DENTAL

CSHCN SERVICES PROGRAM PROVIDER MANUAL

FEBRUARY 2022

TEXAS
Health and Human
Services

DENTAL

Table of Contents

14.1 Enrollment

To enroll in the CSHCN Services Program, dental providers must be actively enrolled in Texas Medicaid, maintain an active license status with the Texas State Board of Dental Examiners (TSBDE) (see Title 22 *Texas Administrative Code* (TAC), §§110.1–110.18), have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state dental providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border.

To be eligible to receive reimbursement for dental anesthesia providers must have the following information on file with TMHP:

- Current anesthesia permit level issued by the TSBDE (applies to all dental providers)
- Proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology (required to be reimbursed at the enhanced rate for procedure codes D9222 and D9223), if applicable

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in 25 TAC, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC §§351.1–351.883 *and specifically including the fraud and abuse provisions contained in 1 TAC §§371.1–*371.1719.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 25 TAC §38.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

14.2 Benefits, Limitations, and Authorization Requirements

Diagnostic, therapeutic, and preventive dental services are a benefit of the CSHCN Services Program. Orthodontic services, medically necessary dental rehabilitation and restoration services, care of dental emergencies, and medically necessary services provided by doctors of dental surgery (DDS) or doctors of dental medicine (DMD) including, but not limited to, cleft-craniofacial surgery are also a benefit of the CSHCN Services Program.

14.2.1 Prior Authorization Requirements

Prior authorization is required for all orthodontia services and selected dental services.

All requests for prior authorization must be submitted using the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. The TMHP-CSHCN Services Program may require the submission of X-rays, models, etc., for specific prior-authorized services. All prior authori-

zation requests must include specific rationale for the requested service, including documentation of medical necessity and appropriateness of the recommended treatment. Additional documentation, including current periapical radiographs, must be maintained in the client's medical or dental record and submitted to the CSHCN Services Program on request.

Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the dental provider treating the client. If indicated on the form, an authorized representative's signature is acceptable. All signatures and dates must be current. Stamped signatures are not permitted. Alterations to dates and signatures, such as cross-outs or white-outs, are not allowed. Submitted forms without an original hand-written signature and date will be rejected. Providers must keep the original, signed forms in the client's medical record as documentation.

Important: *Refer to each individual section under Benefits and Limitations for specific information about prior authorization requirements.*

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Tip: *Photocopy this form and retain the original for future use.*

Note: *Fax transmittal confirmations are not accepted as proof of timely prior authorization submission.*

14.2.2 Substitute Dentist

The following are conditions for reimbursement of services rendered by a substitute dentist:

- Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists.
- This arrangement will be limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. CSHCN accept claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist's active duty as a member of a reserve component of the Armed Forces.
- Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form.
- The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by CSHCN.
- The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services.
- The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid before enrolling in the CSHCN Services Program and must not be on the Texas Medicaid provider exclusion list.
- The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and National Provider Identifier (NPI) must appear in Blocks 53, 54, and 56 of the ADA claim form.

- The substitute dentist's NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature.

Dentists must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation, as detailed above, will be subject to recoupment.

Note: *Dental services must be filed on the ADA claim form.*

14.2.3 Diagnostic Services

The CSHCN Services Program may reimburse the following diagnostic dental services for CSHCN Services Program eligible clients:

- Clinical oral evaluations
- Radiographs or diagnostic imaging
- Tests or examinations, including oral pathology procedures

Based on the American Academy of Pediatric Dentistry's (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, compassionate, culturally competent, and family-centered way. Establishment of a client's dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate.

In providing a dental home for a client, the dentist enhances the ability to assist children and their parents in the quest for optimum oral health care. A First Dental Home (FDH) visit can be initiated as early as 6 months of age and is billed using procedure code D0145. The FDH visit includes, but is not limited to:

- Oral examination.
- Oral hygiene instruction.
- Dental prophylaxis, if appropriate.
- Topical fluoride application using fluoride varnish, if appropriate.
- Caries risk assessment.
- Dental anticipatory guidance.

Diagnostic services should be performed for all clients, preferably starting within the first 6 months of the eruption of the first primary tooth, but no later than 1 year of age. Dental home providers should record the oral and physical health history, perform a caries assessment, develop an appropriate preventive oral health regimen, and communicate with and counsel the client's parent, legal guardian, or primary caregiver.

Caries susceptibility tests (procedure code D0425) are used to analyze the acidic level of the oral cavity using acid or alkali sensitive materials to ascertain the client's likelihood of developing caries. Caries susceptibility tests are considered part of all other dental procedures and are not separately reimbursed.

Requesting providers must retain in the client's medical record all documentation to support the diagnosis and treatment of trauma.

14.2.3.1 Prior Authorization Requirements

Prior authorization is required for cone-beam imaging (procedure code D0367) and for diagnostic services not adequately described by more specific procedure codes where an unspecified procedure code (D0999) is necessary.

To obtain prior authorization, a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted along with documentation supporting medical necessity and appropriateness. Documentation required includes, but is not limited to:

- Presenting condition(s).
- Medical necessity.
- The status of the client's treatment.

Prior authorization is not required for any other diagnostic service.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

Section 14.2.3.3, "Cone-Beam Imaging" in this chapter.

14.2.3.2 Clinical Oral Evaluations

Documentation supporting medical necessity for procedure codes D0140, D0160, D0170, and D0180 must be maintained by the provider in the client's medical record and must include:

- The client complaint supporting medical necessity for the examination.
- The area of the mouth that was examined or the tooth involved.
- A description of what was done during the treatment.
- Supporting documentation of medical necessity, including, but not limited to, radiographs or photographs.

The following clinical oral evaluation procedure codes may be considered for reimbursement:

Procedure Code	Comments and Limitations
D0120	• Used for periodic and comprehensive oral evaluations • Limited to once every 6 months by the same provider • Procedure code D8660 will deny when billed for the same date of service by the same provider • Age limitation = NA
D0140	• Used only for the initial emergency examination of a specific tooth or area of the mouth • Limited to once per day by the same provider and twice per day for any provider • Provider must document the medical necessity and the specific tooth or area of the mouth on the claim • Denied when billed with procedure code D0160 for the same date of service by the same provider • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Age limitation = NA
D0145	• Age limitation = 6 months through 35 months of age

Procedure Code	Comments and Limitations
D0150	• Used for a comprehensive oral evaluation; limited to one service every three years by the same provider; procedure code D8660 will deny when billed for the same date of service by the same provider • Age limitation = NA
D0160	• Used for a problem-focused, detailed, and extensive oral evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Limited to once per day by the same provider • Age limitation = 1 year of age or older
D0170	• Used as a follow up to a problem-focused evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim • Denied when billed with procedure code D0140 or D0160 on the same date of service by the same provider • Limited to once per day by any provider • Age limitation = NA
D0180	• Used for extensive periodontal evaluation of pain or problems • Denied when billed on the same date of service as procedure code D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider • May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period • Age limitation = 13 years of age or older

A caries risk assessment procedure code (D0601, D0602, or D0603) will be required on the same claim, for the same date of service, by the same provider when dental examination procedure code D0120, D0145, or D0150 is submitted for reimbursement. The client's dental condition(s) that justifies the risk assessment classification submitted with the claim must be clearly documented and maintained by the provider in the client's medical record.

Professionally developed caries risk assessment tools are available at:

- American Dental Association (ADA)
- American Academy of Pediatric Dentistry (AAPD)
- Department of State Health Services (DSHS), Oral Health Program

14.2.3.3 Cone-Beam Imaging

Cone-beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone-beam imaging is limited to initial treatment planning, surgery, and post-surgical follow-up.

Procedure code D0367 must be prior authorized by the TMHP Dental Director.

Procedure code D0367 is limited to a combined maximum of three services per calendar year. Additional services may be considered by the TMHP Dental Director with documentation of medical necessity.

14.2.3.4 First Dental Home

Based on the American Academy of Pediatric Dentistry's definition, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following:

- Comprehensive oral examination
- Oral hygiene instruction with primary caregiver
- Dental prophylaxis, if appropriate
- Topical fluoride varnish application when teeth are present
- Caries risk assessment
- Dental anticipatory guidance

The dental home provider must keep supporting documentation for procedure code D0145 in the client's medical record. The supporting documentation must include, but is not limited to, the following:

- Oral and physical health history review
- Dental history review
- Primary caregiver's oral health
- Oral evaluation
- An appropriate preventive oral health regimen
- Caries risk assessment
- Dental prophylaxis, which may include a toothbrush prophylaxis
- Oral hygiene instruction with parent or caregiver
- Anticipatory guidance communicated to the client's parent, legal guardian, or primary caregiver, to include the following:
    - Oral health and home care
    - Oral health of primary caregiver or other family members
    - Development of mouth and teeth
    - Oral habits
    - Diet, nutrition, and food choices
    - Fluoride needs
    - Injury prevention
    - Medications and oral health
    - Fluoride varnish application
    - Any referrals, including dental specialist's name

Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 will be denied when billed on the same date of service, for any provider as D0145.

A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider.

Reimbursement for procedure code D0145 is limited to dentists certified by the Texas Department of State Health Services (DSHS). Providers can complete a free continuing education course online or attend classroom training to be certified to provide First Dental Home services. For information about training, refer to the Department of State Health Services (DSHS) Oral Health Program web page at hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/first-dental-home.

14.2.3.5 * Radiographs or Diagnostic Imaging

The number of radiograph films required for a complete intraoral series is dependent on the age of the client. An intraoral series requires at least eight films. Adults and children older than 12 years of age require 12 to 20 films to be considered an intraoral series. A panoramic radiographic image (procedure code D0330) plus a minimum of four bitewing radiographic images (procedure code D0274) may be considered equivalent to a complete intraoral series including radiographic images (procedure code D0210).

Supporting documentation must be kept in the client's dental record when medical necessity is not evident on radiographs.

