.2. D5120 Complete denture – mandibular

902.15.3. D5130 Immediate denture – maxillary

902.15.4. D5140 Immediate denture – mandibular

One denture per arch per 60 month(s). No reimbursement will be made for dentures replaced or remade within a 60-month period.

The diagnosis for dentures should be based on the total condition of the mouth, the age of the patient, the ability to adjust to dentures, and the desire to wear dentures. Removable Complete or Partial Dentures (including Immediate Complete and Partial Prostheses) are indicated for the definitive replacement of missing teeth lost due to disease, trauma, or injury. Natural teeth, which are sound and have healthy bone and a positive prognosis, should not be removed.

A Member should not be rendered edentulous before approval of dentures.

The practitioner is requested to impress upon the patient the importance of taking care of the dentures. Stolen, lost or broken dentures are not sufficient justification for replacement.

To be consistent when billing for dentures, the date of placement must be used as the date of service when submitting for payment of dentures. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill.

The dentist is responsible for constructing a complete and functional denture.

If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture; does not include required future rebasing/relining procedure(s).

902.16. Prosthodontic Services, Partial Dentures

One partial denture per arch per 60 month(s). No reimbursement will be made for partial dentures replaced or remade within a 60-month period.

902.16.1. D5211 Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)

902.16.2. D5212 Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)

One-tooth maxillary partial is only covered for replacing anterior teeth. Tooth numbers 6, 7, 8, 9, 10, or 11. One tooth partial is not allowed for missing one posterior tooth. There is a tiered fee for one tooth partials.

One-tooth mandibular partial is only covered for replacing anterior teeth. Tooth numbers 22, 23, 24, 25, 26, or 27. One tooth partial is not allowed for missing one posterior tooth. There is a tiered fee for one tooth partials.

When billing for partials, per ADA guidelines, a tooth range must be added to claim to identify teeth being replaced

902.17. Adjustments to Dentures

902.17.1. D5410 Adjustment - Complete Denture maxillary

902.17.2. D5411 Adjustment - Complete Denture-mandibular

902.17.3. D5421 Adjustment - Partial Denture maxillary

902.17.4. D5422 Adjustment - Partial Denture mandibular

These services may only be billed after the six-month seating period. Maximum of two adjustments per calendar year is reimbursable. Approval is required for additional adjustments.

902.18. Repairs and Relines

902.18.1. D5511 Repair broken complete denture base, mandibular.

902.18.2. D5512 Repair broken complete denture base, maxillary.

902.18.3. D5640 Replace broken teeth-per tooth.

902.18.4. D5650 Add tooth to existing partial denture.

902.18.5. D5660 Add clasp to existing partial denture.

These services may only be billed after the six-month seating period. Maximum of two repairs, clasps or teeth per code per calendar year is reimbursable. Approval is required for additional repairs.

902.18.6. D5750 Reline complete maxillary denture (laboratory).

902.18.7. D5751 Reline complete mandibular denture (laboratory).

902.18.8. D5765 Soft liner for complete or partial removable denture-indirect

A discrete procedure provided when the dentist determines placement of the soft liner is clinically indicated.

Limited to two total relines per arch per 12 months.

902.18.9. D5850 Tissue Conditioning maxillary

Treatment relines using materials designed to heal unhealthy ridges prior to more definite final restoration.

902.18.10. D5851 Tissue Conditioning mandibular

Treatment relines using materials designed to heal unhealthy ridges prior to more definite final restoration.

A maximum of two total tissue conditioning treatments per 12 months

902.19. Prosthodontic Services, Fixed

902.19.1. D6240 Pontic – replacement of missing tooth; porcelain fused to high noble metal.

902.19.2. D6750 Retainer Crown – abutment; porcelain fused to high noble metal

Fixed prosthodontics is limited to members whose medical or mental condition precludes the use of removable prosthodontics

Abutment(s) D6750 and adjoining pontic(s) D6240, payable once per tooth per 60 month(s)

902.20. Oral & Maxillofacial Surgery (Extractions) Includes local anesthesia and routine post-operative care)

902.20.1. D7111 Extraction, coronal remnants, primary tooth.

Removal of soft tissue-retained coronal remnants.

902.20.2. D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.

If multiple teeth are being extracted for the same Member on the same date of service procedure code D7111 and D7140 can be used for the first tooth extracted and each additional tooth.

902.20.3. D7210 Surgical removal of erupted tooth requiring removal of bone and/or section of tooth and including elevation of mucoperiosteal flap if indicated.

Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

902.20.4. D7220 Removal of impacted tooth - soft tissue.

Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

902.20.5. D7230 Removal of impacted tooth - partially bony.

Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

902.20.6. D7240 Removal of impacted tooth - completely bony.

Most or all of crown covered by bone; requires mucoperiosteal flap elevation and removal of bone.

902.20.7. D7250 Surgical removal of residual tooth roots (cutting procedure).

Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Suturing in association with extractions is not reimbursable as a separate charge but must be included in the charge for the extraction(s).

When extracting supernumerary teeth, use the following ADA guideline for coding:

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").

It is the American Association of Maxillofacial Surgeons (AAOMS) position that classification of an impacted tooth may be based upon either the anatomical relationship of the impacted tooth to bony and soft tissue structures to another tooth, or the surgical procedures required for removal.

902.21. Oral & Maxillofacial Surgery (Other Surgical Procedures)

902.21.1. D7260 Oroantral fistula closure.

Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.

Narrative of unusual circumstances.

902.21.2. D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth. Include splinting and/or stabilization.

Reimbursement is per accident regardless of the number of teeth involved and covers all needed services (i.e., splints, suturing, and follow-up care).

902.21.3. D7280 Surgical access of an unerupted tooth -

An incision is made, and the tissue is reflected, and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.

902.21.4. D7284 Excisional biopsy of minor salivary glands –

902.21.5. D7286 Biopsy of oral tissue-soft

For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for Apicoectomy/periarticular curettage.

The appropriate coding scheme indicated for biopsy of oral tissue, procedure code D7286.

10 = upper right 20 = upper left
30 = lower right 40 = lower left

A pathology report from the dentist is required for D7284, D7286. It should be attached to the claim that is submitted to the fiscal agent for processing.

Reimbursement for D7286—biopsy of oral tissue-soft (all others) is $219.42; and $29.55 for each additional site. Use procedure code D7286 and the appropriate coding scheme indicated.

902.22. Oral & Maxillofacial Surgery Alveoloplasty

The Alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. The coding scheme below is to be used for Alveoloplasty in conjunction with or without extractions. These codes are to be used in the tooth number field.

UR = upper right UL = upper left
LR - lower right LL = lower left

902.22.1. D7310 Alveoloplasty- in conjunction with extractions – four or more teeth or tooth spaces, per quadrant.

902.22.2. D7311 Alveoloplasty- in conjunction with extractions – one to three teeth or tooth spaces, per quadrant.

902.22.3. D7320 Alveoloplasty- not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant

902.22.4. D7321 Alveoloplasty- not in conjunction with extractions- one to three teeth or tooth spaces, per quadrant.

One Alveoloplasty per quadrant per lifetime

902.23. Oral & Maxillofacial Surgery (Surgical Excision)

902.23.1. D7440 Excision of malignant tumor – lesion diameter up to 1.25 cm

902.23.2. D7450 Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25cm

902.23.3. D7451 Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25cm

902.23.4. D7460 Removal of benign non-odontogenic cyst or tumor– lesion diameter up to 1.25cm

902.23.5. D7461 Removal of benign non-odontogenic cyst or tumor– lesion diameter greater than 1.25cm

902.23.6. D7471 Removal of lateral exostosis– (maxilla or mandible)

The coding scheme for procedure code D7471 (removal of lateral exostosis - maxilla or mandible) is as follows:

01= upper 02 = lower

Write the appropriate coding scheme for procedure codes D7471 (removal of lateral exostosis maxilla or mandible) in the tooth number field on the claim form.

