PART II

POLICIES AND PROCEDURES

FOR

DENTAL SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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PART II POLICIES AND PROCEDURES

FOR

DENTAL SERVICES

Contents

CHAPTER 600 SPECIAL CONDITIONS OF PARTICIPATION..... VI

Section 601 Conditions
Section 602 Teaching or Instructor's Licenses Dental Providers

CHAPTER 700 SPECIAL ELIGIBILITY CONDITIONS VII

Section 701 General
Section 702 HEALTH CHECK (Under 21) Dental Program
Section 703 PeachCare for Kids Benefit Plan
Rev 07/10
Section 704 Adult Dental Program
Section 705 Pregnant Women

CHAPTER 800 PRIOR APPROVAL.....VIII

Section 801 General
Section 802 Prior Approval - HEALTH CHECK ..... (Under 21) Dental Program
Section 803 Adult Dental Program
Section 804 Prior Approval Procedures - HEALTH CHECK and Adult Program
Section 805 Non-Emergency Hospital Admission Precertification - HEALTH CHECK and Adult Program
Section 806 Emergency Hospital Admission - HEALTH CHECK and Adult Program

CHAPTER 900 SCOPE OF SERVICES IX

Section 901 General
Section 902 Covered Services
Section 903 Adjunctive General Services
Section 904 Coverage of Orthodontic Services
Section 905 Non-Covered Services
Section 906 Catastrophic "By Report" Procedures (HEALTH CHECK only)
Section 907 Out-of-State Services
Section 908 Mobile Dentistry Services
Section 909 Dental Services—FQHC/RHC
Section 910 Dental Services in Public Health Clinics

CHAPTER 1000 BASIS FOR REIMBURSEMENT X
Section 1001 Reimbursement Methodology
Section 1002 Member Co-payments

APPENDIX A Medical Assistance Eligibility Certification (MEMBER ID CARD)

APPENDIX B Maximum Allowable Charges

APPENDIX B-1 Schedule of Dental Services for Pregnant Women

APPENDIX B-2 DMA 635 Attestation Pregnancy Form

APPENDIX C Example of a Proper and Valid Dental Treatment Record

APPENDIX D Alliant Health Solutions Contact Information

APPENDIX E Billing Procedures for Open Pulp-Chamber to Establish Drainage and Partially Completed Root Canal Therapy

APPENDIX F Georgia Families (GF)

APPENDIX G National Provider Identifier (NPI) Requirements

APPENDIX H Preventive Oral Health: Fluoride Varnish

APPENDIX I HACs NEs and PPCs

PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

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.

a) **Public Health Dentistry Providers (PHD)** holding a current valid license to practice dentistry or 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 43-11-42, 43-11-7 and 43-11-52, may be enrolled to render services as described below:

Providers enrolled under the PHD license may render services within the Public Health Department or setting. The PHD enrollment status may not be used to render or bill for services rendered outside of the respective assigned Public Health Department setting.

b). **Teaching Dentist or Instructor** holding a current valid Dental Teaching License, in accordance with the Georgia Board of Dentistry Rules, Chapter 150-7-02, may be enrolled.

Dental Teaching or Instructor enrollment status is for the sole purpose of teaching or instructing, in an accredited dental college or training clinic in this state. Refer to Section 601.11 below for service conditions.

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 Agree to bill the Division for only those services rendered personally by the dentist, or by a salaried dental hygienist under the dentist's direct supervision or general supervision as outlined in Article 3, Chapter 11 or Title 43 of the Official Code of Georgia Annotated, related to Dental Hygienists. Under no circumstances may a dental provider bill for services rendered by another dental practitioner who is enrolled or eligible to enroll as a provider of services in the Medical Assistance program. Also, a dental provider may bill for covered services rendered

by a non-licensed individual (i.e., dental school student, dental assistant, etc.) only when that individual has successfully completed and met the requirements of an expanded duty dental assistant as specified and defined by the Rules of the Georgia Board of Dentistry (Rule 150-9-.02 and 150-9-.03), and when the covered services are provided under the direct supervision or general supervision as outlined in Article 3 of Chapter 11 of Title 43 of the Official Code of Georgia Annotated, related to Dental Hygienists.

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

601.5 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 107 and 108.)

601.6 Agree not to bill for services rendered as an assistant surgeon because assistant surgery services are non-covered.

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 records in the office to support the need for any dental service including hospital time and management time. The treatment plan is not sufficient as a medical record.

* A proper and valid record of dental treatment or service rendered must at a minimum include:

  - The patient's name and Medicaid number
  - The provider's name
  - A detailed description of the treatment or service rendered including all problems encountered or any unusual occurrences
  - Tooth number, surface code or quadrant
  - Type of anesthesia utilized
  - Any drugs prescribed
  - The condition of the patient
  - All records must be written in Standard English Language

The following documents do not constitute and are not acceptable records of treatment provided:

- Treatment plans
- Prior approval requests
- Claims submitted for billing purposes
- Patient medical history
- Tooth charts
- Claims used for billing other third-party insurance

601.9 Locum Tenens

It is a long-standing and widespread 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 medical/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.

A patient's regular dentist may submit a claim and receive payment for services (including emergency visits and related services) of a locum tenens dentist who is not an employee of the regular dentist and whose services for patients of the regular dentist are not restricted to the regular dentist's offices, if:

- The regular dentist is unavailable to provide the visit services.
- The Medicaid Member has arranged or seeks to receive the services from the regular dentist.
- The regular dentist pays the locum tenens for his/her services on a per diem or similar fee-for-time basis.
- The substitute dentist does not provide the visit services to Medicaid patients for a period of time not to exceed sixty continuous days.

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

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.

The common practice of one dentist covering for another will not be construed as a violation of this section. The service furnished by the covering dentist is an informal reciprocal arrangement. Dentists should be aware that the services furnished by the substitute dentist should be

identified in the Member's medical record held by the regular dentist, which is available for inspection.

602. **Teaching or Instructor's Licenses Dental Providers**

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

Dental fee schedule payment(s) is made only when:

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

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

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

c). The Teaching Dentist must personally document his/her presence and participation in the services in the patient's medical 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

PART II - CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

701. General

Under the Georgia Medicaid program, there are three (3) 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), the Adult Dental Program for Members over twenty-one as defined above, and Dental Services for Pregnant Women.

702. HEALTH CHECK (Under 21) Dental Program

702.1 Dental services are limited to eligible Members under twenty-one. HEALTH CHECK dental coverage ends as defined above.

702.2 Dental services under this program are available either as a result of the HEALTH CHECK screening process or as a result of a request or need by the Member or caregiver.

a) The Member's proposed dental treatment plan must be completed within the scope of dental policies and procedures as outlined in this manual.

b) An eligible Member under the age of twenty-one (21) years of age may receive services either as the result of a referral at the time of screening or as requested by the parents. NO SCREENING REFERRAL FORM IS REQUIRED.

703 PeachCare for Kids Benefit Plan

Effective for dates of service on or after September 1, 2006, dental services benefits for eligible PeachCare for Kids members were reinstated to match benefit coverage for eligible Medicaid members. Refer to Chapter 902—Covered Services and Appendix B for reinstated Georgia PeachCare for Kids Benefit Plan for covered services.

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

704. Adult Dental Program

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

Dental services under this program are available as a result of need by the Member. Adult dental services only cover emergency and related services, except those services listed on Appendix B-1 for validated pregnant members.

705. Pregnant Women

705.1 Additonal services for pregnant women begin on the date of service following verification of pregnancy and extend to the date of delivery. Refer to Appendix B-1of this manual for covered services.

705.2 Services rendered after the date of delivery will not be reimbursed by the Department. The member is liable for non-covered services and services rendered after the date of delivery or during the member's non-pregnant state.

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).

PART II - CHAPTER 800

PRIOR APPROVAL

801. General

As a condition of reimbursement, the Division requires that certain services be approved before being rendered to a Member. Prior approval review applies only to medical necessity and the appropriateness of the treatment plan. Prior approval does not guarantee that a Member's service limits have not been met. Receipt of prior approval does not guarantee payment, Member eligibility, or payment of submitted fees. 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.

The role of Alliant Health Solutions (AHS) includes processing of 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.

801.2 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 relative to these items.

801.3 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 in order 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.

801.4 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, Section 112 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. The inquiry will be reviewed by AHS to determine if the claims denial is appropriate.

802. Prior Approval - HEALTH CHECK (Under 21) Dental Program

Services, as described in 802.1 require a Prior Approval before services are rendered unless otherwise noted below.

802.1 Failure to obtain the required prior approval prohibits reimbursement. Prior approval is required for only the services listed in Section 802.1, Item b, Page VIII–2.

a. Services that require prior approval but are rendered in an emergency situation 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. An authorization with supporting documentation must be submitted on the MMIS Web Portal within thirty (30) calendar days from the date of service.

