



**Solicitation Information**  
**May 22, 2014**

**Addendum #1**

**RFP # 7548766**

**TITLE: DENTAL SERVICES – RI DEPT. OF CORRECTIONS**

**Submission Deadline: JUNE 16, 2014 @ 2:00 PM (Eastern Time)**

**TRANSMITTED HERewith ARE THE FOLLOWING ATTACHMENTS REFERENCED IN RFP #7548766:**

- 1. ATTACHMENT #1 – RI DEPT. OF CORRECTIONS CENSUS AS OF 11/8/13**
- 2. ATTACHMENT #2 – TOTAL OF DENTAL ENCOUNTERS/DENTAL HYGIENE FOR THE PERIOD 10/12-10/13**
- 3. ATTACHMENT #3 – DENTAL SERVICES COVERAGE POLICY**

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**ATTACHMENT # 1**  
**Rhode Island Department of Corrections Census**

Total number of inmates as of 11/08/2013 – 3311

Total number in jail and prison – 2561 sentenced - 750 awaiting trial

Male/Female inmates – 3159 males – 152 females

Average number last three years – 3208 for fiscal years 11-13

Number of inmates by facility:

- High Security 97
- Maximum 435
- Medium 1069
- Minimum 423
- Women's I 115
- Women's II 37
- Intake Service Center 1135

ATTACHMENT # 2

Dental Encounters	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Total
Absi	2	0	0	0	0	0	0	0	0	0	23	24	0	49
Chan	30	15	23	38	54	63	48	51	39	0	8	17	0	386
DelGizzo	23	0	0	0	0	0	0	0	0	0	0	0	0	23
Kim	0	15	13	18	29	30	32	25	34	17	0	0	0	213
Narayanan								9	29	38	0	0	0	76
Ramirez										6	1	0	4	11
Sicola	19	28	12	22	25	32	34	13	39	29	46	31	43	373
Stengel	66	67	74	117	123	114	133	93	139	139	108	108	163	1444
Skoly	12	15	9	4	0	12	0	0	0	13	15	31	15	126
Stevanovic	23	54	89	78	30	11	3	5	37	35	6	10	25	406
<b>Total Dental Encounters</b>	<b>175</b>	<b>194</b>	<b>220</b>	<b>277</b>	<b>261</b>	<b>262</b>	<b>250</b>	<b>196</b>	<b>317</b>	<b>277</b>	<b>207</b>	<b>221</b>	<b>250</b>	<b>3107</b>
<b>Dental Hygiene</b>														
Durfee (Hygiene)	65	56	33	83	45	68	29	80	77	0	0	0	0	536
Magnusky (Hygiene)	58	59	38	43	42	65	54	64	72	80	93	120	110	898
Moravec							20	53	59	79	98	85	84	478
Riggs							77	105	89	119	110	112	117	729
Servant (Hygiene)	89	69	83	109	111	7	0	0	0	0	0	0	0	468
<b>Hygiene Totals</b>	<b>212</b>	<b>184</b>	<b>154</b>	<b>235</b>	<b>198</b>	<b>140</b>	<b>180</b>	<b>302</b>	<b>297</b>	<b>278</b>	<b>301</b>	<b>317</b>	<b>311</b>	<b>3109</b>

## Rhode Island Department of Human Services Medical Assistance Program Dental Services

### DENTAL SERVICES COVERAGE POLICY

#### Introduction

Dental services are a benefit to eligible recipients under the Rhode Island Medical Assistance Dental Services Program.

#### General Policy Requirements

The Medical Assistance Program will only reimburse providers for medically necessary services. The Medical Assistance Program conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the Medical Assistance Program, trained medical consultants, and independent State and private agencies under contract with the Medical Assistance Program. Services that are denied by Medicare because they are not medically necessary are not reimbursable by the Medical Assistance Program.

Providers must bill the Medical Assistance Program at the same usual and customary rates as charged to the self-pay general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to Medical Assistance. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

#### Purpose of Coverage Policy

The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for medical assistance under the Medical Assistance Program. The General Rules for the Medical Assistance Program and the rules in this policy are to be used together to determine eligibility for services.

#### Recipient Eligibility

The Medical Assistance Program provides coverage for necessary medical services to recipients who are in two basic benefit levels: Categorically Needy and Medically Needy. The scope of services varies according to the benefit level. Refer to Section 100-40 in the Provider Reference Manual for further information.

#### Recipient Eligibility Verification System (REVS)

For automated benefits and Rhode Island Medical Assistance recipient eligibility information/Customer Service access, in-state long distance providers can access the system by dialing (800) 964-6211. Local and out-of-state providers can access REVS by dialing (401) 784-8100. Modem access to REVS is available. If you are interested in obtaining modem access, please call the Customer Service Help Desk at (401) 784-8100. For more information regarding REVS, please see Section 100-40 of the Provider Reference Manual.

#### Retroactive Eligibility

Procedures billed retrospectively for recipients who have retroactive eligibility are valid if all conditions for billing are met.

#### Scope of Services

The Medical Assistance Program provides payment only for services that are included in the scope of services described in the DHS Manual at Section 033.20, Section 0348 for the Rite Care Program, or under a waiver program at Section 0398; or for recipients under the age of 21 pursuant to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, for additional services that are not included in the above sections, and that are definable under Section 1905(a) of the federal Social Security Act. Specific details of services covered and limitations thereon are contained in the Medical Assistance Program Provider Reference Manuals, the Rhode Island Title XIX State Plan, Section 1115 and Section 1915 Waiver requests, and the Rite Care Program Managed Care Plan and Contracts. Payment is not made for services other than those described herein.

#### Medical Necessity

The Medical Assistance Program provides payment/allowance for covered services only when the services are determined to be medically necessary.

The term "medical necessity" or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a detrimental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

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### **Appeal of Denial of Medical Necessity**

Determinations made by the Medical Assistance Program are subject to appeal by the recipient only. Providers may not appeal denials of Medical Necessity.

Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. The route of appeal for Title XIX recipients is through the Department of Human Services. Rlite Care participants may first appeal through the managed care plan, or may appeal directly through the Department of Human Services.

(Appeals rights and procedures are contained in DHS Manual Sections 0110 and 0348.)

Medical Assistance payments are provided only for covered services that are determined to be medically necessary. No Medical Assistance payment will be made for a medical procedure of an investigative or experimental nature.

### **Determinations of Medical Necessity**

Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the Health Care Quality, Financing and Purchasing Division, and by individuals and organizations under contract to the Department of Human Services. Policies relative to medical necessity are set forth in the DHS Manual, the Medical Assistance Program Provider Reference Manuals, and the Rhode Island State Plan under Title XIX of the federal Social Security Act. Medical necessity can be determined on procedure-by-procedure basis.

### **Approval of Medical Necessity**

The Medical Assistance Program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the Medical Assistance Program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the Medical Assistance Program will determine the provider's recommendation to be medically necessary. The Medical Assistance Program is the final arbiter of determination of medical necessity.

### **Investigative/ Experimental Medical Procedures**

Medical procedures of an investigative or experimental nature are not covered by the Medical Assistance Program.

A service that is furnished for research purposes in accordance with medical standards is considered experimental or investigational. A procedure is determined to be investigative or experimental according to the current judgment of the medical community as evidenced by medical research, studies, journals or treatises.

The Medical Assistance Program determines whether a treatment, procedure, facility, drug, or supply (each of which is hereafter called a "service") is experimental or investigational. Medical Assistance uses the following criteria to determine if a service is experimental or investigational:

1. The service is not yet approved by the appropriate governmental regulatory body or the service is approved for a purpose other than the purpose for which it is furnished; or
2. Demonstrated reliable evidence shows the service is (a) the subject of ongoing Phase I or II clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; (b) the subject of a written investigational or research protocol; or (c) the subject of a written informed consent use by the treating facility when the written consent is obtained to assure that the patient acknowledges the non-standard nature of treatment.

### **Demonstrated Reliable Evidence**

Demonstrated reliable evidence means: evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature; and/or final approval of the service from the appropriate governmental regulatory body, demonstrating:

- a) definite, measurable, positive effects of the service on health outcomes, with results supported by positive endorsements of national medical bodies or panels regarding their scientific efficacy and rationale; and proof that, over time, the beneficial effects of the service outweigh any harmful effects;
- b) risk-benefit ratios as factorable as, if not better than, those of conventional treatments and significant advantages over such conventional treatments;

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c) improvement in health outcomes possible under the standard conditions of medical practice, outside the clinical investigatory settings;

d) The service is at least as beneficial in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

### **Denial of Medical Necessity**

When the Medical Assistance Program is requested to pay directly (fee-for-service) for a particular service for a recipient who has other third-party coverage (such as Medicare or Blue Cross), for that particular service, if the third party denies payment for services based on medical necessity, this determination is adopted by the Medical Assistance Program. An independent determination of medical necessity is not made in such circumstances. For example, if federal Medicare determines that a home health service is not medically necessary, then that determination is binding on the Medical Assistance Program and Medical Assistance payment of the service cannot be made.

### **Third Party Liability**

The Medical Assistance Program is the payor of last resort. All third party programs must be utilized before any payment can be made by the Medical Assistance Program.

If payment from other third parties is equal to or exceeds the Medical Assistance Program allowable amount, no payment will be made on the claim by the Medical Assistance Program. If the third party denies payment for any reason related to non-conformity to the plans policies and/or rules, the EOB will be rendered invalid and the Medical Assistance Program will not consider the claim for payment.

The Medical Assistance payment is considered payment in full. The Provider is not allowed to bill the recipient for any additional charges not paid for by the program. For detailed TPL information, refer to page 300-TPL-1 through 300-TPL-11 for further information.

### **Provider Participation**

Dental providers must be licensed by the Rhode Island Department of Health, or by the appropriate agency in the state in which they practice, and enrolled in the Medical Assistance Program to receive reimbursement for dental services.

### **Recertification**

Providers are periodically recertified by the Department of Health (DOH). Providers obtain license renewal through DOH and then forward a copy of the renewal documentation to EDS. EDS should receive this information at least five business days prior to the expiration date of the license. Failure to do so will result in suspension from the program.

A provider may appeal to the DOH if the facility does not meet the recertification criteria. If the appeal to DOH is not successful, the provider may then appeal to the Centers for Medicare and Medicaid (CMS).

### **Claims Billing Guidelines**

Dental claims must be billed on one of the ADA-approved dental claim forms. It is recommended that the most recent ADA dental form be used for billing. Instructions for completing the ADA dental claim form are located in Section 400-10 of the Provider Reference Manual.

### **Reimbursement Guidelines**

The Medical Assistance Program will not pay for canceled or missed office visits.

