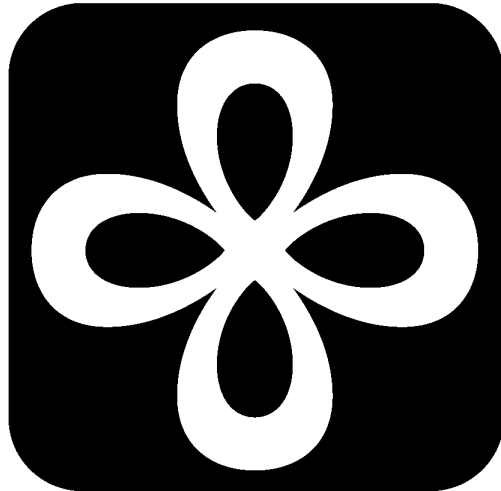


**STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES**

MEDICAID



Provider Manual

Dental Services



CHAPTER E. COVERAGE AND LIMITATIONS

Page

I.	DENTISTS ELIGIBLE TO PARTICIPATE.....	E-1
II.	COVERAGE OF DENTAL SERVICES.....	E-1
A.	Diagnostic Services.....	E-1
1.	Radiographs.....	E-2
2.	Casts.....	E-3
B.	Preventive Services.....	E-3
1.	Oral Prophylaxis.....	E-3
2.	Pit and Fissure Sealants.....	E-3
3.	Care for Kids.....	E-4
C.	Restorative Services.....	E-6
1.	Crowns.....	E-6
2.	Payment Limitations.....	E-7
D.	Endodontic Treatment.....	E-8
E.	Periodontic Services.....	E-9
F.	Prosthetics.....	E-10
1.	Complete Dentures.....	E-10
2.	Removable Partial Dentures.....	E-11
3.	Fixed Partial Dentures.....	E-12
4.	Other Services.....	E-12
G.	Oral Surgery.....	E-13
H.	Orthodontics.....	E-14
I.	Prior Approval.....	E-16
1.	Process for Obtaining Prior Approval.....	E-16
2.	Procedures Requiring Prior Authorization.....	E-17
J.	Documentation of Medical Necessity.....	E-21
K.	Exclusions and Limitations on Coverage.....	E-22
1.	Adult Services.....	E-22
2.	Prescription of Drugs.....	E-25
3.	Hospitalization for Dental Care.....	E-25
4.	Nursing Home Visits.....	E-25
5.	Office Visit After Hours.....	E-25
III.	BASIS OF PAYMENT FOR DENTAL SERVICES.....	E-25



CHAPTER SUBJECT: TABLE OF CONTENTS DENTAL SERVICES	PAGE 5
	DATE July 1, 2002

	<u>Page</u>
IV. DENTAL PROCEDURE CODES AND NOMENCLATURE	E-26
A. Diagnostic Procedures	E-26
B. Preventive Procedures.....	E-28
C. Restorative Procedures	E-30
D. Endodontic Procedures	E-32
E. Periodontic Procedures	E-34
F. Prosthetic Procedures.....	E-37
G. Oral Surgery Procedures.....	E-43
H. Orthodontic Procedures	E-51
I. Adjunctive General Services	E-52

CHAPTER F. BILLING AND PAYMENT

I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS.....	F-1
A. How to Use	F-1
B. Facsimile of Request for Prior Authorization.....	F-1
C. Instructions for Completing Request for Prior Authorization	F-1
II. CLAIM FORM AND INSTRUCTIONS.....	F-7
A. Instructions for Completing the 1999 ADA Claim Form	F-7
B. Facsimile of Dental Claim Form.....	F-12a
III. REMITTANCE STATEMENT AND EXPLANATION	F-15
A. Remittance Statement Explanation	F-15
B. Facsimile of Remittance Statement	F-16
C. Remittance Statement Field Description	F-19
IV. PROBLEMS WITH SUBMITTED CLAIMS	F-21
A. Facsimile of Provider Inquiry, 470-3744.....	F-22
B. Facsimile of Credit/Adjustment Request, 470-0040.....	F-22

APPENDIX

I. ADDRESSES OF COUNTY HUMAN SERVICES OFFICES	1
II. ADDRESSES OF SOCIAL SECURITY ADMINISTRATION OFFICES	9
III. ADDRESSES OF EPSDT CARE COORDINATION AGENCIES	13



CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

DENTAL SERVICES

CHAPTER PAGE

E - 1

DATE

July 1, 2002

I. DENTISTS ELIGIBLE TO PARTICIPATE

All dentists licensed to practice in the state of Iowa are eligible to participate in the Medicaid Program. Dentists in other states are also eligible to participate, providing they are duly licensed in that state.

Note: Payment will not be made to a dental laboratory unless it is under the supervision of a dentist.

II. COVERAGE OF DENTAL SERVICES

Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery, or dental medicine and would be covered if furnished by doctors of medicine or osteopathy.

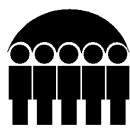
Basic Medicaid dental benefits include those services which are reasonable and necessary for the prevention, diagnosis, and treatment of dental disease or injuries, subject to the limits listed in the following sections. (See items A through H.)

Certain services require prior approval before starting the service. (See item I.) Payment will be made for certain procedures based on documentation of medical necessity. (See item J.)

Section IV lists the procedure codes for which Medicaid payment will be made.

A. Diagnostic Services

A comprehensive oral evaluation is payable once per recipient per dentist in a three-year period when the recipient has not seen that dentist during the three-year period. It is not payable in conjunction with emergency treatment visits, denture repairs, or similar appointments.



A periodic oral evaluation is a payable benefit once in a six-month period. The six-month period starts from the date of the examination.

Payment will be approved for an evaluation limited to a specific oral health problem. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation.

Typically, recipients receiving this type of evaluation have been referred for a specific problem or present with dental emergencies, trauma, acute infections, etc. These office visits should be billed as an emergency oral evaluation under procedure code D0140. These services require documentation on the claim form or attached to the claim form which specifies the medical and dental necessity of the visit.

1. Radiographs

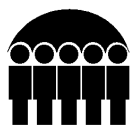
A complete mouth X-ray survey, consisting of a minimum of 14 periapical films and bitewing films, is a covered benefit once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. A panoramic X-ray with bitewings is considered the same as a complete mouth X-ray survey.

Complete mouth radiograph surveys are not payable for children under the age of six. When medically necessary, a panoramic film is payable for a child under the age of six.

Children should receive only the minimum number of X-rays needed to detect anomalies, diseases, and to evaluate development. When a child has received recent radiographs in another dental office, efforts should be made to obtain those radiographs so that re-exposure of the child can be avoided.

Supplemental bitewing films are a covered benefit not more than once every 12 months. Single periapical films are a covered benefit when necessary.

Intraoral and extraoral films are payable when necessary to diagnosis a condition.



A posterior-anterior or lateral skull and facial bone film is payable when necessary to diagnosis a condition.

Temporomandibular joint and cephalometric films are payable when necessary to diagnosis a condition.

2. Casts

Diagnostic casts are a limited benefit and are payable only for orthodontic cases or when requested by a dental consultant. Diagnostic costs are not covered for adults 21 years of age and older.

B. Preventive Services

The intent of preventive services is not only to restore form and function, but also to prevent the occurrence or reoccurrence of oral disease.

1. Oral Prophylaxis

Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period, except for recipients who, because of physical or mental disability need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

Topical application of fluoride is payable once in a six-month period, except for persons who, because of a physical or mental disability need more frequent care. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

2. Pit and Fissure Sealants

Pit and fissure sealants are payable for placement on first and second permanent molars only. Reimbursement for sealants is restricted to work performed on children through 18 years of age for first and second permanent molars and for persons who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene.



Replacement sealants are covered when medically necessary, as documented in the recipient record.

3. Care for Kids

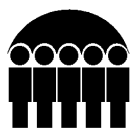
Early and periodic screening, diagnosis, and treatment (known in Iowa as the “Care for Kids” program) is payable for children under age 21. The U.S. Department of Health and Human Services requires that the Medicaid program place special emphasis on early and periodic screening and diagnosis to ascertain physical and mental defects and provide treatment for conditions discovered.

The purpose of the dental screening is to identify dental anomalies or diseases, such as dental caries, soft tissue lesions, or developmental problems and to ensure that preventive dental education is provided to the parent or guardian.

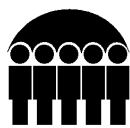
Screening may include the following:

◆ At age 6-12 months:

- The clinical oral examination and appropriate diagnostic tests to assess oral growth and development and pathology.
- Oral hygiene counseling for parents, guardians, and caregivers.
- Assessment of systemic fluoride status and fluoride supplementation, if indicated, following drinking water analysis.
- Assessment of topical fluoride status and parental counseling.
- Assessment of appropriateness of feeding practices.
- Dietary counseling related to oral health.
- Injury prevention counseling for orofacial trauma (play objects, pacifiers, car seats, etc.).
- Treatment of any oral disease or injury.
- Counseling for oral habits (digit, pacifiers, etc.).



- ◆ At age 12-24 months:
 - Repetition of 6-12 month procedures every six months or as indicated by the recipient's susceptibility to disease and needs.
 - Injury prevention counseling for dento-facial trauma (learning to walk, run, etc.).
- ◆ At age 2-6 years:
 - Repetition of 12-24 month procedures every six months, or as indicated by the recipient's susceptibility to disease and needs.
 - Radiographic assessment of pathology and growth and development, as indicated for individual recipient's needs, as determined by the dentist.
 - Prophylaxis twice a year or as determined by the dentist.
 - Topical fluoride treatments twice a year or as determined by the dentist.
 - Pit and fissure sealants as indicated by individual recipient's needs, as determined by the dentist.
 - Counseling for oral habits (digit, pacifiers, etc.).
 - Injury prevention counseling for dento-facial trauma (play, sports, etc.).
 - Assessment and treatment of developing malocclusion, as indicated by individual recipient's needs.
 - Treatment of dental diseases, habits, or injuries, as indicated.
- ◆ At age 6-12 years:
 - Repetition of 2-6 year procedures every six months or as indicated by the individual recipient's susceptibility to disease and needs.
 - Pit and fissure sealants for permanent teeth when indicated, as soon as possible after their eruption.
 - Injury prevention counseling for dento-facial trauma (athletic mouth guards).



◆ At age 12-21 years:

- Repetition of 6-12 years procedures every six months or as indicated by the recipient's susceptibility to disease and needs.
- Assessment and removal of third permanent molars when indicated.
- Referral for regular continuing dental treatment at age determined by recipient, parent, and dentist.
- Substance abuse counseling (smoking, smokeless tobacco, etc.).

Recommended ages for children to receive dental screening is at 12 months, 24 months, and six-month intervals thereafter.

Interperiodic screening is mandated. The periodicity schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Interperiodic screening, diagnosis, and treatment allows the flexibility necessary to strengthen the preventative nature of the program.

C. Restorative Services

Treatment of dental caries is a covered benefit in those areas that require immediate attention. Restoration of incipient or nonactive carious lesions is not a covered benefit. Carious activity may be considered incipient when there is no penetration of the dentoenamel junction as demonstrated in diagnostic X-rays. Prophylactic fillings are not a Medicaid benefit.

Medicaid covers amalgam alloy or composite resin filling material. Composite restorations are payable benefits and are reimbursable only once in a two-year period.

1. Crowns

Effective for services delivered on or after May 10, 2002, crowns for adults 21 years of age and older are covered only on permanent anterior teeth and only when necessary to maintain the integrity of the tooth structure after a root canal treatment.



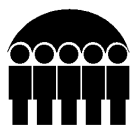
Two laboratory fabricated crowns utilizing non-precious materials are payable per recipient in a 12-month period, unless prior authorization has been obtained. Noble metals are payable when recipients are allergic to all other restoration materials. Stainless steel crowns are provided only when a more conservative procedure would not be serviceable.

Cast post and core, steel post and composite, or steel post and amalgam in addition to a crown are a covered benefit when the tooth is functional and the integrity of the tooth would be jeopardized by no post support. These services are not covered for adults age 21 and over.