902.24. Oral & Maxillofacial Surgery (Surgical Incision)

902.24.1. D7510 Incision and drainage of abscess - intraoral soft tissue

D7510 not payable in connection or same date as extraction in area of abscess. Include narrative with claim submission for D7510, D7512.

902.24.2. D7520 Incision and drainage of abscess - extraoral soft tissue

902.24.3. D7540 Removal of reaction-producing foreign bodies of musculoskeletal system.

902.24.4. D7550 Partial ostectomy/sequestrectomy for removal of no-vital bone.

902.25. Oral & Maxillofacial Surgery (Treatment of Fractures - Simple or Compound)

902.25.1. Fractures must be billed to include acrylic splints, any necessary wiring, office and post-operative visits, radiographs, and suturing.

902.25.2. D7610 Maxilla - open reduction, (teeth immobilized, if present)

902.25.3. D7620 Maxilla - closed reduction, (teeth immobilized, if present)

902.25.4. D7630 Mandible - open reduction, (teeth immobilized, if present)

902.25.5. D7640 Mandible - closed reduction, (teeth immobilized, if present)

902.26. Oral & Maxillofacial Surgery (Treatment of Dislocations)

Dislocations must be billed to include office and post-operative visits, radiographs, and suturing.

902.26.1. D7820 Closed Reduction of dislocation.

902.27. Oral & Maxillofacial Surgery (Repair of Traumatic Wounds)

Not to be used in conjunction with extractions.

902.27.1. D7910 Suture of recent small wounds up to 5cm

902.27.2. D7912 Complicated suture- greater than 5 cm.

(Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

902.28. Oral & Maxillofacial Surgery (Other Repair Procedures)

902.28.1. D7961 Buccal/Labial Frenectomy (frenulectomy)

A buccal/labial frenectomy will not be approved for closure of a diastema unless the patient is currently in orthodontic banding. A detailed narrative and photos are required for approval of maxillary and mandibular frenectomies. Documentation of any orthodontic treatment (present, prior to or after the Frenectomy) should be included.

902.28.2. D7962 lingual frenectomy (frenulectomy)

The lingual frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.

Frenectomy covered once per arch per lifetime

902.28.3. D7970 Excision of Hyperplasic Tissue-per arch

When billing for frenectomy (procedure code D7961) and excision of hyperplasic tissue (procedure code D7970) always use the appropriate coding scheme in the tooth number field for proper reimbursement.

01 = Upper 02 = Lower

Once per arch per lifetime

902.28.4. D7971 Excision of Pericoronal Gingiva

Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. Not payable on same date with extraction.

The coding scheme for this code is per tooth number.

One per tooth per lifetime

902.29. Coverage of Orthodontic Services (Health Check and Special Needs Adults)

Orthodontic services that are medically necessary are covered. Medical necessary orthodontic services are defined as treatment of a medical condition that meets a minimum of the current accepted standards of medical practice. For clinical criteria for approval, see section 802.

902.29.1. D8080 Comprehensive Orthodontic Treatment of The Adolescent Dentition

902.29.2. D8660 Pre-Orthodontic Treatment Examination to Monitor Growth and Development

902.29.3. D8670 Periodic Orthodontic Treatment Visit

A maximum fee of $2,111.46 is allowed, per member for approved comprehensive orthodontic treatment. This treatment includes D8080, placement of the appliance, with a maximum reimbursement of $844.62 and monthly visits, D8670, that are reimbursed at $105.57 with a maximum of twelve (12) visits.

The pre-orthodontic visit (D8660), reimbursed separately, includes the initial exam, ortho treatment plan, scans of study models (if available), photographs, and radiographic images.

If the case is approved, treatment can be scheduled, and claims submitted to the Fiscal Agent using the approved request ID number. The claim submission should occur for D8080 once the initial banding has been completed and for D8670 using the actual date of service for each follow-up visit. The same authorization number is to be used until completion of all orthodontic services.

The Division will begin paying for the banding/orthodontic appliances and the monthly maintenance visits separately. This method of reimbursement will allow the Member to continue treatment if Medicaid member enrolls in one of the state's Care Management Organizations (CMO) or goes from a CMO to Fee for Service (FFS) eligibility.

Continuation of care for member eligibility change from CMO to Fee-For-Service Medicaid can be approved. A new authorization for D8670 and the number of units needed to complete orthodontic treatment which was started under a CMO approval should be submitted on the MMIS Web Portal. A detailed narrative should include the original CMO authorization number, the date of service for banding, the number of units used for D8670 in follow-up visits and the amount of treatment needed for completion of orthodontic services.

A post-treatment summary with post treatment intra and extra oral photographs at case completion must be sent to AHS for attachment to the original authorization on file.

902.30. Adjustive General Services (Health Check and Adults*)

Unclassified Treatment – Unclassified CDT codes are not recognized by the Division and are not eligible for reimbursement.

902.30.1. D9110 Palliative (emergency) treatment of dental pain - minor procedure

Reported on a per visit basis for emergency treatment of dental pain.

902.30.2. D9215 Local Anesthesia (Pregnant Women Only) *

Not reimbursed separately when billed in conjunction with other anesthesia, or dental procedures. Used only for emergency temporary relief of pain.

902.31. Adjunctive - General Anesthesia/Sedation/Anxiolysis

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel, and the doctor may safely leave the room to attend to other patients or duties.
Anesthesia may be administered by means of inhalation (excluding nitrous oxide) or by intravenous or intramuscular injection.

902.31.1. D9222 Deep sedation/General anesthesia – first 15 minutes.

902.31.2. D9223 Deep sedation/General anesthesia - each 15 minutes

D9222 and D9223 can be billed together for eight units (2 hours).

902.31.3. D9230 Analgesia, anxiolysis, inhalation of nitrous oxide

One unit of nitrous oxide must be listed in the quantity field on the claim form, one unit, per member, per date of service.

902.31.4. D9239 Intravenous moderate (conscious) sedation/analgesic first 15 minutes.

902.31.5. D9243 Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes.

D9239 must be billed for the first 15 minutes of sedation. D9243 must be billed for all subsequent time in fifteen-minute intervals.

D9239 and D9243 can be billed together for eight units (2 hours) without prior approval. If additional units are necessary and submitted for post approval, the total number of units should be billed on the same claim, same line item with the authorization number to limit claims denial for duplicate units.

Intravenous sedation is limited to treatment situations where local anesthesia is clinically contraindicated or for patient management purposes and must be administered by someone certified in the use of intravenous sedation.

902.31.6. D9248 Non-Intravenous Conscious Sedation

One unit of D9248 per date of service

D9248 not reimbursable on same date of service as D9230, D9222, D9223, D9239, D9243, D9920

A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring.