### **Prior Authorization**

For some procedures, prior authorization is required before services are performed, unless the service is an emergency. Prior authorization is required for all inpatient or outpatient hospitalization except for life-threatening emergencies or traumatic injuries. Prior authorization requests must include clinical information justifying the need for hospitalization and the name of the facility.

Prior authorization for all inpatient admissions must follow the procedures outlined in Service Utilization Review and Admission Screening, Section 100-70, in the Provider Manual.

Prior authorization does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service by checking the Recipient Eligibility Verification System (REVS). Refer to Section 100-40 in the Provider Manual as well as the REVS User Guide. If there is a verifiable emergency service which requires prior authorization, and needs to be done immediately, the procedure should be performed and the reason written on the

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claim form. The consultants will review these claims and consider them for payment. The Medical Assistance Program Dental policy designates those codes, which require prior authorization.

Payment for any prior authorization services can only be made if the services are provided while the person remains eligible for the Rhode Island Medical Assistance Program. If the case is closed after prior authorization has been granted, but before treatment has been completed, only those services provided while the person was eligible can be considered for payment by the Rhode Island Medical Assistance Program.

### **Services Reviewed by Medical Assistance**

The Medical Assistance Program reserves the right to refuse payment for treatment performed when the prognosis was unfavorable, the treatment impractical, or a lesser cost procedure would have achieved the same ultimate results.

### **Consultants**

The Office of Medical Assistance Programs, in consultation with the Rhode Island Dental Association, contracts with General Practice consultants, Oral Surgery consultants, and Orthodontic consultants for professional review of specific services or billings before payment will be authorized by the Medical Assistance Program.

If, in the opinion of the consultant, the clinical information furnished does not support the treatment or services provided, payment will be denied.

The Rhode Island Dental Association will be requested to provide peer review on specific issues through the regularly established peer review system of the Association. The prevention of fraud and abuse may be pursued at the discretion of the Rhode Island Medical Assistance Program and is not limited to Rhode Island Dental Association peer review.

### **Individual Consideration**

Requests for payment for dental services listed as "IC", or services not included in the procedure code listing, must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or X-rays. Payment for "IC" procedures will be approved in consultation with a Medical Assistance dental consultant.

### **Medical Assistance Requests for X-Rays**

Medical Assistance, in the process of utilization review and/or in determining its responsibility for payment of dental services, may request the treating dentist to submit appropriate X-rays and/or other clinical information, which justifies the treatment to the Medical Assistance Program. Payment may be denied if the requested X-rays and/or other clinical information are not submitted. Any procedure for which prior authorization was not required must be verified, as necessary, by pre-operative and post-operative X-rays or other means prior to payment.

Prior approval for routine diagnostic x-rays for determination of course of treatment will be denied. Prior authorization for these radiographs should only be requested in those instances in which the need for the x-rays is in excess of the dental community standard of care. Routine diagnostic x-rays are considered part of the cost of treatment.

The Medical Assistance Dental Services Program will provide all persons under the age of 21 with a full range of dental services.

Medical Assistance will use the American Dental Association standard insurance form and the Current Dental Terminology (CDT-4) procedure codes.

### **Emergency Dental Services**

Payments for emergencies are restricted to services defined as "Emergency Services" (see Definitions of Terms in this section below).

Emergency services do not require prior authorization by Medical Assistance. Documentation of the need for the emergency services is the responsibility of the provider and subject to audit by Medical Assistance.

### **Service Utilization Review and Admission Screening**

Refer to Section 100-70 in the General Provisions section of the Provider Reference Manual.

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### Procedures Never Considered Emergencies

The following procedures are never considered to be of an emergency nature:

- Appliances (not related to immediate trauma/injury)
- Dentures, full or partial
- Exostosis (Tori) removal
- Flippers (stay plates)
- Frenectomy, Frenulectomy
- Gingivectomy, Gingivoplasty
- Remake or repair of Archwire
- Space maintainers
- Tissue Conditioning

### Services Considered Part of Total Treatment - Not Separate Services

The following services do not warrant an additional fee and are considered to be either minimal a service that are included in the examination, part of another service, or included in routine post-op or follow-up care:

- Alveolectomy, in Conjunction with Extractions
- Analgesia
- Cardiac Monitoring
- Diagnostic Cast construction (study models)
- Diagnostic Photographs
- Dietary Counseling
- Direct and Indirect Pulp Capping
- Dressing Change
- Electrosurgery
- Equilibration of Occlusion
- File Broken Tooth
- Local Anesthesia
- Medicated Pulp Chambers
- Odontoplasty
- Oral Hygiene Instruction
- Periodontal Charting, Probing
- Post Extraction Treatment for Alveolitis
- Pulp Vitality Tests
- Special Infection Control Procedures
- Surgical procedure for isolation of tooth with rubber dam
- Surgical Splint Construction
- Surgical Stent Construction
- Suture Removal

### Definition of Terms

**Emergency Services** are covered services requiring immediate treatment. This includes services to control hemorrhage, relieve pain, and/or eliminate acute infection. This includes immediate treatment of injuries to both dentition and supporting structures, but does not include permanent restorations.

The emergency rule applies only to covered services. Some non-covered services may meet the criteria of emergency, but it is not intended to extend to those non-covered services. Routine dental treatment of incipient decay does not constitute emergency care.

### Preventive Services

This includes the following services:

- Oral Prophylaxis (cleaning of teeth)
- Topical Fluoride Treatment
- Placement of Sealants
- Space maintainers for prematurely lost primary posterior teeth

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### Therapeutic Services

This includes the following services:

- Pulp therapy of permanent and primary teeth - restricted to recipients under age 21
- Restorations of primary and permanent teeth using amalgam, composite materials and/or stainless steel or polycarboxylate
- Subgingival scaling and curettage
- A removable prosthesis when masticatory function is impaired such as is found with less than six (6) opposing teeth

### Covered Services

Covered Services are those services that will be reimbursed to a provider for an eligible recipient as defined in the Dental Services Provider Reference Manual.

### General Anesthesia

General Anesthesia is defined as a controlled state of unconsciousness including the inability to independently maintain an airway or to respond purposefully to physical stimulation or verbal command – **restricted to recipients under age 21 only.**

The use of the following drugs either alone or in combination with other drugs is conclusively presumed to produce general anesthesia:

- Ultra short acting barbiturates including but not limited to sodium methohexital, thiopental, thiamylal
- Other general anesthetics including, but not limited to, ketamine or etomidate; or rapidly acting steroids including, but not limited to, althesin.

### Sedation

Sedation involves the administration of a sedative drug intravenously (in a single injection or injected over an extended period), intramuscularly, submucosally, or subcutaneously.

### Restricted to individuals under age 21

Services with this limitation can only be provided under the Rhode Island Medical Assistance Dental Services Program to individuals who have not attained their 21st birthday prior to the delivery of the service.

### Services Not Covered

Procedure codes not listed in the Medical Assistance Dental Fee Schedule are services not covered under the Medical Assistance Dental Services Program. The following general categories of dental services are not covered, except if deemed medically necessary for patients less than 21 years of age.

- Crowns (Types: ceramco, gold, or other full cast, and porcelain fused to metal)
- Crowns for Bicuspid and Molars
- Desensitization
- Extensive Periodontal Surgery
- Fixed Bridges
- Implants
- Occlusal Equilibration
- Root Canal Therapy for Bicuspid and Molars

### Nursing Home Services

Payment is covered for Medical Assistance recipients for dental services provided in a nursing home or long-term care facility by reporting the appropriate code in addition to the code for actual dental services performed. Fees for all endodontic and oral surgery procedures include the fee for the examination and necessary X-rays.

***Mobile Dental Services in Nursing Homes - Please see separate Certification Standards***

## Rhode Island Department of Human Services Medical Assistance Program Dental Services

### Covered Services

The following dental services and procedure codes are covered by the Medical Assistance Program with limitations, where noted.

### Explanation of Symbols and Tooth Numbering System --

#### Age Restriction

- <21 = Service can only be provided to recipients under age 21
- N = No age restrictions

#### Prior Authorization - (PA) Requirements

- Y = PA is Required, N = No PA is Required

#### Anterior Teeth

- will include teeth number 6-11 and 22-27.

#### Posterior Teeth

- will include all others not considered anterior teeth

## DIAGNOSTIC SERVICES

### Clinical Oral Examinations

A Comprehensive Oral Evaluation is defined as the first exam for a new patient in the dental office. This replaced the initial Oral Exam and each recipient is limited to one Comprehensive Oral Exam per lifetime from the same provider. Each exam after the Comprehensive exam will be paid on the basis of a periodic exam.

The codes in this section have been revised to recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic and/or definitive procedures separately

#### **D0120 Periodic Oral Evaluation**

Age Restriction    PA Requirement  
N                            N

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

*Periodic exams are allowed twice per calendar year, per recipient.*

#### **D0140 Limited Oral Evaluation - problem focused**

N                            N

An evaluation or re-evaluation limited to a specific oral health problem. This may require interpretation of information acquired through additional diagnostic procedures. Emergency examinations based on documented need are allowed per emergency episode. Definitive procedures may be required on the same date as the evaluation. Do not bill for an emergency examination for each visit during the treatment.

Typically, patients receiving this type of evaluation have been referred for a specific problem and/or present with dental emergencies, trauma, acute infections, etc.

#### **D0150 Comprehensive Oral Evaluation**

N                            N

Replaces the former Initial Oral Evaluation procedure- Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions, including periodontal charting hard and soft tissue anomalies, etc.

#### **D0160 Detailed and Extensive Oral Evaluation – problem focused, by report**

N                            N

A detailed and extensive problem-focused evaluation of a specific oral health issue. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required based on the findings of a Comprehensive Oral Evaluation. The condition requiring this type of evaluation should be described and documented.

Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, severe systemic diseases requiring multidisciplinary consultation, etc.

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<u>Age Restriction</u>	<u>PA Requirement</u>
<21	N

**D0180 Comprehensive Periodontal Evaluation**

This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer screening.

**RADIOGRAPHS / DIAGNOSTIC IMAGING**

Radiographs / diagnostic imaging are appropriate only for clinical reasons as determined by a dentist. The films should be of diagnostic quality and properly identified and dated. The results are a part of the patient's clinical record and the original films should be retained by the dentist. Originals should not be used to fulfill requests made by patients or third parties for copies of records.

**Radiographs**

The Medical Assistance Program will allow items in accordance with the provisions of Dental Services policy, with the following limitations:

Intraoral-complete series (D0210) are allowed once every 1460 days (four years).

Panoramic films (D0330) are limited to one every 1460 days (four years).

***Ideally, Intraoral-complete series and Panoramic Radiographs should be performed in alternate years.***

X-rays for routine screening, i.e., Bitewing services - single film (D0270), two films (D0272), and four films (D0274), are allowed once every calendar year, per client. D0274 cannot be performed with D0272 on the same day.