Note: Effective with date of service October 1, 2003, the following units of service can be provided without prior approval and billed for upon the completion of the treatment if medically necessary: D9920 –2 units and D9310- 1-unit, same member, same

provider, same calendar year. Effective January 1, 2016, D9243 – 6 units can be provided without prior approval and billed upon completion of the treatment, same member, same provider, same calendar year.

Effective January 1, 2016, D9241 and D9242 are no longer active codes. D9223 or D9243 are to be used to bill sedation services.

If additional units of the aforementioned services are found to be medically necessary, a post approval request for the remaining units should be submitted within thirty (30) calendar days of the date of service. You must include any narratives as required and all procedures provided in conjunction with these services.

b. Specifically, designated services listed below require a Prior Approval before services are rendered or if allowed for post approval, as described in 802.1a.

- **Hospital Admissions** (both Inpatient and Outpatient)

  All CDT codes rendered in the hospital setting must be on the precert. The treatment plan can be submitted prior to admission and the codes and units adjusted to actual treatment rendered by submitting a Change Request (see 804.2) within 30 days of admit date.

- **Root Canal Therapy** (see page IX-12 for documentation required for authorization).

  Effective with date of service October 1, 2003, procedure code D3330, molar root canal (excluding final restoration), is no longer a covered service. Post approval allowed for emergency root canal only.

- **General Anesthesia**, D9223; post approval allowed

- **Intravenous Sedation**, D9243 additional units over 6 units (1.5 hours); post approval allowed

- **Non-Intravenous Conscious Sedation**, D9248 ; post approval allowed

- **Nitrous Oxide**, D9230; post approval allowed

- **Other Drugs and Medications**, D9630; post approval allowed

- **Local Anesthesia**, D9215; Pregnant Women only
- **Management of Difficult Children**, D9920; only post approval is required

- **Hospital Time or Consultation**, D9240, D9310; D9440 post approval allowed

- **All Periodontal Services**; prior approval only

- **Prosthodontic services**: Dentures, Partial Dentures and Medically Necessary Fixed Prosthodontics; Health Check only; prior approval only

- **Prosthodontics**, **Fixed,** D6240 and D6750; effective 4/1/2016 Effective October 1, 2016, D6240 and D6750 have limited coverage. Fixed prosthodontics require prior approval and are limited to Health Check members whose medical or mental condition precludes the use of removable prosthodontics. All approvals for these procedures must be medically necessary as determined by AHS.

- **More than two denture adjustments**, two laboratories reline, or two-tissue conditioning rendered to a member per calendar year; Health Check only

- **Frenulectomy (Frenectomy),** D7961; Health Check only; prior approval only

- **All Alveoloplasty services**, with and without extractions, Health Check only; prior approval only

- **Medically Necessary Orthodontic procedures**
  Only eligible members, less than 21 years of age, meeting specified criteria may receive orthodontic services. All Orthodontic services must be prior approved. Prior approval procedures are described in Part II, Chapter 900, Section 904.

- **Catastrophic Procedures** (See Sections 906)

803 Adult Dental Program

Members 21 Years of Age and Older

803.1 Effective with dates of service on and after November 1, 1991, eligible adult Members 21 years of age and older may receive only the services listed below.

Radiographs are reimbursable up to $100 per Member per calendar year.

D0220 Intraoral-periapical, first film

D0230 Intraoral-periapical each additional film

D0330 Panoramic film. Limited to one every three calendar years. Example: If a Member has had a panoramic film done in any month of a given year, the member is not eligible to receive this service again until the beginning of year three.

D7111 Extraction, Coronal remnants, deciduous tooth (Removal of soft tissue-retained coronal remnants.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal). Include routine removal of tooth structure and closure, as necessary.

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

D7220 Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 Removal of impacted tooth - partially bony. Part of crown covered by bone, requires mucoperiosteal flap elevation and bone removal.

D7240 Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap between and bone removal.

D7250 Surgical removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Procedure (root recovery) is not reimbursable to the provider performing the extraction.

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

D7286 Biopsy of oral tissue soft. For surgical removal of architecturally intact specimen only. This code is not used at

	the same time as codes for apicoectomy/periradicular curettage.
D7510	Incision and drainage of abscess-intraoral soft tissue
D7520	Incision and drainage of abscess-extraoral soft tissue
D7540	Removal of reaction producing foreign bodies of musculoskeletal system
D7610	Maxilla – open reduction (teeth immobilized if present)
D7620	Maxilla – closed reduction (teeth immobilized, if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7820	Closed Reduction of dislocation
D7910	Suture of recent small wounds up to 5 cm. Excludes closure of surgical incisions)
D7912	Complicated suturing- greater than 5 cm. (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)
D9215	Local Anesthesia (PREGNANT WOMEN ONLY) – not reimbursed separately when billed in conjunction with other anesthesia, endodontic, periodontal, prosthodontic, and oral surgical procedures
D9223	Deep sedation/General anesthesia-each 15 minutes
D9230	Analgesia, anxiolysis, inhalation of Nitrous Oxide
D9243	Intravenous conscious sedation/analgesia-each 15 minutes
D9248	Non-intravenous conscious sedation *Prior Approval is required for non-emergency hospitalization.* *When it is necessary to administer general anesthesia, intravenous sedation or nitrous oxide, a request for POST AUTHORIZATION must be submitted within 30 days of date of service.*
D9440	Office Visit - This examination is reimbursable for emergency situations, which occur <u>after</u> regularly scheduled office hours, not including lunch hour. 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. The

comprehensive or the periodic exam may not occur in conjunction with a limited oral evaluation, D0140 or examination after office hours, D9440

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.

804. <u>Prior Authorization Request Procedures - Health Check and Adult Program</u> The procedures for submitting a prior approval request include:

804.1 <u>Routine Prior Authorization Request</u>

a. 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.

b. Submit any narrative necessary to explain unusual treatments, circumstances or services as listed in Section 802.1 and 803.1.

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

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

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

f. When submitting x-rays for the authorization process, all teeth or areas involved in the treatment request must be <u>visible on X-rays</u>. 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. 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.

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.

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.

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.

g. 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 (see 804.3) to include appropriate x-rays, additional information or clarification.

h. 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.

i. 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.

j. 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 WebPortal.

k. 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 WebPortal; see Dental Billing Manual for specific billing procedures).

l. Each claim submitted for payment must be received by the Division's fiscal agent within six months of the actual month of service in order to be considered a timely submission. (See Section 201.2 Policy Part I).

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

804.2 Change or Addition to a Prior Approval (Change Request)

a. 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 WebPortal/Prior Authorization/Medical Review Portal/Change Request. When the changes have been processed, updates to the authorization can be viewed by the provider online.

b. 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.

804.3 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 decision can be viewed by the provider online.

804.4 Emergency Services

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. 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.

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.

805. Non-Emergency Hospital/Ambulatory Surgical Center Admission Pre-certification – Health Check and Adult Program

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. CPT procedure code 41899 is no longer recognized for dental treatment rendered in the hospital/ASC. Complete documentation and clinical information should be given to warrant dental services in the hospital setting.

The attending dentist must provide the precertification number to the hospital. The dentist's failure to obtain an authorization will result in denial of payment for services rendered.

The hospital must submit Dental charges using the appropriate Current Dental Terminology (CDT) procedure code for the services provided.

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

805.1 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.

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.

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.

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

a. Concurrent serious medical condition(s), (specific condition, illness, syndrome, etc. should be stated);

b. Member with disabilities, (specific disability or special need should be stated)

c. Intellectual Disability, (specific disability or special need should be stated)

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

e. Full-mouth extractions

f. Systemic medical problems, (specific diagnosis or problem(s) should be stated)

A detailed narrative of medical necessity must be included in the request for approval of Precert.
All reasonable effort must be exercised to complete the treatment in the office.

805. 3 When submitting a precertification request on the MMIS Web Portal for hospital/ASC admission, the prior approval procedures outlined in Section 804 should be followed.

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

b. The provider should include the facility Reference ID using

'REF' and the 9-digit number

c. The provider should submit a narrative of medical necessity, clearly stating the reason(s) dental treatment must be rendered in the hospital/ASC setting.

d. 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 (as described in Section 804.2) for additional codes and units. The changes must be submitted within thirty (30) days of the admit date.

e. 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.

f. The provider has the right to request a Reconsideration (as outlined in Section 804.3) for second clinical review of a denied pre-certification request.

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

805.4 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.

805.5 Hospital Call, D9420, is for Health Check only and is not covered for adult dental (patient over the age of 21 years). D9420 may be requested by the dental provider rendering treatment in the hospital or ambulatory surgical center. This code must be in conjunction with the procedure codes for actual services planned. Hospital Call is calculated by determining the time needed to prepare for and render the dental services and is reimbursable in 30-minute increments. One unit is equal to 30 minutes. Hospital Call should not include time spent admitting the

Member, completing the history or making hospital or postoperative visits.