902.32. Adjunctive Service – Professional Consultations (Health Check and Adults)

902.32.1. D9310 Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician

A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem, may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.

902.33. Adjunctive – Professional Visits (Health Check and Adults)

902.33.1. D9420 Hospital or Ambulatory Surgical Center Call

902.33.1.1. Medically necessary complex dental procedures and surgeries can be provided in Ambulatory Surgical Centers or hospital setting. Pre-certification for the ASC or acute care hospital is required for all eligible members, regardless of age (see section 802).

902.33.1.2. Care provided outside the dentist's office to a patient who is in a hospital or ASC. A provider may request reimbursement for time spent performing dental services at a hospital/ASC by billing D9420.

902.33.1.3. Hospital call is calculated by determining the time needed to prepare for and render the dental service and is reimbursable in 30-minute increments, limited to 6 units per 12 months per provider/provider location. One unit equals 30 minutes. D9420 This code must be in conjunction with the procedure codes for actual services planned. Hospital Call should not include time spent admitting the Member, completing the history, or making hospital or postoperative visits.

All attempts should be made to coordinate hospital service needs into one date of service.

902.33.2. D9440 Office Visit After Regularly Scheduled Hours

902.33.2.1. Use of this service is not to exceed two (2) times per member, per calendar year.

902.33.2.2. This is a benefit only when the dental office is closed, and the dentist has physically left the office and must return to provide services outside of normal working hours. This code is technically not used for hospital visits due to not classified as afterhours office visit.

902.33.2.3. Scheduled appointments cannot be billed as (D9440).

902.33.2.4. An examination after office hours, D9440, cannot occur in conjunction with the comprehensive or periodic exam.

902.34. Adjunctive - Drugs (Health Check and Adults)

902.34.1. D9610 Therapeutic parenteral drug, single administration.

Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents.

Clinical narrative should identify name of drug, dosage, quantity, and route of administration. Payable once per date of service.

902.35. D9630 Drugs or medicaments dispensed in the office for home use

Includes but is not limited to oral antibiotics, oral analgesics, and topical fluoride, does not include writing prescriptions

When submitting a request for procedure code D9630, a clinical narrative is required to identify the drug, dosage, and quantity dispensed and reason for dispensing.

902.35.1. Using this code for Office Dispensed Fluoride –service approval will not exceed once per 180 days per dental reviewer's clinical judgement if meets medical necessity as evident by clinical narrative. (Note – manufacturer guidelines will be considered in medical necessity and reimbursement coverage, i.e. Clinpro 3.4 Fl oz. is sufficient for 370 applications/one application per day).

902.35.2. All other drugs and/or medicaments will be approved per dental reviewer's medical judgement if meets medical necessity as evident by clinical narrative. One D9630 per date of service not to exceed two per calendar year.

902.35.3. A provider can alternatively prescribe a member oral antibiotics, oral analgesics, or topical fluoride, but D9630 should NOT be billed for writing prescriptions.

902.36. Adjunctive - Behavior Management

902.36.1. D9920 Behavior Management, by report

902.36.1.1. May be reported in addition to treatment provided. Should be reported in 15-minute increments. Management time is calculated by determining the additional time to be spent beyond the normal time required to complete the service. The minutes or time requested must be only for the additional time - NOT FOR THE FULL APPOINTMENT.

902.36.1.2. When submitting for authorization of management time the treatment plan or treatment rendered must accompany your request.

902.36.1.3. Reimbursement will be allowed for those children or adults (handicapped, Intellectual disability) or age three years old or younger, who cannot be managed or handled in the routine dental office setting through normal office procedures. An explanation of why management time is required must accompany the approval review request.

902.36.1.4. This service is limited to a four-hour maximum (16 units) per Member per calendar year.

902.36.1.5. The dental provider must maintain records in the office to support the need for management time. The treatment plan is not a sufficient medical record to document the need for management time or any other dental services

902.36.1.6. D9920 for behavior management or D9230 for nitrous oxide or other drugs (D9630). Only one of these services will be considered per member per date of service.

903. Non-Covered Services

903.1. The Department of Community Health considers any CDT and HCPCS codes that are not on a state Medicaid fee schedule as not covered for the state's Medicaid program.

903.2. Investigational items and experimental services, drugs, or procedures or those not recognized by the Federal Drug Administration, the United States Public Health Service, Medicare, and the Division's contracted peer review are noncovered.

903.3. Infection Control procedures, and Personal Protective Equipment (PPE) are noncovered services

903.4. Catastrophic Procedures

903.4.1. The Department does not recognize unspecified or unlisted codes and will not recognize D9999 to report "catastrophic procedures" or other dental service procedures. There are no specified CDT code descriptions or designation to report "catastrophic procedures". Providers are directed to use the most appropriate CDT code to report dental service procedures.

904. Out-of-State Services

This policy addresses coverage of services rendered by providers located outside the Georgia boundaries who have **not** signed a Georgia Statement of Participation. Those providers located outside Georgia in bordering cities/areas who have signed a Georgia Statement of

Participation are considered participating Georgia providers and are excluded from the out-of-state policy stated herein. The Division will pay for dental services provided to Georgia Members while out-of-state so long as the claim is received within twelve (12) months from the month of service, and if one or more of the following conditions are met:

904.1. The service was provided as a result of an emergency or life-endangering situation.

904.2. The service was provided in a situation where a delay in treatment would endanger the health of the individual.

904.3. Prior authorization to render the service was obtained from AHS.

904.4. Routine or elective dental care is not covered unless prior authorization obtained.

904.5. Reimbursement is determined in accordance with Part I and Part II of the Policies and Procedures of the Georgia Division of Medical Assistance and contingent upon the Member's eligibility at the time services are provided.

904.6. All services provided to Members when out-of-state by nonparticipating providers will be subject to prepayment review.

904.7. Requests for payment, prior approval, or questions regarding out-of-state-services must be directed to AHS.

905. Mobile Dentistry Services

In the mobile dental services model, dental services are delivered through mobile dental vans or portable dental clinics in population centers, schools, other venues.

905.1. All State of Georgia Dental Practice Acts must be followed

905.2. Any provider rendering services in a mobile dental unit must own, operate or an affiliate/contract with a fully operational stationary dental office, which conforms to all applicable policies and procedures of the Department (this will ensure that the Member will have access to emergency or follow-up care if the mobile unit is out of service and/or is not accessible to the Member).

905.3. Any provider rendering services in mobile dental units must operate within 50 miles of the required stationary office; or otherwise, must hold a contract with such stationary dentist practice to provide emergency or follow up care to members treated at the mobile dental unit (this will ensure that the Member will have access to emergency or follow-up care if the mobile unit is out of service or is not accessible to the Member).

905.4. A dentist rendering services in a mobile unit must be licensed by the State of Georgia and in good standing with all State and Federal requirements.

905.5. Any dentist rendering services in a mobile unit must have the capability to perform all diagnostic, preventive and restorative care, in the mobile dental

unit, which each individual Member requires.

905.5.1. Diagnostic: Those dental services directed toward identifying a disease process from its signs and symptoms presented.

905.5.2. Preventive: Refers to the procedures in dental care and health programs that prevent the occurrence of oral disease.