Payment for some or all multiple X-rays of the same tooth or area may be denied if Medical Assistance determines the number to be excessive.

***The total payment for periapical and/or other radiographs cannot exceed the payment for a complete intraoral series.***

D0210 Intraoral-complete series (including bitewings). The number of films required is dependent upon age of patient -in no case are less than eight films required. Adults and children over 12 require 12-20 films, as is appropriate. Limited to one every 1460 days (four years)

X-rays and/or other diagnostic verification are required with the claim when requesting prior authorization for the following procedures:

- Endodontic procedures
- Fixed prosthodontics
- Oral Surgical procedures
- Orthodontic requests
- Periodontal treatment
- Removable prosthodontics

X-rays should be:

- Originals or duplicates
- Mounted
- In envelope, stapled to invoice
- Clearly labeled with dentist's name, address and patients name

D0210	Intraoral - complete series (including bitewings)
D0220	Intraoral - periapical - first film
D0230	Intraoral - periapical - each additional film
D0240	Intraoral - occlusal film
D0250	Extraoral - first film
D0260	Extraoral - each additional film
D0270	Bitewing - single film
D0272	Bitewings - two films
D0274	Bitewings - four films

<u>Age Restriction</u>	<u>PA Requirement</u>
N	N
N	N
N	N
N	N
N	N
N	N
N	N
N	N
N	N

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	<u>Age Restriction</u>	<u>PA Requirement</u>
D0290 Posterior-anterior or lateral skull and facial bone survey film	N	Y
D0310 Sialography	N	Y
D0320 Temporomandibular joint arthrogram, including injection	N	Y
D0321 Other temporomandibular joint films, by report	N	Y
D0322 Tomographic survey	N	Y
D0330 Panoramic film	N	N
D0340 Cephalometric film	<21	Y

**TESTS AND LABORATORY EXAMINATIONS**

The following procedures have no prior authorization or age limitations and will be priced individually based on submission and review of all medical information.

<b>D0502 Other oral pathology procedures, by report</b> Refers to gross and microscopic evaluations of presumptively abnormal tissue(s).	N	N
<b>D0999 Unspecified diagnostic procedure, by report</b> Used for procedures which are adequately described by a code. Describe procedure.	N	N

**DENTAL PROPHYLAXIS**

**PREVENTIVE SERVICES**

*Prophylaxis - Allowed twice every calendar year.*

<b>D1110 Prophylaxis – adult</b> A dental prophylaxis performed on transitional or permanent dentition, which includes scaling and/or polishing procedures to remove coronal plaque, calculus and stains.	>12	N
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<b>D1120 Prophylaxis – child</b> Refers to a routine dental prophylaxis performed on primary or transitional dentition only.	<13	N
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**TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)**

**Topical Fluoride Treatment (Office Procedure)**

Allowed twice every calendar year for recipients less than 21 years of age and for recipients 21 years and older if any of the following medical conditions apply;

***Covered for recipients 21 years of age or older only who also have medical or dental conditions that significantly interrupt the flow of saliva. These conditions may include, but are not limited to, radiation therapy, tumors, certain drug treatments, such as some psychotropic medications and certain diseases and injuries. When used as a preventive measure only, topical fluoride treatment for recipients 21 years or older is not a covered benefit of the Rhode Island Medical Assistance Program.***

Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or “swish”.

<b>D1203 Topical application of fluoride (prophylaxis not included)-child</b> Used when reporting prophylaxis and fluoride procedures separately.	<20	N
<b>D1204 Topical application of fluoride (prophylaxis not included)-adult</b> Used when reporting prophylaxis and fluoride procedures separately.	>20	N

**OTHER PREVENTIVE SERVICES**

**Sealants**

Sealants are covered only for permanent molars for patients less than 21 years of age. One treatment per tooth every five years. When billing for this service, the occlusal surface must be reported on the claim form.colessx3

<b>D1351 Sealant - per tooth</b> Mechanically and/or chemically prepared enamel surface sealed to prevent decay. <ul style="list-style-type: none"> <li>• <b>Payment for sealant is not allowed when an occlusal restoration exists.</b></li> <li>• <b>Payment for a sealant is not allowed on teeth #1, 16, 17, and 32.</b></li> </ul>	<21	N
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**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

**SPACE MAINTENANCE (PASSIVE APPLIANCES)**

**Space Maintenance**

Service is limited to recipients under 21 years of age. Space maintainers (fixed and/or removable) will not be replaced if lost or damaged. Medical Assistance will only pay once for recementation of any space maintainer (D1550). Passive appliances are designed to prevent tooth movement.

	<u>Age Restriction</u>	<u>PA Requirement</u>
D1510 Space maintainer - fixed - unilateral	<21	N
D1515 Space maintainer - fixed - bilateral	<21	N
D1520 Space maintainer - removable - unilateral	<21	N
D1525 Space maintainer - removable - bilateral	<21	N
D1550 Recementation of space maintainer	<21	N

**RESTORATIVE SERVICES**

*\* Local anesthesia is considered part of restorative procedures.*

- A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial.)
- A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.
- A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.
- A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.
- A one-surface anterior proximal restoration is one in which the neither lingual nor facial margins of the restoration extends beyond the line angle.
- A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.
- A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line angle.
- A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal edge is involved.

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

All adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

**Filled or Unfilled Resin Restorations**

*Resin restorations are allowed only on anterior teeth for recipients >20 years old.*

**RESIN-BASED RESTORATIONS - DIRECT**

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330 Resin - one surface, anterior	N	N
D2331 Resin - two surfaces, anterior	N	N

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	<u>Age Restriction</u>	<u>PA Requirement</u>
D2332 Resin - three surfaces, anterior	N	N
D2335 Resin - four or more surfaces or involving incisal angle	N	N

**Restorative Procedures for Recipients Under 21**

The following Restorative procedures are covered by the Medical Assistance Program only for individuals under age 21.

D2390 Resin, anterior-primary Full resin-based composite coverage of tooth.	<21	Y
D2391 Resin-based - one surface, posterior Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	<21	N
D2392 Resin-based - two surfaces, posterior	<21	N
D2393 Resin-based - three surfaces, posterior	<21	N
D2394 Resin-based - four or more surfaces, posterior	<21	N

**INDIVIDUAL CROWNS**

*Please note: This information also refers to the codes on the following page.*

- Payment for crowns for anterior teeth for recipients over age 20 is limited to prefabricated resin crowns. (D2932)
- Payment for crowns for posterior primary teeth is limited to stainless steel crowns. (D2930)
- Payment for crowns for posterior permanent teeth for recipients over age 20 is limited to stainless steel crowns. (D2931)
- Payment for crowns for crowns, (procedure codes D2710 – D2792) is restricted to anterior teeth for recipients under the age of 21.
- Payment for preparation of the gingival tissue and any temporary restorations needed are included in the fee for the final crown.
- Retention pins are limited to two per tooth in addition to restoration during a 365-day period.
- The Medical Assistance Program will only pay once per tooth per calendar year for recementation of inlays and crowns (D2910 & D2920).

**CROWNS - SINGLE RESTORATIONS ONLY**

**Classification of Metals**

The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined based on the percentage of metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 60% (> 40% Au); noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) > 25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

D2710 Crown - resin (indirect)	<21	N
D2720 Crown - resin with high noble metal	<21	N
D2721 Crown - resin with predominantly base metal	<21	N
D2722 Crown - resin with noble metal	<21	N
D2740 Crown - porcelain/ceramic substrate	<21	N
D2750 Crown - porcelain fused to high noble metal	<21	N
D2751 Crown - porcelain fused to predominantly base metal	<21	N
D2752 Crown - porcelain fused to noble metal	<21	N
D2790 Crown - full cast high noble metal	<21	N
D2791 Crown - full cast predominantly base metal	<21	N
D2792 Crown - full cast noble metal	<21	N

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**OTHER RESTORATIVE SERVICES**

	<u>Age Restriction</u>	<u>PA Requirement</u>
D2910 Recement inlay	N	N
D2920 Recement crown	N	N
D2930 Prefabricated stainless steel crown - primary tooth	<21	N
D2931 Prefabricated stainless steel crown – permanent posterior tooth	N	N
D2932 Prefabricated resin crown – permanent anterior	>20	N
D2933 Prefabricated stainless steel crown with resin window	<21	N
Open-face stainless steel crown with aesthetic resin facing or veneer.		
<b>D2940 Sedative filling</b>	N	N
Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.		
<b>D2950 Core buildup, including any pins</b>	N	N
Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.		
<b>D2951 Pin retention - per tooth, in addition to restoration</b>	<21	N
<b>D2952 Cast post and core in addition to crown</b>	<21	N
Cast post and core is separate from crown.		
<b>D2954 Prefabricated post and core in addition to crown</b>	N	N
Core is built around a prefabricated post. This procedure includes the core material.		
<b>D2980 Crown repair, by report</b>	N	Y
Includes removal of crown, if necessary. Describe procedure.		
<b>D2999 Unspecified restorative procedure, by report</b>	N	Y
Use for procedure which is not adequately described by a code. Describe procedure. (Based on Individual Consideration (IC) upon submission and review of all necessary medical information...)		

**ENDODONTICS**

*\* Local anesthesia is considered part of endodontic procedures.*

Includes primary teeth with no permanent successor and permanent teeth.

Complete root canal therapy: Pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

**Pulp Capping**

Direct and indirect pulp caps are included in the restoration fee. No additional payment will be made.

**PULPOTOMY**

Therapeutic pulpotomy, excluding final restoration, are limited to recipients under age 21.

Therapeutic pulpotomy (D3220) is allowed only for calcium hydroxide pulpotomy on permanent teeth with vital exposed pulps, incompletely formed root apices, and formocresol pulpotomy on deciduous teeth.

Recipients are limited to one (1) pulpotomy per deciduous tooth per lifetime.

**D3220 Therapeutic pulpotomy (excluding final restoration)**

Removal of pulp coronal to the dentinocemental junction and application of medicament Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

- To be performed on primary or permanent teeth.
- This is not to be construed as the first stage of root canal therapy.
- **Limited to <21 only**

<21 N

**ENDODONTIC SERVICES (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)**

**Root Canal Therapy**

Separate reimbursement for open and drain or pulpotomy procedures are only allowed when the root canal is not completed. In that circumstance, these procedures will be reimbursed as a palliative treatment (D9110). Root canal therapy is limited to one (1) procedure per tooth, per recipient, per lifetime.

Root canal therapy is limited to permanent teeth, and only if the treatment will lead to a favorable prognosis. The only time that root canal therapy may be performed on primary teeth is: (1) when there is no permanent successor; and (2) on primary second molars prior to eruption of the first permanent molar.