2. Payment Limitations

Payment for restorative services will be made as follows:

- ◆ Amalgam or acrylic buildups are considered part of the crown preparation for the completed restoration. No additional payment will be made.
- ◆ One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar, or mesial and distal occlusal pits of a lower bicuspid.
- ◆ Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one two-surface restoration.
- ◆ A two-surface anterior composite restoration is payable as a one-surface restoration if it involves the lingual surface.
- ◆ Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia, and inhaled anesthesia are included in the restorative fee and may not be billed separately.
- ◆ Pin retention is paid on a per-tooth basis and in addition to the final restoration. This service is not covered for adults age 21 and over.
- ◆ More than four surfaces on an amalgam restoration will be reimbursed as a “four-surfaced” amalgam.



- ◆ An amalgam restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

D. Endodontic Treatment

No endodontic services were covered for adults from March 1, 2002, to May 10, 2002. Effective May 10, 2002, endodontic services for adults 21 years of age and over are covered only for root canal treatments on permanent anterior teeth numbers 6 through 11 and 22 through 27. Crowns necessary to maintain the integrity of a permanent anterior tooth after a root canal treatment are covered for adults.

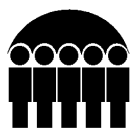
Root canal treatments on permanent anterior and posterior teeth are a covered benefit when extensive posttreatment restorative procedures are not necessary, and when missing teeth do not jeopardize the integrity or function of the dental arches. Root canal treatments do not require prior approval.

Vital pulpotomies are clinical findings and do not require prior approval. Cement bases, pulp capping, and insulating liners are considered part of the restoration and must not be billed separately.

Covered surgical endodontic treatment includes an apicoectomy performed either as a separate surgical procedure or in conjunction with endodontic procedure, an apical curettage, a root resection, and excision of hyperplastic tissue.

Payment shall be approved when nonsurgical treatment has been attempted, a reasonable time has elapsed, and treatment failure has been demonstrated. Surgical endodontic procedures may be indicated when:

- ◆ Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, débrided, or obturated due to calcifications, blockages, broken instruments, severe curvatures, open-ended canals, and dilacerated roots.
- ◆ Problems resulted from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.



E. Periodontal Services

Effective March 1, 2002, periodontal services are not covered for adults 21 years of age and over.

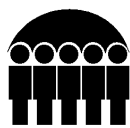
Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis is a covered service and does not require prior approval. It is payable once in a 24-month period. Full mouth debridement is not payable on the same date of services as other prophylactic or preventive procedures.

Periodontal scaling and root planing, gingivoplasty, osseous surgery, osseous allograft, pedicle soft tissue graft, free soft tissue graft, and maintenance therapy are covered periodontic benefits when prior approval has been received. A request for approval must be accompanied by:

- ◆ A periodontal treatment plan,
- ◆ A completed copy of a periodontic probe chart that exhibits pocket depths,
- ◆ A periodontal history, and
- ◆ Radiographs.

Payment for periodontal procedures will be approved as follows:

- ◆ Periodontal scaling and root planing will be approved when:
 - Interproximal and subgingival calculus is evident in X-rays, or
 - You justify and document that curettage, scaling, or root planing is required in addition to routine prophylaxis.
- ◆ Periodontal surgical procedures, including gingivoplasty, osseous surgery, and osseous allograft, will be approved after:
 - Periodontal scaling and root planing has been provided,
 - A reevaluation examination has been completed, and
 - The recipient has demonstrated reasonable oral hygiene, unless the recipient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in demonstrate gingival hyperplasia resulting from drug therapy.



- ◆ Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval and written narrative describing medical necessity.
- ◆ Payment for periodontal maintenance therapy includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling. This procedure may be approved after periodontal scaling and root planing and periodontal surgical procedures have been provided.

Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment.

F. Prosthetics

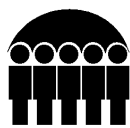
1. Complete Dentures

An immediate and a first-time complete denture, including six months' postdelivery care, are a covered benefit when the denture is provided to establish masticatory function. An immediate or a first time complete denture is payable only once following the removal of teeth it replaces.

A complete denture is payable only once in a five-year period, except when the denture:

- ◆ Is broken beyond repair, lost, or stolen, or no longer fits due to growth or changes in jaw structure and
- ◆ Is required to prevent significant dental problems.

Complete dentures are payable under this exception only if box 55 on the 1999 ADA Dental Claim Form is completed and the reason given for replacement is "broken," "lost," "stolen," or "changes in jaw structure, other than resorption." Complete dentures do not require prior approval.



2. Removable Partial Dentures

A removable partial denture replacing anterior teeth, including six months' postdelivery care, is a covered benefit.

A removable partial denture replacing anterior teeth is payable only once in a five-year period, unless the removable partial denture:

- ◆ Is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, other than resorption, and
- ◆ Is required to prevent significant dental problems.

Partial dentures replacing anterior teeth are payable under this exception only if box 55 on the 1999 ADA Dental Claim Form, is completed and the reason given for replacement is "broken," "lost," "stolen," or "changes in jaw structure, other than resorption."

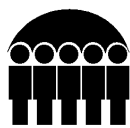
A removable partial denture replacing posterior teeth, including six months' postdelivery care, is a benefit when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when:

- ◆ The recipient has fewer than eight posterior teeth in occlusion, or
- ◆ The recipient has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.

When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved.

A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture:

- ◆ Is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, other than resorption, and
- ◆ Is required to prevent significant dental problems.



3. Fixed Partial Dentures

A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth is a benefit when prior approval has been received. A fixed partial denture replacing anterior teeth shall be approved for recipients whose medical condition precludes the use of a removable partial denture.

High noble or noble metals shall be approved only when the recipient is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair.

A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth is a benefit when prior approval has been received. A fixed partial denture replacing posterior teeth) shall be approved for a recipient:

- ◆ Whose medical condition precludes the use of a removable partial denture and who has less than eight posterior teeth in occlusion or
- ◆ Who has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.

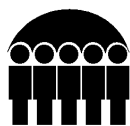
When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the recipient is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair.

4. Other Services

An obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate recipients is a covered benefit.

Chairside relines are a benefit only once per prosthesis every 12 months.

Laboratory processed relines are a benefit only once per prosthesis every 12 months.



Tissue conditioning is a benefit twice per prosthesis in a 12-month period.

Two repairs per prosthesis in a 12-month period are a covered benefit.

Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device do not constitute an adjustment.

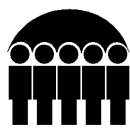
Replacement of complete dentures, removable partial dentures and fixed partial dentures due to resorption are not covered in less than a five-year period.

G. Oral Surgery

Medically necessary oral surgery services furnished by dentists are a covered benefit, to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. These services will be reimbursed in a manner consistent with the physician's reimbursement policy.

The following surgical procedures are also payable when performed by a dentist:

- ◆ Surgical and nonsurgical extractions.
- ◆ Soft tissue impaction that requires an incision of overlying soft tissue and the removal of the tooth (upper or lower).
- ◆ Complete and partial bony impaction that requires an incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth (upper or lower).
- ◆ Root recovery (surgical removal of residual root).
- ◆ Oral antral fistula closure (or antral root recovery).
- ◆ Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.



- ◆ Surgical exposure of impacted or unerupted tooth to aid eruption.
- ◆ General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when:
 - The extensiveness of the procedure indicates it, or
 - A concomitant disease or impairment warrants its use.

“Non-intravenous conscious sedation” is the use of oral medications that require monitoring of vital signs with the use of a pulse oximeter and precordial stethoscope. The provider must have a current conscious sedation permit.

- ◆ Nitrous oxide is not covered as a separate benefit.
- ◆ Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.
- ◆ Payment may be made for postoperative care where:
 - Need is shown to be beyond normal follow-up care, or
 - Another dentist performed the original service.

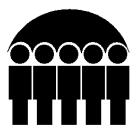
Bill this service as a limited oral evaluation under procedure code 00140, if other treatment procedures are not billed for that visit.

H. Orthodontics

Effective for services delivered on or after March 1, 2002, orthodontic services are not covered for adults 21 years of age and older.

Orthodontic procedures require prior approval. Orthodontia procedures will be approved for the most handicapping malocclusions only. A “handicapping” malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

- ◆ Impaired mastication,
- ◆ Dysfunction of the temporomandibular articulation,
- ◆ Susceptibility to periodontal disease,
- ◆ Susceptibility to dental caries, and
- ◆ Impaired speech due to malpositions of the teeth.



Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.

Approval for treatment will be assessed in a manner consistent with “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J. A. Salzmann, DDS, American Journal of Orthodontics, October 1968.

Your request for prior approval shall be accompanied by:

- ◆ An interpreted cephalometric radiograph (either a full series of radiographs or panograph film).
- ◆ Study models trimmed so that the models simulate centric occlusion of the recipient when the models are placed on their heels.
- ◆ A written plan of treatment.

Post treatment records must be furnished upon the fiscal agent’s request.

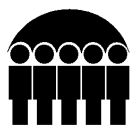
Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the fiscal agent’s orthodontic consultant if found to be medically necessary.

Space management services are a benefit when:

- ◆ Premature loss of teeth would permit existing teeth to shift, causing a handicapping malocclusion, or
- ◆ There is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if not corrected.

The procedure codes for space management services are listed under Part B, **Preventive Procedures**, in Section IV, DENTAL PROCEDURE CODES AND NOMENCLATURE.

Tooth guidance for a limited number of teeth or interceptive orthodontics is a covered benefit when extensive treatment is not required. Prior approval and pretreatment records are not required.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS

DENTAL SERVICES

CHAPTER PAGE

E - 16

DATE

July 1, 2002

I. Prior Approval

Under the Medicaid Program, “prior approval” indicates approval of the selective program benefits. Failure to obtain approval before performing the service for procedures designated “Requires Prior Approval” may lead to denial of payment.

1. Process for Obtaining Prior Approval

Dentists must submit Form 470-0829, *Request for Prior Authorization*, to the Medicaid fiscal agent to request prior approval. (See **Chapter F, Item I**, for form instructions.) A supply of this form is available on request from the fiscal agent. (See Chapter D, Item V.C, for ordering information.)

It is essential that you complete all items on this form and give full and complete information. The fiscal agent will return incomplete forms and forms in which information is not clearly presented.

The fiscal agent dentist consultant will enter the decision in Item 28 on form 470-0829 and return the form to you.

If the fiscal agent denies a request for prior approval, you may resubmit it for reconsideration if you can provide additional information that might have a bearing on the decision.

If the request for reconsideration is also denied, you may submit a further request for reconsideration to the Department of Human Services, Bureau of Managed Care and Clinical Services, 1305 E. Walnut St, 5th Floor, Des Moines 50319-0114.



2. Procedures Requiring Prior Authorization

Dental services that must be submitted for prior approval are:

- ◆ More than two laboratory fabricated **crowns**, other than stainless steel, within a 12-month period. Payment shall be approved when a more conservative procedure would not be serviceable.

Effective for services delivered on or after May 10, 2002, crowns for adults 21 years of age and older are covered only on permanent anterior teeth and only when necessary to maintain the integrity of the tooth structure after a root canal treatment.

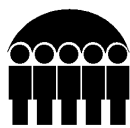
- ◆ **Surgical endodontic treatment** that includes:

- An apicoectomy, performed as a separate surgical procedure;
- An apicoectomy, performed in conjunction with endodontic procedure;
- An apical curettage;
- A root resection; or
- Excision of hyperplastic tissue.

Payment shall be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Endodontic procedures for adults 21 years of age and older are covered only for permanent anterior teeth.

Surgical endodontic procedures may be indicated when:

- Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided, or obturated due to calcifications, blockages, broken instruments, severe curvatures, open-ended canals, and dilacerated roots.
- Problems resulted from conventional treatment, including gross underfilling, perforations, and canal blockages with restorative materials.



- ◆ **Periodontal services** (except for periodontal scaling performed in the presence of gingival inflammation). Effective for services delivered on or after March 1, 2002, periodontal services are not covered for adults 21 years of age and older. A request for approval must be accompanied by:

- A periodontal treatment plan.
- A completed copy of a periodontal probe chart exhibiting pocket depths.
- Periodontal history.
- Radiographs.

Periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling, or root planing is required in addition to routine prophylaxis.

