

**DENTAL**



**COVERED SERVICES  
AND LIMITATIONS  
MODULE**



**Dental  
Covered Services and Limitations Module**

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## Covered Dental Services for Patients Under the Age of 21 Years

### Examinations

- Routine periodic oral evaluations (CDT D0120) are recommended every six (6) months.
- Limited oral evaluations (CDT D0140) are recommended every six (6) months.
- Comprehensive oral evaluations (CDT D0150) are recommended once every twelve (12) months.
- Detailed and extensive oral evaluations (CDT D0160) are recommended once in a two (2) year period.

### Radiographs and Diagnostic Imaging

- Diagnostic radiological procedures, performed in accordance with current American Dental Association guidelines, are to be limited to those instances in which a dentist anticipates that the information is likely to contribute materially to the proper diagnosis, treatment, and prevention of disease. Routine use of periapical radiographs for primary anterior teeth is not considered appropriate unless there is clearly documented medical need.
- Complete mouth x-rays (CDT D0210) are recommended once every five (5) years unless special need is documented.
- Bitewing x-rays (CDT D0270-D0274) are recommended once every year unless special need is documented.
- When making referrals, the referring dentist should send to the specialist a copy of or the current radiographs to prevent unnecessary duplication of services, expenditure and radiation exposure.

### Preventative Dental Care

- Prophylaxis (CDT D1110 and D1120) is recommended every six (6) months.
- Topical fluoride application (office visits) (CDT D1201-D1205) is recommended every six (6) months, if the dentist determines it appropriate.
- The application of sealants is recommended for permanent posterior teeth displaying previously untreated or incipient pits and fissures including enamelplasty or other prophylactic pretreatment or preparation.

### Restorative Treatment

- Restorative treatment is limited to those services essential to restore and maintain adequate dental health.
- Pins and special preparations are reimbursed separately from the restoration.
- Fixed bridges and cast partials are covered only for the replacement of permanent teeth. A fixed bridge is not a reimbursable service when done in conjunction with a removable appliance in the same arch.
- Temporary restorations are reimbursable only as a result of palliative or emergency treatment.

## Crowns

- Preformed metal or tooth colored plastic/composite materials for the fabrication of an interim crown are reimbursable for severely fractured or carious permanent teeth. The dentist may place a permanent crown when determined appropriate.
- Treatment of severely decayed primary posterior teeth is reimbursable for those teeth that are not expected to exfoliate.
- Primary molars, with no permanent tooth bud visible by x-ray, may have permanent crowns placed if decay or marked attrition is present.

## Labial Veneers

Labial veneers may be used instead of full crowns for anterior permanent teeth that are severely fractured or carious, having continuous loss of fillings. Only CDT-3 codes D2961 or D2962 will be reimbursed. Documentation to justify the need for services **must** be included in the patient's record.

## Endodontics

- The fee for endodontic treatment will include all necessary radiographs during treatment, including preoperative and postoperative radiographs.
- Root canal therapy for permanent teeth includes extirpation, treatment, gutta percha filling of root canals, and all necessary radiographs, including a post-treatment radiograph. Permanent teeth filled with materials other than gutta percha will not be considered standard root canal therapy, and are not reimbursable by EqualityCare.
- Emergency endodontic procedures, i.e., open tooth to drain, may be performed prior to root canal therapy. A pulpotomy is not to be billed in conjunction with root canal therapy or as an emergency endodontic procedure.
- Endodontic treatment will only be reimbursed for situations where adequate bone viability can be documented.
- A radiograph demonstrating the completed endodontic treatment is required to be a part of the clinical procedure and must be included in the patient's permanent clinical record.
- Pulpal therapy for primary posterior teeth is reimbursable for those teeth determined by a provider not to exfoliate.

## Apicoectomy

- Preoperative and postoperative radiographs are required as part of the clinical procedure for apicoectomies.
- A retrograde filling may be placed when necessary and billed separately.

## Periodontal Treatment

- Scaling, root planning, curettage and gingivectomies are considered one procedure regardless of the number of visits it takes to complete each of these procedures.
- Minor scaling procedures will be considered part of a prophylaxis.

### Implant Services

All procedures that are described in the *Current Dental Terminology, Fourth Edition* (CDT-4) within the code range D6010-D6199 are covered. Documentation of bone density, bone height and completion of skeletal growth **must** be in the patient record.

### Oral and Maxillofacial Surgery

- Current radiographs and other clinical documentation are required for all teeth that need to be extracted and must be maintained in the patient record.
- Extractions of impacted teeth will only be reimbursed when there is pain and/or infection, radiographically evident pathology, or other documented special need.
- CDT codes D7111-D7140, D7210-D7240, D7250, D7281, D7510 and D7960 are reimbursable when billed on a dental claim form. CDT code D7241 should be billed using a CPT code on a CMS-1500.