The fee for endodontic procedures is inclusive of all examinations and diagnostics. On patients age 21 and older, anterior root canals will only be paid for (1) if all three anterior teeth are present in the involved arch, or (2) if the involved tooth cannot be added to an existing or proposed partial denture and the tooth will not need a post and core and/or crown to be restored.

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D3310 Anterior (excluding final restoration)</b>	N	N
<b>D3320 Bicuspid (excluding final restoration) - limited to recipients &lt;21</b>	<21	N
<b>D3330 Molar (excluding final restoration) - limited to recipients &lt;21</b>	<21	N

**APEXIFICATION/RECALIFICATION PROCEDURES**

Apexification is limited to a maximum of five treatments on permanent teeth only and is limited to recipients under age 21.

**D3351 Apexification/recalcification - initial visit** <21 N  
 (Apical closure/calific repair of perforations, root resorption, etc.) Includes opening tooth, Pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.)

**D3352 Apexification/recalcification - interim medication replacement** <21 N  
 (Apical closure/calific repair of perforations, root resorption, etc.) for visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.

**D3353 Apexification/recalcification - final visit** <21 N  
 (Includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.) Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)

**APICOECTOMY/PERIRADICULAR SERVICES**

Periradicular surgery is a term used to describe surgery to the root surface, (e.g., Apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement. For surgery on root of anterior tooth. Does not include placement of retrograde filling material.

**D3421 Apicoectomy/Periradicular surgery- bicuspid (first root)** <21 Y  
 For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is Treated, see D3426.

**D3425 Apicoectomy/Periradicular surgery - molar (first root)** <21 Y  
 For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

**D3426 Apicoectomy/Periradicular surgery (each additional root)** <21 Y  
 Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

**D3430 Retrograde filling - per root** <21 Y  
 For placement of retrograde filling material during Periradicular surgery procedures. If more than one filling placed in one root-report as D3999 and describe.

**D3450 Root amputation - per root** <21 Y  
 Root resection of a multirouted tooth while leaving the crown. If the crown is sectioned, see D3920.

**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

**OTHER ENDODONTIC PROCEDURES**

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D3920 Hemisection (including any root removal), not including root canal therapy</b>	<b>&lt;21</b>	<b>N</b>
Includes separation of a multirrooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.		
<b>D3999 Unspecified endodontic procedure, by report</b>	<b>N</b>	<b>Y</b>
Used for procedure that is not adequately described by a code. Describe procedure.		

**PERIODONTAL SERVICES**

**SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)**

Periodontal scaling and root planing (D4341) is allowed once every two years. Periodontal charting and X-rays are required. Pockets must be 4mm or greater for approval and are restricted to recipients under age 21.

Records must document the clinical indications for periodontal scaling and root planing and for gingival curettage. Periodontal maintenance procedures (D4910) are allowed once every six months after D4341 and will not be paid during the 6-month period immediately after D4341

Gingival Flap (D4240) and Osseous surgery (D4260) are allowed once every three years unless there is a documented medical indication.

Cavitron scaling/gross scaling does not qualify for a separate reimbursable fee; the fee is included as part of the global periodontal procedures.

Gingivectomy or Gingivoplasty is not covered for those recipients 21 years of age or older except in cases of medically induced gingival hyperplasia, e.g., dilantin hyperplasia.

<b>D4210 Gingivectomy or Gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant</b>	<b>N</b>	<b>N</b>
Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. Performed in shallow to moderate suprabony pockets after adequate initial preparation, for suprabony pockets, which need access for restorative density, when moderate gingival enlargements or aberrations are present, and when there is asymmetrical or unesthetic gingival topography.		
<b>D4211 Gingivectomy or Gingivoplasty – one to three teeth, per quadrant</b>	<b>N</b>	<b>N</b>
See D4210 descriptor.		
<b>D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant</b>	<b>&lt;21</b>	<b>N</b>
Involves surgical debridement of the root surface and the removal of granulation tissue following the resection or reflection of soft tissue flap. Osseous recontouring is not accomplished in conjunction with the procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of probing attachment, need to maintain esthetics, and need for increased access to the root surface and alveolar bone.		
<b>D4241 Gingival flap procedure, including root planing - one to three teeth, per quadrant</b>	<b>&lt;21</b>	<b>N</b>
See D4240 descriptor.		
<b>D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant</b>	<b>&lt;21</b>	<b>N</b>
This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) or non-supporting bone. Other separate procedures including, but not limited to, D3450, D3920, D4263, D4264, D4266, D4267, and D7140 may be required concurrent to D4260.		
<b>D4261 Osseous surgery (including flap entry and closure)-one to three teeth, per quadrant</b>	<b>&lt;21</b>	<b>N</b>
See D4260 descriptor.		

**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

Age Restriction    PA Requirement

**D4263 Bone replacement graft - first site in quadrant**

<21            N

Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. The procedure does not include flap entry and closure and is reported in addition to a procedure that includes flap entry and closure, including, but not limited to D4240, D4260.

**D4264 Bone replacement graft - each additional site in quadrant**

<21            N

Involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. This code is used if performed concurrently with D4263 - bone replacement graft - first site, per quadrant and allows reporting of the exact number of sites involved.

**D4266 Guided tissue regeneration - resorbable barrier, per site,**

<21            N

A membrane is placed over the roof surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.

**D4267 Guided tissue regeneration - nonresorbable barrier, per site, per tooth (includes membrane removal)**

<21            N

Used to regenerate lost or injured periodontal tissue by directing differential tissue responses. A membrane is placed over the roof surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. The procedure requires subsequent surgical procedures to remove the membranes and/or to correct the gingival contours. Guided tissue regeneration may be used in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately.

**D4270 Pedicle soft tissue graft procedure**

<21            N

A pedicle flap of gingival tissue can be raised from an edentulous ridge, adjacent teeth, or from the existing gingival tissue on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a gingival defect if the root is not too prominent in the arch.

**D4271 Free soft tissue graft procedure (including donor site surgery)**

<21            N

Gingival or masticatory mucosa is grafted to create or augment the gingival tissue at another site, with or without root coverage. This graft may also be used to eliminate the pull of frena and muscle attachments, to extend the vestibular fornix, and to correct localized gingival recession.

**D4273 Subepithelial connective tissue graft procedures**

<21            N

This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull, to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingival and/or mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure. After the graft is placed on the recipient site, it is covered with the retained overlying flap.

**D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)**

<21            N

Performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.

**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

**ADJUNCTIVE PERIODONTAL SERVICE**

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D4320 Provisional splinting – intracoronal</b>	<b>&lt;21</b>	<b>N</b>
An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose.		
<b>D4321 Provisional splinting – extracoronal</b>	<b>&lt;21</b>	<b>N</b>
An interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose. Identify the teeth involved and the nature of the splint, by report.		
<b>D4341 Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant</b>	<b>&lt;21</b>	<b>N</b>
This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.		
<b>D4342 Periodontal scaling and root planing – one to three teeth, per quadrant</b>	<b>&lt;21</b>	<b>N</b>
See 4341 descriptor.		
<b>D4355 Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis</b>	<b>&lt;21</b>	<b>N</b>
The removal of subgingival and/or supragingival plaque and calculus. This procedure does not preclude the need for additional procedures.		
<b>D4381 Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report</b>	<b>&lt;21</b>	<b>N</b>
Synthetic fibers or other approved delivery devices containing controlled-release chemotherapeutic agent(s) are inserted into a periodontal pocket. Short-term use of the timed-release therapeutic agent as supplemental or adjunctive therapy provides for reduction of subgingival flora.		

This procedure does not replace conventional or surgical therapy required for debridement, resective procedures or for regenerative therapy.

The use of controlled-release chemotherapeutic agents is an adjunctive procedure for specific sites that are unresponsive to conventional therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy.

**OTHER PERIODONTAL SERVICES**

<b>D4910 Periodontal maintenance</b>	<b>&lt;21</b>	<b>N</b>
For patients who have previously been treated for periodontal disease. Typically, maintenance starts after completion of active (surgical or nonsurgical) periodontal therapy and continues at varying intervals, determined by the clinical diagnosis of the dentist, for the life of the dentition. It includes removal of the supra and subgingival microbial flora and calculus, site specific scaling and root planing where indicated, and/or polishing the teeth. When new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.		
<b>D4999 Unspecified periodontal procedure, by report</b>	<b>N</b>	<b>Y</b>
Used for a procedure that is not adequately described by a code. Describe procedure and submit appropriate medical documentation.		

**Rhode Island Department of Human Services Medical Assistance Program Dental Services  
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)**

**Removable Prosthodontics**

- Removable prosthodontics is limited to the replacement of permanent teeth. X-rays are required.
- Recipients are allowed one (1) set of partial and/or complete dentures during an 1825-day (5-year) period from any provider.
- Adjustments to dentures during the 183-day (6-month) period following delivery of dentures to recipients are included in the fee. Adjustments are allowed once per year thereafter.
- After the initial 183-day (6-month) period from delivery, a reline is allowed once per year as deemed medically necessary.
- A rebase will be covered 730 days (2 years) from the date of delivery of the dentures and then once every 2 years as deemed medically necessary.
- Dentures will not be replaced if lost or damaged for a period of 5 years from the time the dentures were first fabricated.
- Interim partial dentures (D5820 & D5821) will only be considered to replace a missing permanent anterior tooth in a patient under 21 years of age. These procedures require a Prior Authorization.

\* *Local anesthesia is considered part of removable Prosthodontic procedures.*

	<u>Age Restriction</u>	<u>PA Requirement</u>
D5110 Complete denture - maxillary	N	N
D5120 Complete denture - mandibular	N	N

**PARTIAL DENTURE (INCLUDING ROUTINE POST-DELIVERY CARE)**

D5211 Maxillary partial denture - resin base - (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with resin or wrought wire clasps.	N	N
D5212 Mandibular partial denture - resin base - (including any conventional clasps, rests and teeth) Includes acrylic resin base denture with acrylic resin clasps.	N	N
D5213 Maxillary partial denture - case metal framework with resin - denture bases (including any conventional clasps, rests and teeth)	<21	N
D5214 Mandibular partial denture - case metal framework with resin - denture bases (including any conventional clasps, rests and teeth)	<21	N
D5410 Adjust complete denture - maxillary	N	N
D5411 Adjust complete denture - mandibular	N	N
D5421 Adjust partial denture - maxillary	N	N
D5422 Adjust partial denture - mandibular	N	N

**REPAIRS TO COMPLETE DENTURES**

D5510 Repair broken complete denture base	N	N
D5520 Replace missing or broken teeth - complete denture (each tooth)	N	N

**REPAIRS TO PARTIAL DENTURES**

D5610 Repair resin denture base	N	N
D5620 Repair cast framework	N	N
D5630 Repair or replace broken clasp	N	N

Rhode Island Department of Human Services Medical Assistance Program Dental Services

	<u>Age Restriction</u>	<u>PA Requirement</u>
D5640 Replace broken teeth - per tooth	N	N
D5650 Add tooth to existing partial denture	N	N
D5660 Add clasp to existing partial denture	N	N

**DENTURE REBASE PROCEDURES**

Rebase - process of refitting a denture by replacing the base material.