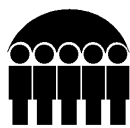
Periodontal surgical procedures include gingivoplasty, osseous surgery, and osseous allograft. These procedures will be approved after:

- Periodontal scaling and root planing has been provided,
- A reevaluation examination has been completed, and
- The recipient has demonstrated reasonable oral hygiene, unless the recipient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or has gingival hyperplasia resulting from drug therapy.

Periodontal maintenance therapy includes oral prophylaxis, measurement of pocket depths, and limited root planing and scaling. This procedure may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided.

Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment.

Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval and written narrative describing medical necessity.



- ◆ Payment for a **removable partial denture replacing posterior teeth** will be approved when the recipient has fewer than eight posterior teeth in occlusion; or the recipient has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.

When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved.

A removable partial denture replacing posterior teeth, including six months' postdelivery care, is payable only once in a five-year period, unless the removable partial denture:

- Is broken beyond repair, lost, stolen, or no longer fits due to growth or changes in jaw structure, and
- Is required to prevent significant dental problems.

- ◆ Payment for a **fixed partial denture replacing anterior teeth** (including an acid etch fixed partial denture) will be approved when recipients have a medical condition that precludes the use of removable partial denture.

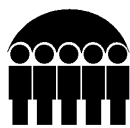
High noble or noble metals shall be approved only when the recipient is allergic to all other restorative materials.

A fixed partial denture replacing anterior teeth, including six months' postdelivery care, is payable only once in a five-year period, unless the fixed partial denture is broken beyond repair.

- ◆ Payment for a **fixed partial denture replacing posterior teeth** (including an acid etch fixed partial denture) shall be approved for a recipient:

- Whose medical condition precludes the use of a removable partial denture and who has less than eight posterior teeth in occlusion, or
- Who has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.

When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved.



High noble or noble metals will be approved only when the recipient is allergic to all other restorative materials.

A fixed partial denture replacing posterior teeth, including six months' postdelivery care, is payable only once in a five-year period, unless the fixed partial denture is broken beyond repair.

◆ A request to perform an **orthodontic procedure** must be accompanied by:

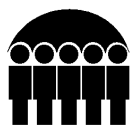
- An interpreted cephalometric radiograph.
- Study models trimmed so that the models simulate centric occlusion of the recipient.
- A written plan of treatment.

Payment shall be approved for the most handicapping malocclusions, determined in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzman, DDS, American Journal of Orthodontics, October 1968. Orthodontic services are not covered for adults 21 years of age and older.

Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the fiscal agent's orthodontic consultant if found to be medically necessary.

You must furnish sufficient information and diagnostic aids when requesting prior approval. The information submitted must clearly establish that these procedures are necessary and represent a type of care usually provided the recipients in your practice to ensure them an adequate level of oral health. Post-treatment records must be furnished upon request of the fiscal agent.

Services for cosmetic and beautifying purposes or recipient preference are not considered justification for granting prior approval.



J. Documentation of Medical Necessity

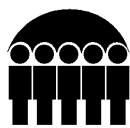
Under the Medicaid Program, the documentation submitted with the claim is the same type of documentation that physicians are required to submit to verify medical necessity. Procedures must be medically necessary to be payable. In dental services, this is usually called “by report.”

Documentation of medical necessity is different from prior approval. The documentation of medical necessity is submitted after the treatment has been provided. The information is included on or attached to the dental claim form.

The documentation of medical necessity includes a brief narrative of the history of the condition for which the diagnostic and treatment services have been provided. This history must include information on any treatments that have been provided and the results of these treatments. If surgical procedures are provided, an operative report must also be submitted.

Claims for dental services which must include documentation of medical necessity and are payable only when medically necessary are as follows:

- ◆ Limited oral evaluation
- ◆ Oral prophylaxis performed more than once in a six-month period
- ◆ A complete mouth X-ray survey provided more often than once every five years
- ◆ Periapical films
- ◆ Panoramic films provided to a child under age six
- ◆ Crown repair
- ◆ Unspecified restorative procedures
- ◆ Maxillofacial prosthesis
- ◆ Tooth reimplantation
- ◆ Vestibuloplasty
- ◆ Excision of bone tissue
- ◆ Condylectomy
- ◆ Meniscectomy
- ◆ Arthrotomy
- ◆ Arthrocentesis



- ◆ Occlusal orthotic appliance
- ◆ Osteoplasty
- ◆ Osteotomy
- ◆ LeFort I, II, III
- ◆ Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible
- ◆ Maxillofacial repair
- ◆ Frenulectomy
- ◆ Excision of hyperplastic tissue
- ◆ Sialolithotomy
- ◆ Sialodochoplasty
- ◆ Coronoideotomy
- ◆ Eminectomy
- ◆ Unspecified oral surgery procedure
- ◆ Therapeutic drug injection
- ◆ Application of desensitizing medicaments
- ◆ Treatment of post-surgical complications
- ◆ Replacement sealants
- ◆ More frequent fluoride applications for people with a mental or physical disability

See also Section K.1.

K. Exclusions and Limitations on Coverage

1. Adult Services

All exclusions for adult services are effective for dates of service as of March 1, 2002, except for root canal treatments and necessary crowns on anterior teeth which are effective for dates of service on or after May 10, 2002.

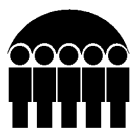
Root canal treatments and crowns are not covered on posterior teeth for adults. Crowns on anterior teeth are not covered unless necessary to maintain the integrity of a tooth following a root canal procedure.

Diagnostic casts, post and cores, periodontal services, and orthodontic procedures are not covered for adults (recipients who are 21 or over).

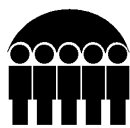


Procedure codes not covered for adults are as follows:

<u>Code</u>	<u>Description</u>
	Diagnostic
D0470	Diagnostic casts
	Restorations
D2710	Crown resin (laboratory)
D2720	Crown, resin with high noble metal
D2721	Crown, plastic with predominantly base metal
D2740	Crown, porcelain/ceramic substance
D2750	Crown, porcelain fused to high noble metal
D2751	Crown, porcelain fused to predominantly
D2752	Crown, porcelain fused to noble metal
D2781	Crown, $\frac{3}{4}$ cast predominantly base metal
D2790	Crown, full cast high noble metal
D2791	Crown, full cast predominantly base metal
D2792	Crown, full cast noble metal
D2910	Recement inlays
D2920	Recement crowns
D2930	Prefabricated stainless steel crown, primary tooth
D2931	Prefabricated stainless steel crown, permanent tooth
D2932	Prefabricated resin crown
D2940	Sedative filling
D2951	Pin retention, per tooth, in addition to restoration
D2952	Cast post and core in addition to crown
D2954	Prefabricated post and core in addition to crown
D2970	Temporary crown (fractured tooth)
D2980	Crown repair
D2999	Unspecified restorative procedure
	Endodontics
D3220	Vital pulpotomy, excluding final restoration
D3320	Root canal therapy-bicuspid (excludes final restoration)
D3330	Root canal therapy-molar (excludes final restoration)
D3340	Root canal therapy, four canals
D3351	Apexification/recalcification, initial visit
D3352	Apexification/recalcification, interim
D3353	Apexification/recalcification, final visit, with root canal therapy



<u>Code</u>	<u>Description</u>
D3410	Apicoectomy-separate surgical, bicuspid
D3421	Apicoectomy/periradicular surgery, bicuspids
D3425	Apicoectomy/periradicular surgery, molar
D3426	Apicoectomy/periradicular surgery, each additional root
D3430	Retrograde filling, per root including apical surgery
D3450	Root amputation, per root
D3999	Unspecified endodontic procedure
Periodontics	
D4210	Gingivectomy or gingivoplasty-per quadrant
D4211	Gingivectomy or gingivoplasty, per tooth
D4260	Osseous surgery, including flap entry and closure
D4263	Bone replacement graft, first site in quadrant
D4264	Bone replacement graft, each additional site
D4270	Pedicle soft tissue grafts
D4271	Free soft tissue grafts (including donor site)
D4341	Periodontal scaling and root planing, per quadrant
D4355	Full mouth debridement
D4910	Preventive periodontal procedures
D4920	Unscheduled dressing change, by nontreating dentist
D4999	Unspecified periodontal procedure
Orthodontia	
D8210	Removable appliance therapy to control harmful habits
D8220	Fixed appliance therapy to control harmful habits
D8549	Maxillary fixed lingual appliance with attachments
D8550	Maxillary fixed lingual appliance with attachments
D8551	Construct and place mandibular appliance
D8552	3-month active treatment maxillary arch
D8553	3-month active treatment mandibular arch
D8557	Appliance without clasps-no teeth
D8558	Anterior ortho wire (labial) 2 clasps
D8559	Chrome wire clasps, each additional
D8999	Unspecified orthodontia procedure



2. Prescription of Drugs

Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If you are eligible to dispense drugs, request a copy of the ***PRESCRIBED DRUGS MANUAL*** from the fiscal agent. Payment will not be made for writing prescriptions.

3. Hospitalization for Dental Care

Payment will be approved for dental treatment rendered a hospitalized recipient only when the mental, physical, or emotional condition of the recipient prevents the dentist from providing necessary care in the office.

4. Nursing Home Visits

A nursing home visit to provide treatment for a recipient is payable under procedure D9410, house/extended care facility call. When more than one recipient is examined during the same house call (or nursing home visit), the Medicaid program pays for only one "house call." Payment for the additional recipients visited on the same call is based on the service provided.

5. Office Visit After Hours

Payment will be approved for office calls after office hours in emergencies under procedure code D9440. The office call will be paid in addition to treatment procedures.

III. BASIS OF PAYMENT FOR DENTAL SERVICES

Basis of payment for services is a fee schedule. The fee schedule amount is a maximum payment amount, not an automatic payment. Reimbursement will be the lower of the customary charge and the fee schedule amount.



IV. DENTAL PROCEDURE CODES AND NOMENCLATURE

Claims submitted without a procedure code will be denied.

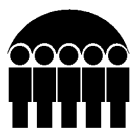
While every effort is made to use procedure numbers to describe services, there are certain instances where an existing procedure code number does not aptly describe a necessary procedure or treatment.

When the need for an unspecified treatment or procedure does arise, the procedure requires prior authorization if it is a periodontal, endodontic, prosthetic, or orthodontic procedure. Documentation of the procedure’s medical necessity is required if it is a diagnostic, restorative or oral surgery procedure. Unspecified procedures may not be payable. Medicaid reserves the right to determine the fee payable for all unlisted procedures.

A. Diagnostic Procedures

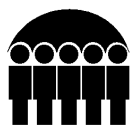
CLINICAL ORAL EVALUATIONS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D0150	Comprehensive oral evaluation	Payable once per recipient per dentist in a three-year period when the recipient has not seen that dentist during the three years.
D0120	Periodic oral evaluation	Payable once every six months.
D0140	Limited oral evaluation	Requires documentation of the medical and dental necessity. An office visit cannot be billed in addition to this code, unless the service was provided after regular office hours. Additional diagnostic or definitive procedures may be required and billed on the same date as the evaluation.
D0180	Comprehensive periodontal evaluation	Payable once per recipient per dentist in a three-year period when the recipient has not seen that dentist during the three years.



RADIOGRAPHS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D0210	Intraoral, complete series (including bitewings)	Payable only once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Not payable for children under six.
D0220	Intraoral periapical, single, first film	Payable only when medically necessary. Attach documentation specifying the need when billing for periapical films.
D0230	Intraoral periapical, each additional film	
D0240	Intraoral, occlusal, film	
D0250	Extraoral, single, first film	
D0260	Extraoral, each additional film	
D0270	Bitewing, single film	Supplemental bitewing films are payable only once in a 12-month period.
D0272	Bitewing, two films	Bitewing films with a panoramic film are considered to be a complete series and are payable only once in a five-year period, except when medically necessary. Bitewing films with a panoramic film are not payable for children under age six.
D0274	Bitewing, four films	
D0290	Posterior or anterior or lateral skull and facial bone survey film	
D0321	Temporomandibular joint, film	



<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D0330	Panoramic film	Payable for a child under age six, when medically necessary. Bitewing films with a panoramic film are considered to be a complete series and are payable only once in a five-year period, except when medically necessary. Bitewing films with a panoramic film are not payable for children under six.

