General Guidelines for All Removable Prosthesis:

- Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.
- Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" (D5850 or D5851) is payable within six (6) months prior to the delivery of new prosthesis.
- Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This included rebasing, relining, adjustments, and repairs. Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service. Prophylaxis and/or scaling and root planning is only payable when performed on natural dentition.
- "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking a final impression. Generally, it is expected that tissue will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review.
- Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment" claims should be submitted following the guidelines for "Interrupted Treatment".
- Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments, or advance payments are prohibited.
- An implant supported prosthetic shall be considered using the medical necessity criteria related to the implants. Please refer to the Implant section below.

C. Implant Supported Dentures

An implant supported prosthetic shall be considered using the medical necessity criteria related to the implants. Please refer to the Implant section below.

Denture Repairs, Relines, and Adjustments

D. Repair/Reline/Adjust

Payment for a new prosthesis includes any adjustments necessary during the 6 month period following delivery.

If the reimbursement for any combination of repairs, relines, and/or adjustments shall exceed 50% of the cost of a new denture, please submit a prior authorization request for consideration of a new denture.

Reimbursement for chairside relines are available once every 24 months. Reimbursement for indirect relines and rebases are available once every 24 months. Adjustments are allowed 4 times per year after the 6 month period following delivery.

E. Rebase and Reline Procedures

Denture Rebasing is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony
- When the base has fractured or cracked

Denture Rebasing is not indicated for the following:

- When the prosthesis is broken or worn to the extent that replacement is warranted
- When the occlusion or structural integrity of the denture teeth are no longer functional
- When a Reline is sufficient

Denture Relining is indicated for the following:

- When changes to the residual ridge result in loss of denture stability, retention, or occlusal disharmony

Denture Rebasing and Relining are not indicated for the following:

- When the prosthesis is broken or worn to the extent that it is no longer functional and replacing the appliance is warranted
- Unresolved soft tissue hyperplasia or stomatitis

Coverage Limitations

- Limited to Relining/Rebasing performed more than 6 months after the initial insertion

Tissue Conditioning

F. Tissue Conditioning

Reimbursement is available once every 12 months.

Implant Services

G. Implants

Dental implants, including single implants, and implant related services will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's dentist. The patient's dentist's office must submit a completed Form **Evaluation of the Dental Implant Patient Form** documenting, among other things, the patient's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition, and certifying that the patient is an appropriate candidate for implant placement. If the patient's dentist indicates that the patient is currently being treated for a serious medical condition, the Department may request further documentation from the patient's treating physician

General Guidelines: The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.

- A complete treatment plan addressing all phases of care is required and should include the following:
    - Accurate pretreatment charting;
    - Complete treatment plan addressing all areas of pathology;
    - Inter-arch distances;
    - Number, type and location of implants to be placed;
    - Design and type of planned restoration(s);
    - Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition

- If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed

- Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
- Treatment on an existing implant/implant prosthetic will be evaluated on a case-by-case basis.
- Documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standards of care.

Fixed Bridgework	**H. Bridgework** Fixed partial dentures are not generally considered within the scope of services covered by the program except for cleft palate stabilization, or when a removeable prosthesis would be contraindicated. If extenuating circumstances exist, please submit a prior authorization request with a narrative for consideration.

VII. ORAL AND MAXILLOFACIAL SURGICAL SERVICES

Summary

A. Oral Surgery Summary

Oral Surgery procedures most commonly include extractions, alveoloplasty, and biopsies.

Reimbursement requests for all oral surgery procedures with exception of non-surgical extractions require clinical review of applicable diagnostics (i.e. pre-operative radiographs, biopsy report, and/or narrative) to substantiate medical necessity.

Oral surgical services (i.e. extractions or exposures) for orthodontic purposes are covered only if the corresponding orthodontic treatment has been approved by Healthplex.

Oral surgical services for implant purposes are covered only if the corresponding implant treatment has been approved by Healthplex.