The following radiographs or diagnostic imaging procedure codes may be considered for reimbursement:

[Revised] Procedure Code	[Revised] Limitations
D0210	• Limited to one service every three years by the same provider • Denied when submitted on an emergency claim • Age limitation = 2 years or older
D0220	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0230	• Age limitation = 1 year of age or older
D0240	• Limited to two per day by the same provider • Age limitation = NA
D0250	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0270	• Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0272	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0273	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 1 year of age or older

[Revised] Procedure Code	[Revised] Limitations
D0274	• Denied when billed with procedure code D0210 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 2 years of age or older
D0277	• Denied when billed with procedure code D0210 same day, by the same provider • Denied when billed with procedure code D0330 same day, by the same provider • Limited to one per day by the same provider • Age limitation = 2 years of age or older
D0310	• Age limitation = 1 year of age or older
D0320	• Age limitation = 1 year of age or older
D0321	• Age limitation = 1 year of age or older
D0322	• Age limitation = 1 year of age or older
D0330	• Limited to one per day by any provider • Limited to one service every 3 years by the same provider • Age limitation = 3 years of age or older
D0340	• [Revised] Denied when billed with procedure code D8080 • Limited to one per day by the same provider • Age limitation = 1 year of age or older
D0350	• Must be used when billing for photographs • Accepted only when diagnostic quality radiographs cannot be taken • Documentation of medical necessity must be submitted with the claim • Limited to one per day by the same provider • Age limitation = NA
D0367	• Age limitation = NA

14.2.3.6 Tests and Oral Pathology Procedures

The following procedure codes may be considered for reimbursement and are limited to clients who are 1 year of age or older:

Procedure Codes			
D0415	D0460	D0470	D0502

Procedure code D0460:

- Includes multiple teeth and contralateral comparisons based on medical necessity.
- Is considered part of any endodontic procedure and is not separately reimbursed when billed on the same date of service as any endodontic procedure.
- Is not payable when billed for primary teeth.
- Is limited to one service per day by the same provider.

Refer to: Section 14.2.6, "Therapeutic Services" in this chapter for additional information about endodontic procedures.

When billing for diagnostic procedures not adequately described by other procedure codes, providers should use procedure code D0999.

Only one emergency or trauma claim per client, per day may be submitted. Separate services may be submitted for the same client on the same date of service, one for emergency or trauma and one for nonemergency or routine care.

When billing electronically for emergency or trauma-related dental services, use the ET modifier to indicate emergency.

14.2.4 Orthodontia Services

Orthodontia services are benefits of the CSHCN Services Program for clients with prior authorization and an appropriate diagnosis code that indicates cleft lip, cleft palate, congenital anomalies of skull and face bones, dentofacial functional abnormalaties, or major anomalies of jaw size.

Orthodontia for cosmetic purposes only is not a benefit of the CSHCN Services Program. All removable or fixed orthodontic appliances must be billed with procedure codes D8210 or D8220.

14.2.4.1 Prior Authorization Requirements

Prior authorization is required for all orthodontic services except for the initial orthodontic visit. Prior authorization is only approved for a complete orthodontic treatment plan, and all active orthodontic treatments must be completed within 36 months. Prior authorization is not transferable to another dentist. The new provider must request prior authorization to complete the orthodontic treatment initiated by the previous provider.

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) require prior authorization and the time frame may be considered for extension not to exceed 36 months of actual treatment.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

14.2.4.2 Required Documentation

To obtain prior authorization, the provider must submit the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form.

The following documentation must accompany the form, and must include the date of service the documentation was obtained:

- A complete orthodontia treatment plan including all the procedures required to complete full treatment such as:
  - Extractions
  - Orthognathic surgery
  - Upper and lower appliances
  - Monthly adjustments
  - Appliance removal (if needed)
  - Special appliances
- All diagnostic models
- A cephalometric radiograph with tracing
- Facial photographs

- A full series or radiographs or a panoramic radiograph

Note: *Diagnostic models, radiographs, and any other paper diagnostic tools submitted to TMHP will be returned to the submitting provider. Requests submitted with damaged diagnostic models will be returned to the provider as an incomplete request.*

A prior authorization request for orthodontia services must include one of the following indications:

- Cleft lip
- Cleft palate
- Congenital anomalies of skull and face bones
- Dentofacial functional abnormalities
- Major anomalies of jaw size

A prior authorization request for comprehensive orthodontic treatment or crossbite therapy submitted without the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form, diagnostic model, radiographs (X-rays), and any other necessary supporting documentation will not be considered and will be returned to the provider as incomplete.

The following information must be provided in the case of a transfer of care from one provider to another:

- A request for prior authorization as outlined above
- Explanation of why the client left the previous provider
- Explanation of the client's treatment status

14.2.4.3 * Submitting Local Codes for Orthodontic Procedures

To ensure appropriate claims processing, the local code reflecting the specific service is required on the claim.

For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure the correct local code is accurately applied to the appropriate claim detail:

1) Submit the DPC prefix in the first three bytes of *NTE02* at the *2400* loop. Submit the DPC prefix only once.
2) Submit the remark code (local code) in bytes 4–8, based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate that the detail is not billed with D8210 or D8220.

Example: *For a claim with three details, where details 1 and 3 are submitted with procedure code W-D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop:*

DPC1014D 1046D
(The space shows that detail 2 needs no local code.)

Example: *If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes:*

DPC1024D1055D1056D
(The absence of spaces indicates that local codes are needed for all three details.)

To submit using TexMedConnect, enter the local code into the Remarks Code field, located under the Details header. The Remarks Code field is the field following the Procedure Code field. TexMedConnect submitters are not required to enter the DPC prefix, because it is automatically placed in the appropriate field on the TexMedConnect electronic claim.

For paper claim submissions, providers must enter the local code in the Remarks section of the claim form.

Failure to follow the above steps does not cause the claim to deny; however, manual intervention is required to process the claim and a delay of payment may be the result.

Orthodontic procedure codes that were local codes used for prior authorization and reimbursement have been converted to Current Dental Terminology (CDT) (national) procedure codes.

The following procedures are not included in comprehensive treatment:

CDT Procedure Code	Remarks Code	Description
D8660	Z2009	Initial orthodontic visit
D8670	Z2013	Orthodontic adjustments, per month
D7997*	Z2016	Premature appliance removal, per arch
***May only be paid to a provider not billing for comprehensive treatment.**		

Procedure code D8080 is a comprehensive code and includes a diagnostic workup as well as all upper and lower orthodontic appliances (braces) necessary to treat the client.

CDT Procedure Code	Remarks Code	Description
D8080	Z2009 *or* Z2011 *or* Z2012	Diagnostic workup, approved *or* Orthodontic appliance, upper (braces) *or* Orthodontic appliance, lower (braces)

When a diagnostic workup is not approved, individual components may be considered for separate reimbursement. Use the following procedure codes:

CDT Procedure Code	Remarks Code	Description
D0330	Z2010	Diagnostic workup, not approved
D0340		
D0350		
D0470		

[Revised] Diagnostic model (procedure code D0470) are included in procedure codes (D8010 or D8020).

[Revised] The orthodontic diagnostic work-up procedures are considered inclusive to procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when billed with any one of the following procedure codes: D8010 or D8020.

Procedure code D8680 includes all retainers necessary to treat the client. Use the following remarks codes according to the services provided:

Remarks Code	Description
1033D	Mandibular, fixed, 2x4 retainer
1034D	Mandibular, fixed, 3x3 retainer
1035D	Mandibular, fixed, 4x4 retainer

Remarks Code	Description
Z2014	Orthodontic retainer, upper
Z2015	Orthodontic retainer, lower

[Revised] Procedure code D8010 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8110D	Crossbite therapy, removable appliance
Z2018	Crossbite, workup

[Revised] Procedure code D8020 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided:

Remarks Code	Description
8120D	Crossbite therapy, fixed appliance
Z2018	Crossbite, workup

The orthodontic diagnostic work up procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic work up procedure.

The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the *Health Insurance Portability and Accountability Act* (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. *Failure to bill the correct procedure codes may result in claim processing delays.*

> ***Note:*** *Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services.*

Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220):

Remarks Code	Fixed Appliances Description
1000D	Appliance for horizontal projections
1001D	Appliance for recurved springs
1002D	Arch wires for crossbite correction, for total treatment
1003D	Banded maxillary expansion appliance
1008D	Bonded expansion device
1012D	Crib
1015D	Distalizing appliance with springs
1016D	Expansion device
1018D	Fixed expansion device
1019D	Fixed lingual arch
1020D	Fixed mandibular holding arch
1021D	Fixed rapid palatal expander
1025D	Herbst appliance, fixed or removable

Remarks Code	Fixed Appliances Description
1026D	Interocclusal cast cap surgical splints
1028D	Jasper jumpers
1029D	Lingual appliance with hooks
1030D	Mandibular anterior bridge
1031D	Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment
1036D	Mandibular lingual, 6x6, arch wire
1042D	Maxillary lingual arch with spurs
1043D	Maxillary and mandibular distalizing appliance
1044D	Maxillary quad helix with finger springs
1045D	Maxillary and mandibular retainer with pontics
1049D	Modified quad helix appliance
1050D	Modified quad helix appliance, with appliance
1051D	Nance stent
1052D	Nasal stent
1057D	Palatal bar
1058D	Post surgical retainer
1059D	Quad helix appliance held with transpalatal arch horizontal projections
1060D	Quad helix maintainer
1061D	Rapid palatal expander (RPE), i.e., quad helix, haas, or menne
1068D	Stapled palatal expansion appliance
1072D	Thumb sucking appliance, requires submission of models
1076D	Transpalatal arch
1077D	Two bands with transpalatal arch and horizontal projections forward
1078D	W-appliance

Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210):

Remarks Code	Removable Appliances Description
1004D	Bite plate/bite plane
1005D	Bionator
1006D	Bite block
1007D	Bite plate with push springs
1010D	Chateau appliance (face mask, palatal expander, and hawley)
1011D	Coffin spring appliance
1013D	Dental obturator, definitive (obturator)
1014D	Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator)
1017D	Face mask (protraction mask)
1022D	Frankel appliance
1023D	Functional appliance for reduction of anterior open bite and crossbite
1024D	Head gear (face bow)