### Interceptive Orthodontic Treatment

- Only CDT-4 codes D8050 and D8060 will be reimbursed. Guidelines in the CDT-4 Manual state: "Treatment using codes for interceptive orthodontic treatment are for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. An extension of preventative orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite or recovery of recent minor space loss where overall space is adequate." Documentation of need for services must be included in the patient's record.

### Anesthesia

- CDT codes within range D9210-D9248 are reimbursable services. Dentists may only administer parenteral sedation, general anesthesia and nitrous oxide if they meet the requirements of the Wyoming State Board of Dental Examiners or the licensing board in the state they practice.
- Sedation and general anesthesia shall not be used routinely, but limited to those patients requiring dental care who would not be expected to tolerate treatment or become unmanageable in the usual office setting due to medical, emotional or developmental limitations, and/or extent of treatment needs that are documented.
- The administration of intravenous (IV) or intramuscular (IM) sedation is subject to the same requirements as general anesthesia. CDT D9248 should be used for billing IM sedation.

### Behavior Management

- Behavior Management, CDT D9920 is a covered benefit for clients under twenty-one (21) years old who exhibit behavior(s) that require additional time for procedure to be completed; documentation must be a part of the patient's record. This procedure is reimbursable based on 15-minute increments, at a maximum of \$60.00 per visit, limited to \$180.00 per year.

## Covered Dental Services for Patients Age 21 Years and Older

EqualityCare clients twenty-one (21) years of age and older are limited to dental services for the emergency relief of pain and/or infection.

An emergency visit for relief of pain or infection may consist of one or more of the following:

- Limited oral evaluation-problem focused (CDT D0140) is reimbursable twice every twelve (12) months for emergency treatment of dental pain.
- Palliative (emergency) treatment of dental pain (CDT D9110) is reimbursable twice every twelve (12) months in addition to CDT D0140.
- Extractions (CDT D7140-D7250), incision and drainage (CDT D7510) are reimbursable when determined to be medically necessary during an emergency exam.
- Diagnostic radiograph(s) to document pathological involvement of the tooth (teeth).
- Extractions are reimbursable only for those teeth that demonstrate radiographically pathologic pulpal involvement, periapical infection, periodontally involved teeth of the class IV category, and large carious lesions that the eligible client wants extracted even though they have been informed of alternate treatment remedies.
- Incision and drainage is reimbursable when an emergency extraction cannot be performed due to health reasons or in the case of gingival infection (pericoronal or lateral abscess due to periodontal pathology).
- Anesthesia is reimbursable including general anesthesia when medically necessary.
- Dentures are **not covered** under EqualityCare. Patients who are 65 years or older can be referred to Wyoming's Dental Health Services Elderly Program at (307) 777- 7945 for more information.

## Procedures Common to Dentistry and Medicine - All Ages

Procedures common to dentistry and medicine, which are currently reimbursed by EqualityCare when performed by a medical practitioner, are reimbursable when performed by a licensed dentist regardless of the age of the client. Oral surgical services are considered such procedures and are not subject to the age limits that apply to dental services described in the Dental Program Covered Services section. **CPT codes** billed on a **CMS-1500** claim form must be used when billing for these services (refer to the CMS-1500 Billing Module for billing instructions).

### Maxillofacial Prosthetics

All procedures that are described in the *Current Dental Terminology, Fourth Edition (CDT-4)* within the code range D5900-D5999 must be billed using **CPT codes** on a **CMS-1500** claim form (refer to the CMS-1500 Manual for billing instructions).

### Oral and Maxillofacial Surgery

All procedure codes within the CDT code range D7000 - D7999 **except** the following codes must be billed using **CPT codes on a CMS-1500** claim form (refer to the CMS-1500 Billing Module for billing instructions).

The following codes can be billed as **CDT codes**:

Extraction codes CDT D7140-D7240 & D7250, Incision and drainage code CDT D7510, Tooth reimplantation CDT D7270, Surgical exposure of impacted tooth CDT D7281, Occlusal orthotic device CDT D7880, Appliance removal CDT D7997.

### Supernummary Teeth

1. For alphabetic tooth codes, add an S to the front of the code (e.g. supernummary tooth B becomes SB).
2. For numeric tooth codes, add 50 to the tooth code value (e.g. supernummary tooth 15 becomes 15 + 50 =65).

### Temporomandibular Joint (TMJ) Treatment Policy

Temporomandibular Joint (TMJ) treatment is a covered service for all EqualityCare clients, when medically necessary, regardless of age.