D9420 is for dental provider's time spent in the OR and does not apply to facility; denial of the line item for this code does not affect the approval of the authorization.

805.6 Dental Services rendered in an Ambulatory Surgical Center

As stated in the Ambulatory Surgical Center Policy and Procedure Manual section 903.10: effective with date of service October 1, 2002, medically necessary dental surgeries can be performed in an Ambulatory Surgical Center. Procedure code D9420 is to be used by the ASC to bill for the facility fee. No other dental procedure code can be used by the ASC to bill for dental surgical services being performed in an ASC. Precertification/Prior Approval is required.

The Ambulatory Surgical Center has an exception to the policy for coverage of D9420 for Adult Dental, patient over the age of 21 years. The ASC policy states that dental services provided in an ASC are billed with code D9420, regardless of age.

Precertification for Health Check dental services can include an additional unit of D9420 for the ASC.

Precertification for Adult Dental services cannot include D9420 because the code in not covered for patients over the age of 21 years. In this case, the dental provider submits a Precert for the dental procedures and the ASC submits a second precertification for approval of D9420. The D9420 will only bill for a patient over the age of 21 with ASC COS.

805.7 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.

805.8 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. (see 804.2) If a Change Request

is not possible, provider should submit the new admit date via the 'Contact Us' link on the initial authorization.

806. Emergency Hospital Admission - HEALTH CHECK and Adult Program

806.1 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 in 805.3g above, it is the dental provider's responsibility to obtain the pre-certification number and give it to the hospital/ambulatory surgery center.

806.2 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.

806.3 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. (see 804.3)

PART II - CHAPTER 900

SCOPE OF SERVICES

901. GENERAL

Dental services are defined as any diagnostic, preventive, or corrective procedures administered by or under the direct 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's 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 of time. 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. Providers' usual and customary submitted fees are recorded and are used when the maximum allowable payments are updated.

901.1 Coding of Claims

The procedure-coding scheme listed herein is based on the American Dental Association (ADA) CDT coding guidelines. 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.

a) Deleted CDT codes are not eligible for reimbursement
b) Unspecified or unlisted" procedures codes are not accepted by the Division
c) Updates to the ADA CDT codes are effective the first day of January following the month of publication or as indicated.
d) 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.

Other modifications to the CDT coding scheme are required by the Division in order to process claims for certain covered services. The special coding requirements and service limitations are discussed in detail in the following section.

902. COVERED SERVICES

This program is intended to assist eligible Medicaid and Peach Care for Kids eligible members in obtaining preventive and therapeutic dental services which decrease the chance of future acute dental problems.

A procedure indicated as Health Check only is available to Members under twenty-one (21) years of age, through the last day of the 21st birthday month.

Unless otherwise noted, procedures are available to all eligible members as indicated. Only emergency and related dental services are available to members 21 years and older, except for eligible pregnant women. Refer to Appendix B-1 and B-2 for services approved for eligible pregnant members.

A procedure indicated as Pregnant Member only is available to members that present a completed DMA 635 "Attestation Pregnancy Form" from their PCP, OB/GYN or other appropriate licensed health care provider. Dental services for the adult pregnant member are limited to the duration of the pregnancy only. Coverage for dental services when patient is pregnant and over the age of 21, end with delivery, miscarriage or abortion.

902.1 Diagnostic Radiographs

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

1. X-Ray film must be properly mounted, or digital film must be adequately printed, clearly readable, and free from defect.

2. The density and clarity must be such that interpretation can be made without difficulty.

3. 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.

4. 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.

5. 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.

6. 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.

7. Radiographs must be maintained by the provider for a period of five years.

a. Full-Mouth Radiographs

The two types of full-mouth radiographs, reimbursable under this program are Full Mouth Series (D0210) and Panoramic Option (D0330).

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

D0210 Intraoral-complete series (including bitewings) Health Check Only

Full mouth radiographs may not be repeated more than once every three (3) calendar years. A full-mouth series includes up to eight frames for children under 12 years of age and 14 frames for patients 12 years of age and older. The radiographs must comply with the conditions of acceptance in Section 902.1

D0330 Panoramic Film 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 full-mouth series, but as a diagnostic tool, is not 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 bitewings for the appropriate treatment areas, the x-rays are reimbursable whether done on the same date of service or separate dates.

If a panoramic x-ray cannot be submitted with the treatment plan for approval of dentures (partially edentulous or edentulous patients), the dentist may submit one of the following:

1. four (4) periapicals (Healthcheck and Adult)
2. four (4) bitewings (Healthcheck Only)
3. two (2) occlusals (Healthcheck Only)
4. full mouth series (Healthcheck Only)
5. Intraoral photograph of the patient's mouth

Reimbursement for Panoramic Option is limited to Members five (5) years of age and older. Neither panoramic nor full-series radiographs are reimbursable more than once every three (3) calendar years for the same Member and not in conjunction with each other.

b. Individual Periapical Radiographs Health Check and Adults

A provider may use periapical frames when rendering routine extractions of individual teeth, root canal therapy (only pretreatment radiographs are reimbursable), anterior restorations and/or crowns.

D0220 Intraoral-periapical, first film

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

c. Occlusal film Health Check only

Rev 10/20

DO240 Intraoral Occlusal film - When billing for this service, list the total number of films taken for D0240, limited to two per calendar year.

d. Individual Bitewing Radiographs Health Check only
A provider may use bitewing x-rays when rendering routine posterior restorative treatment.

D0270 Bitewing, single film

D0272 Bitewing, two films

D0274 Bitewing, four films

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

D0330 Panoramic Film Health Check and Adults

Panoramic radiograph are limited to once every three calendar years and are 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. (See 902.1a for additional details)

902.2 Diagnostic Services (Clinical Examinations)

Clinical oral examinations are reimbursable in one of three ways, depending on the type of examination completed and the age of the Member. The examinations covered are: comprehensive oral examination (initial and periodic), limited oral evaluation (examination during office hours), and office visit after regularly scheduled hours (emergency examination). The examinations are described in subsequent paragraphs.

a. Clinical Examinations Health Check and Pregnant Women included

D0120 Periodic Oral Evaluation – established patient

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.

A child or pregnant woman may have one (1) comprehensive oral evaluation (D0150) and one (1) periodic oral evaluation (D0120) per calendar year, per Member. The comprehensive or the periodic exam may not occur in conjunction with a limited oral evaluation, D0140, or examination after office hours, D9440.

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.

D0150 Comprehensive Oral Evaluation - new or established patient

Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively.

A child or pregnant woman may have one (1) comprehensive oral evaluation (D0150) and one (1) periodic oral evaluation (D0120) per calendar year, per Member. The comprehensive or the periodic exam may not occur in conjunction with a limited oral evaluation, D0140, or examination after office hours, D9440.

D0180 Comprehensive Periodontal Evaluation - new or established patient, Pregnant Women only.

A pregnant woman may have one (1) comprehensive periodontal evaluation per calendar year, per Member. (Please see CDT for detailed descriptor).

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 or periodic 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.

902.3 Preventive Services Health Check only

Prophylaxis and fluoride are reimbursable as separate services.

a. Prophylaxis

This 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.

Only two (2) prophylaxis (one of D1110 and one of D1120 or two of each) are reimbursable in a calendar year for children.

D1110 Prophylaxis-adult to be used for Health Check & Pregnant Women *with permanent dentition.*

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

D1120 Prophylaxis-child *with primary dentition.*
Refers to a dental prophylaxis performed on primary or transitional dentition only.

b. Fluoride

Effective January 1, 2015, the application of topical fluoride varnish by a physician or other qualified health care professional may bill with the new CPT code 99188. This only applies to providers in Georgia Medicaid programs COS 430, 431, and 740.

D1206 Topical application of fluoride varnish; therapeutic application for moderate to high caries risk patients

D1208 Topical application of fluoride (prophylaxis not included)- Health Check and Pregnant Women

Only two fluoride treatments (two of D1206 or D1208 for children, or two of D1208 for pregnant women) are reimbursable per Member, per calendar year.

c. Sealants Health Check Only

D1351 Sealant-per tooth
Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

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

is restricted to Members under twenty-one (21) years of age.

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.

d. Space Management Therapy Health Check only
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 is reimbursable for Members under twenty-one (21) years of age only.

Space management therapy and palliative treatment no longer require prior approval.

D1550 Space Maintainer fixed-unilateral terminated 12/31/2019

These are the replacement codes:
D1551- re-cement/re-bond bilateral space maintainer Maxillary
D1552 -re-cement/ re-bond bilateral space maintainer Mandibular
D1553 -re-cement/re-bond unilateral space maintainer per Quadrant

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

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.

D1516 Space maintainer: fixed-bilateral, maxillary
D1517 Space maintainer: fixed-bilateral, mandibular
D1526 Space maintainer: removable-bilateral, maxillary
D1527 Space maintainer: removable-bilateral, mandibular
D1550 Re-cementation of space maintainer

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 D1516, D1517, D1526, D1527 and D1550, 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.

