Rhode Island Executive Office of Health and Human Services
Medicaid Program

Rhode Island Medicaid

Dental Services Coverage Manual

Version 2.8

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Revision History

Version	Date	Sections Revised	Reason for Revision
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1.2	February 2016	N/A	N/A
1.3	December 2017	N/A	N/A
1.4	January 2018	N/A	N/A
1.5	July 2018	Periodontal Services	Policy Change
1.6	February 2019	Other Preventative Services-Space Maintenance Miscellaneous Services-Occlusal Guards	Policy Change
1.7	September 2019		
2.0	October 2022	All Sections	Manual Update
2.1	July 2023	Adjustments	Policy update Denture billing policy
2.2	November 2023	N/A	N/A
2.3	February 2024	Clinical Oral Examinations	Policy Change
2.4	April 2024	Topical Fluoride Treatment	Benefit Limitation
2.5	August 2024	Periodontal scaling and root planing	Policy Update
2.6	June 2025	Relines, Caries Arresting Material, and anesthesia	N/A
2.7	October 2025	Dental Amalgam	N/A
2.8	December 2025	CDT Copyright Added	N/A

Contents

Introduction

Dental services are a covered benefit to eligible Rhode Island Medicaid (Medicaid) recipients. Coverage of dental services for adults is provided through Medicaid Fee-For-Service (FFS). Coverage for children and young adults who were born after May 1, 2000, is provided through a Medicaid managed care program called RIte Smiles administered through UnitedHealthcare Dental (www.uhc.com/ritesmiles /RIte Smiles).

Policies as described below are specific to the FFS program. For policies related to RIte Smiles, please see applicable Provider Manuals.

General Policy Requirements

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

Providers must bill Medicaid 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 Medicaid. Payments to providers will not exceed the maximum reimbursement rate of Medicaid.

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 Medicaid. The General Rules for Medicaid along with this policy are to be used together to determine coverage for services.

Recipient Eligibility

Recipient eligibility should be verified before services are provided to determine dental coverage and limits.

Retroactive Eligibility

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

Scope of Services

Medicaid provides payment only for services that are included in the scope of services described in the State Plan or for recipients under the age of 21 pursuant to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, or 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 therein are contained in the Medicaid Provider Reference Manuals, the Rhode Island Title XIX State Plan, Section 1115 Waiver requests, and the Medicaid Managed Care Plan and Contracts (for recipients on RIte Smiles). Payment is not made for services other than those described herein.

Medical Necessity

Medicaid 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 should be provided in a cost-effective manner.

Appeal of Denial of Medical Necessity

Determinations made by Medicaid 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 EOHHS. Medicaid payments are provided only for covered services that are determined to be medically necessary. No Medicaid payment will be made for a medical procedure of an investigative or experimental nature. For more information on how consumers may file an appeal, visit How to File an Appeal.

Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by the staff, and consultants of EOHHS based on review of documentation. Policies relative to medical necessity are set forth in the Medicaid Provider Reference Manuals, and the Rhode Island State Plan. Medical necessity can be determined on a procedure-by-procedure basis.

Approval of Medical Necessity

Medicaid and its designees determine which services are medically necessary on a case-by-case basis, both in prepayment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of Medicaid. 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 Medicaid will determine the provider's recommendation to be medically necessary.

Medicaid 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 Medicaid.

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.

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

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.

Third Party Liability

Medicaid is the payer of last resort. All third-party programs must be utilized before any payment can be made by Medicaid.

If payment from other third parties is equal to or exceeds Medicaid allowable amount, no payment will be made on the claim by Medicaid. 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 Medicaid will not consider the claim for payment.

If the third party denies payment for services based on medical necessity, this determination is adopted by Medicaid. An independent determination of medical necessity is not made in such circumstances. For example, if federal Medicare determines that a service is not medically necessary, then that determination is binding on Medicaid and Medicaid payment of the service will not be made.

The Medicaid payment is considered payment in full. The Provider is not allowed to bill the recipient for any additional charges not paid for by Medicaid.

Provider Participation

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

License renewal

Providers' licenses are renewed biannually by RIDOH. Failure to do so will result in termination from the program.

Claims Billing Guidelines

Claims should be filed electronically. For situations that require manual (paper) submission, those claims must be billed on the ADA 2019 dental claim form. Instructions for completing the ADA dental claim form are located EOHHS website. Medicaid will use the Current Dental Terminology (CDT) procedure codes.

Reimbursement Guidelines

Medicaid will not pay for canceled or missed office visits.

Prior Authorization

For some dental 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 does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service. If there is a verifiable emergency service which requires prior authorization, and needs to be done immediately, the procedure should be performed and the prior authorization requested retroactively. The consultants will review these claims and consider them for payment. Medicaid Dental policy designates those codes which require prior authorization.

Effective May 1st, 2025, authorized dates for dental prior authorization will begin the date the dental PA has been reviewed and finalized by the dental consultant. You will no longer need to put in a date range on the prior authorization form. This new policy will supersede any date written on the PA request form. Providers looking for Retroactive dates must state it on the PA form.
The authorized date span will be given according to the EOHHS Dental manual for each procedure code requested.

Payment for any prior authorization services can only be made if the services are provided while the person remains eligible for Medicaid. Access the Prior Authorization Form and instructions for completion at https://eohhs.ri.gov/providers-partners/billing-and-claims/prior-authorization.

Services Reviewed by Medicaid

Medicaid 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.

Individual Consideration

Requests for payment for dental services listed as “By Report” must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or Radiographs. Payment for "By Report" procedures will be approved in consultation with a Medicaid dental consultant.

Medicaid Requests for radiographs

Medicaid, 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 radiographs and/or other clinical information to support medical necessity and clinical care. Payment may be denied if the requested radiographs and/or other clinical information are not submitted. Any procedure for which prior authorization was not required may be verified, as necessary, by preoperative and post-operative radiographs or other means prior to payment.

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 Medicaid. Documentation of the need for the emergency services is the responsibility of the provider and subject to audit by Medicaid.

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 a service that is 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

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

Therapeutic Services

This includes the following services:

- Pulp therapy of permanent and primary teeth - restricted to recipients under 21 years of age
- 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.

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 and other general anesthetics including, but not limited to, ketamine or etomidate.

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 or with Intellectual/Developmental Disability

Services with this limitation can only be provided under the Rhode Island Medicaid Dental Services Program to individuals who have not attained their 21st birthday prior to the delivery of the service or adults with intellectual or developmental disability for whom there is medical necessity.

Services Not Covered

Procedure codes not listed in the Medicaid Dental Fee Schedule are services not covered under the Medicaid 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 premolars and molars
- Desensitization
- Extensive periodontal surgery
- Fixed bridges
- Implants
- Occlusal equilibration
- Root canal therapy for premolars and molars

Nursing Home Services

Payment is covered for Medicaid recipients for dental services provided in a nursing home or long-term care facility. Providers may bill a facility fee but should limit according to guidelines for code D9410.

Teledentistry Policy

Teledentistry is not a specific service but a mode of accomplishing a particular service. Teledentistry may include communication from one dental provider to another. Providers are asked to bill non-paying codes D9995 (Synchronous teledentistry) and D9996 (Asynchronous teledentistry) for documentation but should use applicable D codes. Frequency limitations for service codes apply. Dentists billing for exams completed by dentistry acknowledge they have received and reviewed essential information to make a diagnosis, comparable to what would be used in an in-person visit.