EqualityCare will cover non-surgical and surgical interventions to correct TMJ dysfunctions. Non-surgical interventions must be utilized continuously for at least six months before EqualityCare will reimburse a surgical intervention. The non-surgical interventions (“Phase I”) that are reimbursable by EqualityCare include the following:

- Muscle relaxants and other medications prescribed by a dentist or physician;
- Physical therapy;
- Use of an occlusal orthotic device (dentist can bill using CDT D7880);
- Other non-surgical interventions as prescribed by a dentist or physician including psychological testing and a MRI (refer to the psychiatric services policy in the CMS-1500 Covered Services and Limitations Module for information on EqualityCare eligible providers). **Orthodontic treatment is not reimbursable.**

If the TMJ dysfunction persists after the above non-surgical interventions have been tried for a period of at least six months with a high degree of patient compliance, then EqualityCare will consider reimbursing a surgical intervention if deemed medically necessary by an oral surgeon or physician. All surgical procedures must be billed with a CPT code. Surgical procedures that require prior authorization are noted on the EqualityCare Surgery Fee Schedule.

For those surgical procedures that require prior authorization, the following information must be submitted to ACS, Inc. for review: (Refer to the CMS-1500 Covered Services Module)

- Documentation of the “Phase I” interventions that were used to treat the patient’s TMJ symptoms, including a narrative report on the patient’s level of compliance with treatment during a minimum of six months;
- Radiologic evidence that demonstrates the presence of a TMJ disorder;
- Patient history including a report on previous injuries to the TMJ.

Psychological testing and MRIs are not required in order to receive authorization for TMJ surgery. These procedures should only be prescribed if deemed medically necessary to determine the necessity for surgical intervention.

### Maternal Dental Care Services (MDCS)

The MDCS program covers services for pregnant women over 21. Eligibility for this program is granted by Best Beginnings. Most routine services are covered through MDCS. The following procedures require prior authorization from Dental Health Services:

- Crowns
- Core Build-up
- Pin Retention
- Endodontic Treatments

Each EqualityCare patient's clinical record must include sufficient documentation that would enable a dental consultant to determine the appropriateness of the treatment performed without requiring a patient examination. Each EqualityCare clinical record shall include, at a minimum, documentation of clinical diagnosis, pertinent medical and dental history, a treatment plan, complete anesthesia record is applicable, and any radiographs used to facilitate the development of this plan. EqualityCare clinical records shall be maintained for six years.

### Non-Covered Services

D0425	Caries susceptibility tests
D1310	Nutritional counseling for control and prevention of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1330	Oral hygiene instructions
D2410-D2430	Gold Foil
D2510-D2530	Inlay - metallic
D2542-D2544	Onlay - metallic
D2610-D2630	Inlay - porcelain/ceramic
D2650-D2652	Inlay - resin-based-composite
D2662-D2664	Onlay - resin-based-composite
D2960	Labial veneer (laminare) - chairside
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons
D9940	Occlusal guard
D9941	Fabrication of athletic mouth guard
D9970	Enamel Microabrasion
D9972-D9974	External & Internal Bleaching

### Orthodontics

*EqualityCare does not reimburse LIMITED OR COMPREHENSIVE orthodontic services.*

EqualityCare eligible clients under the age of twenty-one (21) may receive treatment for severe crippling malocclusion through the State of Wyoming's Dental Health Services Program. CDT codes within the code range D8000-D8040 and D8070-D8999 and CDT code D7280 will not be reimbursed through the EqualityCare Dental Program. Patients with this diagnosis should be referred to Wyoming's Dental Health Services Program at (307) 777-7945 for additional information.

## **Medical Necessity**

All dental services shall comply with the medical necessity definition found in “Chapter Three, Provider Participation” of the EqualityCare Rules. The definition reads as follows:

“A health service that is required to diagnose, treat, cure or prevent an illness, injury or disease which has been diagnosed or is reasonably suspected; to relieve pain; or to improve and preserve health and be essential to life. The service must be:

- (i) Consistent with the diagnosis and treatment of the client’s condition;
- (ii) In accordance with the standards of good medical practice among the provider’s peer group;
- (iii) Required to meet the medical needs of the client and undertaken for reasons other than the convenience of the client and the provider; and
- (iv) Performed in the most cost effective and appropriate setting required by the client’s condition.”

EqualityCare shall not reimburse surgical procedures performed exclusively for cosmetic purposes. Cosmetic surgical procedures are defined as those surgical procedures intended solely to improve the physical appearance of an individual, which do not restore bodily function or correct deformity.

## **Prior Authorization**

EqualityCare shall only require prior authorization for those services billed with CPT codes on a CMS-1500 claim form that currently require prior authorization for all medical providers (refer to the CMS-1500 Manual for CPT code billing instructions). These are primarily surgical codes that will typically be used by oral surgeons.

## **Documentation**

Each EqualityCare patient’s clinical record must include sufficient documentation that would enable a dental consultant to determine the appropriateness of the treatment performed without requiring a patient examination. Each EqualityCare clinical record shall include, at a minimum, documentation of clinical diagnoses, pertinent medical and dental history, a treatment plan, complete anesthesia record if applicable, and any radiographs used to facilitate the development of this plan. EqualityCare clinical records shall be maintained for six years.