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).

902.4 Restorative Services – Health Check and Pregnant Women included

Only one (1) restorative (filling) procedure code is reimbursable per tooth, per restoration.

The maximum number of surfaces, which may be reimbursed, is four (4). All surfaces must be identified on the claim form in order 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

Double occlusal restorations or combinations of surfaces involving double occlusals on any tooth will not be separately reimbursed. No reimbursement will be allowed for permanent restorations placed on primary teeth where an early loss of teeth is expected.

a. Amalgam Restorations Health Check and Pregnant Women included (Includes local anesthesia, base and polishing)

D2140	Amalgam-one-surface, primary or permanent
D2150	Amalgam-two surfaces, primary or permanent
D2160	Amalgam-three surfaces, primary or permanent
D2161	Amalgam-four surfaces, primary or permanent

b. Acrylic and Composite Restorations Health Check and Pregnant Women included

Composite restorations are covered for maxillary and mandibular anterior teeth from cuspid to cuspid.
For this program, the use of acid etch technique is considered an integral part of the composite procedure.

D2330	Resin–based composite; one surface, anterior
D2331	Resin-based composite; two surfaces, anterior
D2332	Resin-based composite; three surfaces, anterior
D2335	Resin-based composite; 4 or more surfaces, anterior This is defined as a restoration, which restores a severely fractured or damaged tooth that goes beyond normal restorative procedures.

Composite restorations are covered for maxillary and mandibular posterior teeth. Exceptions to this are Class V restorations on first and second premolars (maxillary and mandibular). For this program, the use of acid etch technique is considered an integral part of the composite procedure.

Health Check and Pregnant Women included

D2391	Resin based composite-one surface posterior Used to restore a carious lesion into the dentin or a

deeply eroded area into the dentin. Not a preventive procedure.

D2392 Resin based composite-two surfaces, posterior

D2393 Resin based composite-three surfaces posterior

D2394 Resin based composite-four or more surfaces posterior

c. Crowns Health Check only

D2930 Prefabricated stainless steel crown-primary tooth.

D2931 Prefabricated stainless steel crown-permanent tooth.

D2932 Prefabricated resin Crown
Limited to anterior teeth from cuspid to cuspid-maxillary to mandibular. The date the impression is made is the date of service. Anterior teeth numbers are 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27.)

D2934 Prefabricated esthetic coated stainless steel crown - Primary tooth.
Limited to anterior teeth from cuspid to cuspid-maxillary to mandibular. The date the impression is made is the date of service.
A child may have one (1) Prefabricated stainless steel crown (D2930) or (1) Prefabricated esthetic coated stainless (D2934) per member, per tooth.

d. Other Restorative Services Health Check only

D2920 Re-cementation Crowns

D2940 Sedative Filling
Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration, or as sealant for deciduous teeth.

D2951 Pin Retention per tooth, in addition to restoration.

D2954 Pre-fabricated post and core in addition to crown
Core is built around a prefabricated post. This procedure includes the core material.

Note: Effective with date of service October 1, 2003 indirect pulp caps, procedure code D3120 and direct pulp caps, procedure code D3110 will no longer be covered services.

902.5 Endodontic Services Health Check only

a. D3220 Therapeutic pulpotomy (excluding final restoration); removal of pulp coronal to the dentinocemental 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.

b. Root Canal Therapy Health Check only
Prior Approval required; Post authorization allowed for emergency treatment but does not guarantee approval.

When submitting approval requests for endodontic care the following documentation is required:

1. Bitewing x-rays to include both the left and right-side bitewing x-rays.
2. Periapical x-rays of tooth (teeth) involved.
3. Complete treatment plan for each case
4. Charting or narrative with tooth numbers of all missing teeth
5. Post-op x- ray - if endodontic treatment is done on an emergency basis the same documentation is required plus a post-op x- ray. Keep in mind the prudent buyer concept as stated in Part I, Chapter 100, Section 104.1, of Policies and Procedures for Medicaid/Peachcare for Kids Manual. *Private insurance carriers refer to this concept as the least expensive alternate treatment plan.*

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.

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.

D3320 Bicuspid tooth (excluding final restoration)

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.

This code should be used only in the presence of swelling or infection in an emergency situation.

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

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

e. <u>Periapical Services</u> Health Check only

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

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. This does not include retrograde filling material placement.

902.6 <u>Periodontal Services</u> Health Check and Pregnant Women as specified **All periodontal services must be prior approved**. These services are not considered emergency procedures and must be submitted as **prior approvals.**

D4210 Gingivectomy or Gingivoplasty four or more contiguous teeth or bounded teeth spaces, per quadrant Health Check only

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.

D4240 Gingival flap procedure, including root planning, four or more contiguous teeth or bonded teeth spaces, per quadrant. (see CDT for detailed descriptor)
Health Check and Pregnant Women included

D4241 Gingival flap procedure, including root planning, one to three contiguous teeth or bonded teeth spaces per quadrant. (See CDT for detailed descriptor) Pregnant women only

D4260 Osseous Surgery (including flap entry and closure)-four or more contiguous teeth or bounded teeth spaces, per quadrant, (see CDT for detailed descriptor)
Health Check only

A narrative of medical necessity must be submitted with requests for a gingivectomy, gingival flap procedure and osseous surgery.

D4341 Periodontal Scaling and Root Planning, four or more teeth per quadrant. Health Check and Pregnant Women included
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces, (see CDT for detailed descriptor)

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

Periodontal charting, x-rays, and a narrative documenting medical necessity are required. Generalized subgingival calculus must be readily visible on radiographs. Additionally, there must be radiographic evidence of bone loss and clinical probing depths of 3mm or greater. Reimbursement for periodontal charting is included in the maximum allowable reimbursement fee.

These services (full mouth) are limited to one per Member per calendar year.

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

When requesting prior approval for procedure codes D4210, D4240, D4241 D4260, D4341 and D4342, 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 must be assigned to each quadrant.

D4270 Pedicle soft tissue Graft procedure – Health Check only (See CDT for detailed descriptor)

D4910 Periodontal Maintenance - (Pregnant Women only)

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 planing where indicated, and polishing the teeth.

902.7 Prosthodontic Services, Removable Health Check only

All dentures must be prior authorized.

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. Natural teeth, which are sound and have healthy bone and a positive prognosis, should not be removed.

No reimbursement will be made for dentures replaced or remade within a three calendar-year period unless prior approval is obtained from AHS.

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 denture impressions are made is the date of service.

The dentist is responsible for constructing a complete and functional denture. The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture.

a. Complete Dentures Health Check only

D5110 Complete denture - maxillary

D5120 Complete denture – mandibular

D5130 Immediate denture – maxillary

Includes limited follow up care only; does not include required future rebasing/relining procedure(s) or a completely new denture

D5140 Immediate denture – mandibular

Includes limited follow-up care only; does not include required future rebasing/relining procedure(s) or a completely new denture

b. Partial Dentures Health Check only

D5211 Maxillary Partial Denture-Resin Base (including any conventional clasps, rests and teeth). Includes acrylic resin base denture with resin or wrought wire clasps.

When submitting an authorization or filing a claim for partial denture, no tooth number, or quadrant or arch designator is required.

One-tooth maxillary partial is <u>not</u> covered unless replacing tooth numbers 6, 7, 8, 9, 10, or 11. One tooth partial is not allowed for missing one posterior tooth.

D5212 Mandibular Partial-Resin Base (including any conventional clasps, rests and teeth). Includes acrylic resin base denture with resin or wrought wire clasps.

When submitting an authorization or filing a claim for partial denture, no tooth number, or quadrant or arch designator is required.

One-tooth mandibular partial is <u>not</u> covered unless replacing tooth numbers 22, 23, 24, 25, 26, or 27. One tooth partial is not allowed for missing one posterior tooth.

D5410 Adjustment - Complete Denture maxillary

D5411 Adjustment - Complete Denture-mandibular

D5421 Adjustment - Partial Denture maxillary

D5422 Adjustment - Partial Denture mandibular

c. <u>Repairs to Dentures</u> Health Check only

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

D5511 Repair broken complete denture base, mandibular

D5512 Repair broken complete denture base, maxillary

D5640 Replace broken teeth-per tooth.

Rev 01/18

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture

D5750 Reline complete maxillary denture (laboratory).

Limited to <u>two total relines per calendar year</u>. Any additional relines during the calendar year must be prior approved.

D5751 Reline complete mandibular denture (laboratory). *Limited to <u>two total relines per calendar year</u>. Any additional relines during the calendar year must be prior approved.*

Rev 01/22

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.

D5850 Tissue Conditioning maxillary
Treatment reline using materials designed to heal unhealthy ridges prior to more definite final restoration.

D5851 Tissue Conditioning mandibular
Treatment reline using materials designed to heal unhealthy ridges prior to more definite final restoration.