Extractions

B. Extractions

Removal of tooth, soft tissue associated with the root, curettage of the socket, local anesthesia, required suturing, and routine post-operative care are included in the fees for extractions and will not be reimbursed separately. Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction.

Extraction of impacted teeth should only be undertaken when conditions arising from such impactions warrant their removal. Extraction of asymptomatic teeth or those where medical/dental necessity cannot be demonstrated shall be disallowed.

Coverage is based on medical necessity and the anatomical position of the tooth.

Surgical extraction of an erupted tooth is indicated for any of the following:

- No clinical tooth is visible in the mouth
- The fracture of tooth or roots during a non-surgical extraction procedure
- Erupted teeth with unusual root morphology (dilacerations, cementosis)
- Erupted teeth with developmental abnormalities that would make non-surgical extraction unsafe or cause harm
- When fused to adjacent tooth
- In the presence of periapical lesions
- For maxillary posterior teeth whose roots extend into the maxillary sinus
- When tooth has been crowned or treated endodontically

Excision and Biopsy

C. Excision

Excision of tissue, particularly cyst removal, requires supporting documentation when billed as an adjunct to tooth extraction.

Excision and biopsy submitted on the same day is considered a duplicate service. Benefit only for the excision shall be considered.

D. Biopsy

Removal or biopsy of a periapical granuloma, dentigerous or odontogenic cyst is generally considered an integral part of the extraction and is not separately billable. Any claim for a biopsy must be accompanied with a biopsy report.

Incision and Drainage

E. Incision and Drainage

Incision and drainage procedures include the insertion and removal of drain(s). When submitted on the same day as another definitive service in the same quadrant, supporting documentation (i.e. radiographs or treatment record) is required for consideration for separate reimbursement.

Alveoloplasty

F. Alveoloplasty

When submitted in conjunction with surgical extractions in the same quadrant, alveoloplasty is considered included in the allowance for the surgical service and not reimbursable as a separate procedure.

If submitted without extractions in the same quadrant, a narrative substantiating medical necessity is required.

If alveoloplasty is performed for less than 4 teeth or tooth spaces in the quadrant, a partial quadrant will be allowed.

Other Surgical Services

G. Other

For all other covered oral surgical services, please submit pre-operative radiographs with a narrative substantiating medical necessity for consideration.

VIII. ORTHODONTIC SERVICES

Summary

A. Orthodontic Summary

All orthodontic services must be prior authorized and must be rendered by an orthodontic specialist. Limited or Interceptive orthodontic services will be considered for the treatment of the primary or transitional dentition. Limited or Comprehensive orthodontic services will be considered for treatment of the transitional, adolescent or permanent dentition.

For comprehensive orthodontic treatment, if the total score on the HLD Assessment Tool is equal to or greater than 26, the pre-orthodontic treatment work-up can proceed. If the total score on the HLD Assessment Tool is less than 26 points, please submit documentation of the extenuating functional difficulties and/or medical anomaly with the submission.

Orthodontic treatment is only covered if treatment that meets the criteria for approval is started prior to the patient's 21st birthday.

The pre-orthodontic treatment visit does not require prior authorization. Reimbursement is available twice per 12 months prior to initiation of orthodontic treatment and includes the consultation; therefore, consultation will not be reimbursed separately.

Providers will generally be reimbursed for orthodontic treatment that meets the criteria for approval at a negotiated case rate. The provider shall continue a course of treatment to completion and will be reimbursed the case rate for completed treatment without regard for the length of time necessary to complete such treatment plan.

Limited Orthodontic Treatment

B. Limited

If within the scope of coverage, consideration is given for treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

For prior authorization the following shall be submitted:

- Narrative of clinical findings and treatment plan;
- Diagnostic photographs;
- Diagnostic radiographs of the entire dentition;

Reimbursement is limited to once per lifetime for an approved course of orthodontic treatment.

Comprehensive Orthodontic Treatment

C. Comprehensive

Comprehensive orthodontic treatment will only be considered for the adolescent or permanent dentition.