Documentation Requirements

Every dentist, dental health professional, or other licensed health professional who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name, or an identification number and initials, next to the service performed and shall date those treatment entries in the record.
Note: Electronic charts should have clear record of the rendering provider in the EHR system, service performed, date of treatment, and the patient's information (including eligibility).

Any person licensed under this chapter who owns, operates, or manages a dental office shall ensure compliance with this requirement.
Record Keeping

- Date of service
- Each service rendered
- Patient information
- Any additional information required by RI Medicaid

Timeliness of Care

To improve efficiency and timely access to care and maintain quality of care for a patient, a treating dental provider shall, when applicable, feasible, and consistent with the **standard of care, minimize the number of dental visits.** Each patient should receive an individualized treatment plan that is safe, effective, patient-centered and equitable.

Each provider shall develop a treatment plan that **optimizes preventive and therapeutic care** and that is in the patient's best interest, taking into consideration their overall health status. **All phases of the treatment plan** shall be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner.

Visits: Face-to-Face Encounters Defined

Practices may render any dental service in a **face-to-face encounter** between a **billable treating provider** and an **eligible patient** that is:

- Within the scope of the treating dental practitioner's scope/licensure
- Complies with the RI Medicaid Dental Manual
- Determined to be "medically necessary"

Visits: Face-to Face Encounters, Qualifying Visits

Providers may bill a visit for dental services rendered to a Medicaid beneficiary even if the beneficiary also received services from another non-dental health professional on the same day.

Visits: Non-Qualifying Visits

Visits at which the patient receives services "incident to" resulting from physician or dental visits do **not** qualify as face-to-face encounters. Examples include:

- Laboratory work

Non-Emergency Visits, Children (Under 21 Years)

Typically includes exam, x-rays, cleaning, fluoride, oral hygiene instruction, nutritional counseling, caries risk assessment, and behavioral evaluation and are expected routinely to be completed in one visit.

If more than one visit is required, documentation in the patient's chart and/or electronic health record should indicate the necessity of any additional visits.

Emergency Visits / Emergency Services

The dentist should provide a definitive care plan and treatment to address the chief complaint during an emergency visit whenever possible.

Visits: Face-to-Face Encounters, Dental Services

SEALANTS – Providers should place sealants on as many eligible teeth as possible during the visit considering the clinical circumstances and patient cooperation.

RESTORATIONS, EXTRACTIONS, OR ENDODONTIC THERAPIES – Providers should perform as many treatment-planned services as possible during the visit, considering the clinical circumstances, what is ethical, and what is tolerable to the patient.

When Multiple Visits are Required

Procedures normally requiring multiple visits (i.e., removable dentures, root canals, crowns, etc.) should be completed in a number of visits that would be considered consistent with the standard of care and the provider's scope of practice. Follow up or post-operative visits that are not routinely billable in the standard of care are not billable in the Medicaid program.

If additional visits are required, documentation in the patient's chart and/or electronic health records should indicate the necessity of each additional visit.

Definitive Services Not Completed During a Single Visit When definitive services are not completed within a single appointment, chart notes must be documented as to why. Examples of definitive services not being performed would include, but may not be limited to, the following:

1. Periodic exams not done at the same time as a prophylaxis visit.
2. Multiple visits to complete evaluation and discussion of treatment plan.
3. Crown impression rendered on a different date than crown preparation.

Medical Necessity – Adult Services

A service is medically necessary or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Treatment Plans Must

- Optimize preventive and therapeutic care
- Be in the **patient's best interest** and consider their overall health status
- Be rendered in a safe, effective, equitable, patient-centered, timely, and efficient manner

Recall visits, Adults (Age 21+)

Typically includes exam, x-rays as needed, cleaning, fluoride as needed, oral hygiene instruction as needed.

Using more than one visit for this appointment is unfavorable to the patient as it requires additional transport or other efforts to plan and extending to more than one appointment increases the likelihood the patient will not return. Performing all care at one visit is favorable to the patient and for the integrity of the Medicaid program. If more than one visit is required, documentation in the patient's chart and/or electronic health records should indicate the necessity of any additional visits.

Treatment Plan: Examples of Inappropriate Plans

Decisive services should be completed within a single appointment. Examples of inappropriate plans/multiple visits without documented medical necessity would include, but may not be limited to, the following:

1. Periodic exams not done at the same time as a prophylaxis visit.

2. Multiple visits to complete evaluation and discussion of treatment plan.
3. Partial dentures started prior to the completion of caries control and periodontal therapy.
4. Extractions and crowns done shortly after the delivery of partial dentures.
5. Numerous and frequent consultations regarding the same tooth with no definitive treatment.
6. Numerous and frequent additional restorations on the same tooth.

Covered Services

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. All exams require recording of findings and must be signed by dentist(s).

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.

CDT Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation – established patient	No	No	Periodic exams are allowed twice per calendar year, per patient.	Update general and oral health histories; examination of extraoral hard and soft tissues, dental and periodontal findings.
D0140	limited oral evaluation – problem focused	No	No	Two of (D0140) per 1 Calendar year(s) per patient. Not covered with D0120, D0150, D0160, D0180 by same provider or provider group on same date of service.	Report of specific concern, to include symptoms and examination findings.
D0145	oral evaluation for a patient under the age of three years and counseling with primary caregiver	< 3	No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Cannot be billed on the same date of service as D0150.	Report on findings, documentation of guidance provided to caregivers.
D0150	comprehensive oral evaluation – new or established patient	No	No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location.	Review and analysis of the patient's health history and chief concerns, clinical evaluation of the intraoral and extraoral hard and soft tissues.
D0160	detailed and extensive oral	No	No		

	evaluation – problem focused, by report				
D0180	comprehensive periodontal evaluation- new or established patient	< 21	No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D0120, D0140, D0145, D0150 by same provider or provider group on same date of service.	

D0190	screening of a patient	No	No	Not currently covered in RI Medicaid program.	
D0191	assessment of a patient	No	No	Assessments are allowed twice per calendar year, per patient.	Only to be used by Public Health Dental Hygienist. Exam may be billed by a dentist if completed via teledentistry but is part of a single encounter when performed by FQHC.

RADIOGRAPHS / DIAGNOSTIC IMAGING

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

Radiographs

Medicaid 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 radiographic images (D0330) are limited to once every 1460 days (four years).

Medicaid believes it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's radiation exposure and follows the recommendations developed by the American Dental Association and the Food and Drug Administration found at this site: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/oral-health-topics/dental_radiographic_examinations_2012.pdf

For new patient adults or adolescents, recommendation is for individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment. Medicaid will not reimburse for both a full mouth series and panoramic radiographic in the same year.

Radiographs for routine screening, i.e., Bitewing services - single radiographic image (D0270), two radiographic images (D0272), three radiographic images (D0273) and four radiographic images (D0274), **are allowed once every calendar year, per patient. D0274 cannot be performed with D0272 on the same day**.

Payment for some or all multiple Radiographs of the same tooth or area may be denied if Medicaid determines the number to be excessive.

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

Intraoral radiograph requirement does not apply to D0330.