905.5.3. Restorative: Refers to the procedures in dentistry which are directed toward restoring the natural dentition to its original form and function, following decay or traumatic injury.

905.6. Any dentist rendering services in a mobile dental unit must own, operate, or otherwise contract with a fully operational stationary dental office that conforms to all applicable policies and procedures of the Division. To meet the requirement that a dental provider own, operate, or otherwise contract with a fully operational stationary dental office, the dentist must:

905.6.1. Hold regular office hours.

905.6.2. Routinely schedule appointments for patients

905.6.3. Accept and render dental services to Medicaid Members

905.6.4. Have the capability of performing all diagnostic, preventive and restorative care to Medicaid Members at the location of the stationary dental office.

905.6.5. Any provider rendering dental services in a mobile dental unit must display, in a prominent location in the mobile dental unit, a copy of his or her current Georgia license, including without limitation dentists, dental hygienists, dental assistants, etc.

905.6.6. Any contractual arrangement between a mobile dental unit and a FQHC and/or RHC all the above conditions apply for the provision of Medicaid dental services. The dentist who renders the services must be enrolled as a Medicaid service provider, designating as the payee the FQHC and/or RHC. Medicaid reimbursement for dental services will only be to the FQHC and/or RHC.

906. Provision of Dental Services—Federally Qualified and Rural Health Centers (FQHC/RHC)

906.1. Federally Qualified Health Centers (FQHCs) are safety net providers that give services in an outpatient clinic setting. FQHCs may be in rural or urban areas and include Community health centers, Migrant health centers, Homeless health centers, Public housing primary care centers, Health center program “look-alikes”, Outpatient health programs or facilities operated by a tribe or tribal organization or an urban Indian organization.

906.2. The FQHC and/or RHC programs, enacted under OBRA the 1989 and expanded under OBRA 1990, provides for reimbursement of reasonable cost for FQHC and/or RHC services covered by Medicare and Medicaid. FQHCs and/or RHCs are non-profit organizations that receive grants under sections 329, 330 or 340 of the Public Health Services Act to provide services in under-served areas. In addition, other non-profit organizations that are determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant may qualify as an FQHC and/or RHC provider.

906.3. FQHC and/or RHC services are of the type normally provided as part of a primary care physician's practice and include physician services, services provided by physician assistants, nurse practitioners and nurse midwives. In addition, FQHC and/or RHC services may also include those provided by clinical psychologists and clinical social workers. The FQHC and/or RHC must provide, directly or by referral, a full range of these primary diagnostic and therapeutic services and supplies.

906.4. FQHCs and/or RHCs may also offer additional services that are beyond the scope of those identified as primary care core services. These additional services have separate provider enrollment and reimbursement.

906.5. FQHC claims must include an FQHC payment code if under a PPS rate. Depending on payment structure of the FQHC, the Department will pay lessor of percent of FQHC charges or the FQHC PPS rate for the specific payment code, which is the national encounter-based rate with geographic and other adjustments.

See section 909 for school-based settings and procedures as applicable also to FQHCs

907. Dental Services in Public Health Clinics

All Dental Hygienists performing services at a Public Health clinic must be licensed by the State of Georgia. The role of the Public Health dental hygienist is to provide initial screening and referral to a dentist for evaluation and treatment. The following codes can be performed and billed in the Public Health or School Setting as performed by dental hygienists under general supervision. Effective 7/1/2017, HB 154 expands the locations where dental hygienists can provide services. Services can now be provided in Federally Qualified Health Centers, volunteer community health settings, senior centers, and family violence shelters.

Department of Public Health (DPH) Districts and Boards of Health Dental Hygienists shall only perform duties under this protocol at the facilities of the DPH District and Board of Health, at school-based prevention programs and other facilities approved by the Board of Dentistry and under the approval of the District Dentist or dentist approved by the District Dentist.

D0270 Bitewing, single radiographic image

D0272 Bitewing, two radiographic images

D0274 Bitewings, four radiographic images

D0330 Panoramic radiographic image (Once every three calendar years)

D1110 Prophylaxis-adult-pregnant women (Two are reimbursable per calendar year)

D1120 Prophylaxis-child (Two are reimbursable per calendar year)

D1206 Fluoride Varnish (Two are reimbursable per calendar year)

D1208 Fluoride, Topical application of fluoride

D1351 Sealant-per tooth (Topical application of sealants is covered once per tooth in a four calendar- year period.)

D1354 Application of caries arresting medicament – per tooth

D1355 Caries preventive medicament application – per tooth

908. Teledentistry

908.1. Teledentistry codes are available to bill for benefits in the Public Health setting. Public health setting per telehealth practice acts includes the following:

Federally Qualified Health Clinics (FQHCs)
School-based health clinics (SBHCs)
Community Health Centers (CHCs)
Rural health clinics
Local health departments or agencies
Post-secondary educational institutions (Dental schools, Residency programs)
Skilled nursing facilities
Senior centers
Family violence shelters
Juvenile Justice System programs
Volunteer community health setting

908.2. D9995 is used to bill when there is a synchronous or real-time encounter instead of information that is stored and sent for review. Department D0140 for the exam and report.

908.3. D9996 is used by the Dental Hygienist when dental information is stored and sent to a licensed Dentist for review via teledentistry technology (asynchronous). The Dentist that does the requested exam then bills the Department D0140 for the exam and report.

908.4. All other treatment services performed by the offsite dental hygienist would be billed by applicable CDT procedure codes. Only services within the scope of general supervision for approved dental facilities of the Department of Public Health, county boards of health, or the Department of Corrections, or the performance of dental hygiene duties by personnel of the Department of Public Health or county boards of health at approved off-site locations; in settings which include: schools; hospitals; clinics; state, county, local, and federal

public health programs; federally qualified health centers; volunteer community health settings; senior centers; family violence shelters, as defined in O.C.G.A. § 19-13-20; while not billed to department for Medicaid programs, free health clinics, as defined in O.C.G.A. § 51-1-29.4 are also included in scope setting. Other health fair settings must be pre-approved by the board of dentistry.

Chapter 1000: Basis For Reimbursement

1001. Reimbursement Methodology

The Division will pay the lower of the provider's usual and customary charge, or the statewide maximum allowable amount for the procedure rendered. This maximum allowable amount is derived from an analysis of the usual and customary fees submitted for a given procedure. "Usual and customary" is defined as the fee charged to private paying patients for the same procedure or service during the same period of time. The provider agrees to bill his/her usual and customary fee for services rendered as required in Section 901.

The maximum allowable amounts for covered procedures are listed in Appendix B of this manual.

1002. Member Co-payments

No Member co-payment is required in the Dental program.