D5710 Rebase complete maxillary denture	N	Y
D5711 Rebase complete mandibular denture	N	Y
D5720 Rebase maxillary partial denture	N	Y
D5721 Rebase mandibular partial denture	N	Y

**DENTURE RELINE PROCEDURES**

Reline - process of resurfacing the tissue side of a denture with new base material.

D5740 Reline maxillary partial denture (chair side)	N	N
D5741 Reline mandibular partial denture (chair side)	N	N
D5750 Reline complete maxillary denture (laboratory)	N	N
D5751 Reline complete mandibular denture (laboratory)	N	N
D5760 Reline maxillary partial denture (laboratory)	N	N
D5761 Reline mandibular partial denture (laboratory)	N	N

**OTHER REMOVABLE PROSTHETIC SERVICES**

A provisional prosthesis designed for use over a limited period, after which it is to be replaced by a more definitive restoration.

D5810 Interim complete denture (maxillary)	<21	Y
D5811 Interim complete denture (mandibular)	<21	Y
D5820 Interim partial denture (maxillary) Includes any necessary clasps and rests.	<21	Y
D5821 Interim partial denture (mandibular) Includes any necessary clasps and rests.	<21	Y
D5860 Overdenture - complete, by report	N	Y

Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.

D5861 Overdenture - partial, by report	N	Y
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Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.

D5862 Precision attachment, by report	<21	Y
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Each set of male and female components should be reported as one precision attachment. Describe the type of attachment used.

D5899 Unspecified removable prosthodontic procedure, by report	N	Y
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Use for a procedure which is not adequately described by a code. Describe procedure.

**MAXILLOFACIAL PROSTHETICS**

**Maxillofacial Prosthetics**

All series CDT D59 - - procedures will be covered by Individual Consideration (IC). Maxillofacial prosthetics services are limited to when medically necessary to correct a handicapping condition.

D5911 Facial moulage (sectional)	N	N
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A sectional facial moulage impression is a procedure used to record the soft tissue contours of a portion of the face. Occasionally several separate sectional impressions are made, and then reassembled to provide a full facial contour cast. The impression is utilized to create a partial facial moulage and generally is not reusable.

D5912 Facial moulage (complete)	N	N
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Synonymous terminology: facial impression, face mask impression. A complete facial moulage impression is a procedure used to record the soft tissue contours of the whole face. The impression is utilized to create a facial moulage and generally is not reusable.

**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

Age Restriction    PA Requirement

**D5913 Nasal prosthesis**

N                    N

Synonymous terminology: artificial nose. A removable prosthesis attached to the skin, which artificially restores part or the entire nose. Fabrication of a nasal prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods. When a new prosthesis is made from the existing mold, this procedure is termed a nasal prosthesis replacement.

**D5914 Auricular prosthesis**

N                    N

Synonymous terminology: artificial ear, ear prosthesis. A removable prosthesis, which artificially restores part or the entire natural ear. Usually, replacement prostheses can be made from the original mold if tissue bed changes have not occurred. Creation of an auricular prosthesis requires fabrication of a mold, from which additional prostheses usually can be made, as needed later (auricular prosthesis, replacement).

**D5915 Orbital prosthesis**

N                    N

A prosthesis which artificially restores the eye, eyelids, and adjacent hard and soft tissue lost because of trauma or surgery.

Fabrication of an orbital prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods. When a new prosthesis is made from the existing mold, this procedure is termed an orbital prosthesis replacement.

**D5916 Ocular prosthesis**

N                    N

Synonymous terminology: artificial eye, glass eye. A prosthesis, which artificially replaces an eye missing because of trauma, surgery or congenital absence. The prosthesis does not replace missing eyelids or adjacent skin, mucosa or muscle.

Ocular prostheses require semi-annual or annual cleaning and polishing. In addition, occasional revisions to re-adapt the prosthesis to the tissue bed may be necessary. Glass eyes are rarely made and cannot be re-adapted.

**D5919 Facial prosthesis**

N                    N

Synonymous terminology: prosthetic dressing. A removable prosthesis, which artificially replaces a portion of the face, lost due to surgery, trauma or congenital absence.

Flexion of natural tissues may preclude adaptation and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.

**D5922 Nasal septal prosthesis**

<21                Y

Synonymous terminology: Septal plug, septal button. A removable prosthesis, which artificially replaces a portion of the face, lost due to surgery, trauma or congenital absence.

Flexion of natural tissues may preclude adaptation and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.

**D5923 Ocular prosthesis, interim**

<21                Y

Synonymous terminology: eye shell, shell, ocular conformer. A temporary replacement generally made of clear acrylic resin for an eye lost due to surgery or trauma. No attempt is made to re-establish esthetics. Fabrication of an interim ocular prosthesis generally implies subsequent fabrication of an esthetic ocular prosthesis.

**D5924 Cranial prosthesis**

<21                Y

Synonymous terminology: Skull plate, cranioplasty prosthesis, cranial impact. A biocompatible, permanently implanted replacement of a portion of the skull bones; an artificial replacement for a portion of the skull bone.

**D5925 Facial augmentation implant prosthesis**

<21                Y

Synonymous terminology: facial implant. An implantable biocompatible material generally onlayed upon an existing bony area beneath the skin tissue to fill in or collectively raise portions of the overlying facial skin tissues to create acceptable contours.

Although some forms of remade surgical implants are commercially available, the facial augmentation is usually custom made for surgical implantation for each individual patient due to the irregular or extensive nature of the facial deficit.

Age Restriction    PA Requirement

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**D5926 Nasal prosthesis, replacement** <21 Y  
 Synonymous terminology; replacement nose. An artificial nose produced from a previously made mold. Replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.

**D5927 Auricular prosthesis, replacement** <21 Y  
 Synonymous terminology; replacement ear. An artificial ear produced from a previously made mold. Replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age-related topographical variations.

**D5928 Orbital prosthesis, replacement** <21 Y  
 A replacement for a previously made orbital prosthesis. Replacement prostheses do not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age-related topographical variations.

**D5929 Facial prosthesis, replacement** <21 Y  
 A replacement facial prosthesis made from the original mold. Replacement prostheses do not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age-related topographical variations.

**D5931 Obturator prosthesis, surgical** N N  
 Synonymous terminology; obturator, surgical stayplate, immediate temporary obturator. A temporary prosthesis inserted during or immediately following surgical or traumatic loss of a portion or all of one or both maxillary bones and contiguous alveolar structures (e.g., gingival tissue, teeth).

Frequent revisions of surgical obturators are necessary during the ensuing healing phase (approximately six months). Some dentists prefer to replace many or all teeth removed by the surgical procedure in the surgical obturator, while others do not replace any teeth. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathologic report indicates margins are not free of tumor).

**D5932 Obturator prosthesis, definitive** N N  
 Synonymous terminology; obturator. A prosthesis, which artificially replaces part or all of the maxilla and associated teeth, lost due to surgery, trauma or congenital defects.

A definitive obturator is made when it is deemed that further tissue changes or recurrence of tumor are unlikely and a more permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.

**D5933 Obturator prosthesis, modification** N N  
 Synonymous terminology: adjustment, denture adjustment, temporary or office reline. Revision or alteration of an existing obturator (surgical, interim, or definitive); possible modifications include relief of the denture base due to tissue compression, augmentation of the seal or peripheral areas to affect adequate sealing or separation between the nasal and oral cavities.

**D5934 Mandibular resection prosthesis with guide flange** N N  
 Synonymous terminology: resection device, resection appliance...A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact. It may also artificially replace missing teeth and thereby increase masticatory efficiency.

**D5935 Mandibular resection prosthesis without guide flange** N N  
 A prosthesis, which helps guide the partially rejected mandible to a more normal relation with the maxilla allowing for increased tooth contact. It does not have a flange or ramp, however, to assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency.

Dentists who treat mandibulectomy patients may prefer to replace some, all or none of the teeth in the defect area. Frequently, the defect's margins preclude even partial replacement. Use of a guide (mandibular resection prosthesis with a guide flange) may not be possible due to anatomical limitations or poor patient tolerance.

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<u>Age Restriction</u>	<u>PA Requirement</u>
<21	Y

**D5936 Obturator prosthesis, interim**

Synonymous terminology; immediate postoperative obturator. A prosthesis which is made following completion of the initial healing after a surgical resection of a portion or all of the maxilla; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator, which is usually inserted at, or immediately following the resection.

Generally, an interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis, which may replace some, or all lost teeth and other lost bone and soft tissue structures. In addition, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g. restorations, gingival surgery, etc.) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.

N	Y
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**D5937 Trismus appliance (not for TMD treatment)**

Synonymous terminology: occlusal device for mandibular trismus, dynamic bite opener. A prosthesis, which assists the patient in increasing their oral aperture width in order to eat as well as maintain oral hygiene.

Several versions and designs are possible, all intending to ease the severe lack of oral opening experienced by many patients immediately following extensive intraoral surgical procedures.

**D5951 Feeding aid**

Synonymous terminology: feeding prosthesis. A prosthesis which maintains the right and left maxillary segments of an infant cleft palate patient in their proper orientation until surgery is performed to repair the cleft. It closes the oral-nasal cavity defect, thus enhancing sucking and swallowing.

Used on an interim basis, this prosthesis achieves separation of the oral and nasal cavities in infants born with wide clefts necessitating delayed closure. It is eliminated if surgical closure can be affected or, alternatively, with eruption of the deciduous dentition, a pediatric speech aid may be made to facilitate closure of the defect.

<21	N
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**D5952 Speech aid prosthesis, pediatric**

Synonymous terminology: nasopharyngeal obturator, speech appliance, obturator, cleft palate appliance, prosthetic speech aid, speech bulb. A temporary or interim prosthesis used to close a defect in the hard and/or soft palate. It may replace tissue lost due to developmental or surgical alterations. It is necessary for the production of intelligible speech.

Normal lateral growth of the palatal bones necessitates replacement of this prosthesis occasionally. Intermittent revisions of the obturator section can assist in maintenance of palatalpharyngeal closure (termed a speech aid prosthesis modification). Frequently, such prostheses are not fabricated before the deciduous dentition is fully erupted since clasp retention is often essential.