D0340	Cephalometric film	
-------	--------------------	--

TESTS AND LABORATORY EXAMINATIONS

D0470	Diagnostic casts	Payable only for orthodontic cases or when requested by the fiscal agent's dental consultant. Not covered for adults.
-------	------------------	---

B. Preventive Procedures

DENTAL PROPHYLAXIS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D1110	Adults and children age 13 and over	Payable only once in a six-month period. Can be more frequent when documentation supports medical necessity.
D1120	Children (12 and under)	

TOPICAL FLUORIDE TREATMENT

D1201	Topical application of fluoride (including prophylaxis), child (12 and under)	Payable only once in a six-month period. Can be more frequent when documentation supports medical necessity.
D1203	Topical application of fluoride (prophylaxis not included), child (12 and under)	



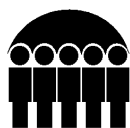
<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D1204	Topical application of fluoride (prophylaxis not included), adults and children age 13 and over	Payable only once in a six-month period. Can be more frequent when documentation supports medical necessity.
D1205	Topical application of fluoride (including prophylaxis), adult and children age 13 and over	

DENTAL SEALANTS

D1351	Sealant, per tooth	Sealants are payable only for children through age 18 and for people who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary as documented in the recipient record. (See II, B, 2.)
-------	--------------------	--

SPACE MANAGEMENT SERVICES

D1510	Space maintainer, fixed, unilateral	Does not require prior authorization. Payable when premature loss of teeth would permit existing teeth to shift causing a handicapping malocclusion.
D1515	Space maintainer, fixed, bilateral	
D1520	Space maintainer, removable unilateral	
D1525	Space maintainer, removable bilateral	
D1550	Recementation of space maintainer	



C. Restorative Procedures

AMALGAM RESTORATION
(including polishing)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D2140	Amalgam, one surface, primary or permanent	
D2150	Amalgam, two surfaces, primary or permanent	
D2160	Amalgam, three surfaces, primary or permanent	
D2161	Amalgam, four or more surfaces, primary or permanent	

FILLED OR UNFILLED RESIN RESTORATIONS

D2330	Resin, one surface, anterior	Composite restorations are payable benefits and are reimbursable only once in a two-year period.
D2331	Resin, two surfaces, anterior	
D2332	Resin, three surfaces, anterior	
D2335	Resin, four or more surfaces or involving incisal angle	
D2390	Resin based composite crown, anterior	Payable for age 20 and under, limited to anterior teeth for age 21 and older.
D2391	Resin based composite-one surface posterior	
D2392	Resin based composite-two surfaces posterior	
D2393	Resin composite-three surfaces posterior	
D2394	Resin composite-four or more surfaces posterior	

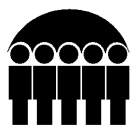


CROWNS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D2710	Crown, resin (indirect)	Effective May 10, 2002, crowns for adults 21 years of age and older are covered only on permanent anterior teeth when necessary to maintain the integrity of the tooth structure after a root canal treatment. Only two laboratory fabricated crowns are payable per recipient in a 12-month period unless prior authorization is obtained. Noble metals are payable only when recipients are allergic to all other restoration material. Stainless steel crowns are payable only when a more conservative procedure would not be serviceable. Amalgam or acrylic buildups are considered part of the preparation for the completed restoration and are not payable separately.
D2720	Crown, resin with high noble metal	
D2721	Crown, resin with predominantly base metal	
D2740	Crown, porcelain/ceramic substrate	
D2750	Crown, porcelain fused to high noble metal	
D2751	Crown, porcelain fused to predominantly base metal	
D2752	Crown, porcelain fused to noble metal	
D2781	Crown, ³ / ₄ cast predominantly base metal	
D2790	Crown, full cast high noble metal	
D2791	Crown, full cast predominantly base metal	
D2792	Crown, full cast noble metal	

OTHER RESTORATIVE SERVICES

D2910	Recement inlay	Effective for dates of service on or after May 10, 2002, other restorative services are not covered for adults 21 years of age and older on posterior teeth.
D2920	Recement crown	
D2930	Prefabricated stainless steel crown, primary tooth	
D2931	Prefabricated stainless steel crown, permanent tooth	
D2932	Prefabricated resin crown	



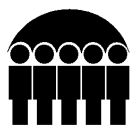
<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D2940	Sedative filling	Note: Restoration is not payable following a sedative filling in the same tooth, unless the sedative filling was placed more than 30 days previously.
D2951	Pin retention, per tooth, in addition to restoration	
D2952	Cast post and core in addition to crown	
D2954	Prefabricated post and core in addition to crown	
D2970	Temporary crown (fractured tooth)	
D2980	Crown repair	This service is payable when the need for the repair is documented.
D2999	Unspecified restorative procedure	Requires documentation of medical necessity and may not be payable.

D. Endodontic Procedures

Only endodontic procedures on permanent anterior teeth numbers 6 through 11 and 22 through 27 are covered for adults age 21 and over.

PULPOTOMY

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D3220	Therapeutic pulpotomy (excluding final restoration)	Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.



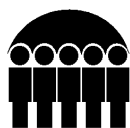
ROOT CANAL THERAPY

(including treatment plan, clinical procedures, and follow-up care)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D3310	Anterior (excluding final restoration)	Root canal procedures do not require prior authorization.
D3320	Bicuspid (excluding final restoration)	Root canal treatments are payable on permanent anterior and posterior teeth when extensive post-treatment restorative procedures are not necessary, and when missing teeth do not jeopardize the integrity or function of the dental arches.
D3330	Molar (excluding final restoration)	
D3351	Apexification/recalcification (initial visit)	
D3352	Apexification/recalcification (interim medication replacement)	
D3353	Apexification/recalcification (final visit includes complete root canal therapy)	

PERIAPICAL SERVICES

D3410	Apicoectomy/periradicular surgery, anterior	Prior authorization is required. Covered only on anterior teeth for adults age 21 and older.
D3421	Apicoectomy/periradicular surgery bicuspid, first root	
D3425	Apicoectomy/periradicular surgery molar, first root	
D3426	Apicoectomy/periradicular surgery, each additional root	
D3430	Retrograde fill/per root	This procedure may be billed in addition to apicoectomy.
D3450	Root amputation, per root	
D3999	Unspecified endodontic	Requires prior authorization and may not be payable.

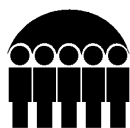


E. Periodontic Procedures

Periodontal procedures are not covered for adults (age 21 or over).

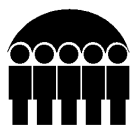
PERIODONTAL SURGERY
(including usual postoperative services)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces	Periodontal surgical procedures require prior authorization.
D4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant	A request for approval must be accompanied by a periodontal treatment plan, a copy of a periodontal probe chart that exhibits pocket depths, a periodontal history, and radiographs.
D4260	Osseous surgery (including flap entry and closure) four or more contiguous teeth or bounded teeth spaces per quadrant	Before payment for these services will be approved, the dentist must have completed periodontal scaling and root planing and a reevaluation examination. The recipient must have demonstrated reasonable oral hygiene, unless unable to because of physical or mental disability.
D4261	Osseous surgery (including flap entry and closure)-one to three teeth per quadrant	
D4263	Bone replacement graft, first site in quadrant	
D4264	Bone replacement graft, each additional site in quadrant	
D4270	Pedicle soft tissue graft procedure	Pedicle soft tissue graft and free soft tissue graft are payable services with prior authorization and written narrative describing medical necessity.
D4271	Free soft tissue graft procedure (including donor site)	
D4275	Soft tissue allograft	



ADJUNCTIVE PERIODONTAL SERVICES

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded spaces per quadrant	Prior authorization is required. A request for approval must be accompanied by: <ul style="list-style-type: none">• A periodontal treatment plan,• A complete copy of the periodontal probe chart that exhibits pocket depths,• A periodontal history, and• Radiographs.
D4342	Periodontal scaling and root planing one to three teeth, per quadrant	Payment for this procedure will be approved when: <ul style="list-style-type: none">• Interproximal and subgingival calculus is evident in X-rays, or• You justify and document that curettage, scaling, or root planing is required in addition to routine prophylaxis.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	This procedure does not require prior authorization and is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or other periodontal services are performed.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

COVERAGE AND LIMITATIONS
DENTAL SERVICES

CHAPTER PAGE

E - 36

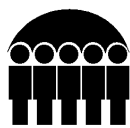
DATE

June 1, 2003

ADJUNCTIVE PERIODONTAL SERVICES

OTHER PERIODONTIC SERVICES

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D4910	Periodontal maintenance	<p>Prior authorization is required. A request for approval must be accompanied by:</p> <ul style="list-style-type: none">• A periodontal treatment plan,• A complete copy of the periodontal probe chart that exhibits pocket depths,• A periodontal history, and• Radiographs. <p>Payment for this procedure will be approved when periodontal scaling and root planing and periodontal surgical procedures have been provided.</p> <p>Periodontal maintenance therapy may be approved once per three-month interval following treatment for moderate to advanced cases if the condition would deteriorate without treatment.</p>
D4920	Unscheduled dressing change (by someone other than treating dentist)	
D4999	Unspecified periodontal procedure	Requires prior authorization and may not be payable.



F. Prosthetic Procedures

COMPLETE DENTURES

(including six months' postdelivery care)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D5110	Complete denture - maxillary	Prior authorization is not required for a complete denture. Immediate or first time complete dentures are payable only once following the removal of the teeth they replace. Complete dentures are payable only once in a five-year period, unless lost, broken beyond repair, stolen, or do not fit due to growth or changes in jaw structure other than resorption. (You must complete Box 55 on the claim form.)
D5120	Complete denture - mandibular	
D5130	Immediate denture - maxillary	
D5140	Immediate denture - mandibular	

REMOVABLE PARTIAL DENTURES

(including six months' postdelivery care)

D5211	Maxillary partial denture, resin base (including any conventional clasp, rests and teeth), removable	Removable partial dentures replacing anterior teeth do not require prior authorization. Removable partial dentures replacing posterior teeth require prior authorization.
D5212	Mandibular partial denture, resin base (including any conventional clasp, rests and teeth), removable	Requests will be approved when:
D5213	Maxillary partial denture, cast metal framework with resin denture base (including any conventional clasps, rests and teeth), removable	<ul style="list-style-type: none"> • The recipient has fewer than eight posterior teeth in occlusion; or • The recipient has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion.
D5214	Mandibular partial denture, cast metal framework with resin denture base (including any conventional clasps, rests and teeth), removable	When one partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved.



CHAPTER SUBJECT:
COVERAGE AND LIMITATIONS
DENTAL SERVICES

CHAPTER	PAGE
	E - 38
DATE	
June 1, 2003	

REMOVABLE PARTIAL DENTURES
(including six months' postdelivery care)

Partial dentures are payable only once in a five-year period unless the dentures:

- Are broken beyond repair, lost, stolen, or do not fit due to growth or changes in jaw structure, and
- Are required to prevent significant dental problems.

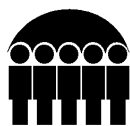
You must complete Box 55 on the claim form. The reason stated must be "broken," "lost," "stolen," or "changes in jaw structure, other than resorption."

ADJUSTMENTS TO REMOVABLE PROSTHESES

- D5410 Adjust complete denture, maxillary
D5411 Adjust complete denture, mandibular
D5421 Adjust partial denture, maxillary
D5422 Adjust partial denture, mandibular

REPAIRS TO COMPLETE DENTURES

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D5510	Repair broken complete denture base	Two repairs are payable per prosthesis in a 12-month period.
D5520	Replace missing or broken teeth, complete denture (each tooth)	

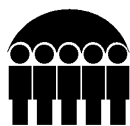


REPAIRS TO REMOVABLE PARTIAL DENTURES

D5610	Repair resin denture base	Two repairs are payable per prosthesis in a 12-month period.
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth-per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	Payable only once per prosthesis every 12 months.
D5731	Reline complete mandibular denture (chairside)	Payable only once per prosthesis every 12 months.
D5740	Reline upper partial denture (chairside)	Payable only once per prosthesis every 12 months.
D5741	Reline lower partial denture (chairside)	Payable only once per prosthesis every 12 months.
D5750	Reline complete upper denture (laboratory)	Payable only once per prosthesis every 12 months.
D5751	Reline complete lower denture (laboratory)	Payable only once per prosthesis every 12 months.
D5760	Reline upper partial denture (laboratory)	Payable only once per prosthesis every 12 months.
D5761	Reline lower partial denture (laboratory)	Payable only once per prosthesis every 12 months.