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D0210	intraoral – comprehensive series of radiographic images	No	No	Intraoral-complete series (D0210) are allowed once every 1460 days (four years).	Findings should be reported.
D0220	intraoral – periapical-first radiographic image	No	No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	Tooth number must be indicated. Findings should be reported.
D0230	intraoral – periapical - each additional radiographic image	No	No		Tooth number must be indicated. Findings should be reported.
D0240	intraoral – occlusal radiographic image	No	No	Two of (D0240) per 1 Calendar year(s) Per Provider OR Location.	Findings should be reported.
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No	No		Findings should be reported.
D0270	bitewing – single radiographic image	No	No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings – two radiographic images	No	No	Once every calendar year, per patient. D0274 cannot be performed with D0272 on the same day.	
D0273	bitewings – three radiographic images	No	No	Once every calendar year, per patient. D0274 cannot be performed with D0272 on the same day.	
D0274	bitewings – four radiographic images	No	No	Once every calendar year, per patient. D0274 cannot be performed with D0272 on the same day.	

D0330	panoramic radiographic image	No	No	Panoramic radiographic images (D0330) are limited to once every 1460 days (four years).
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	< 21	Yes	Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.

Additional imaging: It is anticipated that the following codes would be submitted through the medical carrier using CPT codes.

Code	Procedure	Age Limitation	Authorization Required
D0310	sialography	No	Yes
D0320	temporomandibular joint arthrogram, including injection	No	Yes
D0321	other temporomandibular joint radiographic images, by report	No	Yes
D0322	tomographic survey	<21	Yes

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.

Code	Procedure	Age Limitation	Authorization Required
D0502	other oral pathology procedures, by report	No	No
D0999	unspecified diagnostic procedure, by report	No	No

CARIES RISK ASSESSMENT

The following codes are non-paying codes used to express level of risk and will be used to authorize selected preventive procedures appropriate for medium and high-risk patients. It is anticipated that providers will use a Caries Risk Assessment form, and this will be available for review as needed.

Code	Procedure	Age Limitation	Documentation Required
D0601	caries risk assessment and documentation, finding of low risk	none	Using recognized assessment tools
D0602	caries risk assessment and documentation, finding of medium risk	none	Using recognized assessment tools
D0603	caries risk assessment and documentation, finding of high risk.	none	Using recognized assessment tools

DENTAL PROPHYLAXIS

PREVENTIVE SERVICES

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D1110	prophylaxis – adult	> 12	No	Twice per calendar year
D1120	prophylaxis – child	< 13	No	Twice per calendar year

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

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 leading to HIGH RISK of caries. These conditions may include, but are not limited to, radiation therapy, tumors, and 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 Medicaid.*

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

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D1206	topical application of fluoride varnish	No	No	Two per year in dental setting	Caries risk assessment one time per year
D1208	topical application of fluoride-excluding varnish	No	No	Two per year in dental setting	Caries risk assessment one time per year

- A caries risk assessment procedure code denoting **high risk** (see above) **must** be listed on claims submitted for topical application of fluoride procedure code D1206 or D1208 when used for adults. The codes should be billed at zero dollars ($0). Providers should complete a caries risk assessment form of their choice.

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.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D1351	sealant – per tooth	< 21	2,3,14,15,18,19,30,31	No

Mechanically and/or chemically prepared enamel surface sealed to prevent decay.
Payment for sealant is not allowed when an occlusal restoration exists.
Payment for a sealant is not allowed on teeth #1, 16, 17, and 32.

Caries Arresting Material

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D1354	Interim caries-arresting material application-per tooth	<25		No

See Rite Smiles provider manual for policy.

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. Medicaid will only pay once for recementation of any space maintainer (D1550). Passive appliances are designed to prevent tooth movement.

Code	Procedure	Age Limitation	Authorization Required
D1510	space maintainer – fixed, unilateral- per quadrant	< 21	No
D1516	space maintainer – fixed, bilateral, maxillary	< 21	No
D1517	space maintainer – fixed, bilateral, mandibular	< 21	No
D1520	space maintainer – removable, unilateral -per quadrant	< 21	No
D1526	space maintainer - removable – bilateral, maxillary	< 21	No
D1527	space maintainer - removable – bilateral, mandibular	< 21	No
D1551	re-cement or re-bond bilateral space maintainer-maxillary	< 21	No
D1552	re-cement or re-bond bilateral space maintainer-mandibular	< 21	No
D1553	re-cement or re-bond unilateral space maintainer-per quadrant	< 21	No
D1556	removal of fixed bilateral space maintainer-per quadrant	< 21	No
D1557	removal of fixed bilateral space maintainer-per quadrant	< 21	No
D1558	removal of fixed bilateral space maintainer-per quadrant	< 21	No

RESTORATIVE SERVICES

- 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 neither the 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.

-
- The program does not pay for composite or amalgam restorations replaced within one year of the date of completion of the original restoration when replaced by the same provider or dental group. The initial payment includes all restorations replaced due to defects or failure less than one year from the original placement.

DENTAL AMALGAMS

While dental amalgams have a long history of successful use and may have indications when working in an environment of challenging moisture control, guidance from the Food & Drug Administration (FDA), found HERE, suggests limiting use, and avoiding in specific populations as follows:

- Women who are pregnant or planning to become pregnant
- Nursing mothers
- Children, especially those under the age of six
- People who are more sensitive to mercury or other components of dental amalgam
- People with neurological impairment or kidney dysfunction

In cases where dental amalgam is used, offices should practice best management related to amalgam separators and waste.
References:

- Information for Patients About Dental Amalgam Fillings, U.S. Food & Drug Administration, 09/24/2020.
- Amalgam Separators and Waste: Best Management. American Dental Association.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D2140	Amalgam - one surface, primary or permanent	No	All	No
D2150	Amalgam - two surfaces, primary or permanent	No	All	No
D2160	Amalgam - three surfaces, primary or permanent	No	All	No
D2161	Amalgam - four or more surfaces, primary or permanent	No	All	No

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).

Benefit Limitations: One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 calendar year(s) per business per tooth, per surface. RI Medicaid will not pay more than the multisurface rate for a restoration greater than 1 surface.

RESIN-BASED RESTORATIONS - DIRECT

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

Resin restorations may be indicated to restore areas of decay and should not be used to replace tooth structure lost due to wear or to address non-carious discoloration. Use of composites should be medically necessary and not used for issues that are esthetic only, such as closing diastemas, addressing shallow cervical notching, or improving color. Restorations should address damage caused by caries, trauma, or other pathology.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D2330	resin-based composite - one surface, anterior	No	6 - 11, 22 - 27, C - H, M - R	No
D2331	resin-based composite - two surfaces, anterior	No	6 - 11, 22 - 27, C - H, M - R	No
D2332	resin-based composite- three surfaces, anterior	No	6 - 11, 22 - 27, C - H, M - R	No
D2335	resin-based composite - four or more surfaces (anterior)	No	6 - 11, 22 - 27, C - H, M - R	No
D2390	resin-based composite crown, anterior	< 21	6 - 11, 22 - 27, C - H, M - R	Yes: Full resin-based composite coverage of tooth

Benefit Limitations: One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. RI Medicaid will not pay more than the multisurface rate for a restoration greater than 1 surface.

Restorative Procedures-Posterior Resins

Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. May not be used to replace existing non-carious amalgam restorations.

Guidelines

- May not be performed as a preventative procedure
- Removal of non-carious or non-defective amalgam restorations and replacement with composite resin is not a covered benefit and subject to post-procedural review
- Removal and replacement of amalgam restorations solely for esthetic concerns is not a covered benefit and subject to post-procedural review
- Removal and replacement of amalgam restorations based on a perceived health benefit is not a covered benefit and subject to post-procedural review

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D2391	resin-based composite - one surface, posterior	No	All posterior	No
D2392	resin-based composite - two surfaces, posterior	No	All posterior	No
D2393	resin-based composite - three surfaces, posterior	No	All posterior	No
D2394	resin-based composite - four or more surfaces, posterior	No	All posterior	No

Benefit Limitations: One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. RI Medicaid will not pay more than the multisurface rate for a restoration greater than 1 surface.