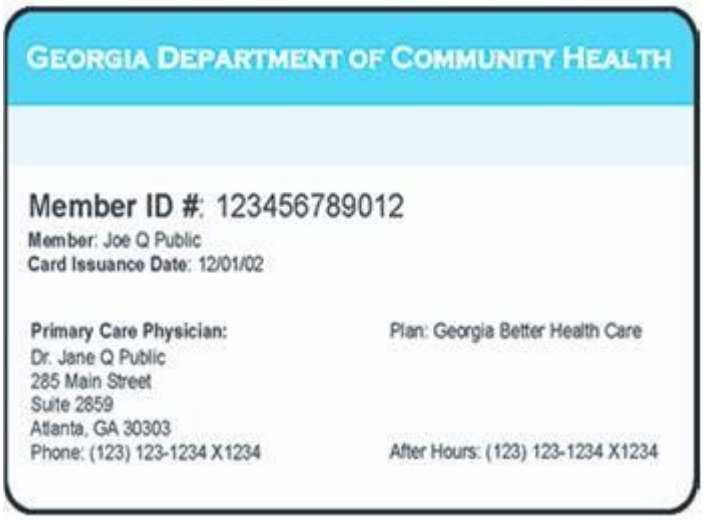
1003. Balance Billing

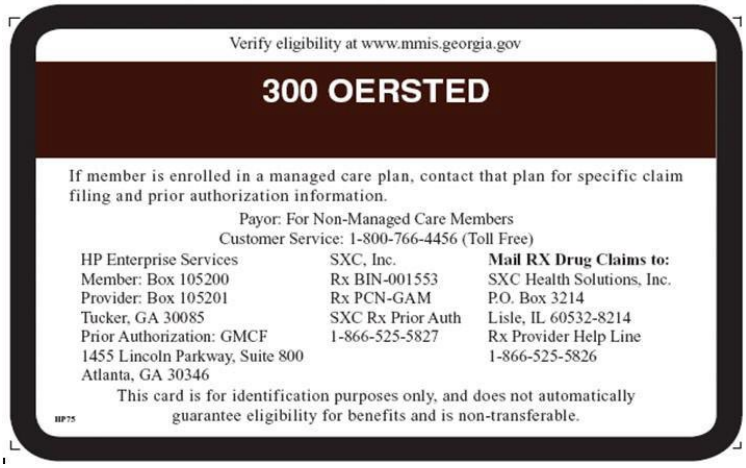
1003.1. A provider should not conduct any balance billing for services that Medicaid covers. This means that the provider cannot charge a Member more than what Medicaid paid.

1003.2. A provider must receive written consent prior to rendering any service not covered, confirming the Member agreed to pay out of pocket for it. This does not include any EPSDT medically necessary exception requests for Health Check Members under age 21 that would be submitted for prior approval and if approved the Member should not be charged for the noncovered exception approval.

Appendix A
Medical Assistance Eligibility Certification
Medicaid & PeachCare for Kids Member Identification Card Sample

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids Plans.





Providers are required to verify member eligibility prior to rendering treatment for each date of service.

Appendix B
Maximum Allowable Charges

Due to space limitation and to minimize duplication, specific service limitations and prior/post approval requirements are not contained on the schedule. Please refer to Chapter 800, 900, and other sections for specific service limitation, prior/post approval requirements, and descriptions and procedures for coding use.

CDT Code	Description	COS	Indicator	Max Allow
D0120	Periodic Oral Evaluation-established patient	Health Check & Adults		$25.30
D0140	Limited Oral Evaluation-problem focused	Health Check & Adults		$38.29
D0150	Comprehensive Oral Evaluation-new or established patient	Health Check & Adults		$43.70
D0180	Comprehensive Periodontal Evaluation	Pregnant Women Only		$39.33
D0210	Intraoral- Comprehensive series of radiographic images	Health Check & Adults		$72.45
D0220	Intraoral-periapical first radiographic image	Health Check & Adults		$16.00
D0230	Intraoral periapical, each additional radiographic image	Health Check & Adults		$11.50
D0240	Intraoral - Occlusal radiographic image	Health Check & Adults		$19.66
D0270	Bitewing, single radiographic image	Health Check & Adults		$15.50
D0272	Bitewing, two radiographic images	Health Check & Adults		$25.84
D0274	Bitewing, four radiographic images	Health Check & Adults		$39.38
D0330	Panoramic radiographic image	Health Check & Adults		$63.25
D0604	Antigen test Coronavirus	Health Check & Adults		$28.74
D0605	Antibody test Coronavirus	Health Check & Adults		$36.18
D1110	Prophylaxis-adult	Health Check & Adults		$35.64
D1120	Prophylaxis-child	Health Check & Adults		$35.64
D1206	Topical fluoride varnish	Health Check & Adults		$19.54
D1208	Topical application of fluoride	Health Check & Adults		$19.54
D1351	Sealant-per tooth	Health Check & Adults		$31.05
D1354	Application of Carie arresting medicament – per tooth	Health Check & Adults		$15.00
D1355	Caries Preventive Medicament Application - per tooth	Health Check & Adults		$10.70
D1510	Space maintainer-fixed unilateral Space maintainer-fixed unilateral - per quadrant	Health Check & Adults		$180.09

CDT Code	Description	COS	Indicator	Max Allow
D1516	Space maintainer- fixed bilateral, maxillary	Health Check & Adults		$238.05
D1517	Space maintainer-fixed bilateral, mandibular	Health Check & Adults		$238.05
D1526	Space maintainer-removable bilateral, maxillary	Health Check & Adults		$210.76
D1527	Space maintainer-removable bilateral, mandibular	Health Check & Adults		$210.76
D1551	Re-cementation/Re-bond of bilateral space maintainer-Maxillary	Health Check & Adults		$45.54
D1552	Re-cementation/Re-bond of bilateral space maintainer-Mandibular	Health Check & Adults		$45.54
D1553	Re-cementation/Re-bond of unilateral space maintainer per Quadrant	Health Check & Adults		$27.98
D2140	Amalgam-one surface	Health Check	Primary	$65.91
D2140	Amalgam-one surface	Health Check & Adults	Permanent	$73.51
D2150	Amalgam-two surfaces	Health Check Only	Primary	$84.91
D2150	Amalgam-two surfaces	Health Check & Adults	Permanent	$95.05
D2160	Amalgam-three surfaces	Health Check Only	Primary	$91.25
D2160	Amalgam-three surfaces	Health Check & Adults	Permanent	$103.80
D2161	Amalgam 4+, primary and permanent	Health Check & Adults		$98.08
D2330	Resin-based composite- one surface anterior	Health Check & Adults		$81.06
D2331	Resin-based composite- two surfaces anterior	Health Check & Adults		$103.39
D2332	Resin based composite-three surfaces, anterior	Health Check & Adults		$125.71
D2335	Resin-based comp, 4+ anterior	Health Check & Adults		$149.20
D2391	Resin based composite-once surface, posterior	Health Check & Adults		$89.70
D2392	Resin based composite-two surfaces, posterior	Health Check &Adults	Primary	$105.80
D2392	Resin based composite-two surfaces, posterior	Health Check & Adults	Permanent	$110.74
D2393	Resin based composite-three surfaces, posterior	Health Check & Adults	Primary	$130.41
D2393	Resin based composite-three surfaces, posterior	Health Check & Adults	Permanent	$156.26
D2394	Resin based composite-four or more surfaces, posterior	Health Check & Adults	Primary	$143.45
D2394	Resin based composite-four or more surfaces, posterior	Health Check & Adults	Permanent	$171.88
D2920	Re-cement Crowns	Health Check & Adults		$41.40