<21	N
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**D5953 Speech aid prosthesis, adult**

Synonymous terminology: prosthetic speech appliance, speech aid, speech bulb. A definitive prosthesis which can improve speech in adult cleft palate patients either by obturating (sealing off) a palatal cleft or fistula, or occasionally by assisting an incompetent soft palate. Both mechanisms are necessary to achieve velopharyngeal competency.

Generally, this prosthesis is fabricated when no further growth is anticipated and the objective is to achieve long-term use. Hence, more precise materials and techniques are utilized. Occasionally such procedures are accomplished in conjunction with precision attachments in crown work undertaken on some or all maxillary teeth to achieve improved esthetics.

N	N
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**D5954 Palatal augmentation prosthesis**

Synonymous terminology: superimposed prosthesis, maxillary glossectomy prosthesis, maxillary speech prosthesis, palatal drop prosthesis. A removable prosthesis, which alters the hard and/or soft palate's topographical form adjacent to the tongue.

N	N
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**D5955 Palatal lift prosthesis, definitive**

A prosthesis which elevates the soft palate superiorly and aids in restoration of soft palate functions which may be lost due to an acquired, congenital or developmental defect.

N	N
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A definitive palatal lift is usually made for patients whose experience with an interim palatal lift has been successful, especially if surgical alterations are deemed unwarranted.

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Age Restriction    PA Requirement  
 <21                      Y

**D5958 Palatal life prosthesis, interim**

Synonymous terminology: diagnostic palatal lift. A prosthesis which elevates and assists in restoring soft palate function which may be lost due to clefting, surgery, trauma or unknown paralysis. It is intended for interim use to determine its usefulness in achieving palatalpharyngeal competency or enhance swallowing reflexes.

This prosthesis is intended for interim use as a diagnostic aid to assess the level of possible improvement in speech intelligibility. Some clinicians believe use of a palatal lift on an interim basis may stimulate an otherwise flaccid soft palate to increase functional activity, subsequently lessening its need.

**D5959 Palatal lift prosthesis, modification**

<21                      Y

Synonymous terminology: revision of lift, adjustment. Alterations in the adaptation, contour, form or function of an existing palatal lift necessitated due to tissue impingement, lack of function, poor clasp adaptation or the like.

**D5960 Speech aid prosthesis, modification**

N                              Y

Synonymous terminology: adjustment, repair, revision. Any revision of a pediatric or adult speech aid not necessitating its replacement.

Frequently, revisions of the obturating section of any speech aid are required to facilitate enhanced speech intelligibility. Such revisions or repairs do not require complete remaking of the prosthesis, thus extending its longevity.

**D5982 Surgical Stent**

<21                      Y

Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissues to facilitate healing and prevent cicatrization or collapse; a surgical stent may be required in surgical and post-surgical revisions to achieve close approximation of tissues. Usually such materials as temporary or interim soft denture liners, gutta percha, or dental modeling impression compound may be used.

**D5983 Radiation carrier**

N                              N

Synonymous terminology: radiotherapy prosthesis, carrier prosthesis, radiation applicator, radium carrier, intracavity carrier, intracavity applicator. A device used to administer radiation to confined areas by means of capsules, beads or needles of radiation emitting materials such as radium or cesium. Its function is to hold the radiation source securely in the same location during the entire period of treatment.

Radiation oncologists occasionally request these devices to achieve close approximation and controlled application of radiation to a tumor deemed amiable to eradication.

**D5984 Radiation shield**

N                              N

Synonymous terminology: radiation stent, tongue protector, lead shield. An intraoral prosthesis designed to shield adjacent tissues from radiation during radiation treatment of malignant lesions of the head and neck region.

**D5985 Radiation cone locator**

N                              N

Synonymous terminology: docking device, cone locator. The prosthesis utilized to direct and reduplicate the path of radiation to an oral tumor during a split course of irradiation.

**D5986 Fluoride gel carrier**

N                              N

Synonymous terminology: fluoride applicator. A prosthesis which covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.

**D5987 Commissure splint**

<21                      Y

Synonymous terminology: lip splint. A device placed between the lips which assist in achieving increased opening between the lips. Use of such devices enhances opening where surgical, chemical or electrical alterations of the lips have resulted in severe restriction or contractures.

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<u>Age Restriction</u>	<u>PA Requirement</u>
<21	Y

**D5988 Surgical splint**

Synonymous terminology: Gunning splint, modified Gunning splint, labiolingual splint, fenestrated splint, Kingsley splint, cast metal splint. Splints are designed to utilize existing teeth and/or alveolar processes as points of anchorage to assist in stabilization and immobilization of broken bones during healing. They are used to re-establish, as much as possible, normal occlusal relationships, during the process of immobilization. Frequently, existing prostheses (e.g., a patient's complete dentures) can be modified to serve as surgical splints. Frequently, surgical splints have arch bars added to facilitate intermaxillary fixation. Rubber elastics may be used to assist in this process. Circummandibular eyelet hooks can be utilized for enhanced stabilization with wiring to adjacent bone.

**D5999 Unspecified maxillofacial prosthesis, by report**

Used for procedure that is not adequately described by a code. Describe procedure and submit appropriate documentation.

N	Y
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**IMPLANT SERVICES**

Implants are not a covered service.

**FIXED PROSTHODONTICS**

*\* Local anesthesia is considered part of Fixed Prosthodontic procedures.*

- Permanent bridges will be allowed for anterior permanent teeth only. *Recipients must be less than 21 years of age.*
- Permanent bridges will be allowed for a maximum of four (4) units. If greater than four units, a partial denture should be billed.
- If anterior and posterior teeth are missing, a partial denture should be provided and billed.

Prosthodontics, fixed - each abutment and each pontic constitutes a unit in a fixed partial denture.

The words "bridge" and "bridgework" have been replaced by the statement "fixed partial denture" throughout this section.

**Classification of Metals** - The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined based on the percentage of noble metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) >60% (with at least 40% Au); noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) >25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

**FIXED PARTIAL DENTURE PONTICS**

D6210 Pontic - cast high noble metal	<21	N
D6211 Pontic - cast predominantly base metal	<21	N
D6212 Pontic - cast noble metal	<21	N
D6240 Pontic - porcelain fused to high noble metal	<21	N
D6241 Pontic - porcelain fused to predominantly base metal	<21	N
D6242 Pontic -porcelain fused to noble metal	<21	N
D6250 Pontic - resin with high noble metal	<21	N
D6251 Pontic - resin with predominantly base metal	<21	N
D6252 Pontic - resin with noble metal	<21	N

**FIXED PARTIAL DENTURE RETAINERS - CROWNS**

D6720 Crown - resin with high noble metal	<21	N
D6721 Crown - resin with predominantly base metal	<21	N
D6722 Crown - resin with noble metal	<21	N
D6750 Crown - porcelain fused to high noble metal	<21	N
D6751 Crown - porcelain fused to predominantly base metal	<21	N
D6752 Crown - porcelain fused to noble metal	<21	N
D6780 Crown - 3/4 cast high noble metal	<21	N
D6790 Crown - full cast high noble metal	<21	N
D6791 Crown - full cast predominantly base metal	<21	N
D6792 Crown - full cast noble metal	<21	N

**OTHER FIXED PARTIAL DENTURE SERVICES**

D6999 Unspecified, fixed prosthodontic procedure, by report	N	Y
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**ORAL SURGERY SERVICES**

- Tooth replantation (D7270) is allowed only in cases of traumatic avulsion of a permanent anterior tooth where there are good indications of success.
- **A biopsy (D7285 & D7286) will only be allowed with verification of the presence of inflammation, interference with dental function, or suspicion of a malignancy.**
- **Skin grafts (D7920) are not allowed in conjunction with a vestibuloplasty.**
- **For recipients 21 years of age and older, procedures D7950 and D7955 are only allowed for reconstruction secondary to tumor surgery.**
- **For recipients 21 years of age and older, excision of hyperplastic tissue (D7970) is only allowed when the condition was caused by denture irritation.**
- **The fee for all oral surgical procedures is inclusive of all examinations and diagnostics, with the following exceptions:**
  1. One panoramic film will be allowed for patients presenting with bilateral problems and no panoramic film is available.
  2. One panoramic film will be allowed if the patient is presenting with bilateral impacted third molars.
  3. One panoramic film will be allowed if the radiographs from the referring dentist are not of diagnostic quality. A copy of the film must be sent to the primary care dentist.
  4. One panoramic film will be allowed if the patient is a self-referral with no primary care dentist.

**\*\* Extractions are limited to once per tooth per recipient's lifetime.**

Oral surgical procedures that can be provided by dental surgeons within the scope of their licensure will be considered on a PA basis for individuals under age 21. Payment will be made in accordance with the Medical Assistance Surgical Fee Schedule.

Allowance for surgical assistance is restricted to services by dentists and physicians. Surgical assistance will be allowed only when the assistant's services qualify as a dental or medical necessity. Only one surgical assistant will be allowed. Primary surgeons, assistant surgeons, and anesthesiologists must bill separately for their services. Oral surgical assistance will be allowed in the same manner as physician surgical assistance.

**EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)**

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D7111 Coronal remnants – primary teeth - Includes soft tissue-retained coronal Remnants</b>	N	N
<b>D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal) Includes routine removal of tooth structure and closure, as necessary</b>	N	N

**SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)**

<b>D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</b> Includes cutting of gingiva and bone, removal of tooth structure, and closure.	N	N
<b>D7220 Removal of impacted tooth - soft tissue</b> Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.	N	N
<b>D7230 Removal of impacted tooth - partially bony</b> Part of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	N	N

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	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D7240 Removal of impacted tooth - completely bony</b> Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal.	N	N
<b>D7241 Removal of impacted tooth - completely bony, with unusual surgical complications</b> Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.	N	N
<b>D7250 Surgical removal of residual tooth roots (cutting procedure)</b> Includes cutting of gingiva and bone, removal of tooth structure, and closure.	N	N
<b>OTHER SURGICAL PROCEDURES</b>		
<b>D7260 Oroantral fistula closure</b> Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.	N	N
<b>D7270 Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus</b> - Includes splinting and/or stabilization.	<21	N
<b>D7280 Surgical exposure of unerupted tooth</b> An incision is made and the tissue is reflected and bone removed as necessary to expose the crown. This procedure may include but is not limited to situations whereby an attachment is placed to facilitate eruption.	<21	N
<b>D7285 Biopsy of oral tissue - hard (bone, tooth)</b> For surgical removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular curettage.	N	N
<b>D7286 Biopsy of oral tissue - soft (all others)</b> For surgical removal of specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage. For surgical oral pathology procedures, See D0502.	N	N
<b>ALVEOLOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES</b>		
<b>D7320 Alveoloplasty not in conjunction with extractions - per quadrant</b> No extractions performed in an edentulous area.	N	N
<b>VESTIBULOPLASTY</b>		
<b>D7340 Vestibuloplasty - ridge extension (secondary epithelialization)</b>	N	Y
<b>D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic issue).</b>	N	Y
<b>SURGICAL EXCISION OF SOFT TISSUE LESIONS</b>		
<b>D7410 Excision of benign lesion diameter up to 1.25 cm</b>	N	N
<b>D7411 Excision of benign lesion diameter greater than 1.25 cm</b>	N	N
<b>SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS</b>		
<b>D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm</b>	N	N
<b>D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm</b>	N	N
<b>D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm</b>	N	N
<b>D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm</b>	N	N
<b>D7460 Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm</b>	N	N
<b>D7461 Removal of nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm</b>	N	N

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**EXCISION OF BONE TISSUE**

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D7471 Removal of lateral exostosis --(maxilla or mandible)</b>	N	N
<b>D7490 Radical resection of mandible with bone graft</b>	N	N
Partial resection of mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.		