INDIVIDUAL CROWNS

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

Payment for crowns for:

- posterior primary teeth for recipients under the age of 21 is limited to stainless steel crowns. (D2930)
- posterior permanent teeth for all recipients, regardless of age is limited to stainless steel crowns. (D2931)
- anterior teeth for recipients over age 20 is limited to prefabricated resin crowns. (D2932)
- anterior teeth for recipients under the age of 21 is limited to procedure codes D2710 – D2792.

Other Related Limitations

- 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.
- Medicaid will only pay once per tooth per calendar year for re-cementation of inlays and crowns (D2910 & D2920).

CROWNS - SINGLE RESTORATIONS ONLY

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%.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D2710	crown – resin-based composite (indirect)	<21		No
D2720	crown - resin with high noble metal	<21		No
D2721	crown - resin with predominantly base metal	<21		No
D2722	crown - resin with noble metal	<21		No
D2740	crown - porcelain/ceramic	<21		No
D2750	crown - porcelain fused to high noble metal	<21		No
D2751	crown - porcelain fused to predominantly base metal	<21		No
D2752	crown - porcelain fused to noble metal	<21		No
D2790	crown - full cast high noble metal	<21		No
D2791	crown - full cast predominantly base metal	<21		No
D2792	crown - full cast noble metal	<21		No

OTHER RESTORATIVE SERVICES

Code	Procedure	Age or Benefit Limitation	Teeth Covered	Authorization Required
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No age limitation. Once per tooth per calendar year for re-	**Not covered within 6**	No

		cementation of inlays and crowns	**months of initial placement.**	
D2920	re-cement or re-bond crown	No age limitation. Once per tooth per calendar year for re-cementation of inlays and crowns	**Not covered within 6 months of initial placement.**	No
D2930	prefabricated stainless steel crown – primary tooth	< 21	**Teeth A-T**	No
D2931	prefabricated stainless steel crown – permanent tooth	No	**Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31**	No
D2932	prefabricated resin crown – permanent anterior	>20		No
D2933	prefabricated stainless steel crown with resin window	< 21		No
D2940	protective restoration	No		No

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D2950	core buildup, including any pins when required	No		No	
D2951	pin retention - per tooth, in addition to restoration	No		No	**Must be billed with a two-or-more surface restoration on a permanent tooth**
D2952	post and core in addition to crown, indirectly fabricated	< 21		No	
D2954	prefabricated post and core in addition to crown	No	Only anterior teeth for age 21 and over	No	**Limited to teeth where root canal is allowed; only anterior teeth for age 21 and over.**
D2980	crown repair, by report	No		Yes	**Chairside**
D2999	unspecified restorative procedure, by report	No		Yes	

ENDODONTICS

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 (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. It includes removal of pulp coronal to the dentinocemental junction and application of medicament.

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

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D3220	therapeutic pulpotomy (excluding final restoration)	<21	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320 or D3330).

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

Root Canal Therapy

Root canal therapy is limited to one (1) procedure per tooth, per recipient, per lifetime, 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.

For 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.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D3310	endodontic therapy, anterior tooth (excluding final restoration)	No	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment.
D3320	endodontic therapy, premolar tooth (excluding final restoration)	< 21	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth.
D3330	endodontic therapy, molar tooth (excluding final restoration)	< 21		No	One of (D3330) per 1 Lifetime Per patient per tooth.

APEXIFICATION/RECALIFICATION PROCEDURES

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

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D3351	apexification/recalcification - initial visit	< 21		No
D3352	apexification/recalcification - interim medication replacement	< 21		No
D3353	apexification/recalcification - final visit	< 21		No

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.

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D3421	apicoectomy – premolar (first root)	< 21	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No
D3425	apicoectomy – molar (first root)	< 21	Teeth 1 - 3, 14 - 19, 30 - 32	No
D3426	apicoectomy (each additional root)	< 21	Teeth 1 - 3, 14 - 19, 30 - 32	No
D3430	retrograde filling - per root	< 21		No
D3450	root amputation - per root	< 21		No

OTHER ENDODONTIC PROCEDURES

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3920	hemisection (including any root removal), not including root canal therapy	< 21		No		
D3999	unspecified endodontic procedure, by report	No		Yes		

PERIODONTAL SERVICES

Surgical Services (Including usual postoperative care)

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.**

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	< 21	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes, only for 21 and over.	
D4211	gingivectomy or gingivoplasty – one to three teeth, per quadrant	< 21	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes, only for 21 and over.	

Non-Surgical Periodontal Services

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D4322	splint – intra-coronal natural teeth or prosthetic crowns	< 21	No		
D4323	splint – extra-coronal natural teeth or prosthetic crowns	< 21	No		

Periodontal Scaling and Root Planing Guidelines

- *Scaling and root planing for adults is permitted with prior authorization. Approval will indicate which quadrant(s) are approved as applicable.
- Prior authorization should be submitted to provide evidence of medical necessity and prognosis.
- For D4341 and D4342, Prior authorization requires submission of full mouth probing depths and intraoral radiographs (recent bitewings and full mouth series or panorex within five years).
- Expectation is moderate bone loss with radiographic calculus noted on root surfaces
- The expectation is that teeth have a good long-term prognosis and scaling and root planing will impact the long-term prognosis of the teeth favorably.

- Only 2 codes of D4341, D4342, or D4346 are permitted per visit; In cases of D4341 or D4342, it is anticipated that providers will perform 2 codes at a visit unless chart notes reflect high degree of complexity. **Applicable to all ages**.
- D4346, scaling in the presence of inflammation, is a full-mouth additional cleaning and may be employed at a separate appt from the prophy (D1110) when the high level of inflammation needs to resolve before the patient can perform adequate homecare or allow an acceptable prophy (D1110). Calculus, plaque and other debris are on the enamel or cemento-enamel junction. Local anesthetic may be used at the discretion of the provider. It is distinguished from scaling and root planning as much of the pocket depth is related to gingival inflammation as opposed to infrabony bone loss.
- In cases where D4341 or D4342 are denied due to lack of radiographic root surface calculus, lack of infrabony pocketing, etc., D4346 may be performed without prior authorization provided medical necessity is met.

Periodontal scaling and root planing, per quadrant, 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 planning 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 as a part of presurgical procedures in others.
It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e., late Type II, III, or IV periodontitis) where definitive comprehensive root planning requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:
“Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic.”

Criteria for Periodontal Treatment
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- At least one of the following is present:
    - Radiographic evidence of root surface calculus; or
    - Radiographic evidence of noticeable loss of bone support.
    - Favorable long-term prognosis

Periodontal scaling and root planing (D4341 or D4342) is allowed once every 3 (three) years. Periodontal charting and Radiographs are required. Pockets must be 5 mm or greater. See complete guidelines below.

Records must document the clinical indications for periodontal scaling and root planing and for gingival curettage. Periodontal maintenance procedures (D4910) are allowed only for recipients under 21 and once every six months after D4341 and will not be paid during the 6-month period immediately after D4341.