CDT Code	Description	COS	Indicator	Max Allow
D2928	Prefabricated Porcelain Ceramic crown	Health Check & Adults		$147.28
D2930	Prefabricated stainless steel crown primary tooth	Health Check & Adults		$176.15
D2931	Prefabricated stainless steel crown permanent tooth	Health Check & Adults		$184.45
D2932	Prefabricated resin crown-composite Crown	Health Check & Adults		$176.98
D2934	Resin based composite-four or more surfaces, posterior	Health Check & Adults		$143.86
D2940	Placement of interim direct restoration	Health Check & Adults		$54.85
D2951	Pin Retention per tooth in addition to restoration.	Health Check & Adults		$28.98
D2954	Prefabricated post and core in addition to crown	Health Check & Adults		$54.22
D2991	Application of hydroxyapatite regeneration medicament - per tooth	Health Check & Adults		$70.00
D3220	Therapeutic pulpotomy (excluding final Restoration)	Health Check & Adults		$102.21
D3221	Pulpal Debridement, Primary and Permanent Teeth	Health Check & Adults		$91.08
D3310	Anterior (excluding final restoration)	Health Check & Adults	Primary	$77.64
D3310	Anterior (excluding final restoration)	Health Check & Adults	Permanent	$379.84
D3320	Bicuspid (excluding final restoration)	Health Check & Adults		$463.68
D3410	Apicoectomy/peri radicular surgery anterior	Health Check & Adults		$229.81
D3426	Apicoectomy/peri radicular surgery (each additional root)	Health Check & Adults		$38.06
D4210	Gingivectomy or Gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	Health Check & Adults		$157.38
D4240	Gingival flap procedure, including root planning-four or more contiguous teeth or bounded teeth spaces, per quadrant.	Health Check & Adults		$129.37
D4241	Gingival flap, including root planning 1-3 teeth	Pregnant Women Only		$97.03
D4260	Osseous Surgery (including flap entry and closure)-four or more contiguous teeth or bounded teeth spaces, per quadrant	Health Check & Adults		$341.00

CDT Code	Description	COS	Indicator	Max Allow
D4270	Pedicle soft tissue graft procedure **always use appropriate coding scheme indicated in Chapter 900*	Health Check & Adults		$272.14
D4341	Periodontal Scaling and Root Planning four or more contiguous teeth or bounded teeth spaces per quadrant	Health Check & Adults		$140.76
D4342	Periodontal scaling 1-3 teeth	Pregnant Women Only		$105.57
D4910	Periodontal Maintenance	Pregnant Women Only		$42.20
D5110	Complete denture maxillary	Health Check & Adults		$673.78
D5120	Complete denture mandibular	Health Check & Adults		$673.78
D5130	Immediate denture maxillary	Health Check & Adults		$554.12
D5140	Immediate denture mandibular	Health Check & Adults		$554.12
D5211	Maxillary Partial-Resin Base (Including any Conventional Clasps, Rests and Teeth)	Health Check & Adults	Single tooth partial	$276.64
D5211	Maxillary Partial-Resin Base (Including any Conventional Clasps, Rests and Teeth)	Health Check & Adults	Two or more tooth	$569.25
D5212	Mandibular Partial-Resin Base Rests and Teeth)	Health Check & Adults	Two or more tooth	$661.36
D5212	Mandibular Partial-Resin Base Rests and Teeth) (Including any Conventional Clasps,	Health Check & Adults	Single tooth partial	$276.64
D5410	Adjust Complete Denture-maxillary	Health Check & Adults		$23.77
D5411	Adjust complete denture-mandibular	Health Check & Adults		$23.77
D5421	Adjust Partial Denture-maxillary	Health Check & Adults		$11.76
D5422	Adjust - Partial Denture-mandibular	Health Check & Adults		$11.76
D5511	Repair broken complete denture base, mandibular	Health Check & Adults		$73.48
D5512	Repair broken complete denture base, maxillary	Health Check & Adults		$73.48
D5640	Replace broken teeth – per tooth	Health Check & Adults		$92.17
D5650	Add tooth to existing partial denture	Health Check & Adults		$92.17
D5660	Adding clasp to existing partial denture	Health Check & Adults		$110.74
D5750	Reline complete maxillary denture (laboratory)	Health Check & Adults		$156.56
D5751	Reline complete mandibular denture (laboratory)	Health Check & Adults		$156.56

CDT Code	Description	COS	Indicator	Max Allow
D5765	Soft liner for complete or partial removable denture-indirect	Health Check & Adults		$149.55
D5850	Tissue Conditioning/ maxillary	Health Check & Adults		$47.54
D5851	Tissue Conditioning/ mandibular	Health Check & Adults		$47.54
D6240	Pontic, Porcelain fused to high noble metal	Health Check & Adults		$556.07
D6750	Retainer Crown, Porcelain fused to high noble metal	Health Check & Adults		$581.17
D7111	Extraction, coronal remnants – deciduous tooth	Health Check		$53.03
D7111	Extraction, coronal remnants – deciduous tooth	Adults	(retained deciduous in adult)	$54.62
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Health Check & Adults		$80.78
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Health Check & Adults	Each additional tooth	$77.26
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (Includes cutting of gingival and bone and/or tooth)	Health Check & Adults		$149.77
D7220	Removal of impacting tooth – soft tissue. Tooth is embedded in soft tissue.	Health Check & Adults		$160.42
D7230	Removal of impacted tooth-partially bony	Health Check & Adults		$214.24
D7240	Removal of impacted tooth – completely bony. Crown of tooth is completely covered by bone.	Health Check & Adults		$251.50
D7250	Surgical removal of residual tooth roots (cutting procedure)	Health Check & Adults		$135.58
D7260	Oroantral fistula closure	Health Check & Adults		$307.45
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Health Check & Adults		$276.34
D7280	Surgical access of an unerupted tooth	Health Check & Adult		$256.68
D7284	Excisional biopsy of minor salivary glands	Health Check & Adult		$136.01
D7286	Biopsy of oral tissue-soft	Health Check, & Adult		$219.42

CDT Code	Description	COS	Indicator	Max Allow
D7286	Biopsy of oral tissue-soft	Health Check, & Adult	Each additional lesion	$29.55
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Health Check & Adults		$150.07
D7311	Alveoplasty in conjunction with extractions One to three teeth or tooth spaces, per quadrant	Health Check & Adults		$54.22
D7320	Alveoplasty not in conjunction with extractions – four or teeth or tooth spaces, per quad	Health Check & Adults		$669.64
D7321	Alveoplasty not in conjunction with extractions, per tooth space(s)	Health Check & Adults		$63.86
D7440	Excision of malignant tumor Lesion diameter up to 1.25cm	Health Check & Adults		$843.52
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25cm	Health Check & Adults		$477.13
D7451	Removal of benign odontogenic cyst or tumor diameter greater than 1.25cm	Health Check & Adults		$750.37
D7460	Removal of benign non-odontogenic cyst or tumor - up to 1.25cm	Health Check & Adults		$477.13
D7461	Removal of benign non-odontogenic cyst or tumor lesion diameter greater than over 1.25cm	Health Check & Adults		$769.00
D7471	Removal of lateral exostosis (maxilla or mandible)	Health Check & Adults		$230.55
D7510	Incision and drainage of abscess - intraoral soft tissue	Health Check & Adults		$142.83
D7520	Incision and drainage of abscess – extraoral soft tissue	Health Check & Adults		$682.06
D7540	Removal of reaction-producing foreign bodies of musculoskeletal system. May include, but is not limited to removal of splinters	Health Check & Adults		$62.99
D7550	Partial ostectomy/Sequestrectomy for removal of non-vital bone	Health Check & Adults		$231.31
D7610	Maxilla - open reduction (teeth immobilized, if present)	Health Check & Adults		$994.11
D7620	Maxilla - closed reduction, (teeth immobilized, if present)	Health Check & Adults		$645.45