Remarks Code	Removable Appliances Description
1027D	Intrusion arch
1032D	Mandibular lip bumper
1037D	Mandibular removable expander with bite plane (crozat)
1038D	Mandibular ricketts rest position splint
1039D	Mandibular splint
1040D	Maxillary anterior bridge
1041D	Maxillary bite-opening appliance with anterior springs
1046D	Maxillary Schwarz
1047D	Maxillary splint
1048D	Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment
1053D	Occlusal orthotic device
1054D	Orthopedic appliance
1055D	Other mandibular utilities
1056D	Other maxillary utilities
1062D	Removable bite plane
1063D	Removable mandibular retainer
1064D	Removable maxillary retainer
1065D	Removable prosthesis
1066D	Sagittal appliance, 2-way
1067D	Sagittal appliance, 3-way
1069D	Surgical arch wires
1070D	Surgical splints (surgical stent/wafer)
1071D	Surgical stabilizing appliance
1073D	Tongue thrust appliance, requires submission of models
1074D	Tooth positioner, full maxillary and mandibular
1075D	Tooth positioner with arch

The following procedure codes are used to bill orthodontic services:

[Revised] ADA Procedure Codes									
D5951	D5952	D5953	D5954	D5955	D5958	D5959	D5960	D7280	D7997
D8010	D8020	D8080	D8210	D8220	D8660	D8670	D8680	D8999	

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.5 Preventive Services

The following dental preventive services are benefits of the CSHCN Services Program:

- Oral hygiene instruction
- Dental prophylaxis and topical fluoride treatment
- Dental sealants

- Space maintainers, including recementation and removal

14.2.5.1 Authorization Requirements

Authorization or prior authorization is not required for preventive dental services.

14.2.5.2 Oral Hygiene Instruction

Procedure code D1330 may be considered for reimbursement for clients who are 1 year of age or older when the services are above and beyond the routine brushing and flossing instructions included in the prophylaxis procedure codes and when additional time and expertise is directed toward the client's care. Procedure code D1330 is limited to once per year by any provider and is denied when billed on the same day as procedure codes D1110, D1120, D1206, or D1208 by any provider.

Procedure code D1330 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.5.3 Dental Prophylaxis and Topical Fluoride Treatment

When performing fluoride treatments, procedure code D1120 and D1208 or procedure code D1110 and D1208 must be billed on the same date of service.

Procedure codes D1110 and D1120 include oral health instructions, and are limited to one prophylaxis per 6 calendar months, by any provider. Procedure codes D1110 and D1120 will be denied when submitted on an emergency claim.

The following procedure codes may be considered for reimbursement but are not payable on the same date of service as any D4000 series (periodontal) procedure codes:

Procedure Code	Age Limitation
D1110	13 years of age or older
D1120	6 months through 12 years of age
D1206	NA
D1208	NA

The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

14.2.5.4 Dental Sealants

Dental sealants may be considered for reimbursement when applied to the deciduous (baby or primary) teeth or permanent teeth for clients who are 1 year of age or older. Dental sealants may be applied by a dentist or dental hygienist.

Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth. The tooth must be at risk for dental decay and be free of proximal caries and restorations on the surface to be sealed. Each tooth must be billed separately using procedure code D1351. Reimbursement is on a per tooth basis, regardless of the number of surfaces sealed. Tooth numbers and surfaces must be indicated on the claim form.

Dental sealants and replacement sealants are limited to one every 3 years, per tooth, for the same provider. Procedure code D1351 is not payable on the same date of service as any of D4000 series (periodontal) procedure codes. During claims processing or retrospective review, if the claim, narrative, documentation, or charting by a provider includes language, terms, or acronyms indicating a preventative resin was applied, the procedure will be reimbursed as a dental sealant, not as a restorative procedure.

Procedure code D1351 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

Procedure code D1352 may be reimbursed for posterior permanent teeth only to clients who are 5 years of age or older.

Procedure code D1352 will be denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior to procedure code D1352.

14.2.5.5 Space Maintainers

One space maintainer per tooth ID may be reimbursed per lifetime, per client. Replacement space maintainers may be considered on appeal with documentation supporting medical or dental necessity.

Space maintainers may be reimbursed with procedure codes D1510, D1516, D1517, D1520, D1526, D1527, and D1575.

Procedure codes D1551, D1552, D1553, D1556, D1557, and D1558 may be reimbursed to clients who are 1 through 20 years of age. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider.

When procedure codes D1510, D1516, or D1517 have been previously reimbursed, the recementation of space maintainers may be considered for reimbursement to either the same or a different CSHCN Services Program dental provider when billed with procedure codes D1551, D1552, or D1553.

Procedure codes D1510, D1516, D1517, D1520, D1526, and D1527 may be reimbursed for clients who are 1 year of age or older. These procedure codes are not reimbursed to orthodontists or oral maxillo-facial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims.

Space maintainers are designed to prevent tooth movement and are a benefit in the following situations:

- After premature loss of a deciduous (primary) tooth, first or second molars (tooth identification) (TID): A, B, I, and J for clients who are 1 through 12 years of age.
- After premature loss of deciduous (primary) tooth, first or second molars (tooth identification) (TID): K, L, S, and T for clients who are 1 through 12 years of age.
- After loss of a permanent first molar (TID: 3 and 14) for clients who are 3 years of age or older.
- After loss of a permanent first molar (TID: 19 and 30) or clients who are 3 years of age or older.
- After premature loss of a deciduous (primary) second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age billed with (procedure code D1575).

Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client.

14.2.5.6 Noncovered Counseling Services

14.2.5.6.1 Dental Nutrition Counseling

Procedure code D1310 is not a benefit of the CSHCN Services Program as a separate procedure. Dental nutrition counseling is included as part of all preventive, therapeutic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to their primary care physician. The provider can refer the client to a CSHCN Services Program-enrolled licensed dietitian for further nutrition counseling.

14.2.5.6.2 Tobacco Counseling

Procedure code D1320 is not a benefit of the CSHCN Services Program as a separate procedure. Tobacco counseling may be reimbursed as a part of all preventive, therapeutic, and diagnostic dental procedures.

14.2.6 Therapeutic Services

The following therapeutic dental services are benefits of the CSHCN Services Program:

- Restorations
- Endodontics
- Periodontics
- Prosthodontics, both fixed and removable
- Maxillofacial prosthetics
- Implants
- Oral and maxillofacial surgery
- Adjunctive general services, including, but not limited to:
  - Dental anesthesia
  - Dental hospital call
  - Desensitizing medicaments
  - Dental behavior management
  - Internal bleaching of discolored tooth
  - Occlusal adjustments

14.2.6.1 Prior Authorization Requirements

Prior authorization requirements for specific procedures are contained within each section below. Prior authorization for therapeutic services is valid up to 90 days (this does not apply to orthodontic services).

To obtain prior authorization, the following must be submitted:

- The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form
- Provider documentation supporting the medical necessity and appropriateness of the recommended treatment

Each distinct dental procedure code to be performed that requires prior authorization must be listed on the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed.

Additional documentation, including current periapical radiographs, must be maintained in the client's medical record and submitted to the CSHCN Services Program on request.

Refer to: Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

14.2.6.2 Anesthesia Requirements for Clients who are Six Years of Age or Younger

For clients who are six years of age or younger, the following will apply:

- All Level 4 sedation/general anesthesia services provided by a dentist (procedure codes D9222 and D9223), and any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) (procedure code 00170 with modifier U3) provided in conjunction with dental therapeutic services must be prior authorized.
- The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization and is also responsible for providing the anesthesia prior authorization information to the anesthesiology provider.

- The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger.

Procedure code 00170 with modifier U3, and procedure codes D9222 and D9223 is limited to once per six calendar months by any provider.

Requests for prior authorization must include, but is not limited to, the following client-specific documents and information:

- A completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form
- A completed CSHCN Services Program Prior Authorization Request for Dental of Orthodontia Services form
- The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital)
- Name of the group providing the Level 4 anesthesia services
- A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170 with modifier U3). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s).
- Diagnostic quality radiographs or photographs
  - When appropriate radiographs or photographs cannot be taken prior to general anesthesia. The narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director.

Note: *In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP dental director.*

14.2.6.3 Interrupted Treatment Plan

Prior authorization for an incomplete treatment plan is not transferable to the new provider. The new provider must obtain prior authorization to complete the treatment plan initiated by the original provider.

14.2.6.4 Restorations

Restorations do not require prior authorization except for inlay or onlay restorations and crowns (single restorations only) in excess of four in a lifetime by any provider. Procedure code D2999 requires prior authorization.

Consideration of restoration reimbursement is contingent on compliance with the following limitations:

- Restorations on primary teeth and permanent posterior teeth may be reimbursed on the basis of the surface or surfaces restored and are paid as a total maximum fee per tooth.
- More than one restoration on a single surface is considered a single restoration. A multiple surface restoration cannot be billed as two or more separate one-surface restorations.

- The restorations must show definite crossing of the plane of each surface listed for primary and permanent tooth restoration completed to be considered for reimbursement as a multiple surface restoration.
- All reimbursement for tooth restorations include local anesthesia and pulp protection media, where indicated, without additional charges. These services will deny as part of another service if billed separately.
- The CSHCN Services Program may reimburse restorations and therapeutic care based on medical necessity. Therapeutic procedures are not reimbursed for preventive purposes.

Inlay or onlay restorations and crowns–single restorations only may be reimbursed a maximum fee when performed on permanent teeth. This fee includes the actual inlay or onlay or crown, any provisional crown, and any preparatory work before the seating of the permanent crown.

Single restoration only crown procedure codes are limited to CSHCN Services Program clients who are 13 years of age or older.

Procedure code D2799 is denied as part of the global fee for a crown.