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required

D4341	periodontal scaling and root planning – four or more teeth per quadrant	No	Yes, only for 21 and over.	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.	Probing depths Radiographs. Radiographs should show calculus fully on cementum surface beyond enamel.
D4342	periodontal scaling and root planing – one to three teeth per quadrant	No	Yes, only for 21 and over.	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.	Probing depths Radiographs. Radiographs should show calculus fully on cementum surface beyond enamel.
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	No	No	Limited to once every two years. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.	
D4355	full mouth debridement to enable comprehensive periodontal and diagnosis evaluation	< 21	No		
D4381	localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth	< 21	Yes		

OTHER PERIODONTAL SERVICES

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D4910	periodontal maintenance	< 21	No		
D4999	unspecified periodontal procedure, by report	No	Yes		

REMOVABLE PROSTHODONTICS (INCLUDING ROUTINE POST-DELIVERY CARE)

- Removable prosthodontics is limited to the replacement of permanent teeth. Radiographs are required. Medicaid pays for removable partial denture construction only if there are two or more missing posterior teeth on a side, not including second or third molars, or one or more missing anterior teeth and the remaining teeth are in good occlusion.

- Recipients are allowed one (1) set of partial and/or complete dentures during an 1825-day (5-year) period from any provider.

- Adjustments to full or partial dentures during the 183-day (6-month) period following delivery of dentures to recipients are included in the fee. Two denture/partial adjustments per calendar year are covered after the first 6 months following initial placement. This includes repairs, rebases and relines within 6 months of delivery except in the case of immediate dentures. Immediate dentures are exempt from the time limitation. Adjustments are allowed once per 6 months.

- After the initial 183-day (6-month) period from delivery, a reline is allowed once per 12 months 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. In extenuating circumstances, providers may reach out to discuss prior authorization.

- D5650-Up to four teeth may be added to an existing partial denture. Adding more than 4 teeth requires prior authorization. Prior authorization requests must include a letter and available radiographs.

- Billing for Partial and Complete Dentures

    - Providers must use the date of delivery as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed or delivered. Therefore, claims for complete or partial dentures ***must not*** be filed until the date the appliances are delivered to the beneficiary. Medicaid payment may be recouped for claims filed using a date other than the delivery date.

  Note: If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use either the final impression date or the last date of eligibility as the date of service for denture delivery. This exception is allowed ***only*** when the dentist has completed the final impression on a date for which the beneficiary is eligible ***and*** has actually delivered the denture(s) within six (6) months of the final impression. The delivery date ***must*** be recorded in the beneficiary's chart.

Complete Dentures

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5110	complete denture – maxillary	No	No	One of D5110 or D5130 per 60 Month(s) Per patient.
D5120	complete denture – mandibular	No	No	One of D5120 or D5140 per 60 Month(s) Per patient.

Partial Dentures

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5211	maxillary partial denture - resin base - (including retentive/clasping materials, rests and teeth)	No	No	One of (D5211, D5221, D5213) per 60 Month(s) Per patient. Providers should assess health of abutments by radiographs. Radiographs may be requested for post-payment review. Documentation must indicate that there are two or more missing posterior teeth or one or more

				missing anterior teeth, the remaining dentition is sound and there is a good prognosis.
D5212	mandibular partial denture - resin base - (including any retentive/clasping materials, rests and teeth)	No	No	One of (D5212, D5222, D5214) per 60 Month(s) Per patient. Providers should assess health of abutments by radiographs. Radiographs may be requested for post-payment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.
D5213	maxillary partial denture - case metal framework with resin - denture bases (including any conventional clasps, rests and teeth)	< 21	No	One of (D5211, D5221, D5213) per 60 Month(s) Per patient. Providers should assess health of abutments by radiographs. Radiographs may be requested for post-payment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.
D5214	mandibular partial denture - case metal framework with resin – denture bases (including any conventional clasps, rests and teeth)	<21	No	One of (D5212, D5222, D5214) per 60 Month(s) Per patient. Providers should assess health of abutments by radiographs. Radiographs may be requested for post-payment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.

Immediate Dentures

Immediate dentures should be selected judiciously with the understanding that a traditional denture of the comparable type/arch will not be covered within 60 months. Adjustments and any relines are included in the first 6 months. Maxillary immediate dentures are best accomplished by extraction of all posterior teeth with healing followed by impression of anterior teeth. Ref: Seals et al.1996 Dent Clin North Am. Mandibular immediate dentures may be less predictable.

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5130	immediate denture – maxillary	No	No	One per lifetime per member
D5140	immediate denture – mandibular	No	No	One per lifetime per member
D5221	immediate maxillary partial denture-resin base	No	No	One per lifetime per member
D5222	immediate mandibular partial denture-resin base	No	No	One per lifetime per member

Currently we're still waiting for these codes to be fully implemented. In the interim if you have a patient who would benefit from this service you may use corresponding conventional denture codes. Those corresponding codes are listed below. Existing frequency limitations apply.

Use the Following Corresponding Codes below in place of the Immediate Denture codes	Immediate Denture Codes
D5110 - Complete denture – maxillary	D5130- Immediate denture – maxillary
D5120 -Complete denture – mandibular	D5140- Immediate denture – mandibular
D5211- Maxillary partial denture - resin base - (including retentive/clasping materials, rests and teeth)	D5221- Immediate maxillary partial denture-resin base
D5212- Mandibular partial denture - resin base - (including any retentive/clasping materials, rests and teeth)	D5222- Immediate mandibular partial denture-resin base

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5410	adjust complete denture - maxillary	No	No	One per 6 months. Not covered within first 6 months of delivery of denture.
D5411	adjust complete denture - mandibular	No	No	One per 6 months. Not covered within first 6 months of delivery of denture.

D5421	adjust partial denture - maxillary	No	No	One per 6 months. Not covered within first 6 months of delivery of denture.
D5422	adjust partial denture - mandibular	No	No	One per 6 months. Not covered within first 6 months of delivery of denture.

REPAIRS TO COMPLETE DENTURES

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5511	Repair broken complete denture base, mandibular	No	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable. Allowed once per year as deemed medically necessary.
D5512	Repair broken complete denture base, maxillary	No	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable. Allowed once per year as deemed medically necessary.
D5520	Replace missing or broken teeth - complete denture (each tooth)	No	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.

REPAIRS TO PARTIAL DENTURES

Benefit limitation for following codes: Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable. Allowed once per year as deemed medically necessary.

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5611	repair resin denture base, mandibular	No	No	As noted above
D5612	repair resin denture base, maxillary	No	No	As noted above
D5621	repair cast partial framework, maxillary	No	No	As noted above
D5622	repair cast partial framework, mandibular	No	No	As noted above
D5630	repair or replace broken clasp	No	No	As noted above
D5640	replace broken teeth - per tooth	No	No	As noted above
D5650	add tooth to existing partial denture	No	No-*more than four (4) units requires prior authorization*	As noted above
D5660	add clasp to existing partial denture	No	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable. Allowed once per year as deemed medically necessary.

DENTURE REBASE PROCEDURES

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

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5710	rebase complete maxillary denture	No	Yes	One of (D5710, D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.

D5711	rebase complete mandibular denture	No	Yes	One of (D5711, D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5720	rebase maxillary partial denture	No	Yes	One of (D5720, D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5721	rebase mandibular partial denture	No	Yes	One of (D5721,D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.