CDT Code	Description	COS	Indicator	Max Allow
D7630	Mandible - open reduction, (teeth immobilized, if present)	Health Check & Adults		$994.11
D7640	Mandible - closed reduction, (teeth immobilized, if present)	Health Check & Adults		$645.45
D7820	Closed Reduction of dislocation	Health Check & Adults		$115.71
D7910	Suture of recent small wounds up to 5cm	Health Check & Adults		$218.38
D7912	Complicated suture greater than 5cm	Health Check & Adults		$982.21
D7961	Buccal / Labial Frenectomy (Frenulectomy)	Health Check & Adults		$131.04
D7962	Lingual Frenectomy (Frenulectomy)	Health Check & Adults		$131.04
D7970	Excision of Hyperplastic Tissue (per arch)	Health Check & Adults		$324.99
D7971	Excision of Pericoronal gingiva	Health Check & Adults		$85.90
D7997	Appliance Removal (not by dentist who placed appliance), includes removal of arch bar	Health Check & Adults		$19.03
D8080	Comprehensive Orthodontic Treatment of Adolescent Dentition	Health Check & Adults		$844.62
D8660	Pre-Orthodontic treatment visit	Health Check & Adults		$83.53
D8670	Monthly maintenance visits (12 visits)	Health Check & Adults		$105.57
D9110	Palliative (emergency) treatment of dental pain, minor procedure	Health Check & Adults		$51.75
D9215	Local Anesthesia	Pregnant Women		$10.00
D9222	Deep Sedation/general anesthesia – first 15 minutes	Health Check & Adults		$115.19
D9223	Deep Sedation/general anesthesia – each additional 15 minutes	Health Check & Adults		$115.19
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Health Check & Adults		$26.91
D9239	Intravenous conscious sedation/analgesia, first 15 minutes	Health Check & Adults		$113.28
D9243	Intravenous conscious sedation/analgesia each additional 15 minutes	Health Check & Adults		$113.28
D9248	Non-Intravenous Conscious Sedation	Health Check & Adults		$50.00

CDT Code	Description	COS	Indicator	Max Allow
D9310	Consultation diagnostic service provided by dentist or physician other than practitioner providing services	Health Check & Adults		$104.53
D9420	Hospital Call – each unit 30 minutes	Health Check & Adults		$94.70
D9440	Office Visit After Regularly Scheduled Hours Office or hospital setting	Health Check & Adults		$66.03
D9610	Therapeutic parenteral drug, single administration	Health Check & Adults		$53.82
D9630	Other drugs & medication, by report	Health Check & Adults		$38.29
D9920	Behavior Management, by report (Only post approval is required)	Health Check & Adults		$56.92

Appendix B-1
Covered Dental Services for Pregnant Women

Pregnant Women receive all benefits noted in section 900 covered services per their applicable age categories during the extent of their Member eligibility. In addition to those services, they receive the following pregnancy only benefits after presentation of the DMA 635 Attestation of Pregnancy form. The pregnancy only benefit codes are only covered up until 12 months post-partum.

All covered dental services & procedures are subject to the terms & conditions outlined Part I Policy & Procedure manual for Medicaid/PeachCare for Kids. Refer to the Part II Policy & Procedure for Dental Services manual, Appendix B, for reimbursement rates.

CDT Codes	Short Description
D0180	Comprehensive Periodontal Evaluation
D4241	Gingival flap, including root planning 1-3 teeth
D4342	Periodontal scaling 1-3 teeth
D4910	Periodontal maintenance
D9215	Local Anesthesia not in conjunction with other services

Appendix B-2

DMA 635 Form—Attestation of Pregnancy

The **Attestation of Pregnancy** form serves to validate current pregnancy for the purpose of determining whether the member is eligible to obtain certain Medicaid dental service benefits. The member is directed to present completed & signed Attestation of Pregnancy statement to her dentist prior to seeking dental services.

Attestation of Pregnancy

_____ Is currently pregnant & under my care for related services.

Patient Name (please print)

The patient's estimated date of delivery is _____

Please advise of any medical limitations/or restrictions prohibiting the provision of dental care

☐ None

☐ Specify limitations/restrictions (if applicable): _____

_____

_____

_____

_____

I affirm the above information is factual to the best of my knowledge & under penalty of perjury.

_____ _____

Provider Name (please print) Provider Signature

Signed this _____ day of _____ _____

Date Month Year

Appendix C
Example of a Proper and Valid Dental Treatment Record

As noted by the American Dental Association Standard of Care, information typically noted in the dental record includes:

1.1	personal data, such as the patient's name, birth date, address and contact information including home, work, and mobile telephone numbers (include Medicaid ID number)
1.2	the patient's place of employment if applicable
1.3	medical and dental histories, notes, and updates
1.4	progress and treatment notes
1.5	recaps of conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment. Include conversations that took place in the office, over the phone and even calls received outside the office. Make sure that the recaps are dated and initialed.
1.6	diagnostic records, including charts and study models
1.7	medication prescriptions, including types, dose, amount, directions for use and number of refills
1.8	radiographs
1.9	photographs
1.10	intraoral photographs
1.11	treatment plan notes
1.12	patient complaints and resolutions
1.13	referral letters and consultations with referring or referral dentists and/or physicians
1.14	patient noncompliance and missed appointment notes
1.15	follow-up and periodic visit records
1.16	postoperative or home instructions, or a notation about any pamphlets or reference materials provided
1.17	Informed consent/refusal forms
1.18	waivers and authorizations
1.19	correspondence, including a dismissal letter; if appropriate

Dental Records

The original handwritten personal signature, initial or electronic signature of the person performing the service must be on the patient ‘s dental records within three months of the date of service. This includes but is not limited to progress notes, radiological and lab reports for each date of services billed to the Division. The signature on the super bill does not satisfy this requirement. Dental record entries without specified signature may result in recoupment of payment.

Appendix D
Alliant Health Solutions Contact Information

Gainwell Technologies

Provider Inquiry Number
1-800-766-4456 (Toll free)
The web contact address is
www.mmis.georgia.gov

Alliant Health Solutions
1-800-766-4456, option 5

Gainwell Technologies Post Office Boxes:
Refer to the Policies and Procedures Medicaid/PeachCare for Kids Manual, Part 1, Section 112 [Paperless Initiatives]

Appendix E
Billing Root Canal Therapy

Billing Procedures for Open Pulp-Chamber to stablish Drainage and Partially Completed Root Canal Therapy

Root Canal Therapy (RCT) is available to eligible members & the procedures must be billed as detailed in the following section. Post-operative x-rays are to be taken as part of the Root Canal Therapy charge & are to be maintained by the dentist. The Division may request these x-rays at a future time.

Emergency Root Canal Procedures, Procedure Code D3221—Pupal debridement, primary and permanent teeth.