Use the following procedure codes for restoration services:

Procedure Codes	Limitations
Amalgam Restorations	
D2140	A = NA
D2150	A = NA
D2160	A = 1 year of age or older
D2161	A = 1 year of age or older
Resin-Based Composite Restorations	
D2330	A = NA
D2331	A = NA
D2332	A = 1 year of age or older
D2335	A = 1 year of age or older
D2390	A = NA
D2391	A = NA
D2392	A = NA
D2393	A = 1 year of age or older
D2394	A = 1 year of age or older
Inlay or Onlay Restorations	
D2510	A = 13 years of age or older
D2520	A = 13 years of age or older
D2530	A = 13 years of age or older
D2542	A = 13 years of age or older
D2543	A = 13 years of age or older
D2544	A = 13 years of age or older
D2650	A = 13 years of age or older
D2651	A = 13 years of age or older
D2652	A = 13 years of age or older
A = Age limitation	

Procedure Codes	Limitations
D2662	A = 13 years of age or older
D2663	A = 13 years of age or older
D2664	A = 13 years of age or older
D2710	A = 13 years of age or older
D2720	A = 13 years of age or older
D2721	A = 13 years of age or older
D2722	A = 13 years of age or older
D2740	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2750	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2751	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2752	A = 16 years of age or older, limited to TID #4-13 and 20-29 only.
D2780	A = 13 years of age or older
D2781	A = 13 years of age or older
D2782	A = 13 years of age or older
D2783	A = 13 years of age or older
D2790	A = 13 years of age or older
D2791	A = 13 years of age or older
D2792	A = 13 years of age or older
D2794	A = 13 years of age or older
D2910	A = 13 years of age or older
D2915	A = 6 years of age or older
D2920	A = 1 year of age or older, payable to any CSHCN Services Program dental provider, including the same provider that performed the original crown cementation
D2930	A = NA
D2931	A = 6 years of age or older
D2932	A = 1 year of age or older, limited to TID C-H, M-R, and all permanent teeth.
D2933	A = NA, limited to TID C-H and M-R primary teeth.
D2934	A = NA
D2940	A = NA
D2950	A = 6 years of age or older
D2951	A = 6 years of age or older
D2952	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2952 for the same tooth, for the same date of service, by the same provider
D2953	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2953 for the same tooth, for the same date of service, by the same provider
D2954	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2954 for the same tooth, for the same date of service, by the same provider
A = Age limitation	

Procedure Codes	Limitations
D2955	A = 4 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2955 for the same tooth, for the same date of service, by the same provider
D2957	A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2957 for the same tooth, for the same date of service, by the same provider
D2960	A = 13 years of age or older
D2961	A = 13 years of age or older
D2962	A = 13 years of age or older
D2971	A = 13 years of age or older, limited to four services per lifetime for each tooth by any provider
D2980	A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2980 for the same tooth, for the same date of service, by the same provider
D2999	A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2999 for the same tooth, for the same date of service, by the same provider, prior authorization
A = Age limitation	

The following dental restoration procedure codes will be limited to once per rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2391	D2392	D2393
D2394									

Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as the following procedure codes:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2932
D2933	D2934								

Total reimbursement for direct restorations on primary teeth cannot exceed the total dollar amount allowed for a stainless steel crown, per TID, per date of service. This limitation does not apply to procedure code D2335.

14.2.6.4.1 Direct Restorations and Other Restorative Services

Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown procedure codes D2930, D2932, D2933, and D2934 during pre-payment review.

Procedure code D2930 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391

Procedure Codes		
D2392	D2393	D2394

Procedure codes D2933 and D2934 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes								
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390

Procedure codes D2931 and D2932 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2931	D2932					

14.2.6.5 Endodontics

The following procedures are limited to four permanent teeth without prior authorization:

- Initial endodontic therapy (procedure codes D3310, D3320, and D3330)
- Retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348)

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

14.2.6.5.1 Prior Authorization

Prior authorization is required for root canal therapy and retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348) in excess of four root canals. To obtain prior authorization, the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted with documentation of medical necessity.

Documentation supporting medical necessity must be maintained in the client's dental record and include the following:

- The medical necessity before treatment, during treatment, and post treatment
- Periapical radiographs
- The final size of the file to which the canal was enlarged and the type of filling material used
- Any reason that the root canal may appear radiographically unacceptable must be documented in the client's dental record

Prior authorization is required for procedure code D3460. Documentation of medical necessity must include the following:

- The client is 16 years of age or older.
- Regular treatment failed.
- The client's anatomy is such that no other fixed or removable prosthodontic alternatives are available, including, but not limited to anodontia, a result of trauma, or birth defect.

Prior authorization is required for an unspecified endodontic procedure, procedure code D3999.

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

14.2.6.5.2 Pulp Caps and Pulpotomy

Procedure Code	Limitations
D3110	A = 1 year and older
D3120	A = 1 year and older
D3220	• A = NA. • Limited to once per lifetime, per primary tooth (TID A through T) • Will be denied when performed within 6 months of pulpal therapy (procedure codes D3230 and D3240) on the same primary TID, by the same provider • Will be denied when performed within 6 months of root canal therapy (procedure codes D3310, D3320, and D3330) on the same permanent TID by the same provider
D3230	A = 1 year and older
D3240	A = 1 year and older
A = Age limitation	

Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only (TID 1-32).

Direct pulp caps (procedure code D3110) may be reimbursed when billed with the following procedure codes for the same tooth ID, on the same date of service, by the same provider:

Procedure Codes									
D2140	D2150	D2160	D2161	D2330	D2331	D2332	D2335	D2390	D2391
D2392	D2393	D2394	D2510	D2520	D2530	D2542	D2543	D2544	D2650
D2651	D2652	D2662	D2663	D2664	D2710	D2720	D2721	D2722	D2740
D2750	D2751	D2752	D2780	D2781	D2782	D2783	D2790	D2791	D2792
D2794	D2931	D2932							

Indirect pulp caps (procedure code D3120) may be reimbursed when billed with procedure code D2940 for the same tooth ID, on the same date of service by the same provider.

Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately.

14.2.6.5.3 Root Canals

Root canals may only be reimbursed when performed on permanent teeth.

Reimbursement for endodontic therapy (procedure codes D3310, D3320, and D3330), or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348) includes all appointments, radiographs, and procedures necessary to complete the treatment, including, but not limited to:

- Pulpotomy
- Radiographs performed pre-, intra-, and postoperatively

Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal.

Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must also include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist.

Note: *The identified, original treating dentist or dental group will not be considered for reimbursement.*

The following services are not considered part of the endodontic therapy procedures or the retreatment procedures of a previous root canal and may be reimbursed separately:

- Diagnostic evaluation
- Radiographs performed at the initial, periodic, or emergency service visits

Root canal therapy not carried to completion with a final filling should not be billed using a root canal therapy procedure code. It must be billed using procedure code D3999. Providers must file the claim with a narrative description of the procedures that were completed.

The date of service for a root canal is the date when the service was initiated.

Procedure codes D3220, D3351, D3352, and D3353 performed on a tooth within the 6 months preceding a root canal is considered part of the root canal. The total amount reimbursed will not exceed the total dollar amount allowed for procedure codes D3310, D3320, and D3330, or D3346, D3347, and D3348.

Apicoectomy (procedure codes D3410, D3421, D3425, and D3426) billed after root canal therapy or retreatment of a previous root canal may be reimbursed separately.

Refer to the following table for additional limitations for endodontic services:

Procedure Codes	Limitations
D3110	A = 1 year of age or older, refer to Section 14.2.6.4, "Restorations" in this chapter for additional limitations
D3120	A = 1 year of age or older
D3220	A = NA; see additional restrictions in Section 14.2.6.5.2, "Pulp Caps and Pulpotomy" in this chapter
D3230	A = 1 year of age or older
D3240	A = 1 year of age or older
D3310	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3320	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3330	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3346	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3347	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3348	A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only
D3351	A = 6 years of age or older
D3352	A = 6 years of age or older
A = Age limitation	

Procedure Codes	Limitations
D3353	A = 6 years of age or older
D3410	A = 6 years of age or older
D3421	A = 6 years of age or older
D3425	A = 6 years of age or older
D3426	A = 6 years of age or older
D3430	A = 6 years of age or older
D3450	A = 6 years of age or older
D3460	A = 16 years of age or older, prior authorization
D3470	A = 6 years of age or older
D3910	A = 1 years of age or older
D3920	A = 6 years of age or older
D3950	A = 6 years of age or older
D3999	A = 1 year of age or older, prior authorization
A = Age limitation	

14.2.6.6 * Periodontics

Medical necessity for *third-molar* sites includes, but is not limited to:

- Medical or dental history documenting need due to inadequate healing of bone following third-molar extraction, including date of third-molar extraction.
- Secondary procedure several months postextraction.
- Position of the third molar preoperatively.
- Postextraction probing depths to document continuing bony defect.
- Postextraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Medical necessity for *other than third-molar* sites, includes, but is not limited to:

- Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injury).
- Intra- or extra-oral radiographs of treatment sites.
- If medical necessity is not radiographically evident, intraoral photographs would be appropriate to request; otherwise, intraoral photographs would be optional unless requested preoperatively by the Health and Human Services Commission (HHSC) or its agent.
- Periodontal probing depths.
- Number of intact walls associated with an angular bony defect.
- Bone graft and barrier material used.

The preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when billed on the same date of service as any D4000 series periodontal procedure code.

Procedure code D4341 will not be reimbursed within 21 days of procedure code D4355.

Periodontal scaling and root planing (procedure codes D4341 and D4342) will be denied when submitted for the same date of service as other D4000 series codes, except D4341 and D4342, any provider.

Full mouth debridement (procedure code D4355) will be denied when submitted for the same date of service as the following procedure codes by any provider:

[Revised] Procedure Codes									
D4210	D4211	D4230	D4231	D4240	D4241	D4245	D4249	D4260	D4261
D4266	D4267	D4270	D4273	D4274	D4275	D4276	D4277	D4278	D4283
D4285	D4381	D4910	D4920	D4999					

Periodontal medicaments (procedure code D4381) must be applied to all affected teeth at the same visit to be effective, and are limited to one service per client per year for clients who are 13 years of age or older.