**SURGICAL INCISION**

<b>D7510 Incision and drainage of abscess - intraoral soft tissue</b>	N	N
Involves incision through mucosa, including periodontal origins.		
<b>D7520 Incision and drainage of abscess - extraoral soft tissue</b>	N	N
Involves incision through skin.		
<b>D7530 Removal of foreign body from mucosa , skin, or subcutaneous alveolar tissue</b>	N	N
<b>D7540 Removal of reaction-producing foreign bodies-musculoskeletal system</b>	N	N
May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone		
<b>D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone</b>	N	N
Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.		
<b>D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body</b>	N	N

**TREATMENT OF FRACTURES – SIMPLE**

<b>D7610 Maxilla - open reduction (teeth immobilized, if present)</b>	N	N
Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.		
<b>D7620 Maxilla - closed reduction (teeth immobilized, if present)</b>	N	N
No incision required to reduce fracture. See D7610 if interosseous fixation is applied.		
<b>D7630 Mandible - open reduction (teeth immobilized, if present)</b>	N	N
Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required to reduce fracture.		
<b>D7640 Mandible - closed reduction (teeth immobilized, if present)</b>	N	N
No incision required to reduce fracture. See D7630 if interosseous fixation is applied.		
<b>D7650 Malar and/or zygomatic arch - open reduction</b>	N	N
<b>D7660 Malar and/or zygomatic arch - closed reduction</b>	N	N
<b>D7670 Alveolus –closed reduction, may include stabilization of teeth</b>	N	N
Teeth may be wired, banded or splinted together to prevent movement.		
<b>D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches</b>	N	N
Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.		

**TREATMENT OF FRACTURES - COMPOUND**

<b>D7710 Maxilla - open reduction-Surgical incision required to reduce fracture</b>	N	N
<b>D7720 Maxilla - closed</b>	N	N
<b>D7730 Mandible - open reduction-Surgical incision required to reduce fracture</b>	N	N
<b>D7740 Mandible - closed reduction</b>	N	N
<b>D7750 Malar and/or zygomatic arch - open reduction-Surgical incision required to reduce fracture</b>	N	N
<b>D7760 Malar and/or zygomatic arch - closed reduction</b>	N	N
<b>D7770 Alveolus - open reduction stabilization of teeth</b>	N	N
Fractured bone(s) are exposed to mouth or outside the face; see D7670. Surgical incision required to reduce fracture		

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	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D7780 Facial bones - complicated reduction with fixation and multiple surgical approaches</b> Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose, and ears.	N	Y
<b>REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS</b> Procedures which are an integral part of a primary procedure should not be reported separately.		
<b>D7810 Open reduction of dislocation - Access to TMJ via surgical opening.</b>	N	N
<b>D7820 Closed reduction of dislocation - Joint manipulated into place; no surgical exposure</b>	N	N
<b>D7830 Manipulation under anesthesia</b> Usually done via general anesthesia or intravenous sedation.	N	N
<b>D7840 Condylectomy</b> Surgical removal of all or portion of the mandibular condyle (separate procedure).	<21	N
<b>D7850 Surgical discectomy, with/without implant - Excision of the intra-articular disc of a joint</b>	<21	N
<b>D7852 Disc repair</b> Repositioning and/or sculpting of disc; repair of perforated posterior attachment	<21	N
<b>D7854 Synovectomy - Excision of a portion or all of the synovial membrane of a joint</b>	<21	N
<b>D7856 Myotomy - Cutting of muscle for therapeutic purposes (separate procedure).</b>	<21	N
<b>D7858 Joint reconstruction</b> Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.	<21	N
<b>D7860 Arthrotomy - Cutting into joint (separate procedure).</b>	<21	N
<b>D7865 Arthroplasty</b> Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).	<21	N
<b>D7870 Arthrocentesis - Withdrawal of fluid from a joint space by aspiration.</b>	<21	N
<b>D7872 Arthroscopy - diagnosis, with or without biopsy</b>	<21	N
<b>D7873 Arthroscopy – surgical: lavage and lysis of adhesions</b> Removal of adhesions using the arthroscope and lavage of the joint cavities.	<21	N
<b>D7874 Arthroscopy – surgical: disc repositioning and stabilization</b> Repositioning and stabilization of disc using arthroscopic techniques.	<21	N
<b>D7875 Arthroscopy – surgical: synovectomy</b> Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.	<21	N
<b>D7876 Arthroscopy – surgical: discectomy</b> Removal of disc and remodeled posterior attachment via the arthroscope.	<21	N
<b>D7877 Arthroscopy – surgical: debridement</b> Removal of pathologic hard and/or soft tissue using the arthroscope.	<21	N
<b>D7880 Occlusal orthotic device, by report</b> Presently includes splints provided for treatment of temporomandibular joint dysfunction	<21	N
<b>D7899 Unspecified TMD therapy, by report</b> Used for procedure that is not adequately described by a code. Describe procedure:	<21	N

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REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions

D7910 Suture of recent small wounds up to 5 cm

Age Restriction	PA Requirement
N	N

**COMPLICATED SUTURING** (*reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure*)

Excludes closure of surgical incisions

D7911 Complicated suture - up to 5 cm

N	N
N	N

D7912 Complicated suture - greater than 5 cm

OTHER REPAIR PROCEDURES

D7920 Skin graft (identify defect covered, location and type of graft)

N	N
<21	N

D7940 Osteoplasty - for orthognathic deformities

Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.

D7941 Osteotomy –mandibular rami

<21	N
<21	N

D7943 Osteotomy – mandibular rami with bone graft; includes obtaining the graft

D7944 Osteotomy - segmented or subapical - per sextant or quadrant

<21	N
<21	N

D7945 Osteotomy - body of mandible

Surgical section of the lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care

Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.

D7947 LeFort I (maxilla - segmented)

<21	N
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When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be "by report."

D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) -without bone graft

<21	N
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Surgical section of upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation; routine wound closure and normal post-operative follow-up care.

D7949 LeFort II or LeFort III - with bone graft-Includes obtaining autografts.

<21	N
N	N

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones – autogenous or nonautogenous, by report

Includes obtaining autograft and/or allograft material and ridge augmentation/sinus lift procedure.

D7955 Repair of maxillofacial soft and hard tissue defect

N	N
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Various soft tissue-grafting procedures may be used alone or in combination with autograft, allograft, or alloplastic materials to augment or repair the defect and restore anatomic structure to required form and function. These procedures may require multiple surgical approaches.

D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure

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

D7970 Excision of hyperplastic tissue - per arch

N	N
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D7971 Excision of pericoronal gingiva

<21	N
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Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.

D7980 Sialolithotomy

N	N
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Surgical procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.

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	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D7981 Excision of salivary gland, by report</b>	N	N
<b>D7982 Sialodochoplasty</b> Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.	<21	Y
<b>D7983 Closure of salivary fistula</b> Surgical closure of an opening between a salivary duct and/or gland and the cutaneous surface, or an opening into the oral cavity through other than the normal anatomic pathway.	<21	Y
<b>D7990 Emergency tracheotomy</b> Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.	N	N

### ORTHODONTIC SERVICES

**Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age 21.** The HDL (RI Mod) Index (Handicapping Labio-lingual Deviation Index) is applied to each individual case by Board qualified orthodontic consultants to identify those cases that clearly demonstrate medical necessity by determining the degree of the handicapping malocclusion. The HDL Index is a tool that has proven to be successful in identifying a large range of very disfiguring malocclusions and two known destructive forms of malocclusion (deep destructive impinging bites and destructive individual anterior crossbite). *Please see example HDL scoring sheet at the end of this section.*

#### Handicapping Malocclusion

An occlusion that has an adverse effect on the quality of a person's life that could include speech, function or esthetics that could have sociocultural consequences. Examples would be significant discrepancies in the relationships of the jaws and teeth in anteroposterior, vertical or transverse directions.

#### Medically Necessary

When a situation exists, that could have a detrimental effect on the structures that support the teeth, and if damaged sufficiently, could lead to the loss of function.

Allowance may continue for orthodontic services on recipients losing EPSDT eligibility (reaching their 21st birthday) under the following circumstances:

1. Eligibility for Medical Assistance is maintained;
2. The request for prior authorization is approved and the work is initiated prior to the recipient's 21st birthday.

#### Prior Authorization Requests

All requests for prior authorization of payment must include the diagnosis, length, and type of treatment. Records, which include diagnostic casts (study models), cephalometric film, panoramic film or a complete series of intraoral radiographs, and diagnostic photographs, must be submitted for full orthodontic treatment review.

Orthodontic treatment will be approved only where there is evidence of a favorable prognosis and a high probability of patient compliance in completing the treatment program.

#### Payment for Orthodontic Records

If an orthodontic case is not approved for payment, Medical Assistance will pay the orthodontist a fee for examination and records when a claim is submitted using procedure code **D8660**. ***This is limited to once every two (2) years.*** This code is tied to each distinct Prior Authorization (PA) request for full orthodontic treatment. If a subsequent request is received in less than two years, and denied at that time, an allowance would not be made. If a subsequent request is received in less than two years and approved because of changes in the child's mouth, an allowance would be made.

If an orthodontist sees a patient for an examination only, and the patient does not proceed with diagnostic records, Medical Assistance will pay for a Comprehensive Oral Evaluation.

Post-treatment maintenance retainers will not be replaced if lost or damaged.

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### Orthodontic Services Claims Coding and Reimbursement

#### DENTITION

**Primary Dentition:** Teeth developed and erupted first in order of time.

**Transitional Dentition:** The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are.

**Adolescent Dentition:** The dentition that is present after the normal loss of primary teeth AND PRIOR to cessation of growth; that would affect orthodontic treatment.

**Adult Dentition:** The dentition that is present after the cessation of growth that would affect orthodontic treatment.

#### LIMITED ORTHODONTIC TREATMENT

Orthodontic treatment with a limited objective, not involving the entire dentition. May be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego therapy that is more comprehensive.