Rev 04/16

A maximum of <u>two total treatments per calendar year</u> may be performed. Any additional treatments must be prior approved.

902.8 <u>Prosthodontic Services, Fixed</u> Health Check only

Effective October 1, 2016, D6240 and D6750 have limited coverage. Fixed prosthodontics require prior approval and are limited to members whose medical or mental condition precludes the use of removable prosthodontics. All approvals for these procedures must be medically necessary as determined by GMCF.

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

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

902.9 <u>Oral Surgery</u> Health Check and Adults

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").

a. Simple Extractions (Includes local anesthesia and routine post-operative care)

D7111 Extraction, coronal remnants, deciduous tooth. Removal of soft tissue-retained coronal remnants.

D7140 Extraction of erupted tooth or exposed root (elevation and/or forceps removal). Includes routine 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.

b. Surgical Extractions (Includes local anesthesia, suturing and routine post-operative care)

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.

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

Effective for dates of service on and after January 1, 2003, x-rays MUST be submitted for extraction procedure codes D7220, D7230 and D7240 when done on the same date of service with nitrous oxide, general anesthesia, intravenous sedation, other drugs or non-intravenous sedation. As a reminder, a narrative of need must also accompany the approval request for the aforementioned sedations.

D7220 Removal of impacted tooth - soft tissue. Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

D7230 Removal of impacted tooth - partially bony. Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

D7240 Removal of impacted tooth - completely bony. Most or all of crown covered by bone; requires mucoperiosteal flap elevation and removal of bone.

D7250 Surgical removal of residual tooth roots (cutting procedure). Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

D7260 Oroantral fistula closure. Health Check only
Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap. Note unusual circumstances with a narrative

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).

D7280 Surgical access of an unerupted tooth - Health Check
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.

D7286 Biopsy of oral tissue-soft Health Check and Adults

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

The appropriate coding scheme indicated in Chapter 900 for the 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. 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.

c. Alveoplasty Health Check

Surgical preparation of ridge for dentures. The coding scheme below is to be used for alveoplasty 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 right

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

D7311 Alveoloplasty- in conjunction with extractions – one to three teeth or tooth spaces, per quadrant.
The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions.

. D7320 Alveoloplasty- not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
No extractions performed in an edentulous area. See if teeth are being extracted concurrently with the alveoloplasty.

D7321 Alveoloplasty- not in conjunction with extractions- one to three teeth or tooth spaces, per quadrant.
Coding for D7321 by tooth number.

d. Surgical Excision Health Check only

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

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

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

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

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

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.

e. Surgical Incision Health Check and Adults

D7510 Incision and drainage of abscess - intraoral soft tissue

D7520 Incision and drainage of abscess - extraoral soft tissue

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

D7550 Partial ostectomy/sequestrectomy for removal of no-vital bone. Health Check only

f. Treatment of Fractures - Simple or Compound
Health Check and Adults

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

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

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

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

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

g. Treatment of Dislocations Health Check and Adults

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

D7820 Closed Reduction of dislocation

h. Other Oral Surgery (repair of Traumatic Wounds) Health Check and Adults

Not to be used in conjunction with extractions.

D7910 Suture of recent small wounds up to 5cm

D7912 Complicated suture- greater than 5 cm. (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

i. Other Repair Procedures Health Check only

D7961 Frenulectomy (Frenectomy or frenotomy) separate procedure

The 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.

Effective with date of service October 1, 2003, a maxillary 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.

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

D7971 Excision of Pericoronal Gingiva

Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth. D7971 does not require prior authorization. The coding scheme for this code is per tooth number.

903 Adjuntive General Services

a. Unclassified Treatment – *Unclassified CDT codes are not recognized by the Department and are not eligible for reimbursement.*

D9110 Palliative (emergency) treatment of dental pain - minor procedure
Health Check and Pregnant Women

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

b. Anesthesia (Prior or Post Approval Required as indicated)

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.

All authorization requests submitted for approval of I.V. sedation, non-intravenous conscious sedation, general anesthesia, management time, hospital call, hospital consultation (a copy of the hospital consultation report is also needed for this service), and analgesia must be accompanied by a narrative of medical necessity, type of anesthesia used (if applicable) and treatment done or to be done.

D9215 Local Anesthesia Pregnant Women Only

Not reimbursed separately when billed in conjunction with other anesthesia, endodontic, periodontal, prosthodontic and oral surgical procedures.

D9222 Deep sedation/General anesthesia – first 15 minutes.

D9223 Deep sedation/General anesthesia - each 15 minutes, (See CDT for descriptor). Health Check and Adults
Reimbursement for general anesthesia will only be made when AHS has granted prior approval or post-treatment approval.

The use of general anesthesia will cause a state of unconsciousness. Prior approval must be obtained from AHS to render this service except in emergency situations. Whenever anesthesia is requested, a written narrative detailing the type of anesthesia to be used, rationale of medical necessity, and when applicable, the nature of the emergency must accompany the request. Anesthesia records should be submitted with the request if an unusual number of additional units are submitted for approval.

D9230 Analgesia, anxiolysis, inhalation of nitrous oxide (Post Approval allowed)
Health Check and Adults

A written narrative detailing the rationale of need, treatment rendered or treatment planned, and when applicable, the nature of the emergency must accompany the request.

Reimbursement for nitrous oxide will be made only when prior approval or post treatment approval has been given by AHS.

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

D9239 Intravenous moderate (conscious) sedation/analgesia-first 15 minutes.

D9243 Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes. (See CDT for descriptor)
Health Check and Adults

Rev 1/18

Effective January 1, 2018, 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 six units (1.5 hours) per calendar year 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.

D9248 Non-Intravenous Conscious Sedation (Health Check and Adults)

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.

D9310 Consultation diagnostic service provided by dentist, Oral Maxillofacial Surgeon or physician other than the practitioner providing treatment in the hospital setting... Health Check only

Type of service provided by a dentist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist, physician or other appropriate source. The consulted practitioner may initiate diagnostic and/or therapeutic services.

Consultation must be performed in a hospital setting. The consultation must be for a patient that is admitted to the hospital for inpatient or outpatient services. Consultation (D9310) may be added to an existing precertification or new post authorization as applicable. Reimbursements are in 30-minute increments. One unit equals 30 minutes.

c. Hospital Call Health Check only (Prior Approval required)

Medically necessary dental 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.**

D9420 Hospital Call Health Check Only

May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate treatment codes for actual services performed. Hospital Call is **not** covered for adult dental.

A provider may request reimbursement for time spent performing dental services at a hospital by including D9420 when submitting an authorization request to AHS for hospital admission pre-certification. Hospital call is calculated by determining the time needed to prepare for and render the dental service and is reimbursable in 30-minute increments. One unit equals 30 minutes. Hospital Call should not include time spent admitting the Member, completing the history or making hospital or postoperative visits.

Hospital Call is limited to a three-hour maximum per admission when requesting approval and is applicable only to a hospital setting. Any additional time needed must be by report and requires approval. Provider can submit a Change Request (See 804.2) for additional time. Requires attachment of hospital records to document start and stop times of surgical treatment.

D9420 Ambulatory Surgical Center, exception to coverage for Adult Dental.

The ASC policy states that dental services provided in the ASC are billed with code D9420, regardless of age.

Precertification for Health Check dental services can include an additional unit of D9420 for the ASC to use in billing.

Precertification for Adult Dental services cannot include D9420 because the code is not covered for patients over the age of 21 years. In this case, the dental provider submits a precert for the dental

procedures and the ASC submits a second precertification for approval of D9420. The D9420 will only bill for a patient over the age of 21 with the ASC COS on a separate authorization.

d. Office Visit - After Regularly Scheduled Hours

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 or periodic 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.

e. Drugs Health Check only (Requires authorization)

D9610 Therapeutic parenteral drug, single administration**.** Includes antibiotic or injection of sedative.

D9630 Other Drugs and/or Medicaments, Health Check only (Authorization required)
By report, includes but is not limited to, oral antibiotics, oral analgesics, and topical fluoride dispensed in the office for home use. Does not include writing prescriptions. D9630 will only be approved once per 6 months for take home fluoride if meets medical necessity as evident by clinical narrative. All other drugs and/or medicaments will be approved per dental reviewer's medical judgement if meets medical necessity as evident by clinical narrative.

When submitting a request for procedure code D9630, a narrative is required to identify the dosage and the technique for administering the drug or preventive product.

f. Management of Difficult Children Health Check only (Authorization required)

D9920 Behavior Management, post approval allowed
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.
Management by report must be requested in 15-minute increments (one unit equals 15 minutes).

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

Reimbursement will be allowed for those children (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. This service can be post approved and is limited to a four-hour maximum per Member per calendar year. An explanation of why management time is required must accompany the approval review request.

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.