Periodontal maintenance (procedure code D4910) may be reimbursed only if one of the following occurs:

- A periodontal surgery or nonsurgical periodontal service (procedure code (D4240, D4241, D4260, or D4261) is billed for the same client by any provider.
- There is documented evidence of periodontal therapy while the client was not CSHCN Services Program eligible in the client's dental record within 90 days before the periodontal maintenance.

Periodontal maintenance may be reimbursed no more than 3 times within this 90-day period for the same client, by any provider.

The periodontic procedure codes in the following table that are limited to clients who are 13 years of age or older may also be considered for younger clients based on the medical condition with supporting documentation of medical necessity.

[Revised] Procedure Codes	[Revised] Limitations
D4210	A = 13 years of age or older, DOC, PP1
D4211	A = 13 years of age or older, DOC, PP1
D4230	A = 13 years of age or older
D4231	A = 13 years of age or older
D4240	A = 13 years of age or older, DOC, PP2
D4241	A = 13 years of age or older, DOC, PP2
D4245	A = 13 years of age or older, prior authorization, DOC, PP2
D4249	A = 13 years of age or older, prior authorization
D4260	A = 13 years of age or older, limited to once per quadrant, per day, same provider
D4261	A = 13 years of age or older, limited to once per quadrant, per day, same provider
D4266	A = 13 years of age or older, prior authorization, DOC, PP2
D4267	A = 13 years of age or older, prior authorization, DOC, PP2
D4270	A = 13 years of age or older, prior authorization, DOC, PP1
D4273	A = 13 years of age or older, prior authorization, DOC, PP1
D4274	A = 13 years of age or older, prior authorization
A = Age limitation. **Photo = photographs are required when medical necessity is not evident on the radiographs.** **DOC = Documentation is required when medical necessity is not evident on radiographs.** **PP1 = Pre- and postoperative photographs are required, pre- and postoperative.** **PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.**	

[Revised] Procedure Codes	[Revised] Limitations
D4275	A = 13 years of age or older, DOC, PP1, limited to one service per day, same provider
D4276	A = 13 years of age or older, prior authorization, DOC, PP1
D4277	A = 13 years of age or older, prior authorization, DOC, PP1
D4278	A = 13 years of age or older, prior authorization, DOC, PP1; procedure code D4278 must be billed on the same date of service as procedure code D4277 or it will be denied
D4283	A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4283 must be billed with primary procedure code D4273 on the same claim, for the same date of service, by the same provider
D4285	A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4285 must be billed with primary procedure code D4275 on the same claim, for the same date of service, by the same provider
D4341	A = 13 years of age or older, prior authorization, denied if billed within 21 days of procedure code D4355; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.
D4342	A = 13 years of age or older, prior authorization; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity.
D4355	A = 13 years of age or older, DOC, PP1
D4381	A = 13 years of age or older, limited to one service per client, per year
D4910	A = 13 years of age or older, denied if billed within 90 days after a full mouth debridement, additional limitations, DOC, PP1
D4920	A = 13 years of age or older
D4999	A = 13 years of age or older, prior authorization
A = Age limitation. **Photo = photographs are required when medical necessity is not evident on the radiographs.** **DOC = Documentation is required when medical necessity is not evident on radiographs.** **PP1 = Pre- and postoperative photographs are required, pre- and postoperative.** **PP2 = Pre- and postoperative photographs are required when medical necessity is not evident on the radiographs.**	

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7 Prosthodontics (Removable) and Maxillofacial Prosthetics

Local anesthesia is denied as part of removable prosthodontics procedures.

Denture reline procedures are allowed if the reline makes the denture serviceable. Denture reline and rebase procedures are denied if billed within 1 rolling year of a complete or partial denture.

- Maxillary reline and rebase procedure codes D5710, D5720, D5730, D5740, D5750, and D5760 are denied as part of complete or partial maxillary denture procedures D5110, D5130, D5211, and D5213.
- Mandibular reline and rebase procedure codes D5711, D5721, D5731, D5741, D5751, and D5761 are denied as part of complete or partial mandibular denture procedures D5120, D5140, D5212, and D5214.

Repairs to partial maxillary dentures (procedure code D5670) are denied as part of maxillary procedure codes D5211, D5213, and D5640.

Repairs to partial mandibular dentures (procedure code D5671) are denied as part of mandibular procedure codes D5212, D5214, and D5640.

The cost of repairs cannot exceed replacement costs.

Procedure codes D5867 and D5875 are denied as part of any repair or modification of any removable prosthetic.

Use the following procedure codes for prosthodontic (removable) services:

Procedure Codes	Limitations
D5110	A = 1 year of age or older, prior authorization
D5120	A = 1 year of age or older, prior authorization
D5130	A = 3 years of age or older, prior authorization
D5140	A = 3 years of age or older, prior authorization
D5211	A = 6 years of age or older, prior authorization
D5212	A = 6 years of age or older, prior authorization
D5213	A = 6 years of age or older, prior authorization
D5214	A = 6 years of age or older, prior authorization
D5410	A = 1 year of age or older
D5411	A = 1 year of age or older
D5421	A = 6 years of age or older
D5422	A = 6 years of age or older
D5511	A = 1 year of age or older, prior authorization
D5512	A = 1 year of age or older, prior authorization
D5520	A = 3 years of age or older, prior authorization
D5611	A = 3 years of age or older
D5612	A = 3 years of age or older
D5630	A = 6 years of age or older
D5640	A = 6 years of age or older
D5650	A = 6 years of age or older
D5660	A = 6 years of age or older
D5670	A = 6 years of age or older
D5671	A = 6 years of age or older
D5710	• A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider.
D5711	• A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider.
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D5720	• A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider.
D5721	• A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider.
D5730	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider.
D5731	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.
D5740	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5750, and D5760, same provider.
D5741	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider.
D5750	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider.
D5751	• A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider.
D5760	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider.
D5761	• A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider.
D5810	A = 1 year of age or older, prior authorization
D5811	A = 1 year of age or older, prior authorization
D5820	A = 6 years of age or older, prior authorization
D5821	A = 6 years of age or older, prior authorization
D5850	A = 1 year of age or older, prior authorization
D5851	A = 1 year of age or older, prior authorization
D5862	A = 13 years of age or older, prior authorization
D5863	A = 6 years of age or older, prior authorization
D5864	A = 6 years of age or older, prior authorization
D5865	A = 6 years of age or older, prior authorization
D5866	A = 6 years of age or older, prior authorization
D5899	A = 1 year of age or older, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7.1 Maxillofacial Prosthetics

Use the following procedure codes for maxillofacial prosthetic services:

Procedure Codes	Limitations
D5911	A = NA, prior authorization
D5912	A = NA, prior authorization
D5913	A = NA, prior authorization
D5914	A = NA, prior authorization
D5915	A = NA, prior authorization
D5916	A = NA, prior authorization
D5919	A = NA, prior authorization
D5922	A = NA, prior authorization
D5923	A = NA, prior authorization
D5924	A = NA, prior authorization
D5925	A = NA, prior authorization
D5926	A = NA, prior authorization
D5927	A = NA, prior authorization
D5928	A = 1 year of age or older, prior authorization
D5929	A = 1 year of age or older, prior authorization
D5931	A = 1 year of age or older, prior authorization
D5932	A = NA, prior authorization
D5933	A = NA, prior authorization
D5934	A = 1 year of age or older, prior authorization
D5935	A = 1 year of age or older, prior authorization
D5936	A = 1 year of age or older, prior authorization
D5937	A = NA, prior authorization
D5951	A = NA, prior authorization
D5952	A = birth through 12 years of age, prior authorization
D5953	A = 13 years of age or older, prior authorization
D5954	A = NA, prior authorization
D5955	A = 13 years of age or older, prior authorization
D5958	A = NA, prior authorization
D5959	A = NA, prior authorization
D5960	A = NA, prior authorization
D5982	A = NA, prior authorization
D5983	A = NA, prior authorization
D5984	A = NA, prior authorization
D5985	A = NA, prior authorization
D5986	A = NA, prior authorization
D5987	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D5988	A = NA, prior authorization
D5999	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.7.2 Implants

Implants require prior authorization.

Use the following procedure codes for implant services:

Procedure Codes	Limitations
D6010	A = 16 years of age or older, prior authorization
D6040	A = 16 years of age or older, prior authorization
D6050	A = 16 years of age or older, prior authorization
D6055	A = 16 years of age or older, prior authorization
D6056	A = 16 years of age or older, prior authorization
D6057	A = 16 years of age or older, prior authorization
D6080	A = 16 years of age or older, prior authorization
D6090	A = 16 years of age or older, prior authorization
D6092	A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider
D6093	A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider
D6095	A = 16 years of age or older, prior authorization
D6100	A = 16 years of age or older, prior authorization
D6199	A = 16 years of age or older, prior authorization
A = Age limitation	

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

14.2.6.7.3 Fixed Prosthodontics

Prior authorization is required for fixed prosthodontics. Fixed prosthodontics are limited to CSHCN Services Program clients who are 16 years of age or older, as the client must be old enough to have mature teeth and minimal jaw growth remaining.

Required documentation for prior authorization includes, but is not limited to:

- The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form.
- Documentation of medical necessity for the requested procedure includes, but is not limited to:
  - Documentation supporting that the mouth is free of disease; no untreated periodontal, endodontic disease, or rampant caries.
  - Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown, except when a Maryland bridge is placed.
  - Tooth Identification (TID) System noting only permanent teeth.

- Documentation supporting that a removable partial is not a viable option to fill the space between the teeth.
- Appropriate pretreatment radiographs of each involved tooth, such as periapical views must be maintained in the client's medical record and submitted to the CSHCN Services Program on request. Panoramic films are inadequate to detect caries or tooth structure necessary to evaluate the request.

Prior authorization will not be given when:

- Films show two good abutment teeth, except when a Maryland bridge will be replaced.
- There is untreated periodontal or the presence of endodontic disease, or rampant caries which would contraindicate the treatment.

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter.

The following fixed prosthetics (pontics, retainers, and abutments), may be reimbursed with a maximum fee and include any preparatory work before placement of the fixed prosthetic.