OTHER PROSTHETIC SERVICES

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D5850	Tissue conditioning, maxillary	Payable twice per prosthesis in a 12-month period.
D5851	Tissue conditioning, mandibular	
D5860	Overdenture, complete	Requires prior authorization and may not be payable.
D5861	Overdenture, partial	Requires prior authorization and may not be payable.
D5862	Precision attachment	Requires prior authorization and may not be payable.
D5899	Unspecified removable prosthodontic procedure	Requires prior authorization and may not be payable.

MAXILLOFACIAL PROSTHETICS

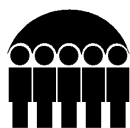
D5931	Obturator prosthesis, surgical	Requires documentation of medical necessity. Payable only if medically necessary.
D5932	Obturator prosthesis, definitive	
D5933	Obturator prosthesis, modification	
D5999	Unspecified maxillofacial prosthesis	Requires documentation of medical necessity and may not be payable.



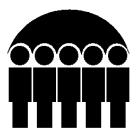
FIXED PROSTHODONTICS

(Each abutment and each pontic constitutes a unit in a bridge.)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
FIXED PARTIAL DENTURE PONTICS		
D6210	Pontic, cast high noble metal	<p>Prior approval is required for a fixed partial denture (including an acid-etch fixed partial denture). Approval will be granted for a denture replacing <u>anterior</u> teeth when:</p> <ul style="list-style-type: none"> ◆ The recipient's medical condition precludes the use of a removable partial denture. ◆ The recipient has not received a fixed partial denture in the last five years, unless the denture is broken beyond repair. ◆ The denture is not made of high noble or noble metals, unless the recipient is allergic to all other restorative materials. <p>Approval will be granted for a denture replacing <u>posterior</u> teeth when the case meets the requirements for replacement of anterior teeth <u>and</u> either:</p> <ul style="list-style-type: none"> ◆ The recipient has fewer than eight posterior teeth in occlusion, or ◆ The recipient has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. <p>When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved.</p>
D6211	Pontic, cast predominantly base metal	
D6212	Pontic, cast noble metal	
D6240	Pontic, porcelain fused to high noble metal	
D6241	Pontic, porcelain fused to predominantly base metal	
D6242	Pontic, porcelain fused to noble metal	
D6250	Pontic, resin with high noble metal	
D6251	Pontic, resin with predominantly base metal	
D6252	Pontic, resin with noble metal	
FIXED PARTIAL DENTURE RETAINERS		
D6545	Cast metal retainer for resin banded fixed prosthesis	



<u>Code</u>	<u>Procedure</u>	<u>Comment</u>	
	FIXED PARTIAL DENTURES RETAINERS-CROWNS	Prior approval is required for a fixed partial denture (including an acid etch fixed partial denture). Approval will be granted for a denture replacing <u>anterior</u> teeth when:	
D6720	Crown, resin with high noble metal	<ul style="list-style-type: none"> ◆ The recipient's medical condition precludes the use of a removable partial denture. ◆ The recipient has not received a fixed partial denture in the last five years, unless the denture is broken beyond repair. ◆ The denture is not made of high noble or noble metals, unless the recipient is allergic to all other restorative materials. 	
D6721	Crown resin with predominantly base metal		
D6722	Crown, resin with noble metal		
D6750	Crown, porcelain fused to high noble metal		
D6751	Crown, porcelain fused to predominantly base metal		
D6752	Crown, porcelain fused to noble metal		
D6780	Crown, 3/4 cast high noble metal		
D6790	Crown, full cast high noble metal		
D6791	Crown, full cast predominantly base metal		Approval will be granted for a denture replacing <u>posterior</u> teeth when the case meets the requirements for replacement of anterior teeth <u>and</u> either:
D6792	Crown, full cast noble metal		<ul style="list-style-type: none"> ◆ The recipient has fewer than eight posterior teeth in occlusion, or ◆ The recipient has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. <p>When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved.</p>



OTHER FIXED PROSTHETIC SERVICES

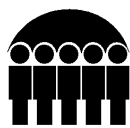
<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D6930	Recement fixed partial denture	No prior authorization is necessary for this procedure.
D6940	Stress breaker	
D6950	Precision attachment	
D6970	Cast post and core in addition to fixed partial denture retainer	
D6971	Cast post as part of fixed partial denture	
D6972	Prefabricated post and core in addition to fixed partial denture	
D6980	Fixed partial denture repair, by report	
D6999	Unspecified fixed prosthodontic procedure	

G. Oral Surgery Procedures

EXTRACTION

(includes local anesthesia and routine postoperative care)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7111	Coronal remnants, deciduous tooth	
D7140	Extraction, erupted tooth or exposed root	



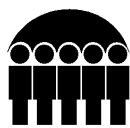
SURGICAL EXTRACTION

(includes local anesthesia and routine postoperative care)

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth, soft tissue	
D7230	Removal of impacted tooth, partially bony	
D7240	Removal of impacted tooth, completely bony	
D7241	Removal of impacted tooth, completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	

OTHER SURGICAL PROCEDURES

D7260	Oral antral fistula closure	
D7261	Primary closure of a sinus perforation	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Requires documentation of medical necessity. Payable only if procedure is medically necessary.
D7280	Surgical exposure of an unerupted tooth	
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	
D7285	Biopsy of oral tissue, hard	
D7286	Biopsy of oral tissue, soft	
D7287	Cytology sample collection	



ALVEOLOPLASTY
(surgical preparation of ridge for dentures)

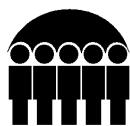
<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7310	Alveoloplasty in conjunction with extractions, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions, per quadrant	

VESTIBULOPLASTY

D7340	Vestibuloplasty-ridge extension (secondary epithelialization)	All the procedures under this section require documentation of medical necessity.
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)	Payable if medically necessary because other treatments have not been successful, and the procedure provided is a proven treatment used to treat the condition. Procedures provided for cosmetic reasons are not payable.

SURGICAL EXCISION OF REACTIVE INFLAMMATORY LESIONS
(scar tissue or localized congenital lesions)

D7410	Radical excision, of benign lesion diameter up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion complicated



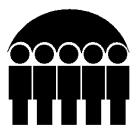
Code Procedure Comment

REMOVAL OF TUMORS, CYSTS, AND NEOPLASMS

- D7440 Excision of malignant tumor, lesion diameter up to 1.25 cm
- D7441 Excision of malignant tumor, lesion diameter greater than 1.25 cm
- D7485 Surgical reduction of osseous tuberosity
- D7450 Removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25 cm
- D7451 Removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25 cm
- D7460 Removal of benign nonodontogenic cyst or tumor, lesion diameter up to 1.25 cm
- D7461 Removal of benign nonodontogenic cyst or tumor, lesion diameter greater than 1.25 cm

EXCISION OF BONE TISSUE

- D7471 Removal of lateral exostosis, (maxilla or mandible)
 - D7472 Removal of torus palatinus
 - D7473 Removal of torus mandibularis
 - D7485 Surgical reduction of osseous tuberosity
 - D7490 Radical resection of mandible with bone graft
 - D7510 Incision and drainage of abscess, intraoral soft tissue
 - D7520 Incision and drainage of abscess, extraoral soft tissue
- These procedures are payable if:
- ◆ The procedures are medically necessary because other treatments have not been successful, and
 - ◆ The procedure provided is a proven treatment used to treat the condition.
- Procedures provided for cosmetic reasons are not payable.

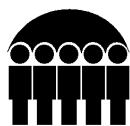


SURGICAL INCISION

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7530	Removal of foreign body from mucosa, skin, or subcutaneous areolar tissue	
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	
D7560	Maxillary sinusotomy for removal of tooth fragment of foreign body	

TREATMENT OF SIMPLE FRACTURES

D7610	Maxilla, open reduction (teeth immobilized if present)	
D7620	Maxilla, closed reduction (teeth immobilized if present)	
D7630	Mandible, open reduction (teeth immobilized if present)	
D7640	Mandible, closed reduction (teeth immobilized if present)	
D7650	Malar or zygomatic arch, open reduction	
D7660	Malar or zygomatic arch, closed reduction	
D7670	Alveolus closed reduction may include stabilization of teeth	
D7671	Alveolus-open reduction, may include stabilization	
D7680	Facial bones, complicated reduction with fixation and multiple surgical approaches	



TREATMENT OF COMPOUND FRACTURES

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7710	Maxilla, open reduction	
D7720	Maxilla, closed reduction	
D7730	Mandible, open reduction	
D7740	Mandible, closed reduction	
D7750	Malar or zygomatic arch, open reduction	
D7760	Malar or zygomatic arch, closed reduction	
D7770	Alveolus-stabilization of teeth, open reduction splinting	
D7771	Alveolus-closed reduction, stabilization of teeth	
D7780	Facial bones, complicated reduction with fixation and multiple surgical approaches	

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

D7810	Open reduction of dislocation	
D7820	Closed reduction of dislocation	
D7830	Manipulation under anesthesia	
D7840	Condylectomy	Requires documentation of medical necessity. Payable only if the procedure is medically necessary because other treatments have not been successful, and the procedure provided is a proven treatment used to treat the condition. Procedures provided for cosmetic reasons are not payable.
D7850	Meniscectomy	
D7860	Arthrotomy	
D7870	Arthrocentesis	
D7880	Occlusal orthotic appliance	



REPAIR OF TRAUMATIC WOUNDS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7910	Suture of recent small wounds up to 5 cm	

COMPLICATED SUTURING

(Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

D7911	Suture-up to 5 cm	
D7912	Suture-greater than 5 cm	

OTHER REPAIR PROCEDURES *

D7920	Skin grafts (identify defect covered, location, and types of graft)	
D7940*	Osteoplasty, for orthognathic deformities	* These procedures require documentation of medical necessity. They are payable only if the procedure is medically necessary because other treatments have not been successful, and the procedure provided is a proven treatment used to treat the condition. Procedures provided for cosmetic reasons are not payable.
D7941*	Osteotomy, mandibular rami	
D7943*	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	
D7944*	Osteotomy, segmented or subapical, per sextant or quadrant	
D7945*	Osteotomy, body of mandible	
D7946*	LeFort I (maxilla-total)	
D7947*	LeFort I (maxilla-segmented)	
D7948*	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) without bone graft	
D7949*	LeFort II and LeFort III, with bone graft	



<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D7950*	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible, autogenous or nonautogenous	
D7955*	Repair of maxillofacial soft and hard tissue defects	
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	Requires documentation of medical necessity.
D7970	Excision of hyperplastic tissue, per arch	Requires documentation of medical necessity.
D7971	Excision of pericoronal gingiva	Requires documentation of medical necessity and may not be payable.
D7972	Surgical reduction of fibrous tuberosity	
D7980*	Sialolithotomy	Requires documentation of medical necessity and may not be payable.
D7982*	Sialodochoplasty	Requires documentation of medical necessity and may not be payable.
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7981	Excision of salivary gland	
D7991*	Coronoidectomy	Requires documentation of medical necessity and may not be payable.
D7999	Unspecified oral surgery procedures	Requires documentation of medical necessity and may not be payable.

* These procedures are payable only if they are medically necessary because other treatments have not been successful, and the procedure provided is a proven treatment used to treat the condition. Procedures provided for cosmetic reasons are not payable.



H. Orthodontic Procedures

Orthodontic procedures are not covered for adults 21 years of age and older.

MINOR TREATMENT TO CONTROL HARMFUL HABITS

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D8210	Removable appliance therapy	Requires prior authorization.
D8220	Fixed appliance therapy	Requires prior authorization.

COMPREHENSIVE ORTHODONTIC TREATMENT OF PERMANENT DENTITION

These procedures require prior authorization. Orthodontia procedures will be approved for the most handicapping malocclusions only. The request for prior approval shall be accompanied by:

- An interpreted cephalometric radiograph (either a full series of radiographs or pantograph film),
- Study models trimmed so that the models simulate centric occlusion of the recipient when the models are placed on their heels, and
- A written plan of treatment.