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

904. COVERAGE OF ORTHODONTIC SERVICES Health Check only

Orthodontic services that are medically necessary for Members under 21 years of age 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 further information, please see Part I, Policies and Procedures for Medicaid/Peachcare for Kids, Page 6, and Definitions 43.

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. This evaluation should precede the taking of orthodontic records. Treatment must begin prior to the patient's 21st birthday.

Comprehensive orthodontic services will be prior authorized for the correction of severe functionally handicapping malocclusions on a case-by-case basis. Effective with date of service October 1, 2012, 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.

When a request for full orthodontic treatment meets the Medicaid medical necessity criteria, the approval is issued for the initial banding and monthly maintenance visits, not to exceed a total of 12 visits. In approving orthodontic treatment, factors other than functional need will be considered. These other factors include the following:

1. Patient's willingness and ability to meet appointments

2. Patient's ability to follow instructions and cooperate to the end of the lengthy treatment period

3. Patient's ability to maintain an acceptable level of oral hygiene which is vital to success of orthodontic treatment during the treatment period

If a patient is uncooperative for any reason, termination of treatment will be left to the discretion of the provider. A statement reporting the termination of treatment must be sent to AHS with reference to prior authorization.

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 visits. The pre-orthodontic visit (D8660), which includes the initial exam, photographs of study models (if available), photographs, and x-rays are reimbursed separately.

D8660 Pre-Orthodontic Visit – Exam, composite photographs, cephologram and analysis, x-rays, and photgraphs of study models (if available),

D8670 Periodic orthodontic treatment visit (12 visits)

D8080 Comprehensive Orthodontic Treatment of the Adolescent Dentition (initial banding or placement of appliances)

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

Rev 07/20 **Prior Authorization Request Procedures for Orthodontic Services**

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

A. Submit an authorization request on the MMIS Web Portal. The provider should request procedure code D8660 for the initial exam and records, 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.

B. Attach the following as supporting documentation:

1. An interpreted cephalometric x-ray with analysis
2. A panograph or full series of intra-oral radiographs
3. An intra-oral and facial photograph composite
4. A detailed narrative describing the patient's condition, medical necessity for orthodontics, anticipated compliance with treatment, estimated treatment period and fee.
5. A completed Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet

Attachments can be made 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.
The AHS orthodontic consultants will determine the presence of a handicapping malocclusion on a case-by-case basis whether or not to authorize coverage.

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

Deep impinging overbite that shows palatal impingement of the majority of lower incisors.
True anterior open bite. (Not including one or two teeth slightly out of occlusion or

where the incisors have not fully erupted).
Anterior crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).
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).
Overjet in excess of 9 mm.
Negative Overjet greater than 3.5mm.
Cleft Lip/Palate deformities and other significant craniofacial anomalies.
Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.

The approval or denial of services can be viewed on the MMIS WebPortal/prior authorization/medical review web portal.

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.

As stated in Section 804.1 (d and i), each claim submitted for payment must be received by the Division's fiscal agent within six months of the actual month of service in order to be considered a timely submission. (See Section 201.2 Policy Part I).

C. 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 804.3) 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.

D. 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.

905. NON-COVERED SERVICES

1. Services and/or procedures performed without regard to the policies contained in this Policy Manual.

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

3. Infection Control

906. CATASTROPHIC PROCEDURES

The Department does not recognize unspecified or unlisted codes and will not recognize D9999 to report "catastrophic procedures" or other dental service procedures. CPT procedure code 41899 is no longer recognized for dental treatment rendered in the hospital/ASC. 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

907. 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 months from the month of service, and if one or more of the following conditions are met:

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

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

c. prior authorization to render the service was obtained from AHS.

Routine or elective dental care is not covered unless prior authorization is obtained, as in (c) above.

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.

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

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

908 MOBILE DENTISTRY SERVICES

A Mobile Dental Unit is a fully operational dental vehicle, unit or office, which is not stationary and travels on wheels to different locations for the provision of dental services.

1. Any provider rendering dental services in a mobile dental unit must have the capability to perform all diagnostic, preventive and restorative care that each individual Member requires.

Rev. 07/10

2. Any provider rendering services in a mobile dental unit must own or operate a fully operational stationary dental office, which conforms to all applicable policies and procedures of the Division (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).

Rev. 07/10

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.

908.1 DENTAL COVERAGE / MOBILE DENTAL UNITS

Rev. 07/10

Other conditions that must be met in order to be an approved mobile dental unit provider are the following:

1. 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.

2. 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.

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

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

   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.

Rev. 07/10

3. 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:
    a. Hold regular office hours
    b. Routinely schedule appointments for patients
    c. Accept and render dental services to Medicaid Members
    d. Have the capability of performing all diagnostic, preventive and restorative care to Medicaid Members at the location of the stationary dental office.

4. 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.

Rev. 07/10

Any provider rendering dental services in mobile dental units must operate within 50 miles of the required stationary dental office.

909 PROVISION OF DENTAL SERVICES—FEDERALLY QUALIFIED AND RURAL HEALTH CENTERS (FQHC/RHC)

Any contractual arrangement between a mobile dental unit and a FQHC and/or RHC for the provision of Medicaid dental services is subject to the following conditions:

1. The services must be provided by dentists licensed by the State of Georgia

2. The services must be covered by the Medicaid dental services program and subject to the same limitations and prior authorization requirements that apply to the Medicaid dental services program

3. 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

4. The services must be provided in accordance with the terms and conditions specified in the Medicaid FQHC and/or RHC program policies and procedures manual

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.
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.

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.

910 Dental Services in Public Health Clinics

Effective September 1, 2016 Public Health Dentists may bill for Services provided by dental hygienists in Public Health locations, consistent with the Georgia Board of Dentistry rules and state law. *Georgia Board of Dentistry rule 150-5-.03(3) (b) and Georgia law O.C.G.A. 43-11-74(d).*

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. 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.

Effective 1/1/2018, additional teledentistry codes are available to bill for benefits in the Public Health setting. D9996 is the originating site fee and D0140 is used for the Teledentistry Exam code by the Dentist that is receiving the information. D9995 is used to bill when there is a synchronous or real-time encounter instead of information that is stored and sent for review.
D9996 is used by the Dental Hygienist when dental information is sent to a licensed Dentist for review via telemedicine technology. The Dentist that does the requested exam then bills the Department D0140 for the exam and report.

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.)

D9995 Teledentistry – Real time encounter with initiating site and Dentist.

Rev D9996 Teledentistry - Information stored and forwarded to dentist for review
1/1/18 D0140 Teledentistry Exam

PART II - 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.

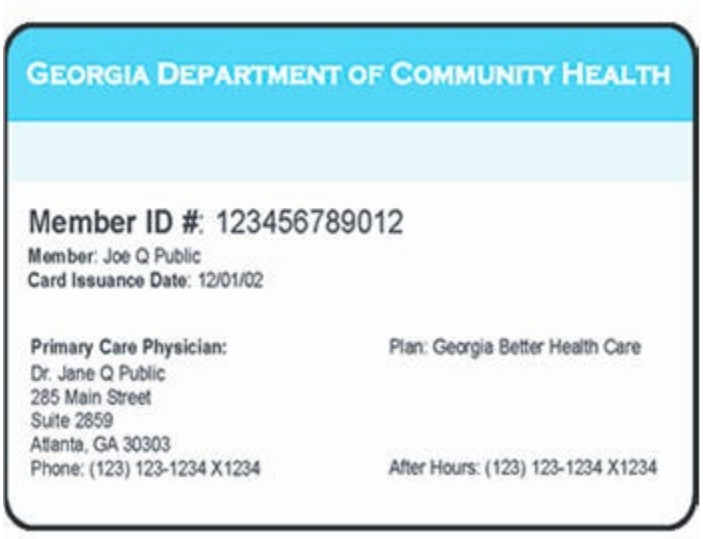
1002. Member Co-payments

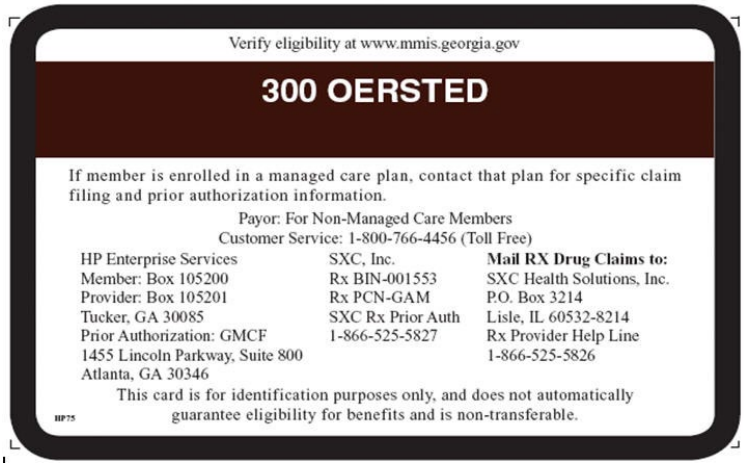
No Member co-payment is required in the Dental program.