Procedure Codes									
D6210	D6211	D6212	D6240	D6241	D6242	D6245	D6250	D6251	D6252
D6545	D6548	D6549	D6720	D6721	D6722	D6740	D6750	D6751	D6752
D6780	D6781	D6782	D6783	D6790	D6791	D6792			

Each abutment and each pontic constitutes a unit in a fixed partial-denture bridge (bridgework).

The following procedure codes are considered part of any other service and are not reimbursed separately:

Procedure Codes									
D6600	D6601	D6602	D6603	D6604	D6605	D6606	D6607	D6608	D6609
D6610	D6611	D6612	D6613	D6614	D6615				

Use the following procedure codes for fixed prosthodontics services. These codes require prior authorization:

Procedure Codes Limitations									
Fixed Partial Denture Pontics									
D6210	D6211	D6212	D6240	D6241	D6242	D6245	D6250	D6251	D6252
Fixed Partial Denture Retainers—Inlays or Onlays									
D6545	D6548	D6549							
Fixed Partial Denture Retainers—Crowns									
D6720	D6721	D6722	D6740	D6750	D6751	D6752	D6780	D6781	D6782
D6783	D6790	D6791	D6792						
Other Fixed Partial Denture Services									
D6920	D6930	D6940	D6950	D6980	D6999				

14.2.6.8 Oral and Maxillofacial Surgery

Prior authorization is required for most oral and maxillofacial surgery, including, but not limited to, invasive procedures for clients with cleft lip, cleft palate, or craniofacial anomalies, which must be performed by a cleft and craniofacial team or a coordinated multidisciplinary team.

All oral surgery procedures include local anesthesia and visits for routine postoperative care.

Use the following table for oral and maxillofacial surgery procedure codes and prior authorization requirements.

Procedure Codes	Limitations
D7111	A = NA
D7140	A = NA
D7210	A = NA
D7220	A = NA
D7230	A = NA
D7240	A = NA
D7241	A = 1 year of age or older
D7250	A = 1 year of age or older
D7260	A = NA, prior authorization
D7261	A = NA, prior authorization
D7270	A = NA
D7272	A = 1 year of age or older, prior authorization
D7280	A = 1 year of age or older. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider.
D7282	A = 1 year of age or older
D7283	A = 1 year of age or older, prior authorization, permanent dentition only (tooth identification [TID] 2-15 and 18-31). To obtain prior authorization, a copy of the orthodontic treatment plan must be submitted along with a current panoramic radiograph to determine medical necessity and a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form.
D7285	A = NA, prior authorization
D7286	A = NA, prior authorization
D7290	A = NA, prior authorization
D7291	A = 1 year of age or older, prior authorization
D7310	A = 1 year of age or older, prior authorization
D7320	A = 1 year of age or older, prior authorization
D7340	A = 1 year of age or older, prior authorization
D7350	A = 1 year of age or older, prior authorization
D7410	A = NA, prior authorization
D7411	A = NA, prior authorization
D7413	A = NA, prior authorization
D7414	A = NA, prior authorization
D7440	A = NA, prior authorization
D7441	A = NA, prior authorization
D7450	A = NA, prior authorization
D7451	A = NA, prior authorization
D7460	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Procedure Codes	Limitations
D7461	A = NA, prior authorization
D7465	A = NA, prior authorization
D7471	A = NA, prior authorization
D7472	A = NA, prior authorization
D7510	A = NA
D7520	A = NA
D7530	A = NA, prior authorization
D7540	A = NA, prior authorization
D7550	A = NA, prior authorization
D7560	A = NA, prior authorization
D7670	A = NA
D7820	A = NA, prior authorization
D7880	A = NA, prior authorization
D7899	A = 1 year of age or older, prior authorization
D7910	A = NA
D7911	A = NA
D7912	A = NA
D7955	A = NA, prior authorization
D7961	A = 12 through 20 years of age, prior authorization
D7962	A = NA, prior authorization
D7970	A = NA, prior authorization
D7971	A = NA, prior authorization
D7972	A = 1 year of age or older, prior authorization
D7980	A = NA, prior authorization
D7983	A = NA, prior authorization
D7997	A = NA, prior authorization
D7999	A = NA, prior authorization
A = Age limitation and NA = Not applicable	

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter.

14.2.6.9 Adjunctive General Services

Refer to individual procedure codes in the following table for prior authorization requirements:

Procedure Code	Limitations
D9110	A = NA, see additional benefit information listed below table
D9120	A = 13 years of age or older, prior authorization
D9210	A = NA, denied when billed for the same date of service as procedure code D9248
D9211	A = NA, denied when billed for the same date of service as procedure code D9248
D9212	A = NA, denied when billed for the same date of service as procedure code D9248
A = Age limitation, NA = Not applicable, and DOC = Documentation required	

Procedure Code	Limitations
D9222	A = NA, prior authorization, DOC, limited to 15 minutes (1 unit) per day, denied when billed for the same date of service as procedure code D9248
D9223	A = NA, prior authorization, DOC, limited to 2 hours and 45 minutes (11 units) per day must be billed with primary procedure code D9222, same provider
D9230	A = NA, denied when billed for the same date of service as procedure code D9248
D9239	A = NA, limited to 15 minutes (1 unit) per day, any provider, denied when billed on the same date of service as procedure code D9222 or D9248
D9243	A = NA, limited to 1 hour and 15 minutes per day (5 units), must be billed with primary procedure code D9239, same provider
D9248	A = NA, DOC, limited to one service per day and two services per 12 months, refer to Section 14.2.6.10, "Dental Anesthesia" in this chapter. Denied when billed for the same date of service as procedure code D9420, any provider.
D9310	A = NA, prior authorization
D9420	A = NA, prior authorization, DOC, refer to Section 14.2.7.1, "Dental Hospital Calls" in this chapter.
D9430	A = NA
D9440	A = NA
D9610	A = NA, prior authorization, limited to once per client per day, DOC
D9612	A = NA, prior authorization, limited to once per client per day, DOC
D9630	A = NA, prior authorization, DOC
D9910	A = NA, limited to once per year, not to be used for bases, liners, or adhesives
D9920	A = 1 year of age or older, prior authorization, denied when billed on the same day as procedure code D9222, D9230, D9239, or D9248 or with an evaluation, prophylactic treatment, or radiographic procedure, DOC; claim must include diagnosis of intellectual disability, refer to Section 14.2.6.11, "Dental Behavior Management" in this chapter.
D9930	A = NA
D9944	A = NA
D9950	A = 13 years of age or older, prior authorization
D9951	A = 13 years of age or older, prior authorization, may be reimbursed once per year per client, considered full-mouth procedure
D9952	A = 13 years of age or older, prior authorization, may be reimbursed once per lifetime per provider, considered full-mouth procedure
D9970	A = NA, one service per day, any provider
D9974	A = 13 years of age or older, DOC, refer to Section 14.2.6.12, "Internal Bleaching of Discolored Tooth" in this chapter
D9999	A = NA, prior authorization, DOC
A = Age limitation, NA = Not applicable, and DOC = Documentation required	

Note: *For those procedures requiring prior authorization, the prior authorization is valid up to 90 days from the date it is issued.*

Refer to: Section 14.2.6.1, "Prior Authorization Requirements" in this chapter for more information about prior authorization requirements.

Section 4.4, "Prior Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about prior authorization requirements.

14.2.6.9.1 Emergency Dental Treatment Services

Procedure code D9110 is an emergency service only. The type of treatment rendered and tooth identification must be indicated. It must be for a service other than a prescription or topical medication. The reason for the emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form.

Procedure code D9110 is a benefit for the following:

- Sedative or periodontal dressing
- Starting root canal procedure; (i.e.:, open and drain tooth or re-medication of previously opened tooth)
- Smoothing fractured tooth that is cutting lips or cheek
- Debridement or curettage of wound
- Excision of operculum over an erupting tooth
- Limited gingivectomy
- Suture removal by dentist other than the dentist who placed suture(s)
- Placement of a temporary crown by other than the patient's regular dentist and one who is not in the process, has not previously, or does not in the future intend to perform an acrylic, polycarbonate, stainless steel or cast crown on this same tooth
- Tissue conditioning of a full or partial denture
- Removal of spontaneously or post-surgically sequested bone spicule
- Spot or limited scaling and root planing
- Procedures necessary to treat a dry socket
- Procedures necessary to control bleeding
- Non-surgical reduction of TMJ dislocation
- Procedures necessary to relieve pain associated with pericoronitis, particularly third molars

Procedure code D9110 is not a benefit for the following:

- Prescription written
- Medication given or administered
- Application of topical medication to teeth or gums
- Occlusal adjustments
- Oral hygiene instructions

14.2.6.10 Dental Anesthesia

All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia.

Providers must have a level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to receive an enhanced rate for procedure codes D9222 and D9223.

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support medical necessity of the service. The client's dental record must be available for review by representatives of HHSC or it's designee.

14.2.6.10.1 Anesthesia Permit Levels

The following table shows the levels of anesthesia permits that are issued by the TSBDE:

Permit Level	Description of Level	Permit Privileges
Nitrous oxide/oxygen inhalation conscious sedation		Stand-alone permit
Level 1	Minimal sedation	Stand-alone permit
Level 2	Moderate enteral	Automatically qualifies for Level 1 and Level 2 permit privileges
Level 3	Moderate parenteral	Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges
Level 4	Deep sedation/general anesthesia	Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges

Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following procedure codes may be used to bill dental anesthesia and indicates the minimum anesthesia permit level to be reimbursed for these procedure codes:

Procedure Codes	Level of Sedation
D9211	Level 3
D9212	Level 3
D9222	Level 4
D9223	Level 4
D9230	Level 1
D9239	Level 3
D9243	Level 3
D9248	Level 2

Dental anesthesia is not age-restricted.

Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately.

Procedure codes D9239 is limited to 15 minutes (1 unit) per day. Procedure code D9243 is limited to 1 hour and 15 minutes per day (5 units).