* Only providers with a completed form 470-3174, *Addendum to Dental Provider Agreement*, on file can bill these codes. Obtain the form from ACS, Provider Relations.

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D8080 *	Construct and place maxillary or mandibular appliance with retainer and active treatment (ages 20 and under)	
D8690 *	Active treatment, transfers (ages 20 and under)	Use when recipient transfers from one provider to another.
D8999	Unspecified orthodontic procedure	



CHAPTER SUBJECT:
COVERAGE AND LIMITATIONS
DENTAL SERVICES

CHAPTER	PAGE
	E - 52
DATE	
July 1, 2003	

I. Adjunctive General Services

ANESTHESIA

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D9220	Deep sedation/general anesthesia, first 30 minutes	These procedures are payable when an extensive procedure indicates it or there is a concomitant disease or impairment which warrants its use.
D9221	Deep sedation/general anesthesia, each additional 15 minutes	
D9241	Intravenous conscious sedation/analgesia, first 30 minutes	
D9242	Intravenous conscious sedation/analgesia, each additional 15 minutes	
D9248	Non-intravenous conscious sedation (use of oral medications that require monitoring of vital signs, use of a pulse oximeter and precordial stethoscope)	The provider must have a current conscious sedation permit and document the drug and dosage used on the claim form.



PROFESSIONAL CONSULTATION

<u>Code</u>	<u>Procedure</u>	<u>Comment</u>
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Only one consultation is allowed per recipient per condition.

PROFESSIONAL VISITS

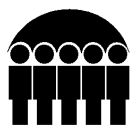
D9410	House/extended care facility calls	When more than one recipient is examined during the same nursing home visit, payment will be made for only one visit to the nursing home.
D9420	Hospital calls	Payable when the mental, physical, or emotional condition of the recipient prevents the dentist from providing necessary care in the office.
D9440	Office visit, after regularly scheduled hours	

DRUGS

D9610	Therapeutic drug injection	Requires documentation
-------	----------------------------	------------------------

MISCELLANEOUS SERVICES

D9910	Application of desensitizing medicaments	Requires documentation of medical necessity.
D9930	Treatment of complications (postsurgical), unusual circumstances	Requires documentation.
D9999	Unspecified dental service	Requires documentation



I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

A. How to Use

For services requiring prior approval (see **Chapter E**), form 470-0829, *Request for Prior Authorization*, must be completed and submitted to the fiscal agent. The request will be reviewed by the Medical Unit and a determination of coverage will be made. When a determination has been made, the form will be returned to you. Do not use this form unless prior approval is required by Medicaid for the service being provided.

If the service is approved for coverage, you may then submit your claim for reimbursement. **Important:** Do not return the prior authorization form. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

B. Facsimile of Request for Prior Authorization

(See page F – 3.)

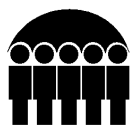
C. Instructions for Completing Request for Prior Authorization

1. RECIPIENT NAME

Complete the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.

2. RECIPIENT IDENTIFICATION NUMBER

Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER	PAGE
	F - 2
DATE	
July 1, 1997	

3. COUNTY NO.
This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.
4. DATE OF BIRTH
Copy the recipient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).
5. PROVIDER TELEPHONE NO.
Completing this area may expedite the processing of your request for prior authorization. This area is optional.
6. PROVIDER NO.
Leave blank.
7. PAY TO PROVIDER NO.
Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program.
8. DATES COVERED BY THIS REQUEST
Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM,DD,YY). If this request is approved, it will be valid only for this period of time.
9. PROVIDER NAME
Enter the name of the provider requesting prior authorization.
10. STREET ADDRESS
Enter the street address of the provider requesting prior authorization.
11. CITY, STATE, ZIP
Enter the city, state and zip of the provider requesting prior authorization.
12. PRIOR AUTHORIZATION NO.
Leave blank.
The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

Iowa Department of Human Services

REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

1. Recipient Name (Last) (First) (Initial)			2. Recipient Identification No.		3. Co. No.	4. Date of Birth Mo. Day Year			
5. Provider Phone No.	6. Provider No.	7. Pay to Provider No.		8. Dates Covered by Request					
				From			To		
9. Provider Name				Mo.	Day	Year	Mo.	Day	Year
10. Street Address				12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized.					
11. City, State, Zip									
13. Reasons For Request (use additional sheet if necessary)									

SERVICES TO BE AUTHORIZED

14. Line No.	15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description	16. Procedure, Supply, Drug or Diagnosis Code*	17. Units of Service	18. Leave Blank Authorized Units	19. Amount	20. Leave Blank Authorized Amount	21. Leave Blank Status
01							
02							
03							
04							
05							

IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

22. Provider Name		23. Telephone No.	24. Provider No.		25. Pay to Provider No.	
26. Street Address			City		State	Zip
IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.				27. Requesting provider		
				Signature of Authorized Representative		Date

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS ARE HEREBY <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.
29. Comments or Reasons for Denial of Benefits

*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM

30. Signature	
Fiscal Agent's Authorized Representative	Date

Page 4 was intentionally left blank.



13. REASON FOR REQUEST

Provide the required information in this area for the type of approval being requested. Refer to the Chapter E of this manual. (For enteral products, enter the number of cans or packets administered per day.)

SERVICES TO BE AUTHORIZED

14. LINE NO.

No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR
DIAGNOSIS DESCRIPTION

Enter the description of the service or services to be authorized. (For enteral products, enter the product name and NDC number.)

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE

Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE

Complete with the amount or number of times the service is to be performed. (For enteral products, enter the number of cans or packets dispensed for the time span requested.)

18. AUTHORIZED UNITS

Leave blank, the fiscal agent will indicate the number of authorized units.

19. AMOUNT

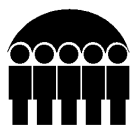
Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT

Leave blank, the fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS

Leave blank. The fiscal agent will indicate "A" for approved or "D" for denied.



22. PROVIDER NAME
Complete the name of the provider who will provide services, if other than requestor of prior authorization.
 23. TELEPHONE NO.
Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.
 24. PROVIDER NO.
Enter the seven-digit Medicaid provider number of the treating provider, if other than requestor of prior authorization.
 25. PAY TO PROVIDER NO.
Enter the seven-digit group provider number for the treating provider, if other than requestor of prior authorization.
 26. STREET ADDRESS, CITY, STATE, ZIP
Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.
 27. REQUESTING PROVIDER
Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.
- FISCAL AGENT USE ONLY
28. MEDICAID BENEFITS REQUESTED ARE HEREBY
Do not complete. The fiscal agent will complete this item after evaluating the request.
 29. COMMENTS OR REASON FOR DENIAL OF BENEFITS
Do not complete. The fiscal agent will complete this section should this request be denied.
 30. SIGNATURE
Do not complete. The person making the final decision on this request will sign date.



CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER	PAGE
	F - 7
DATE	
January 1, 2000	

II. CLAIM FORM AND INSTRUCTIONS

Bill for Medicaid-covered services using the *Dental Claim Form* published by the American Dental Association.

A. Instructions for Completing the 1999 ADA Claim Form

For electronic media claim (EMC) submitters, refer to your EMC specifications for applicable claim completion instructions.

(R) = Required, (O) = Optional, (C) = Conditional

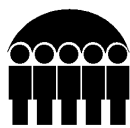
LOCATOR #/FIELD REQ.		LOCATOR NAME	DENTAL CLAIM FORM DESCRIPTION AND INSTRUCTIONS
1.	O	DENTIST'S PRE-TREATMENT ESTIMATE/ DENTIST'S STATEMENT OF ACTUAL SERVICES	Check "Dentist's statement of actual services." This area is optional.
	O	SPECIALTY (SEE REVERSE)	This box is optional.
2.	C	MEDICAID CLAIM/EPSTD	Check the EPSTD box if the service is a referral resulting from an EPSTD Care for Kids screening examination.
	C	PRIOR AUTHORIZATION #	If applicable, enter the Medicaid prior authorization number for the services.
3.	O	CARRIER NAME	No entry is required.
4. through 7.	O	CARRIER ADDRESS, CITY, STATE, ZIP	No entry is required.
RECIPIENT SECTION – BOXES 8 AND 13 ARE REQUIRED.			
8.	R	RECIPIENT NAME (LAST, FIRST, MIDDLE)	Enter the last name, first name and middle initial of the recipient. Use the <i>Medical Assistance Eligibility Card</i> for verification.
9. through 11.	O	RECIPIENT ADDRESS, CITY, STATE	No entry is required.



CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER PAGE
 F - 8
 DATE
 January 1, 2000

12.	O	RECIPIENT DATE OF BIRTH (MM/DD/YYYY)	Enter the recipient's birth date in MM/DD/YYYY format. This box is optional.
13.	R	RECIPIENT ID #	Enter the recipient's Medicaid identification number, found on the <i>Medical Assistance Eligibility Card</i> . This number consists of seven digits and an ending letter (e.g. 1234567A).
14.	O	RECIPIENT SEX	Check the applicable box. This is optional.
15.	O	RECIPIENT PHONE NUMBER	No entry is required.
16.	O	RECIPIENT ZIP CODE	No entry is required.
17.	O	RELATIONSHIP TO SUBSCRIBER/EMPLOYEE	Check the applicable box. No entry is required.
18.	O	EMPLOYER/SCHOOL	No entry is required.
SUBSCRIBER/EMPLOYEE SECTION – THIS SECTION IS OPTIONAL.			
19.	O	SUBSCRIBER/EMPLOYEE ID #/SSN#	No entry is required.
20.	O	EMPLOYER NAME	No entry is required.
21.	O	SUBSCRIBER/EMPLOYEE GROUP NUMBER	No entry is required.
22.	O	SUBSCRIBER/EMPLOYEE NAME	Enter last name, first name, and middle initial. No entry is required.
23. through 27.	O	SUBSCRIBER/EMPLOYEE ADDRESS, PHONE NUMBER, CITY, STATE, ZIP	No entry is required.
28.	O	SUBSCRIBER/EMPLOYEE DATE OF BIRTH	Enter the recipient's birth date. No entry is required.
29.	O	SUBSCRIBER/EMPLOYEE MARITAL STATUS	Check the applicable box. No entry is required.
30.	O	SUBSCRIBER/EMPLOYEE SEX	Check the applicable box. No entry is required.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER	PAGE
	F - 9
DATE	
January 1, 2000	

OTHER POLICIES SECTION – THIS SECTION IS CONDITIONAL TO THE RECIPIENT CARRYING OTHER INSURANCE.			
31.	C	IS RECIPIENT COVERED BY ANOTHER PLAN?	<p>If payment was received from another insurance, or the medical resource codes on the recipient's eligibility card indicate that there is other dental insurance, check YES in box 31. Enter the amount paid by the other insurance in the "Payment by other plan" box in the treatment and fees section of the dental claim.</p> <p>If you have received a denial from another insurance, check BOTH YES and NO in box 31 to indicate that there is other insurance, but the benefits were denied.</p> <p>Random audits are performed to ensure correct billing.</p>
32.	C	POLICY #	If YES is checked in box 31, complete by entering the insurance policy number.
33.	C	OTHER SUBSCRIBER'S NAME	If YES is checked in box 31, complete by entering the name of the subscriber.
34.	C	DATE OF BIRTH (MM/DD/YYYY)	If YES is checked in box 31, complete by entering the subscriber's birth date.
35.	O	SUBSCRIBER'S SEX	Check the applicable box. No entry is required.
36.	C	PLAN/PROGRAM NAME	If YES is checked in box 31, complete by entering the insurance carrier's name.
37.	O	EMPLOYER/SCHOOL NAME AND ADDRESS	No entry is required.
SUBSCRIBER/EMPLOYEE SECTION (CONT.)			
38.	O	SUBSCRIBER/EMPLOYEE STATUS	Check the applicable box. No entry is required.
39.	O	RECIPIENT/GUARDIAN SIGNATURE	No entry is required.
40.	O	RECIPIENT EMPLOYER/SCHOOL	No entry is required.