	<u>Age Restriction</u>	<u>PA Requirement</u>
<b>D8010 Limited orthodontic treatment of the primary dentition</b>	<21	Y
<b>D8020 Limited orthodontic treatment of the transitional dentition</b>	<21	Y
<b>D8030 Limited orthodontic treatment of the adolescent dentition</b>	<21	Y
<b>D8040 Limited orthodontic treatment of the adult dentition</b>	<21	Y

#### INTERCEPTIVE ORTHODONTIC TREATMENT

Orthodontic therapy that reduces or eliminates the severity of an existing malocclusion. It most often involves early correction of vertical, horizontal, or anteroposterior skeletal discrepancies. Included would be such procedures as distalization, protraction, expansion, space maintenance, and in control of harmful oral habits.

<b>D8050 Interceptive orthodontic treatment of the primary dentition</b>	<21	Y
<b>D8060 Interceptive orthodontic treatment of the transitional dentition</b>	<21	Y
<b>D1515 Space maintainer, fixed bilateral</b>	<21	N

#### COMPREHENSIVE ORTHODONTIC TREATMENT

The coordinated diagnosis and treatment leading to the improvement of a patient's dentofacial deformity or dentoalveolar skeletal discrepancies including anatomical, functional and esthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patients' needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development. Orthodontic treatment involves the placement of bands or bonded brackets for at least a two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient. Comprehensive treatment ends when the entire adult dentition (except third molars) has been placed in proper occlusion.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

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When billing for comprehensive orthodontia treatment services, the following codes will be used, as appropriate:

Units	Transitional	Adolescent	Adult	Age Restriction	PA Requirement
Procedure code: 1	D8070	D8080	D8090	<21	Y
	Procedure codes - 1st 6 months				
1-6	D8071	D8081	D8091	<23*	Y
	Procedure codes - 2nd 6 months				
1-6	D8072	D8082	D8092	<23*	Y
	Procedure codes - 3rd 6 months				
1-6	D8073	D8083	D8093	<23*	Y
	Procedure codes - 4th 6 months				
1-6	D8074	D8084	D8094	<23*	Y

*\*applies only if recipients >20 meet all of the following conditions:*

1. Eligibility for Medical Assistance is maintained;
2. The request for prior authorization is approved and the work is initiated *prior* to the recipient's 21st birthday.

**TREATMENT FOR CORRECTION OF HARMFUL HABITS**

	<u>Age Restriction</u>	<u>PA Requirement</u>
D8210 Removable appliance therapy Includes appliances for thumb sucking and tongue thrusting.	<21	Y
D8220 Fixed appliance therapy Includes appliances for thumb sucking and tongue thrusting.	<21	Y

**OTHER ORTHODONTIC SERVICES**

D8660 Pre-Orthodontic treatment visit Payment for orthodontic records when an orthodontic case is not approved.	<21	N
D8670 Periodic Orthodontic treatment visit (as part of contract)	<21	N
D8999 Unspecified orthodontic procedure, by report Used for procedure, that is not adequately described by a code. Describe procedure and submit appropriate documentation.	<21	Y

Full course orthodontic treatment usually involves the placement of bands or bonded brackets for a minimum two-year period during which time appropriate adjustments are made to achieve a proper occlusion for the patient.

Certain appliances, such as a lingual arch, tooth positioner, head gear therapy or Hawley Appliance, may be required in conjunction with a full course of orthodontic treatment. In other instances, these appliances may be utilized alone and preclude the necessity for a full course of orthodontic treatment.

When an appliance is provided in conjunction with a full course of treatment, a separate prior authorization request will be required for the provision of the special appliance. Payment will be processed when the special appliance has actually been provided to the patient.

The following codes should be utilized when requesting the appliances listed below:

D1510 Space maintainer - fixed - unilateral	<21	N
D1515 Space maintainer - fixed - bilateral	<21	N
D1520 Space maintainer - removable - unilateral	<21	N
D1525 Space maintainer - removable - bilateral	<21	N
D1550 Recementation of space maintainer	<21	N
D1515 Orthodontic - Space Maintainer, fixed bilateral	<21	N
D8020 Orthodontic-Head Gear Therapy	<21	N
D8030 Orthodontic-Minor Tooth Movement with Hawley Appliance	<21	N
D8060 Orthodontic-Maxillary Expansion Appliance	<21	N
D8220 Orthodontic-Tongue Guard Fixed/Removable	<21	N
D8680 Orthodontic-Tooth Retainer	<21	N

Requests for payment can only be submitted after placement of permanent bands / wires and completion of six-month time intervals.

Orthodontic services and supplies authorized for eligible recipients will be allowed only as long as they remain eligible for the Medical Assistance Program and continue to meet the age limitations.

Rhode Island Department of Human Services Medical Assistance Program Dental Services

Handicapping Labiolingual Deviation (HLD) Index – (Ri-Mod)  
Orthodontic Diagnostic Score Sheet

Date of Review \_\_\_\_\_  
Client Name: \_\_\_\_\_ Client Medicaid Number: \_\_\_\_\_ Client DOB: \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Provider RI Medicaid ID: \_\_\_\_\_  
Provider Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
State of Dentition: \_\_\_\_\_ Primary \_\_\_\_\_ Transitional \_\_\_\_\_ Permanent \_\_\_\_\_

**PART A. PROCEDURE:**

Note: 1 – 6 - If any one of these conditions exists, indicate an "X" and score no further.

1. Deep impinging overbite when lower incisors are destroying the soft tissue of the palate. \_\_\_\_\_
2. Crossbite of three or more permanent and/or deciduous posterior teeth or anterior crossbite of one to two individual teeth when destruction of soft tissue is present. \_\_\_\_\_
3. Congenital birth defect (e.g. cleft palate) or deviations that affect skeletal relationship and/or dentition. \_\_\_\_\_
4. Impacted permanent teeth with most of the permanent dentition present (excluding third molars). \_\_\_\_\_
5. Overjet greater than 6 mm with incompetent lips or reverse overjet. \_\_\_\_\_
6. Malocclusion with open bite from canine to canine. \_\_\_\_\_

**PART B. PROCEDURE:**

Complete 7. - 10. if case does not qualify in 1 – 6 above. The total score in Part B. will determine if the case qualifies for orthodontic treatment. A score of 20 or more qualifies for authorization. Completion instructions are attached.

- Position the patient's teeth in centric occlusion. Record measurements in the order given and round to the nearest millimeter (mm).
- Enter Score "0" if condition is absent.
- Note: If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.

**CONDITIONS HLD SCORE**

7. Overjet in mm. (1 – 5 mm) \_\_\_\_\_
8. Overbite in mm. \_\_\_\_\_
9. Ectopic eruption, other than anterior teeth. Count each tooth excluding 3rd molar(s) (Score= # of teeth x 3)  
List teeth: \_\_\_\_\_
10. Anterior crowding: Score one point for MAXILLA, and/or one point for MANDIBLE:  
(Two point maximum for anterior crowding) (Score x 5 = \_\_\_\_\_)

**(PART B.) TOTAL SCORE** \_\_\_\_\_

Reviewing Consultant \_\_\_\_\_

**PART B.**

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. (Enter the number of millimeters as the HLD score).

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. "Reverse" overbite may exist in certain conditions and should be measured and recorded. (Enter the number of millimeters as the HLD score).

9. Ectopic Eruption: Count each tooth. Teeth deemed ectopic must be blocked out of and clearly out of alignment in dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #10, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.

10. Anterior Crowding: Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #9, ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter a score of one if crowding is present in the maxillary arch and a score of one if crowding is present in the mandibular arch. There is a two-point maximum for anterior crowding. Multiply this score by five (5). Enter the multiplied total as the HLD score

**Rhode Island Department of Human Services Medical Assistance Program Dental Services**

**ADJUNCTIVE GENERAL SERVICES**

**UNCLASSIFIED TREATMENT**

<b>D9110 Palliative (emergency) treatment of dental pain-minor procedure</b>	<u>Age Restriction</u> <21	<u>PA Requirement</u> N
This is typically reported on a "per visit" basis for emergency treatment of dental pain.		

**ANESTHESIA**

General anesthesia and IV sedation are limited to recipients <21. General anesthesia is paid for the first 30 minutes (D9220) and each additional 15 minutes (D9221) for up to one hour on the same day of service for services rendered in the office setting. Anesthetic Management is limited to one (1) method per patient for the same day of service.

When billing for D9221, indicate the number of units in the Description of Service section of the ADA claim form and circle the section. The billed amount should correspond to the number of units. Providers are required to submit a copy of their permit to administer anesthesia and/or sedation to Medical Assistance, upon request.

Providers are required to submit a copy of their permit to administer anesthesia and/or sedation to Medical Assistance, upon request.

<b>D9212 Trigeminal divisional block anesthesia</b>	<21	N
<b>D9220 Deep sedation/general anesthesia - first 30 minutes</b>	<21	N
<b>D9221 Deep sedation/general anesthesia - each additional 15 minutes</b>	<21	N
<b>D9230 Analgesia, anxiolysis, inhalation of nitrous oxide</b>	<21	N

**PROFESSIONAL CONSULTATION**

<b>D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)</b>	N	N
Type of service provided by a dentist or dental specialist whose opinion or advice regarding evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate source. The dentist may initiate diagnostic and/or therapeutic services.		

**PROFESSIONAL VISITS**

<b>D9410 House call / Extended Care Facility Call</b>	N	N
Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate procedure codes for actual services performed.		

<b>D9420 Hospital call</b>	N	N
May be reported when providing treatment in hospital or ambulatory surgicenter, in addition to reporting appropriate codes for actual services performed.		

**DRUGS**

<b>D9610 Therapeutic drug injection, by report</b>	N	Y
Includes antibiotics, intravenous, or injection of sedative.		

<b>D9630 Other drugs and/or medicaments, by report</b>	N	Y
Includes, but not limited to, oral antibiotics, oral analgesics, oral sedatives, and topical fluoride dispensed in the office for home use; does not include writing prescriptions.		

**MISCELLANEOUS SERVICES**

<b>D9910 Application of desensitizing medicament</b>	<21	Y
Includes in-office treatment for root sensitivity. Typically reported on a "per visit" basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.		

<b>D9920 Behavior Management, Dental</b>	N	N
For patients whose medical status and/or behavior require special management techniques for the safe delivery of necessary oral health services. To be reported in addition to treatment provided.		

<b>D9930 Treatment of complications (post-surgical) - unusual circumstances, by report</b>	N	Y
For example, treatment of a dry socket following extraction or removal of bony sequestrum.		

<b>D9940 Occlusal guard, by report</b>	<21	Y
Removable dental appliance which is designed to minimize the effects of bruxism (grinding) and other occlusal factors.		