Reimbursement of procedure code D9248 is limited to one service per client per day. Procedure code D9248 is limited to two times per year, per client.

If more than two nonintravenous (IV) conscious sedation services are required by the same provider in a 12 month period, prior authorization is required.

Any dentist providing nonintravenous (IV) conscious sedation must comply with all TSBDE Rules and American Academy of Pediatric Dentistry (AAPD) Guidelines, including maintaining a current permit to provide non-IV conscious sedation. Claims must include a provider statement indicating that the procedure was provided in full compliance with these guidelines. Documentation supporting medical necessity and appropriateness for the use of non-IV conscious sedation must be maintained in the client's records and is subject to retrospective review.

Supporting documentation includes, but is not limited to the following:

- Narrative addressing the reason non-IV conscious sedation was necessary

- Medications used to provide the non-IV conscious sedation
- The duration of the non-IV conscious sedation, including the start and end times
- Monitored statistics, such as vital signs and oxygen saturation levels
- Any resuscitative measures that may have been necessary

The following procedure codes are denied when billed for the same date of service as procedure code D9248:

Procedure Codes						
D9210	D9211	D9212	D9222	D9230	D9239	D9920

Refer to: Section 14.2.7.3, "Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)" in this chapter.

14.2.6.10.2 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

All levels of sedation must have clinical documentation and a narrative in the client's dental record to support the necessity of the service. Documentation must include the sedation record that indicates sedation start and end times in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines. The client's dental record must be available for review by representatives of HHSC or its designee.

14.2.6.11 Dental Behavior Management

Procedure code D9920 is considered for prior authorization in addition to therapeutic procedures when provided in the office and when the client has a diagnosis of an intellectual disability described as mild, moderate, severe, profound, or unspecified.

Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and is subject to retrospective review.

Supporting documentation includes, but is not limited to, the following:

- A current physician statement addressing the intellectual disability, signed and dated within 1 year before the dental behavior management
- The client's diagnosis of intellectual disability
- A description of the service performed, including the specific problem and the behavior management technique applied
- Personnel and supplies required to provide the behavioral management
- The duration of the behavior management, including the start and end times

Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure.

Except for those procedures requiring prior authorization, admission to an outpatient or freestanding ambulatory surgical center (ASC) for the purpose of performing dentistry services must be authorized.

Refer to: Section 24.5.1, "Benefits, Limitations, and Authorization Requirements" in Chapter 24, "Hospital" for more information about prior authorization in an ASC.

14.2.6.12 Internal Bleaching of Discolored Tooth

Internal bleaching of a discolored tooth is an accepted endodontic treatment for clients who are 13 years of age or older. It is intended to remove and change the organic material in the enamel of an infected or traumatized tooth. It is considered medically necessary when chemical change of the contents in the interior of the tooth is judged necessary to complete an endodontic treatment to the tooth for therapeutic, not cosmetic purposes. Prior authorization is not required. Procedure code D9974 may be considered for reimbursement when the claim is filed with documentation supporting medical necessity. Claims that are filed without documentation supporting medical necessity are denied as incomplete.

14.2.6.13 Noncovered Services

The following therapeutic services are not benefits of the CSHCN Services Program.

Procedure Codes									
D3331	D3332	D3333	D6058	D6059	D6060	D6061	D6062	D6063	D6064
D6065	D6066	D6067	D6068	D6069	D6070	D6071	D6072	D6073	D6074
D6075	D6076	D6077	D6094	D6194	D7412	D7671	D7771	D7830	D9972
D9973									

14.2.7 Dental Treatment in Hospitals and ASCs

Dental rehabilitation and restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

14.2.7.1 Dental Hospital Calls

Dental hospital calls may be reimbursed for clients of any age that require medically necessary general anesthesia or dental treatment in the inpatient or outpatient hospital setting. Providers may bill procedure code D9420 in addition to the dental services performed in the inpatient or outpatient setting. Documentation supporting the medical necessity of the dental hospital call must be retained in the client's dental record and is subject to retrospective review. Procedure code D9420 is limited to twice per rolling year, per client, any provider.

Refer to: Chapter 24, "Hospital" for more information about requirements for inpatient and outpatient services.

14.2.7.2 Authorization and Prior Authorization Requirements

All inpatient hospital admissions for dental services require prior authorization. Except for those specific procedures that require prior authorization, admission to freestanding ASCs or outpatient hospital ambulatory surgical centers (HASCs) for the purpose of performing dentistry services require authorization.

The CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia must be submitted to the TMHP-CSHCN Services Program with supporting documentation of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations" for additional information.

Chapter 24, "Hospital."

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only form

Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only form.

14.2.7.3 Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)

Dental rehabilitation or restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting.

CSHCN Services Program dental services should be billed using the following Current Procedural Terminology (CPT) procedure codes and modifier where appropriate:

- Anesthesia services for general dental anesthesia, procedure code 00170 with modifier U3
- ASC or HASC dental rehabilitation or restoration, procedure code 41899 with modifier U3
- Physical examinations before dental restorations under anesthesia, procedure codes 99202, 99222, and 99282
- Restorations under anesthesia, procedure codes 99222 and 99282

Supporting documentation must be retained in the client's chart and must reflect compliance with the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia and the CSHCN Services Program Policy About the Criteria for Dental Therapy Under General Anesthesia, Attachment 1. Dental general anesthesia may be reimbursed once every 6 months per client any provider.

All supporting documentation must be maintained in the client's medical record. The client's record must be available for review by representatives of the CSHCN Services Program, the Department of State Health Services (DSHS), the CSHCN Services Program claims contractor, and HHSC. The dental provider is required to maintain the following documentation in the client's dental record:

- The medical evaluation justifying the need for anesthesia
- Description of relevant behavior and reference scale
- Other relevant narrative justifying the need for general anesthesia
- Client's demographics, including date of birth
- Relevant dental and medical history
- Dental radiographs, intraora or perioral photography, or diagram of dental pathology

- Proposed dental plan of care
- Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained
- Completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form
- The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that the parent or guardian understands and agrees with the dentist's assessment of their child's behavior
- Dentist's attestation statement and signature, which is put on the bottom of the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form or included in the client's dental record as a separate form

Hospital and outpatient facility admissions are subject to medical necessity review.

14.2.8 Doctor of Dentistry Services as a Limited Physician

The CSHCN Services Program covers services provided by a DDS or DMD if the services are a benefit and furnished within the dentist's scope of practice as defined by Texas state law. To participate in the CSHCN Services Program as a dentist practicing as a limited physician, a dentist (DDS or DMD) must be enrolled separately as a dentist practicing as a limited physician.

The CSHCN Services Program recognizes the standards of care needed to appropriately address the repair of cleft and craniofacial anomalies as outlined in the guidelines prepared by the American Cleft Palate - Craniofacial Association (acpa-cpf.org).

A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients with complex medical conditions who require treatment by a broad range of medical specialists. Standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach either by a C/C team or by an equivalent coordinated multidisciplinary team. The following exceptions may be considered to this requirement:

- A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. (Medical record documentation must explain the reasons the client is unable to travel.)
- A C/C or equivalent multidisciplinary team is not available in the area, or the team approach cannot be coordinated over multiple locations. (Medical record documentation must describe attempts to coordinate a team approach.)
- A C/C or equivalent multidisciplinary team is available but the client or the client's parent/ guardian refuses to receive care from the team. (Medical record documentation must explain the reason for the refusal of the care offered by the team.)

Refer to: Section 31.2.39.11, "Cleft/Craniofacial Procedures" in Chapter 31, "Physician" for more detailed information.

If a client has third-party insurance coverage available that requires reconstructive facial surgery involving the bony skeleton of the face (including midface osteotomies and cleft lip and palate repairs performed by a physician), the CSHCN Services Program cannot consider a claim for payment unless all third-party payer requirements are met.

14.2.8.1 Authorization Requirements

The following procedure codes require prior authorization and may be considered with medical review of documentation of medical necessity. These procedures may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.

Procedure Codes									
11950	11951	11952	11954	15630	15780	15781	15788	15789	15876

Documentation of medical necessity indication that the procedure was performed due to trauma or injury must be submitted with the authorization request.

Unless otherwise noted in the following tables, all other procedure codes in this section do not require authorization or prior authorization.

14.2.8.2 * Surgery

The following surgery CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

[Revised] Procedure Codes									
10060	10061	10140	10160	10180	11000	11010	11011	11012	11042
11043	11044	11102	11103	11104	11105	11106	11107	11200	11201
11305	11306	11307	11308	11310	11311	11312	11313	11420	11421
11422	11423	11424	11426	11440	11441	11442	11443	11444	11446
11620	11621	11622	11623	11624	11626	11640	11641	11642	11643
11644	11646	11900	11901	11950**	11951**	11952**	11954**	11960	11970
11971	12001	12002	12004	12005	12006	12007	12011	12013	12014
12015	12016	12017	12018	12020	12021	12031	12032	12034	12035
12036	12037	12051	12052	12053	12054	12055	12056	12057	13120
13121	13122	13131	13132	13133	13151	13152	13153	13160	14020
14021	14040*	14041*	14060*	14061*	14301	14302	15004	15005	15115
15116	15120*	15121*	15135*	15136*	15155*	15156*	15157*	15240*	15241*
15260*	15261*	15275	15276	15277	15278	15574	15576*	15620	15630**
15730	15733	15740	15750	15756	15757	15758	15760	15769	15770
15780**	15781**	15786	15787	15788**	15789**	15819	15820*	15821*	15850
15851	15852	15876**	17250	20100	20525	20551	20552	20600	20604
20605	20606	20615	20660	20670	20680	20690	20692	20693	20694
20696	20697	20900	20902*	20910	20912	20920	20922	20955	20956
20957	20962	20969	20970	20972	20973	20999*	21010	21011	21012
21013	21014	21025	21026	21029	21030	21031	21032	21040	21046
21047	21048	21049	21050	21060	21070	21073	21076*	21077*	21079*
21080*	21081*	21082*	21083*	21084*	21085*	21086*	21087*	21088*	21089*
21100*	21110*	21116	21120*	21121*	21122*	21123*	21125*	21127*	21137*
21138*	21139*	21141*	21142*	21143*	21145*	21146*	21147*	21150*	21151*
21154*	21155*	21159*	21160*	21172*	21175*	21179*	21180*	21181*	21182*
21183*	21184*	21188*	21193*	21194*	21195*	21196*	21198*	21199*	21206*