For prior authorization requests the following shall be submitted:

- The completed HLD Assessment Tool;
- Narrative of clinical findings for dysfunction or deformity and dental diagnosis;
- The comprehensive orthodontic treatment plan;
- Diagnostic photographs;
- Diagnostic panoramic radiographs and cephalometric films with tracing (when applicable);
- For orthognathic surgical cases: the surgical consult, complete treatment plan and approval for surgical treatment with a statement signed by the parent/guardian and recipient that they understand and accept the proposed treatment is necessary; and,
- Medical diagnosis (when applicable).

Please note: All needed dental treatment (preventive and restorative) should be completed prior to initiating orthodontic treatment.

In addition to submission requirements already noted, the following must be met:

- The prior authorization request to start a case must include treatment visits.

  Treatment visits will be considered for 4 quarterly intervals. The maximum number of treatment visits to be considered on any one prior authorization is 4;
- After the initial 4 quarterly treatment visits, recertification for the remainder of the treatment is necessary. Please submit current progress photographs with a copy of the treatment record for review.
- The case start date is considered to be the banding date which must occur within six (6) months of approval;
- The case fee includes active and retention phase of treatment and is based on eligibility and age limitations.

Documentation for Completion of Comprehensive Cases – Final Records

Attestation of case completion must be submitted on the provider's letterhead to document that active treatment had a favorable outcome and that the case is ready for retention. Procedure code D8680, orthodontic retention shall be submitted on the visit to remove the bands and place the case in retention.

Prior Authorization for Orthodontic Services Transferred or Started Outside of the Program

For continuation of care for transfer cases, a prior authorization must be submitted to request the remaining treatment visits for case completion. The following must be submitted with the prior authorization:

- A copy of the initial orthodontic case approval if applicable;
- A copy of the orthodontic treatment notes if available from provider that

started the case;
- Recent diagnostic photographs; and,
- The date when active treatment was started and the expected number of months for active treatment.

IX. ADJUNCTIVE GENERAL SERVICES

Summary

A. Summary

Adjunctive general services most commonly include general anesthesia, intravenous sedation, consultations and palliative services provided for relief of dental pain.

Palliative Treatment

B. Palliative

Reimbursement is per visit and is generally limited to twice every 12 months and is not separately payable if rendered on the same day as another payable procedure other than diagnostic services.

Please include tooth number or area and a description of the procedure rendered.

Please note: Follow-up visits related to previous treatment are not billable and therefore shall not be considered for separate reimbursement.

Inhalation, Non Intravenous Conscious Sedation and General Anesthesia	**C. Sedation** Inhalation of Nitrous Oxide/Analgesia, Anxiolysis and Non-Intravenous Conscious Sedation are separately reimbursable for members/enrollees through 20 years of age (inclusive) with documentation of clinical necessity and in conjunction with covered dental services. For members/enrollees 21 years of age and older, D9230 and D9248 are only approvable for those members/enrollees identified with a intellectual/developmental disability. Intravenous conscious sedation and general anesthesia are payable only if the provider holds a current certification and licensure to administer such anesthesia per state and federal guidelines. For cases requiring intravenous sedation or general anesthesia, providers must retain the anesthesia record which documents time and amounts of drugs administered, pulse rate, blood pressure, respiration, etc. in the patient's treatment record. Healthplex recommends that providers exercise professional judgment when diagnosing the necessity for administration of intravenous sedation or general anesthesia. Apprehension alone is not typically considered a medical necessity. Anesthesia/sedation procedures within the scope of coverage will be allowed only if the corresponding dental treatment has been approved by Healthplex.
Consultation (D9310)	**D. Consultation** A consultation includes an oral evaluation and will only be reimbursed to a specialist. Reimbursement for a consultation is generally limited to once per 6 months (per treatment plan).
Guard Occlusal	**E. Occlusal Guard** One occlusal guard is allowed every 12 months.