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.





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

Appendix B

MAXIMUM ALLOWABLE CHARGES

Note: 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 refer to Chapter 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 & Pregnant Women		$ 25.30
D0140	Limited Oral Evaluation-problem focused ***Note:*** *This procedure code is to be used for emergency examinations during regularly scheduled office hours.*	Health Check & Adults		$ 38.29
D0150	Comprehensive Oral Evaluation-new or established patient	Health Check & Pregnant Women		$ 43.70
D0180	Comprehensive Periodontal Evaluation	Pregnant Women ONLY		$ 39.33
D0210	Intraoral-complete series of radiographic images	Health Check ONLY		$ 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 ONLY		$ 19.66
D0270	Bitewing, single radiographic image	Health Check ONLY		$ 15.50
D0272	Bitewing, two radiographic images	Health Check ONLY		$ 25.84
D0274	Bitewing, four radiographic images	Health Check ONLY		$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

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
D1110	Prophylaxis-adult	Health Check & Pregnant Women		$ 35.64
D1120	Prophylaxis-child	Health Check ONLY		$ 35.64
D1206	Topical fluoride varnish	Health Check Only		$ 19.54
D1208	Topical application of fluoride	Health Check and Pregnant Women		$ 19.54
D1351	Sealant-per tooth	Health Check ONLY		$ 31.05
D1354	Interm caries arresting medicament	Health Check Only		$ 15.00
D1355	Caries Preventive Medicament	Health Check Only		$10.70
D1510	Space maintainer-fixed unilateral	Health Check ONLY		$ 180.09
D1516	Space maintainer- fixed bilateral, maxillary	Health Check Only		$238.05
D1517	Space maintainer-fixed bilateral, mandicular	Health Check Only		$238.05
D1526	Space maintainer-removable bilateral, maxillary	Health Check Only		$210.76
D1527	Space maintainer-removable bilateral, mandibular	Health Check ONLY		$ 210.76
D1551	Re-cementation/Rebond of bilateral space maintainer-Maxillary	Health Check ONLY		$ 45.54
D1552	Re-cementation/Rebond of bilateral space maintainer-Mandibular	Health Check Only		$45.54
D1553	Re-cementation/Rebond of unilateral space maintainer per Quadrant	Health Check Only		27.98
D2140	Amalgam-one surface	Health Check Only	Primary	$ 65.91
D2140	Amalgam-one surface	Health Check	Permanent	$ 73.51

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
		& Pregnant Women		
D2150	Amalgam-two surfaces	Health Check Only	Primary	$ 84.91
D2150	Amalgam-two surfaces	Health Check & Pregnant Women	Permanent	$ 95.05
D2160	Amalgam-three surfaces	Health Check Only	Primary	$ 91.25
D2160	Amalgam-three surfaces	Health Check & Pregnant Women	Permanent	$ 103.80
D2161	Amalgam 4+, primary and permanent	Health Check & Pregnant Women		$ 98.08
D2330	Resin-based composite- one surface-anterior	Health Check & Pregnant Women		$ 81.06
D2331	Resin-based composite- two surfaces-anterior	Health Check & Pregnant Women		$ 103.39
D2332	Resin based composite-three surfaces, anterior	Health Check & Pregnant Women		$ 125.71
D2335	Resin-based comp, 4+ anterior	Health Check & Pregnant Women		$ 149.20
D2391	Resin based composite-once surface, posterior	Health Check	Primary	$ 89.70
D2391	Resin based composite-once surface, posterior	Health Check & Pregnant Women	Permanent	$ 88.81
D2392	Resin based composite-two surfaces, posterior	Health Check	Primary	$ 105.80
D2392	Resin based composite-two surfaces, posterior	Health Check & Pregnant Women	Permanent	$ 110.74
D2393	Resin based composite-three surfaces,	Health Check	Primary	$ 130.41

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
	posterior			
D2393	Resin based composite-three surfaces, posterior	Health Check & Pregnant Women	Permanent	$ 156.26
D2394	Resin based composite-four or more surfaces, posterior	Health Check	Primary	$ 143.45
D2394	Resin based composite-four or more surfaces, posterior	Health Check & Pregnant Women	Permanent	$ 171.88
D2920	Re-cement Crowns	Health Check Only		$ 41.40
D2928	Prefabricated Porecelain Ceramic crown	Health Check Only		$147.28
D2930	Prefabricated stainless steel crown-primary tooth	Health Check Only		$ 176.15
D2931	Prefabricated stainless steel crown-permanent tooth	Health Check Only		$ 184.45
D2932	Prefabricated resin crown-composite Crown	Health Check Only		$ 176.98
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth.	Health Check Only		$ 143.86
D2940	Direct placement of a restorative material to protect tooth and/or tissue and may be used to relieve pain.	Health Check Only		$ 54.85
D2951	Pin Retention per tooth in addition to restoration.	Health Check Only		$ 28.98
D2954	Prefabricated post and core in addition to crown	Health Check & Pregnant Women		$ 54.22
D2991	Application of hydroxyapatite regeneration medicament – per tooth	Health Check		$70.00
D3220	Therapeutic pulpotomy (excluding final Restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament	Health Check ONLY		$ 102.21
D3221	Pulpal Debridement, Primary and Permanent Teeth	Health Check ONLY		$ 91.08

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
D3310	Anterior (excluding final restoration)	Health Check ONLY	Primary	$77.64
D3310	Anterior (excluding final restoration)	Health Check ONLY	Permanent	$379.84
D3320	Bicuspid (excluding final restoration)	Health Check ONLY		$ 463.68
D3410	Apicoectomy/periradicular surgery-anterior	Health Check ONLY		$ 229.81
D3426	Apicoectomy/periradicular surgery (each additional root)	Health Check ONLY		$ 38.06
D4210	Gingivectomy or Gingivoplasty-four or more contiguous teeth or bounded teeth spaces per quadrant	Health Check ONLY		$ 157.38
D4240	Gingival flap procedure, including root planning-four or more contiguous teeth or bounded teeth spaces, per quadrant.	Health Check & Pregnant Women		$ 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 Only		$ 341.00
D4270	Pedicle soft tissue graft procedure **always use appropriate coding scheme indicated in Chapter 900*	Health Check Only		$ 272.14
D4341	Periodontal Scaling and Root Planning four or more contiguous teeth or bounded teeth spaces per quadrant	Health Check & Pregnant Women		$ 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 Only		$ 673.78
D5120	Complete denture mandibular	Health Check Only		$ 673.78
D5130	Immediate denture maxillary	Health Check		$ 554.12

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
		Only		
D5140	Immediate denture mandibular	Health Check Only		$ 554.12
D5211	Maxillary Partial-Resin Base (Including any Conventional Clasps, Rests and Teeth)	Health Check Only	Age 0-16 yrs	$ 276.64
D5211	Maxillary Partial-Resin Base (Including any Conventional Clasps, Rests and Teeth)	Health Check Only	>age 16 yrs	$ 569.25
D5212	Mandibular Partial-Resin Base Rests and Teeth)	Health Check Only	>age 16 yrs	$ 661.36
D5212	Mandibular Partial-Resin Base Rests and Teeth) (Including any Conventional Clasps,	Health Check Only	Age 0-16yrs	$ 276.64
D5410	Adjust Complete Denture-maxillary	Health Check Only		$ 23.77
D5411	Adjust complete denture-mandibular	Health Check Only		$ 23.77
D5421	Adjust Partial Denture-maxillary	Health Check Only		$ 11.76
D5422	Adjust - Partial Denture-mandibular	Health Check Only		$ 11.76
D5511	Repair broken complete denture base, mandibular	Health Check Only		$73.48
D5512	Repair broken complete denture base, maxillary	Health Check Only		$ 73.48
D5640	Replace broken teeth – per tooth	Health Check Only		$ 92.17
D5650	Add tooth to existing partial denture	Health Check Only		$ 92.17
D5660	Adding clasp to existing partial denture	Health Check Only		$ 110.74
D5750	Reline complete maxillary denture (laboratory)	Health Check Only		$ 156.56
D5751	Reline complete mandibular denture (laboratory)	Health Check Only		$ 156.56
D5765	Soft liner for complete or partial	Health Check		$149.55

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
	removable denture- indirect	Only		
D5850	Tissue Conditioning/ maxillary	Health Check Only		$ 47.54
D5851	Tissue Conditioning/ mandibular	Health Check Only		$ 47.54
D6240	Pontic, Porcelain fused to high noble metal	Health Check Only		$556.07
D6750	Retainer Crown, Porcelain fused to high noble metal	Health Check Only		$581.17
D7111	Extraction, coronal remnants – deciduous tooth	Health Check		$53.03
D7111	Extraction, coronal remnants – deciduous tooth	Health Check & Adults		$ 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 ONLY		$ 307.45
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Health Check & Adults		$ 276.34