DENTURE RELINE PROCEDURES

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

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D5730	reline complete maxillary denture (direct)	No	Yes	One of (D5710, D5730, D5750) per 12 Month(s) Per patient. Fee for denture D5110, D5130 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5731	reline complete mandibular denture (direct)	No	Yes	One of (D5711, D5731, D5751) per 12 Month(s) Per patient. Fee for denture D5120, D5140 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5740	reline maxillary partial denture (direct)	No	No	One of (D5720, D5740, D5760) per 12 Month(s) Per patient. Fee for denture D5211, D5221 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5741	reline mandibular partial denture (direct)	No	No	One of (D5721, D5741, D5761) per 12 Month(s) Per patient. Fee for denture D5212, D5222 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5750	reline complete maxillary denture (indirect)	No	No	One of (D5710, D5730, D5750) per 12 Month(s) Per patient. Fee for denture D5110, D5130 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5751	reline complete mandibular denture (indirect)	No	No	One of (D5711, D5731, D5751) per 12 Month(s) Per patient. Fee for denture D5120, D5140 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5760	reline maxillary partial denture (indirect)	No	No	One of (D5720, D5740, D5760) per 12 Month(s) Per patient. Fee for denture D5211, D5221 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.
D5761	reline mandibular partial denture (indirect)	No	No	One of (D5721, D5741, D5761) per 12 Month(s) Per patient. Fee for denture D5212, D5222 includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.

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.

Code	Procedure	Age Limitation	Authorization Required
D5862	Precision attachment, by report	< 21	Yes
D5899	Unspecified prosthodontic removal procedure, by report	No	Yes

DENTURE FABRICATION BILLING FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

Providers are able to bill encounters to Medicaid for removable prosthetics during the fabrication phase based on standard of care. While post-insertion inspection and adjustments are anticipated, these are not covered per Medicaid policy in the first 6 months after delivery and similarly are not covered in the FQHC setting as additional encounters. The expected and allowed number of visits based on standard of care are listed below. Providers may be able to accomplish with fewer visits and should then bill fewer encounters. If additional visits are required during fabrication, it is allowed with documentation and subject to post-payment review.

Single complete denture, single complete denture with partial denture, or both upper and lower complete dentures.
Five encounters may be billed to Medicaid, based on anticipated appointments as follows: 1. Preliminary impressions, 2: Final impressions, 3. Jaw relation records, 4. Wax try-in, 5. Delivery. The appropriate appliance D codes should be included on the dental claim form only once for the appliances on the date they are delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

Single partial denture:
Three encounters may be billed to Medicaid, based on anticipated appointments as follows: 1. Impression and bite registration 2. Wax try-in, 3. Delivery. The appropriate appliance D code should be included in the dental claim form only once for the appliance on the date it is delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

Upper and lower partial denture
Four encounters may be billed to Medicaid, based on anticipated appointments as follows: 1. Impressions, 2. Bite registration, 3. Wax try-in, 4. Delivery. The appropriate appliance D codes should be included on the dental claim form only once for the appliances on the dates they are delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

MAXILLOFACIAL PROSTHETICS *-these services should be billed to the medical carrier using CPT codes. Contact Medicaid Provider Services for further information. Providers wishing to use CDT codes for maxillofacial prostheses should contact Medicaid Provider Services for further information.*

IMPLANT SERVICES

Implants are not a covered service.

FIXED PROSTHODONTICS

- Permanent bridges will be allowed for anterior permanent teeth only. ***Recipients must be less than 21 years of age.*** Please consult RIteSmiles provider manual for all policies related to recipients under age 21.

- 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

Code	Procedure	Age Limitation
D6211	pontic - cast predominantly base metal	< 21
D6212	pontic - cast noble metal	< 21
D6240	pontic - porcelain fused to high noble metal	< 21
D6241	pontic - porcelain fused to predominantly base mental	< 21
D6242	pontic - porcelain fused to noble metal	< 21
D6250	pontic - resin with high noble metal	< 21
D6251	pontic - resin with predominantly base metal	< 21
D6252	pontic - resin with noble metal	< 21

FIXED PARTIAL DENTURE RETAINERS - CROWNS

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

OTHER FIXED PARTIAL DENTURE SERVICES

Code	Procedure	Age Limitation	Teeth Covered	Authorization Required
D6999	unspecified, fixed prosthodontic procedure, by report	No		Yes

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.
- 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 hyperplasic 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**:**

- One panoramic radiographic image will be allowed for patients presenting with bilateral problems and no panoramic radiographic image is available.
- One panoramic radiographic image will be allowed if the patient is presenting with bilateral impacted third molars.
- One panoramic radiographic image will be allowed if the radiographs from the referring dentist are not of diagnostic quality. A copy of the radiographic image must be sent to the primary care dentist.
- One panoramic radiographic image will be allowed if the patient is a self- referral with no primary care dentist.

EXTRACTIONS

Extractions are limited to once per tooth per recipient's lifetime and include local anesthesia, suturing, if needed, and routine postoperative care.

Code	Procedure	Age Limitation	Authorization Required
D7111	extraction, coronal remnants – primary tooth	No	No
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	No

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

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth - soft tissue	No	No	Only covered for teeth that are symptomatic, carious, or pathologic.	
D7230	removal of impacted tooth - partially bony	No	No	Only covered for teeth that are symptomatic, carious, or pathologic.	
D7240	removal of impacted tooth - completely bony	No	No	Removal of asymptomatic tooth not covered.	Narrative of med necessity & full mouth x-rays

D7241	removal of impacted tooth - completely bony, with unusual surgical complications	No	No	Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	No	No	Only covered for teeth that are symptomatic, carious, or pathologic.	

Certain oral and maxillofacial surgery procedures are considered in-plan services for recipients enrolled in RIteCare, Medicaid Expansion and Rhody Health Partners. These procedures must be billed directly to the health plans. It is the providers' responsibility to contact the health plan(s) directly for claim submission guidelines. For a complete list of codes, please see the EOHHS website.
See here for listing and below.
Providers wishing to bill the services through the dental plan are asked to contact Medicaid services.

- Treatment of fractures, simple and compound; reduction of dislocation and management of other temporomandibular joint dysfunctions; cyst removal and tumor excision/resection.

OTHER SURGICAL PROCEDURES

Code	Procedure	Age Limitation	Authorization Required	In-plan oral health benefit
D7260	oroantral fistula closure	No	No	Yes
D7261	primary closure of a sinus perforation	No	No	Yes
D7270	tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth	< 21	No	Yes
D7280	exposure of an unerupted tooth	< 21	No	No
D7285	incisional biopsy of oral tissue - hard (bone, tooth)	No	No	Yes
D7286	Incisional biopsy of oral tissue - soft	No	No	Yes
D7320	alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant.	No	No	No
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	No	Yes	No
D7350	ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	No	Yes	No
D7410	excision of benign lesion up to 1.25 cm	No	No	Yes
D7411	excision of benign lesion greater than 1.25 cm	No	No	Yes
D7471	removal of lateral exostosis (maxilla or mandible)	No	No	Yes
D7510	incision and drainage of abscess - intraoral soft tissue	No	No	Yes
D7520	incision and drainage of abscess - extraoral soft tissue	No	No	Yes
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	No	No	Yes
D7540	removal of reaction-producing foreign bodies-musculoskeletal system	No	No	Yes
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	No	No	Yes
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	No	No	Yes
D7670	alveolus – closed reduction, may include stabilization of teeth	No	No	Yes
D7880	occlusal orthotic device, by report	Contact medical plan	Yes	Yes
D7899	unspecified TMD therapy, by report	Contact medical plan	Yes	Yes

REPAIR OF TRAUMATIC WOUNDS

Excludes closure of surgical incisions

Code	Procedure	Age Limitation	Authorization Required	In-plan oral health benefit
D7910	suture of recent small wounds - up to 5 cm	No	No	**Yes**

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

Excludes closure of surgical incisions

Code	Procedure	Age Limitation	Authorization Required	In-plan oral health benefit
D7911	complicated suture - up to 5 cm	No	No	**Yes**
D7912	complicated suture - greater than 5 cm	No	No	**Yes**

Frenectomy (Frenulectomy)

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. When the procedure is performed for an infant for breastfeeding purposes, it is a medical benefit only.