***If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.**

**** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.**

[Revised] Procedure Codes									
21208*	21209*	21210*	21215*	21230*	21235*	21240	21242	21243	21244*
21245*	21246*	21247*	21248*	21249*	21255*	21256*	21260*	21261*	21263*
21267*	21268*	21270*	21275*	21280*	21282*	21295*	21296*	21299*	21315
21320	21325	21330	21335	21336	21337	21338	21339	21340	21343
21344	21345	21346	21347	21348	21355	21356	21360	21365	21366
21385	21386	21387	21390	21395	21400	21401	21406	21407	21408
21421	21422	21423	21431	21432	21433	21435	21436	21440	21445
21450	21452	21453	21454	21461	21462	21465	21470	21480	21485
21490	21497*	21499*	21685	29800	29804	29999*	30000	30020	30120
30124	30125	30130	30140	30150	30160	30200	30300	30310	30460*
30462*	30580*	30600*	30620*	30630*	30801	30802	30901	30903	30905
30906	30930	30999*	31020	31080	31081	31084	31085	31086	31087
31090	31200*	31201	31603	31605	31830	40490	40500	40510	40520
40525	40527*	40530*	40650*	40652*	40654*	40700*	40701*	40702*	40720*
40761*	40799*	40800	40801	40804	40805	40806	40808	40810	40812
40814	40816	40818	40819	40820	40830	40831	40840	40842	40843
40844	40845	40899*	41000	41005	41006	41007	41008	41009	41010
41015	41016	41017	41018	41100	41105	41108	41110	41112	41113
41114	41115	41116	41120	41130	41250	41251	41252	41510	41520
41599*	41800	41805	41806	41820	41821	41822	41823	41825	41826
41827	41828	41830	41850	41870	41872	41874	41899*	42000	42100
42104	42106	42107	42120	42140	42145*	42160	42180	42182	42200*
42205*	42210*	42215*	42220*	42225*	42226*	42227*	42235*	42260*	42280*
42281*	42299*	42300	42305	42310	42320	42330	42335	42340	42400
42405	42408	42409	42410	42415	42420	42425	42426	42440	42450
42500	42505	42507	42509	42510	42550	42600	42650	42660	42665
42699*	42700	42720	42725	42800	42804	42806	42808	42809	42810
42815	42890	42892	42894	42900	42950	42960	42961	42962	42970
42999*	61501	61559*	62147	64400	64640	64681	64722	64736	64738
64740	64742	67900	67914	67915	67916	67917	67921	67922	67923
67924	67930	67935	67950*	67961*	67966*	67971	67973	67974	67975
J0558	J0561								

***If performed as part of a repair or reconstruction of cleft lip, cleft palate, or craniofacial anomaly, must be prior authorized and performed by a CSHCN Services Program provider that is a member of, or affiliated with, an approved cleft/craniofacial team or an equivalent coordinated multidisciplinary team.**

**** Authorization is required and may be considered with medical review of documentation of medical necessity. These procedure may be considered cosmetic and are not a benefit when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues.**

14.2.8.3 Cleft/Craniofacial Surgery by a Dentist Physician

The following additional codes may be reimbursed to a provider enrolled as a cleft/craniofacial surgeon. Prior authorization is required.

Procedure Codes									
30540	30545	30560	61550	61552	61556	61557	61558	62115	62117

Septoplasty (procedure code 30520) for nonrelated repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies may be prior authorized with documentation to support medical necessity.

14.2.8.4 Evaluation and Management or Consultation

The following evaluation and management or consultation service procedure codes are payable to a dentist physician:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
99218	99219	99220	99221	99222	99223	99231	99232	99233	99238
99241	99242	99243	99244	99245	99251	99252	99253	99254	99255
99281	99282	99283	99284	99285					

Evaluation and management codes for home services are not reimbursed to dentists or dentistry groups.

14.2.8.5 Radiology and Laboratory Procedures

The following diagnostic radiology and laboratory procedure codes are payable to a dentist physician:

Procedure Codes									
70100	70110	70120	70130	70140	70150	70160	70170	70190	70200
70250	70260	70300	70310	70320	70328	70330	70332	70336	70350
70355	70370	70371	70380	70390	73100	76942	88305	88331	88332

Refer to: The CMS website at www.cms.gov/CLIA/10 Categorization of Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders.

14.2.8.6 Other Procedures Payable to a Dentist Physician

The following additional CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician:

Procedure Codes									
90284	92511	96369	96370	96372	96374	J0121	J0290	J0295	J0330
J0558	J0561	J0690	J0692	J0694	J0696	J0697	J0698	J0702	J0720
J0744	J1020	J1030	J1040	J1100	J1165	J1170	J1200	J1364	J1580
J1631	J1720	J1790	J1810	J1840	J1850	J1885	J1940	J2010	J2060
J2400	J2510	J2540	J2560	J2700	J2770	J2920	J2930	J3000	J3260
J3300	J3301	J3303	J3370	J3430	J3480	J3490	T1013		

Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service.

Procedure code T1013 billed with modifier U1 is limited to once per day, per provider; procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day.

Procedure codes 90284, J1459, J1561, J1568, J1569, and J1572 will be denied if billed with the same date of service by any provider as the following procedure codes (unless otherwise indicated):

Procedure Codes									
90284	J1459*	J1460	J1560	J1561*	J1566	J1568*	J1569*	J1572*	J7504
J7511									
***These procedure codes may be billed more than once per day but will not be reimbursed if billed in combination with any other procedure code in this table.**									

14.2.8.7 Anesthesia by Dentist Physician

In addition to the procedure codes discussed under "Benefits and Limitations" in this chapter, the following anesthesia CPT procedure codes are payable to a dentist physician:

Procedure Codes									
00100	00102	00160	00162	00164	00170	00190	00192	00300	99100
99116	99135	99140							

14.3 * Claims Information

Dental services must be submitted to TMHP in an approved electronic format or on a paper ADA Dental Claim Form. Providers can obtain copies of this form by contacting the ADA at 1-800-947-4746 or ordering online from the ADA website at www.ada.org. TMHP does not supply the forms. Any paper dental claim submitted using any other version of the dental claim form is not processed and is returned to the submitter.

When completing a paper ADA Dental Claim Form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Providers billing electronically must submit dental claims in American National Standards Institute (ANSI) ASC X12 837D format. Specifications are available to providers developing in-house systems, software developers, and vendors. Because each software package is different, field locations may vary. Providers should contact the software developer or vendor for information about their software. Providers or software vendors may direct questions about development requirements to the TMHP EDI Help Desk at 1-888-863-3638.

Claims must contain the billing provider's full name, address, and provider identifier. The billing provider's full name and address must be entered in Block 48 of the paper ADA Dental Claim Form, and the ten-digit NPI must be entered in Block 49. *A claim without a provider name, address, and NPI cannot be processed.*

[Revised] The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.cms.gov/medicare/coding/ncci-coding-edits or correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.13, "Instructions for Completing the Paper ADA Dental Claim Form" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

14.3.1 Dental Emergency Claims

The Emergency Indicator field has been removed from the HIPAA-approved 837D electronic transaction. Dental providers submitting electronic claims in the 837D format must use modifier *ET* to report emergency services. Modifier ET must be placed in the SVC01 section of the 837D format.

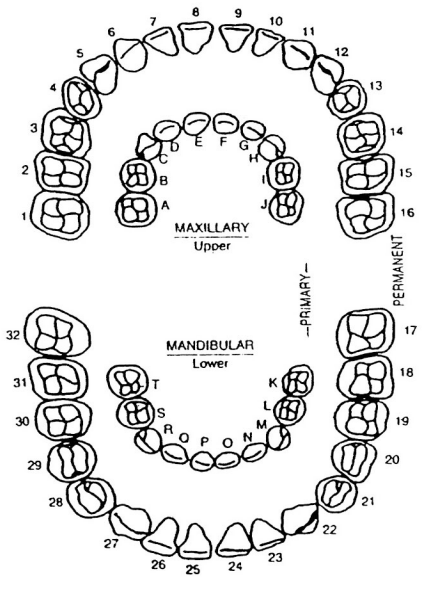
Additionally, the Comments field should be used to document the specific nature of the emergency. The Comments field in the HIPAA-approved 837D electronic transaction is 80 bytes long.

To indicate a dental emergency on a paper claim submission (ADA Dental Claim Form), check Block 45, Treatment Resulting From (check the applicable box), and check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35, Remarks.

Only one emergency or trauma claim per client, per day may be submitted. Separate services (one for emergency or trauma and one for nonemergency or routine) may be submitted for the same client on the same day, any provider, for separate services and procedure codes.

14.3.2 Tooth Identification (TID) and Surface Identification (SID) Systems

Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. Anterior teeth have facial and incisal surfaces only. Posterior teeth have buccal and occlusal surfaces only.



SID	SID	SID	SID
Buccal	DB	DFI	DLIF
Distal	DF	DFL	DOLB
Facial	DI	DFM	MIDF
Incisal	DL	DIL	MIDL
Lingual	DO	DLB	MIDLF
Mesial	IL	DLM	MIFL
Occlusal	MB	DOB	MLBD
	MI	DOL	MLDF
	ML	ILF	MODB
	MO	MBD	MODL
	OB	MID	MODLB
	OL	MIF	MOLB
		MLB	
		MLF	
		MLI	
		MOB	
		MOD	
		MOL	
		OBL	

14.3.3 Supernumerary Tooth Identification

Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the CDT published by the ADA.

The TID for each identified supernumerary tooth is used for paper and electronic claims and can only be billed with the following codes:

- For primary teeth only: D7111
- For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510

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

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

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

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

14.4 Reimbursement

Dental services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

14.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.