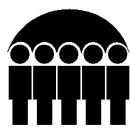


CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER PAGE
F - 10

DATE
January 1, 2000

41.	O	EMPLOYEE/SUBSCRIBER SIGNATURE	No entry is required.
<p>BILLING DENTIST SECTION – BOXES 42, 44, 46, 49, AND 50-52 ARE REQUIRED. THIS SECTION CONTAINS CONDITIONAL RESPONSES THAT NEED ATTENTION AS WELL.</p>			
42.	R	NAME OF BILLING DENTIST OR DENTAL ENTITY	Enter the dentist's name or the name of the group practice.
43.	O	DENTIST'S PHONE NUMBER	Completing this item may expedite the processing of your claim.
44.	R	PROVIDER ID NUMBER	Enter the Medicaid provider ID number. If this is a group practice, enter the group Medicaid ID number in box 44 and the treating provider's Medicaid ID number in box 45.
45.	C	DENTIST SSN OR TIN	If part of a group, enter the group's Medicaid provider ID number in box 44 and the treating provider's Medicaid provider ID number in box 45. Otherwise, leave blank.
46.	R	DENTIST ADDRESS	Enter the street address where services were rendered.
47.	O	DENTIST LICENSE #	No entry is required.
48.	O	FIRST VISIT DATE OF CURRENT SERIES	No entry is required.
49.	R	PLACE OF TREATMENT	Check the applicable box.
50. through 52.	R	DENTIST CITY, STATE, ZIP	Enter the city, state, and zip code of the address where services were performed.
53.	O	RADIOGRAPHS OR MODELS ENCLOSED	No entry is required.
54.	C	IS TREATMENT FOR ORTHODONTICS?	If treatment is for orthodontics, check YES and enter the date orthodontics were placed and the number of treatment months remaining. Otherwise, no entry is required.



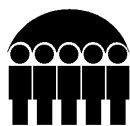
55.	C	IF PROSTHESIS (CROWN, BRIDGE, DENTURES), IS THIS INITIAL PLACEMENT? IF NO, REASON FOR REPLACEMENT	When billing for partial or complete dentures, check the applicable box. If no is checked, indicate the reason for the replacement.
56.	C	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	Complete only if treatment is result of occupational illness or injury. Check the applicable box and enter a brief description and dates.
57.	C	IS TREATMENT RESULT OF AUTO ACCIDENT OR OTHER ACCIDENT?	Complete only if treatment is the result of an auto accident or some other type of accident. Check the applicable box and enter a brief description and dates.
TREATMENT AND FEES SECTION – BOXES 59A, 59E-I AND 62 ARE REQUIRED.			
58.	O	DIAGNOSIS CODE INDEX	Leave blank. No entry is required.
59. EXAMINATION AND TREATMENT PLANS – LIST TEETH IN ORDER			
59A.	R	DATE SERVICE PERFORMED (MM/DD/YYYY)	Enter the month, day, and year for each procedure code billed. Please do not use ditto marks or arrows.
59B.	C	TOOTH	Enter the tooth number (permanent teeth) or tooth letter (deciduous teeth) when billing an applicable procedure code.
59C.	C	TOOTH SURFACE	Enter the standard ADA designation of the tooth surfaces when billing an applicable procedure code.
59D.	O	DIAGNOSIS INDEX #	Leave blank. No entry is required.
59E.	R	PROCEDURE CODE	Enter the applicable five-digit procedure code from the list provided in Chapter E of this manual for each line item.
59F.	R	QTY (UNITS OF SERVICE)	Enter the units of service for each procedure code billed in this box.
59G.	R	DESCRIPTION	Enter a narrative description of the service provided for each line item billed.



CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER PAGE
 F - 12
 DATE
 January 1, 2000

59H.	R	FEE	Enter your usual and customary charge for each line item billed. Do not enter numbers from the Medicaid fee schedule.
59I.	R	TOTAL FEE	Add the total fees of all line items billed and enter the number in this box. If more than one claim form is used, total each claim form separately. Do not carry over or forward any charges to another claim form.
59J.	C	PAYMENT BY OTHER PLAN	Enter only the amount paid by other insurance. Never enter previous Medicaid payments or recipient copayment in this box. See box 31 .
59K.	O	MAX. ALLOWABLE	Leave blank. No entry is required.
59L.	O	DEDUCTIBLE	Leave blank. No entry is required.
59M.	O	CARRIER %	Leave blank. No entry is required.
59N.	O	CARRIER PAYS	Leave blank. No entry is required.
59o.	O	RECIPIENT PAYS	Leave blank. No entry is required.
	C	FOR ADMINISTRATIVE USE ONLY	Enter the word "Pregnant" if the recipient was pregnant when services were rendered.
60.	O	IDENTIFY ALL MISSING TEETH WITH "X"	Leave blank. No entry is required.
61.	O	REMARKS FOR UNUSUAL SERVICES	Enter your recipient account number.
62.	R	SIGNED (TREATING DENTIST), LICENSE # AND DATE (MM/DD/YYYY)	<p>The signature of either the treating dentist or authorized representative is required. If the signature is computer-generated block letters; the signature must be initialed. A signature stamp may be used.</p> <p>Also enter the ORIGINAL filing date of the claim. Do not sign and submit the claim until service is completed. The only exception in orthodontia for children.</p>



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER PAGE
 F - 12a

DATE
January 1, 2000

63. through 66.	O	ADDRESS WHERE TREATMENT WAS PERFORMED	Leave blank. No entry is required.
BACK OF FORM		REQUIRED	On every claim form submitted, the printed back side of this form must be intact.

B. Facsimile of Dental Claim Form

(See the following pages for a facsimile of the front and back of the 1999 ADA
Dental Claim Form.)

Dental Claim Form

©American Dental Association, 1999 version 2000

1. <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Specialty (see backside)	3. Carrier Name
2. <input type="checkbox"/> Medicaid Claim <input type="checkbox"/> EPSDT	Prior Authorization #	4. Carrier Address
		5. City
		6. State
		7. Zip

PATIENT	8. Patient Name (Last, First, Middle)	9. Address	10. City	11. State	
	12. Date of Birth (MM/DD/YYYY) / /	13. Patient ID #	14. Sex <input type="checkbox"/> M <input type="checkbox"/> F	15. Phone Number ()	
	17. Relationship to Subscriber/Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			16. Zip Code	
	18. Employer/School Name _____ Address _____				

SUBSCRIBER / EMPLOYEE	19. Subs./Emp. ID#/SS#	20. Employer Name	21. Group #	OTHER POLICIES	31. Is Patient covered by another plan <input type="checkbox"/> No (Skip 32-37) <input type="checkbox"/> Yes: <input type="checkbox"/> Dental or <input type="checkbox"/> Medical	32. Policy #	
	22. Subscriber/Employee Name (Last, First, Middle)				33. Other Subscriber's Name		
	23. Address				24. Phone Number ()	34. Date of Birth (MM/DD/YYYY) / /	35. Sex <input type="checkbox"/> M <input type="checkbox"/> F
	25. City		26. State		27. Zip Code	36. Plan/Program Name	
	28. Date of Birth (MM/DD/YYYY) / /		29. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		37. Employer/School Name _____ Address _____		
			30. Sex <input type="checkbox"/> M <input type="checkbox"/> F		38. Subscriber/Employee Status <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Status <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. X _____ Signed (Patient/Guardian) _____ Date (MM/DD/YYYY) _____				40. Employer/School Name _____ Address _____			
				41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. X _____ Signed (Employee/Subscriber) _____ Date (MM/DD/YYYY) _____			

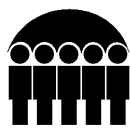
BILLING DENTIST	42. Name of Billing Dentist or Dental Entity			43. Phone Number ()	44. Provider ID #	45. Dentist Soc. Sec. # or T.I.N.
	46. Address			47. Dentist License #	48. First visit date of current series:	49. Place of treatment <input type="checkbox"/> Office <input type="checkbox"/> Hosp. <input type="checkbox"/> ECF <input type="checkbox"/> Other
	50. City	51. State	52. Zip Code	53. Radiographs or models enclosed? <input type="checkbox"/> Yes, How many? _____ <input type="checkbox"/> No		54. Is treatment for orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No If service already commenced: Date appliances placed _____ Total mos. of treatment remaining _____
	55. If prosthesis (crown, bridge, dentures), is this initial placement? <input type="checkbox"/> Yes <input type="checkbox"/> No			If no, reason for replacement: _____ Date of prior placement: _____		
	56. Is treatment result of occupational illness or injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Brief description and dates _____			57. Is treatment result of: <input type="checkbox"/> auto accident? <input type="checkbox"/> other accident? <input type="checkbox"/> neither Brief description and dates _____		
	58. Diagnosis Code Index (optional) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____					

59. Examination and treatment plans - List teeth in order								Admin. Use Only																		
Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee																			
60. Identify all missing teeth with "X"							Total Fee																			
Permanent				Primary																						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable
61. Remarks for unusual services							Deductible																			
							Carrier %																			
							Carrier pays																			
							Patient pays																			

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. X _____ Signed (Treating Dentist) _____ License # _____ Date (MM/DD/YYYY) _____	63. Address where treatment was performed
	64. City
	65. State
	66. Zip Code

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.
- 3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.
- 8-11,16. Patient name, address, city, state and zip code: Include the patient's legal name.
12. Patient date of birth: Necessary to determine eligibility.
13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
14. Sex: Necessary for identification purposes and for statistical analysis.
15. Patient phone number: Necessary if questions arise that require immediate attention.
17. Relationship to subscriber/employee: Relationship between the insured person and the patient may effect the patient's eligibility, as well as level of benefits available.
18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
19. Subscriber/Employee ID# or Social Security Number: This information refers to the insured person and is not necessarily the patient. The Social Security Number (SSN) is commonly used for computer and manual processing of claims.
20. Employer name: Self explanatory.
21. Group number: Refers to the master contract policy number assigned to the employer group.
- 22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.
31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
32. Policy #: Refers to master contract policy number assigned to the employer group.
- 33-35. Other subscriber's information: Refers to employee with policy number in box #32.
36. Plan/Program name: Necessary to identify national programs such as TRICARE.
37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
41. Employee/Subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
- 42-43,46,50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
44. Provider ID#: Necessary when carriers assign unique numbers to providers that differ from the Social Security Number or the taxpayer identification number (T.I.N.).
45. Dentist's Social Security Number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security Number or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility".
53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
54. Is treatment for orthodontics?: Necessary to determine the prorated benefit.
55. If prosthesis is for a crown, bridge or denture, is this initial placement?: Determines eligibility and liability.
56. Is treatment result of occupational illness or injury?: Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
57. Is treatment result of auto accident?: Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
58. Diagnosis Code Index: When reporting the diagnosis for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnosis as necessary for each procedure code. When a patient has more than one diagnosis per procedure, separate index number with a comma.
60. Identify all missing teeth with "X".
61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
- 63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52. For administrative use only: Area where carrier calculates benefits.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER PAGE

F - 15

DATE

July 1, 1997

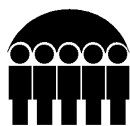
III. REMITTANCE STATEMENT AND EXPLANATION

A. Remittance Statement Explanation

In order to simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive Remittance Statement with each Medicaid payment. The Remittance Statement (which is also available on magnetic computer tape for automated accounts receivable posting) contains up to three sections for each category of service provided. (Examples of category of service are inpatient hospital services, clinic services, physician services, lab and radiology services, dental services, prescribed drugs, medical supplies, etc.)

The first section, titled PAID CLAIMS, contains all processed claims, credits, and adjustments for which full or partial reimbursement is being made. The second section, the CLAIMS DENIED portion, reflects all processed claims which have been denied (no reimbursement made), stating the denial reason in each case. The third and final section shows all claims which are suspended, or currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.). This part is referred to as the CLAIMS IN PROCESS section and may or may not print, based upon which option you specified on your Medicaid Provider Application. One of the following options was chosen:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims (until paid or denied).
- ◆ Do not print suspended claims.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER	PAGE
	F - 16
DATE	
	July 1, 1997

Your Remittance Statement will be in one of four sequences, once again as directed by you on your Medicaid Provider Application. One of the following sequences was selected:

- ◆ Recipient Name
- ◆ Recipient Identification Number
- ◆ Provider Number
- ◆ Medical Record Number

It should be noted that claims which are credits or recoupments (reversed) appear exactly as regular claims except that all money fields contain a minus (-) sign. An adjustment to a previously paid claim produces two transactions on a Remittance Statement; the first is a credit to negate the original claim, followed by the second, which is the replacement or adjusted claim. If the check amount is less than a resulting credit amount from the applied credits and/or adjustments, the credit balance is carried forward and no check will be produced. Subsequent payments will be applied toward the credit balance until it is exhausted.