Code	Procedure	Age Limitation	Authorization Required	In-plan oral health benefit
D7961	buccal/labial frenectomy (frenulectomy)	No	No	**Yes**
D7962	lingual frenectomy (frenulectomy)	No	No	**Yes**
D7970	excision of hyperplastic tissue - per arch	No	No	**Yes**
D7971	excision of pericoronal gingiva	< 21	No	**Yes**
D7980	surgical sialolithotomy	No	No	**Yes**
D7981	excision of salivary gland, by report	No	No	**Yes**
D7982	sialodochoplasty	< 21	Yes	**Yes**
D7983	closure of salivary fistula	< 21	Yes	**Yes**
D7990	emergency tracheotomy	No	No	**Yes**

ORTHODONTIC SERVICES

Orthodontics is medically necessary services needed to correct handicapping malocclusion in recipients under age 21. The HLD (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 HLD 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 HLD 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 Medicaid 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 radiographic image, panoramic radiographic image 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, Medicaid 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, Medicaid will pay for a Comprehensive Oral Evaluation.

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

Orthodontic Services Claims Coding and Reimbursement

DENTITION

- ***Primary Dentition:*** *Teeth developed and erupted first in order of time.*
- ***Transitional (Mixed) Dentition:*** *The teeth in the jaws after the eruption of some of the permanent teeth but before all the primary teeth are exfoliated.*
- ***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.

Code	Procedure	Age Limitation	Authorization Required
D8010	limited orthodontic treatment of the primary dentition	< 21	Yes
D8020	limited orthodontic treatment of the transitional dentition	< 21	Yes
D8030	limited orthodontic treatment of the adolescent dentition	< 21	Yes
D8040	limited orthodontic treatment of the adult dentition	< 21	Yes

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.

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	Yes
		Procedure	**codes -**	**1st 6 months**	
1-6	D8071	D8081	D8091	< 23*	Yes
		Procedure	**codes -**	**2nd 6 months**	
1-6	D8072	D8082	D8092	< 23*	Yes
		Procedure	**codes -**	**3rd 6 months**	
1-6	D8073	D8083	D8093	< 23*	Yes
		Procedure	**codes -**	**4th 6 months**	
1-6	D8074	D8084	D8094	< 23*	Yes

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

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

MINOR TREATMENT TO CONTROL HARMFUL HABITS

Code	Procedure	Age Limitation	Authorization Required
D8210	removable appliance therapy	< 21	Yes
D8220	fixed appliance therapy	< 21	Yes

OTHER ORTHODONTIC SERVICES

Code	Procedure	Age Limitation	Authorization Required
D8660	pre-orthodontic treatment examination to monitor growth and development	< 21	No
D8670	periodic orthodontic treatment visit	< 21	No
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	< 21	No
D8695	removal of fixed orthodontic appliances for reasons other than the completion of treatment	< 21	No
D8999	unspecified orthodontic procedure, by report	< 21	Yes

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:

Code	Procedure	Age Limitation	Authorization Required
D8020	orthodontic-head gear therapy	< 21	Yes
D8030	orthodontic-minor tooth movement with Hawley appliance	< 21	Yes
D8060	orthodontic-maxillary expansion appliance	< 21	Yes
D8220	orthodontic-tongue guard fixed/removable	< 21	Yes
D8680	orthodontic-tooth retainer	< 21	No

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 Medicaid and continue to meet the age limitations.

CLIENT NAME	CLIENT DATE OF BIRTH	CLIENT ID
PROVIDER NAME	PROVIDER PHONE #	DATE OF EXAM

PART 1. TREATMENT REQUESTED

FULL TREATMENT ☐	INTERCEPTIVE TREATMENT ☐	TRANSFER CASE ☐
REQUIRES MAXILLO-FACIAL SURGERY? ☐	NO ☐	
YES		
PLEASE EXPLAIN:		

PART 2. DIAGNOSTIC INFORMATION

STAGE OF DENTITION:	PRIMARY	PERMANENT ☐	MIXED ☐
SKELETAL CLASSIFICATION:			
CLASS 1 ☐	CLASS 2 ☐		CLASS 3 ☐
POSTERIOR CROSSBITE (Indicate teeth involved below)	YES ☐		NO ☐

Please refer to the ADA Glossary of Clinical and Administrative Terms @ www.ada.org for definitions:			***LOCATION in Mouth***
ECTOPIC ERUPTION (EXCLUDING 3RDs):	YES ☐	NO ☐	
MISSING (indicate teeth)	YES ☐	NO ☐	
IMPACTED (indicate teeth)	YES ☐	NO ☐	
ANKYLOSED (indicate teeth)	YES ☐	NO ☐	
SUPERNUMERARY (indicate teeth)	YES ☐	NO ☐	
SEVERE TRAUMATIC DEVIATION- Please explain:			

PART 3. BRIEF INITIAL OPINIONS

RESTORATIONS COMPLETE: YES NO

If no, please explain plan: ___ ___

In approving orthodontic treatment, factors other than functional need will be considered. These other factors include the following:

	GOOD	FAIR	POOR
Current Oral Hygiene			
Patient's willingness and ability to meet appointments			
Patient's ability to follow instructions and cooperate to the end of the lengthy treatment period			
Patient's ability to maintain an acceptable level of oral hygiene, which is vital to success of orthodontic treatment during the treatment period			

PART 4.HLD INDEX (Please complete the following PARTS A & B--See instructions below for scoring guideline

PART A.		Requesting Dentist	Reviewer
1. CLEFT LIP & PALATE DEFORMITIES: Indicate with an X			
2. IMPACTED ANTERIOR TEETH when extraction is not indicated: Indicate with an X			
3. DEEP IMPINGING OVERBITE: Indicate with an X only if tissue damage is present			
4. ANTERIOR CROSSBITE: Indicate with an X only if tissue destruction is present			
5. OVERJET in mm (> 9 mm) - Indicate with an X			
6. REVERSE OVERJET (MANDIBULAR PROTRUSION) (> 3.5 mm) Indicate with an X			
PART B.		Requesting Dentist	Reviewer
7. OVERJET in mm (= to or < 9 mm)			
8. SEVERE TRAUMATIC DEVIATION: must document in PART 2.- Score 15 points			
9. OVERBITE in mm	x1=		
10. REVERSE OVERJET (MANDIBULAR PROTRUSION) in mm (= to or < 3.5 mm)	x5=		
11. OPENBITE in mm	x4=		
12. ANTERIOR CROWDING Score 1 point for maxillary and 1 point for mandibular -- maximum # of 10 points	x5=		
13. ECTOPIC ERUPTION: count each tooth Do not score both anterior crowding & anterior ectopic eruption, use more severe of two.	x3=		
14. POSTERIOR UNILATERAL CROSSBITE: Score 4 points			
TOTAL POINTS- PART B.			