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
D7280	Surgical access of an unerupted tooth	Health Check ONLY		$ 256.68
D7284	Excisional biopsy of minor salivary glands	Health Check		$136.01
D7286	Biopsy of oral tissue-soft	Health Check, Adults, & Pregnant Women		$ 219.42
D7286	Biopsy of oral tissue-soft	Health Check, Adults, & Pregnant Women	Each additional lesion	$ 29.55
D7310	Alveoplasty in conjunction with extractions – **four or more teeth or tooth spaces**, per quadrant	Health Check ONLY		$ 150.07
D7311	Alveoplasty in conjunction with extractions One to three teeth or tooth spaces, per quadrant	Health Check ONLY		$ 54.22
D7320	Alveoplasty not in conjunction with extractions – four or teeth or tooth spaces, per quadrant	Health Check ONLY		$ 669.64
D7321	Alveoplasty not in conjunction with extractions, per tooth space(s)	Health Check ONLY		$ 63.86
D7440	Excision of malignant tumor Lesion diameter up to 1.25cm	Health Check ONLY		$ 843.52
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25cm	Health Check ONLY		$ 477.13
D7451	Removal of benign odontogenic cyst or tumor diameter greater than 1.25cm	Health Check ONLY		$ 750.37
D7460	Removal of benign non-odontogenic cyst or tumor - up to 1.25cm	Health Check ONLY		$ 477.13
D7461	Removal of benign non-odontogenic cyst or tumor lesion diameter greater than over 1.25cm	Health Check ONLY		$ 769.00
D7471	Removal of lateral exostosis (maxilla or mandible)	Health Check ONLY		$ 230.55
D7510	Incision and drainage of abscess -	Health Check		$ 142.83

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
	intraoral soft tissue	& Adults		
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 ONLY		$ 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
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 ONLY		$131.04
D7962	Lingual Frenectomy (Frenulectomy)	Health Check ONLY		$131.04
D7970	Excision of Hyperplastic Tissue (per arch)	Health Check ONLY		$ 324.99
D7971	Excision of Pericoronal gingiva	Health Check ONLY		$ 85.90
D7997	Appliance Removal (not by dentist who placed appliance), includes removal of archbar	Health Check ONLY		$ 19.03
D8080	Comprehensive Orthodontic Treatment of Adolescent Dentition	Health Check ONLY		$844.62

Appendix B

MAXIMUM ALLOWABLE CHARGES

CDT Code	Description	COS	Indicator	Max Allow
D8660 D8670	Pre-Orthodontic treatment visit Monthly manintenance visits (12 visits)	Health Check ONLY		$ 83.53 $105.57
D9110	Palliative (emergency) treatment of dental pain, minor procedure	Health Check & Pregnant Women		$ 51.75
D9215	Local Anesthesia (*not covered in conjunction with other procedures & services*)	Pregnant Women ONLY		$ 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
D9310	Consultation diagnostic service provided by dentist or physician other than practitioner providing services Hospital setting only	Health Check ONLY		$ 104.53
D9420	Hospital Call – each unit 30 minutes	Health Check ONLY		$ 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 ONLY		$ 53.82
D9630	Other drugs & medication, by report	Health Check ONLY		$ 38.29
D9920	Behavior Management, by report (Only post approval is required)	Health Check ONLY		$ 56.92

APPENDIX B-1

Covered Dental Services for Pregnant Women

Effective for dates of services on or after October 1, 2006, the following services are covered for eligible pregnant women. 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.

Except for approved services already listed elsewhere in this manual for non-pregnant women, the following CDT codes apply ONLY to eligible pregnant women.

CDT Code	Short description
D1110	Prophylaxis - Adult
D0120	Periodic Oral Exam
D0150	Comprehensive Evaluation
D0180	Comprehensive Periodontal
D2140	Amalgam-one surface
D2150	Amalgam-two surface (primary)
D2150	Amalgam-two surface (permanent)
D2160	Amalgam-three surface (primary)
D2160	Amalgam-three surface (permanent)
D2161	Amalgam - 4+, primary & perm.
D2330	Resin based composite-one surface anterior
D2331	Resin-based composite, two surfaces anterior
D2332	Resin based composite-three surface anterior
D2335	Resin-based comp, 4+ anterior
D2391	Resin based composite-one surface posterior
D2392	Resin based composite-two surfaces, posterior
D2393	Resin based composite-three surfaces, posterior
D2394	Resin based composite-four surface posterior
D4240	Gingival flap procedure, including root planning four + continuous teeth
D4241	Gingival flap, including root planning 1-3 teeth
D4341	Periodontal Scaling & root planning four + teeth
D4342	Periodontal scaling 1-3 teeth
D4910	Periodontal maintenance
D7286	Biopsy oral tissue soft
D9110	Palliative (emergency) treatment of dental pain
D9215	Local Anesthesia (not in conjunction with other services & procedures)

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

The treatment record must include information regarding patient contact, contact with DMA or GHP, accounting records, & services to be rendered at the next appointment (see attached).

PATIENT NAME/NUMBER & DENTIST NAME/NUMBER

DATE	TOOTH	TREATMENT RENDERED FEE
		Initial exam, prophy, Fl. tx., 2PA's, O.H. good,
		med. history taken tooth chart completed tx.
		Needed - E, F ext., S, T, A, P - Amal; D-comp; Sp
		main U. Sent for prior approval - requested mgt.
		Time 1 hour - pt. MR & difficult to h&le.
		PA received from Medicaid - schedule tx.
	E	Rout. ext. pt. 30 min. late
	F	Rout. ext. 1.0cc xy/o 2%
		Impression taken space maint. for E & F .30 min.
		Mgt. time - pt screamed & fought full appt.
		2 assistants needed. next appt. - 1 week
		No show - pt has no phone - sent card for re-appt.
	S	OL amal, B - SSC - c duralon
	T	BOL amal. 1.8cc xy/o
	A	MOD amal
		Insert spacer w/duralon

PATIENT NAME/NUMBER & DENTIST NAME/NUMBER

DATE	TOOTH	TREATMENT RENDERED FEE
		.30 min mgt time - needed mom & two assistants
		Pt fought & wouldn't open mouth.
		Recall exam, prophy fltx. 2BW's updated &
		history.
	D	F comp. behavior improved.

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 PROCEDURES FOR OPEN PULP-CHAMBER TO ESTABLISH DRAINAGE AND PARTIALLY COMPLETED ROOT CANAL THERAPY

Root Canal Therapy (RCT) is available only to eligible HEALTH CHECK 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.

1. Emergency Root Canal Procedures, Procedure Code D3221—P*upal debridement, primary and permanent teeth.*

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

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

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

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

        3. If the Root Canal treatment is not completed. The provider should bill for what treatment is completed.

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

            b. 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**.

2. Partially Completed Root Canal Therapy

APPENDIX F

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child

510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged

225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind

306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/Georgia Medicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan

Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX G
NATIONAL PROVIDER IDENTIFIER (NPI) REQUIREMENTS

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health & Human Services to meet HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally.

Who needs an NPI?
All Medicaid providers, both individuals & organizations, who are eligible to receive an NPI, are required to have an NPI. This includes

- All Medicaid healthcare providers &
- All CMO healthcare providers.

The NPI will be required on electronic claims.
Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID. A table showing the types of Medicaid providers & whether they are required to get and use an NPI is included at the end of this Appendix.

When do I need to use my (National Provider Identifier) NPI with Georgia Medicaid?

- Applying to be a Medicaid Provider
- On all electronic claims submissions.

When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances.

- Submission of web claims
- IVR System inquiries
  - Provider authentication
  - All claim inquiries
  - All other inquiries
- Telephone inquiries
  - Provider authentication
  - All claim inquiries
  - All other inquiries
- Prior authorizations
  - Requests
  - Inquiries
- Referrals
  - Request
  - Inquiries
  -
- Medicaid forms

When do I need both my NPI & my Medicaid Provider Number?

- Adding a location to my Provider record
- Changing my Provider information
- Written inquiries & correspondence
- E-mail & 'Contact Us' inquiries

Rev 07/07

Refer to the Part I Policy & Procedure Manual for Medicaid & PeachCare for Kids, Billing Manual, for a list of provider types, categories of service (COS), specialty codes, & specialty descriptions for Georgia Medicaid.

Rev 07/10
Rev 07/11
Rev 4/15

APPENDIX H

Preventive Oral Health: Fluoride Varnish

Note: 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.

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 (effective 1/1/2010):

- Dentists: under category of service 450
- Physicians: under category of service 430
- Physician Assistants (PA): under category of service 431
- Advanced Registered Nurse Practitioners (ARNP): under category of service 740

Effective January 1, 2015, 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 I

PROVIDER PREVENTABLE CONDITIONS, NEVER EVENTS, and HOSPITAL ACQUIRED CONDITIONS

Effective October 1, 2012, 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 to 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.