This code is intended to meet the acute pain, which may arise from the urgencies for root canals.

A provider may only "open the pulp-chamber" to establish drainage in an emergency.

The provider should submit an authorization request on the MMIS Web Portal with supporting radiographs and narrative of medical necessity for approval.

<u>If the Root Canal treatment is completed.</u> The provider should not bill for D3221, open pulp-chamber but should bill for the completed RCT procedure.

<u>If the Root Canal treatment is not completed</u>. The provider should bill for what treatment is completed.

If the provider only performed the open pulp-chamber procedure, the provider should bill for D3221, open pulp-chamber.

If the Member fails to return for the completion of the RCT, the provider should bill for that portion of the treatment rendered, adjusting the fee accordingly.

A provider may bill for either a root canal therapy (procedure codes D3310 or D3320) or an open pulp-chamber (procedure code D3221) **but not both**.

Appendix F
Preventive Oral Health: Fluoride Varnish

Only providers and PCPs enrolled in and filing claims under GA Medicaid programs 430, 431, 450, and 740 may bill Code D1206 Fluoride Varnish.

Fluoride varnish acts to retard, arrest, and reverse the caries process. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities. It is not a substitute for fluoridated water or toothpaste.

A. HCPCS Code: D1206

HCPCS Description: Topical fluoride varnish

Limited to Medicaid or PeachCare for Kids recipients.

Providers and PCPs enrolled in these GA Medicaid programs may bill D1206:

i. Dentists: under category of service 450 and 460

ii. Physicians: under category of service 430

iii. Physician Assistants (PA): under category of service 431

iv. Advanced Registered Nurse Practitioners (ARNP): under category of service 740

The application of topical fluoride varnish by a physician or other qualified health care professional may bill with the new CPT code 99188. This applies to providers and PCPs enrolled in and filing claims under Georgia Medicaid programs 430, 431, and 740.

For more information including the payment rate for this service, please see the Part II Policies and Procedures Manual for Dental Services.

Providers may not bill for an Evaluation and Management (E/M) visit in addition to billing for the application of fluoride varnish if the sole purpose of the visit was to apply the fluoride varnish. In this instance, the provider may bill for the fluoride varnish code only.

Appendix G
Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions

The Centers for Medicare and Medicaid Services (CMS) directed all state Medicaid agencies to implement its final rule outlined in 42 CFR 447.26, regarding PROVIDER PREVENTABLE CONDITIONS (PPCs), NEVER EVENTS (NEs), and HOSPITAL ACQUIRED CONDITIONS (HACs) acquired in ALL hospital settings and other non-inpatient health care settings.

HACs are defined as diagnoses determined by either the state and/or Medicare to be reasonably preventable, i.e., Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following a total knee replacement or hip replacement surgery, and PPCs, i.e., the wrong body part and surgical invasive procedures performed by a practitioner or provider to the wrong patient that should never happen in an admission to treat a medical condition. CMS specifically in Section 2702 of the Patient Protection and Affordable Care Act, prohibits payment to providers for Other Provider-Preventable Conditions (OPPPCs) as specified in 42 CFR 434, 438, and 447 of the Federal Register, page 32816.

The Hospital Services Manual in Section 1102(e) outlines the Department's policies and procedures on HACs as identified by Medicare' federal regulations published in October 2010. The Georgia Medicaid Management System (GAMMIS) was configured on October 1, 2011, with the HACs edits. The Department of Community Health will not reimburse inpatient facilities (if applicable) or enrolled Medicaid practitioners/providers for treatment of any HACs and/or PPCs identified through the claims adjudication and/or medical records review process. NEs in Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners and providers regardless of the healthcare setting are required to report NEs. Refer to the Reimbursement sections of the Hospital Services and Physician Services Policies and Procedures Manuals for additional information.

Claims will be subject to retrospective review in accordance with CMS' directive and the State Plan Amendment, Appendix 4.19. When a claim's review indicates an increase of payment to the provider for an identified PPC, HAC, or NE, the amount for the event or provider preventable condition will be excluded from the provider's total payment.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Appendix H
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. Georgia Families Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

ii. Georga Families 360 Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. Non-Emergency Medical Transportation Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

Appendix I
Handicapping Labio-Lingual Deviations (HLD)

HANDICAPPING LABIO-LINGUAL DEVIATIONS (HLD)

Member Name_____ Member Medicaid ID_____ Member DOB_____ Todays Date_____

The Handicapping Labio-Lingual Deviations Form (HLD) is a quantitative, objective method for measuring **the presence or absence, as well as the degree** of a handicap malocclusion caused by the components of the index. It is not used to diagnose malocclusion. The HLD provides a single score, based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion. Deciduous teeth and teeth not fully erupted should not be scored. Please follow the **scoring instructions** attached and include the required documentation.

Conditions Observed	**HLD Score**
THE FOLLOWING IF DETERMINED BY CLINICAL REVIEW, MAY BE AUTOMATIC QUALIFYING CONDITIONS	
If any condition #1 through #9 applies, please indicate with an "X" in the column and submit the form.	
1. Jaws and/or dentition profoundly affected by congenital or developmental disorder (craniofacial anomalies), trauma, or pathology	☐
2. Severe Traumatic Deviations (e.g. accidental loss of premaxilla, gross pathology)	☐
3. Facial discrepancy requiring combined orthodontics and Orthognathic surgery	☐
4. Overjet greater than 9mm	☐
5. Reverse overjet greater than 3.5mm	☐
6. Deep Impinging Overbite (that shows palatal impingement of the majority of lower incisors) (must be visible on photographic images)	☐
7. True anterior open bite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).	☐
8. Anterior or posterior crossbite. (Involves three or more teeth in crossbite and/or in cases where gingival stripping from the crossbite is demonstrated).	☐
9. Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).	☐

THE REMAINING CONDITIONS REQUIRE A MINIMUM <u>SCORE OF 28</u> TO QUALIFY FOR COMPREHENSIVE TX **Score each condition that applies according to examination findings using the HLD Index Scoring Instructions**		
1. Overjet in mm	mm x1	
2. Reverse Overjet (Mandibular Protrusion) in mm – see scoring instructions	mm x5	
3. Overbite in mm	mm x1	
4. Open Bite in mm	mm x4	
5. Ectopic Eruption, (Number of teeth, excluding third molars) (Do not double score with crowding)	# x3	
6. Anterior Crowding: __Maxilla __ Mandible Anterior arch length insufficiency must exceed 3.5mm; score one point for maxilla and one point for mandible; 2 points maximum for anterior crowding. The maximum number of points for this item is therefore 10 points (5 upper and 5 lower)	pts x5:	
7. Labio-Lingual Spread in mm (anterior spacing) – see scoring instructions	mm x1	
8. Posterior Unilateral Crossbite (must involve two or more adjacent teeth, one of which must be a molar) or an Anterior Crossbite (Must involve two or more teeth and visibly show clinical attachment loss and recession of the gingival margin are present	Score 4	
9. Bilateral Crossbite (Must involve two or more teeth including a molar on both sides)	Score 8	
10. Impacted **posterior** teeth required for function that will not erupt without surgical intervention or congenitally missing **anterior** or **posterior** teeth (excluding third molars)	# x3:	
Total		

Signature Treating Provider_____ **Date** _____