Treatment Narrative: Please provide any additional information that will substantiate your treatment request.

PLEASE NOTE: The HLD scoring is a guideline for your use and is a reference for the Rhode Island Medicaid Program consultant. You will still be required to submit photographs and supporting radiographs. The Rhode Island Medicaid Program will make the final decision regarding medical necessity and scoring criteria.

I certify that I am the Performing Provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I certify that I performed the above noted examination on this client.

TREATING PROVIDER'S SIGNATURE	PRINT NAME	DATE

FOR REVIEW PURPOSES ONLY:

RHODE ISLAND MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATION INDEX SCORING INSTRUCTIONS

The intent of the HLD Index is to measure the presence or absence and the degree of the handicap caused by the components of the Index, and not to diagnose "malocclusion". All measurements are made with a Boley Gauge scaled in millimeters. Absence of any conditions must be recorded by entering "0". (Refer to attached score sheet.) The following information should help clarify the categories on the HLD Index:

PART A. Note: 1 – 6 - If any one of these conditions exist, it is automatically considered to be a severe handicapping malocclusion and is indicated by an "X" and scored no further.

1. Cleft Palate Deformities: Indicate an "X" on the score sheet. (This condition is considered to be handicapping malocclusion.)

2. Impacted Anterior Teeth: Indicate an "X" on the score sheet when there is/are anterior tooth or teeth (incisors and cuspids) is/are impacted (soft or hard tissue) and not indicated for extraction and treatment planned to be brought into occlusion.

3. Deep Impinging Overbite: Indicate an "X" on the score sheet when lower incisors are damaging the soft tissue of the palate. **This should only be marked if there is tissue laceration and/or clinical attachment loss is present. Palatal indentations are not considered tissue destruction. Photographic documentation must be present.**

4. Crossbite of Individual Anterior Teeth: Indicate an "X" on the score sheet when destruction of soft tissue is present. **This should only be marked if there is clinical attachment loss and/or recession of the gingival margin is present. Photographic documentation must be present.** 5. Overjet in Millimeters: Indicate an "X" on the score sheet if the overjet measures greater than 9 millimeters. This is recorded with the patient in the centric relationship and should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. The measurement could apply to a protruding single tooth as well as to the whole arch.

5. Reverse Overjet (Mandibular Protrusion) > 3.5 Millimeters: Measured from the labial of the lower incisor to the labial of the upper incisor. Indicate an "X" on the score sheet if a reverse overjet of greater than 3.5 millimeters is present.

6. **PART B. Complete 7. - 13. 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 26 or more qualifies for authorization. Completion instructions are below.**

7. Overjet equal to or less than 9mm: Overjet is recorded as in condition #5 above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.

8. Severe Traumatic Deviations: Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. The presence of severe traumatic deviations is indicated by a score of 15 on the score sheet.

9. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

10. Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. The measurement is entered on the score sheet and multiplied by 4. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

11. Reverse Overjet (Mandibular Protrusion) equal to or less than 3.5mm: Mandibular protrusion (reverse overjet) is recorded as in condition #6 above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

12. 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. Enter 5 points each for maxillary and mandibular anterior crowding. If condition No. 13, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. **Do not score both conditions.**

13. Ectopic Eruption: Count each tooth, excluding third molars. Enter the number of teeth on the score sheet and multiply by 3. In condition No. 12, 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.**

14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the score sheet.

ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations
D9110	palliative treatment of dental pain -per visit	No	No	Other non-emergency medically necessary treatment may be provided during the same visit. Treatment that relieves pain but is not curative; services provided do not have a distinct procedure code. Not to be used for prescriptions, or to address routine post-procedural complications

ANESTHESIA

General anesthesia and IV sedation are limited to recipients < 21 and patients with special healthcare needs, including intellectual and developmental disability. General anesthesia is paid for the first 15-minutes (D9222) and up to three (3) subsequent 15-minute increments (D9223) on the same day of service for services rendered in the office setting. The same guidelines apply to IV moderate sedation procedures D9239 and D9243. Anesthetic Management is limited to one (1) method per patient for the same day of service.

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

Code	Procedure	Age Limitation	Authorization Required
D9212	trigeminal divisional block anesthesia	< 21	No
D9222	deep sedation/general anesthesia – first 15 minutes	< 21	Yes, for 21and over
D9223	deep sedation/general anesthesia – each subsequent 15 minutes increment	< 21	Yes, for 21 and over
D9230	inhalation of nitrous oxide/ analgesia, anxiolysis	< 21	Yes, for 21 and over
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	< 21	Yes, for 21 and over
D9243	intravenous moderate (conscious) sedation/analgesia each subsequent 15-minute increment	< 21	Yes, for 21 and over

PROFESSIONAL CONSULTATION

Code	Procedure	Age Limitation	Authorization Required
D9310	consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician	No	No

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. Not to be used by treating dentist routinely performing exams and not to be used in addition to exams including D0120, D0140, D0150.

Code	Procedure	Age Limitation	Authorization Required
D9410*	house call / extended care facility call	No	No

Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate procedure codes for actual services performed.

**The D9410-House/Extended Care Facility Call procedure code must be billed with a CDT code indicating a service provided and cannot be billed alone.*

Mobile services provided by fee-for–service providers to long term care/home care residents may only be reimbursed for a maximum of five visits per day, per facility, per provider. Providers may not bill the D9410-House/Extended Care Facility Call for each recipient seen during a single nursing home visit beyond five even when a reimbursable Medicaid Service is being rendered to multiple recipients. Claim must be submitted with one of the following place of service (POS) codes to be considered for payment

(03,04,12,13,14,31,32,33,34, or 99). Facility name and address must be placed on the claim form in the narratives section.

Mobile dental providers who bill fee-for–service, may bill the D9410 for nursing home or other long term care visits related to procedures whose payment is considered all-inclusive. i.e., impressions, try-in, adjustments, related to the fabrication of dentures, and should use the non-paying code D0999 representing an interim denture step. These are subject to post-procedure review.

Code	Procedure	Age Limitation	Authorization Required
D9420	hospital or ambulatory surgical center call	No	No

May be reported when providing treatment in hospital or ambulatory surgicenter, in addition to reporting appropriate codes for actual services performed.

DRUGS

Code	Procedure	Age Limitation	Authorization Required
D9610	therapeutic parenteral drug, single administration	No	Yes
D9630	drugs or medicaments dispensed in the office for home use	No	Yes

MISCELLANEOUS SERVICES

Code	Procedure	Age Limitation	Authorization Required	Benefit Limitations	Documentation Required
D9910	application of desensitizing medicament	< 21	Yes		
D9920	behavior management, by report	No	No	One of (D9920) per 1 Day(s) Per Provider OR Location.	Include a description of the members illness or disability and types of services furnished. Should not be used solely based on diagnosis if significant modifications to care were not required.
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	No	Yes		
D9944	occlusal guard—hard appliance, full arch	< 21	Yes		
D9945	occlusal guard—soft appliance, full arch	< 21	Yes		
D9946	occlusal guard—hard appliance, partial arch	< 21	Yes		
D9995	teledentistry- synchronous; real-time encounter	No	No	Limitations apply to procedure code used with teledentistry code	Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.
D9996	teledentistry- asynchronous; information stored and forwarded to dentist for subsequent review	No	No	Limitations apply to procedure code used with teledentistry code	Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.