The following pages contain exhibits of each section of the Remittance Statement, including detailed field-by-field descriptions of each informational line. It is important that you study these examples and obtain a thorough understanding of each element. Doing so will reduce the amount of correspondence with the fiscal agent in order to answer your questions about your payments. Should you find it necessary to inquire about a particular claim, regardless of which section it appears in, always reference the TRANSACTION CONTROL NUMBER. This will greatly facilitate the location of the necessary records and reduce resolution time to a minimum.

B. Facsimile of Remittance Statement

(See following page.)

IAMC8000-R001 (CP-0-12)
AS OF 06/06/97

IOWA DEPARTMENT OF HUMAN SERVICES
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 06/10/97

REMITTANCE ADVICE

TO: [REDACTED] (1)
(2) R.A. NO.: 0179344 (3) DATE PAID: 06/06/97 PROVIDER NUMBER: [REDACTED] P: [REDACTED] 1
(4)

**** PATIENT NAME **** RECIP ID / TRANS-CONTROL-NUMBER / BILLED OTHER PAID BY COPAY MED RCD NUM
LAST FIRST MI LINE SVC-DATE PROC/MODS UNITS AMT. SOURCES MCAID AMT. PERF. PROV. S EOB EOB (12.)

*** CLAIM TYPE: DENTAL

*** CLAIM STATUS: SUSPENDED (13.)

ORIGINAL CLAIMS:

(6.)	(7.)	(8.)	(9.)	(10.)	(11.)	(13.)
[REDACTED]	0-97147-11-367-0029-00	207.00	0.00	0.00	0.00	900 000
01	03/24/97 00120	1	24.00	0.00	12.00	0 000 000
02	03/24/97 00220	1	14.00	0.00	5.21	0 000 000
03	03/24/97 00230	1	48.00	0.00	3.67	0 000 000
04	03/24/97 01205	1	61.00	0.00	36.14	0 900 000
05	03/24/97 07110	1	60.00	0.00	23.29	0 000 000

REMITTANCE TOTALS

PAID ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PAID ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ORIGINAL CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
DENIED ADJUSTMENT CLAIMS:	NUMBER OF CLAIMS	0	-----	0.00	0.00
PENDED CLAIMS (IN PROCESS):	NUMBER OF CLAIMS	1	-----	207.00	0.00
AMOUNT OF CHECK:			-----		0.00

MONTH-TO-DATE TOTALS: NUMBER OF PAID CLAIMS 0.00
YEAR-TO-DATE TOTALS: NUMBER OF PAID CLAIMS 0.00

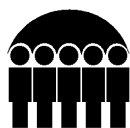
---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

COUNT:

2

Page 18 was intentionally left blank.



C. Remittance Statement Field Description

1. Pay-to provider name as specified on the Medicaid Provider Enrollment Application.
2. *Remittance Advice* Number.
3. Date claim paid.
4. Medicaid (Title XIX) pay to provider number.
5. Recipient last and first name.
6. Recipient Medicaid ID number.
7. Transaction control number assigned by fiscal agent to each claim. Please use this number when making inquiries about claims.
8. Total charges submitted by provider.
9. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
10. Total amount paid by Medicaid for this claim.
11. Total amount of recipient copayment deducted from this claim.
Allowed charge source code.

B Billed charge	F Fee schedule
M Manually priced	N Provider charge rate
P Group therapy	Q EPSDT total screen over 17 years
R EPSDT total under 18 years	S EPSDT partial over 17 years
T EPSDT partial under 18 years	U Gynecology fee
V Obstetrics fee	W Child fee



12. Medical record number or performing provider number (if other than pay to provider).
13. Explanation of benefits code indicates the reason for claim denial. Refer to explanation at end of the remittance for each EOB code in the *Remittance Advice*.
14. Line item number.
15. The first date of service for the procedure billed.
16. The procedure code for the service billed. **Please note:** In the format of the American Dental Association procedure codes, the letter “D” replaces the first character of each code. For example, 00210 is now D0210.
17. The number of units of service rendered.
18. Line item Medicaid charge as allowed.
19. Remittance totals (found at the end of the remittance advice).
 - ◆ Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.
 - ◆ Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid.
 - ◆ Number of denied original claims and amount billed by provider.
 - ◆ Number of denied adjusted claims and amount billed by provider.
 - ◆ Number of pended claims (in process) and amount billed by provider.
 - ◆ Amount of check.
20. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:
BILLING AND PAYMENT
DENTAL SERVICES

CHAPTER	PAGE
	F - 21
DATE	
June 1, 2003	

IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice*, and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

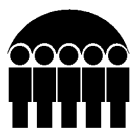
To make an adjustment to a claim following receipt of the *Remittance Advice*, use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- ◆ A paid claim amount needs to be changed, or
- ◆ Money needs to be credited back, or
- ◆ An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.



Iowa
Department
of
Human
Services

CHAPTER SUBJECT:

BILLING AND PAYMENT

DENTAL SERVICES

CHAPTER PAGE

F - 22

DATE

January 1, 2000

A. Facsimile of Provider Inquiry, 470-3744

You can obtain the *Provider Inquiry* form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain the *Credit/Adjustment Request* form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program
PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: Claim copy Remittance copy
 Other pertinent information for possible claim reprocessing.

1. 17-DIGIT TCN																			
2. NATURE OF INQUIRY																			
I N Q U I R Y A	_____																		

	(Please do not write below this line) FISCAL AGENT RESPONSE																		

1. 17-DIGIT TCN																			
2. NATURE OF INQUIRY																			
I N Q U I R Y B	_____																		

	(Please do not write below this line) FISCAL AGENT RESPONSE																		

Provider Signature/Date:	MAIL TO: ACS P. O. BOX 14422 DES MOINES IA 50306-3422	ACS Signature/Date:
Provider Please Complete:	7-digit Medicaid Provider ID# _____ Telephone _____	(FOR ACS USE ONLY) PR Inquiry Log # _____ Received Date Stamp:
Name Street City, St Zip		

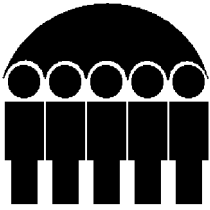
Page 24 was intentionally left blank.

Iowa Medicaid Program

CREDIT/ADJUSTMENT REQUEST

Do not use this form if your claim was denied. Resubmit denied claims.

SECTION A: Check the most appropriate action and complete steps for that request.														
<input type="checkbox"/> CLAIM ADJUSTMENT <ul style="list-style-type: none"> ◆ Attach a complete copy of claim. (If electronic, use next step.) ◆ Attach a copy of the Remittance Advice with corrections in red ink. ◆ Complete Sections B and C. 	<input type="checkbox"/> CLAIM CREDIT <ul style="list-style-type: none"> ◆ Attach a copy of the Remittance Advice. ◆ Complete Sections B and C. 	<input type="checkbox"/> CANCELLATION OF ENTIRE REMITTANCE ADVICE <ul style="list-style-type: none"> ◆ Use only if all claims on Remittance Advice are incorrect. This option is rarely used. ◆ Attach the check and Remittance Advice. ◆ Skip Section B. Complete Section C. 												
SECTION B:														
1. 17-digit TCN														
2. Pay-to Provider #:							4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A)							
3. Provider Name and Address:														
5. Reason for Adjustment or Credit Request:														
SECTION C:		Provider/Representative Signature:												
		Date:												
FISCAL AGENT USE ONLY: REMARKS/STATUS														
Return All Requests To: <div style="float: right; text-align: right;"> ACS PO Box 14422 Des Moines, IA 50306-3422 </div>														



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-52
Employees' Manual, Title 8
Medicaid Appendix

March 30, 1998

DENTAL SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Dental Services Manual*, Table of Contents, page 5, revised; Chapter E, *Coverage and Limitations*, pages 17 and 18, revised; and Chapter F, *Billing and Payment*, pages 1 through 20, revised.

This transmittal adopts the American Dental Association (ADA) claim form.

Date Effective

July 1, 1997

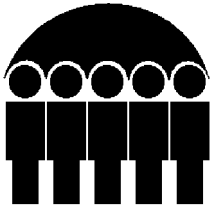
Material Superseded

Remove the following pages from *Dental Services Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 5)	January 1, 1995
Chapter E	
17, 18	January 1, 1994
Chapter F	
1	March 1, 1993
2	7/86
3-6	March 1, 1993
7, 8	12/92
9-21	March 1, 1993

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-74
Employees' Manual, Title 8
Medicaid Appendix

July 6, 1998

DENTAL SERVICES MANUAL TRANSMITTAL NO. 98-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Dental Services Manual*, Table of Contents (pages 4 and 5), revised; Chapter E, *Coverage and Limitations*, pages 2 through 4, 7, 13 through 39, 47, and 48, revised.

This transmittal adopts the American Dental Association (ADA) coding and description.

Prior authorization for post care and oral prophylaxes more frequently than six months is eliminated and the age for sealants is revised.

Date Effective

July 1, 1998

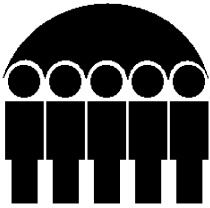
Material Superseded

Remove the following pages from *Dental Services Manual* and destroy them:

<u>Page</u>	<u>Date</u>
Contents (page 4)	January 1, 1994
Contents (page 5)	July 1, 1997
Chapter E	
2-4, 7, 13-16	January 1, 1994
17, 18	July 1, 1997
19	January 1, 1994
20	January 1, 1995
21-39	January 1, 1994
47, 48	January 1, 1995

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-145
Employees' Manual, Title 8
Medicaid Appendix

June 19, 2000

DENTAL SERVICES MANUAL TRANSMITTAL NO. 00-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: *Dental Services Manual*, Table of Contents (page 5), revised; Chapter F, *Billing and Payment*, pages 7 through 14 and 20, revised, and pages 12a and 21 through 25, new.

Chapter F is revised to provide claim completion instructions for the 1999 ADA *Dental Claim Form*.

Forms 470-3744, *Provider Inquiry*, and 470-0040, *Credit/Adjustment Request*, are added to Chapter F for provider convenience.

Date Effective

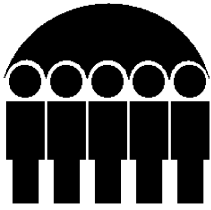
January 1, 2000

Material Superseded

Remove from the *Dental Services Manual*, Table of Contents, page 5, dated July 1, 1998, and Chapter F, pages 7 through 14 and 20, dated July 1, 1997, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-195

Employees' Manual, Title 8

Medicaid Appendix

October 2, 2002

DENTAL PROVIDER MANUAL TRANSMITTAL NO. 02-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***DENTAL PROVIDER MANUAL***, Table of Contents, pages 4 and 5, revised; Chapter E, *Coverage and Limitations*, pages 1 through 51, revised, and pages 52 and 53, new; and Chapter F, *Billing and Payment*, page 3, revised.

Revisions to Chapter E include:

- ◆ Reductions in coverage of services for adults, which were announced in Informational Letter Nos. 297, dated February 21, 2002, and 304, dated July 1, 2002.
- ◆ Changing the first digit of the procedure codes to "D" to match CDT-3 codes.
- ◆ Elimination of the requirement that documentation of the necessity for more frequent prophylaxis accompany the claim.
- ◆ Elimination of the requirement for prophylaxis before topical application of fluoride and allowance of more frequent applications for persons with a mental or physical disability.
- ◆ Coverage for replacement sealants and sealants through 18 years of age and for others with a physical or mental disability.
- ◆ Coverage for a comprehensive oral evaluation by the same dentist when the recipient has not seen that dentist for three years.
- ◆ A requirement for prior authorization for more than two porcelain crowns in a 12-month period.
- ◆ Clarification that full mouth debridement is not payable on the same date of service when other prophylaxis or periodontal services are performed.
- ◆ Removal of the 24-month limitation on periodontal scaling and root planing.
- ◆ Addition of non-intravenous conscious sedation (D9248) as an alternative to general anesthesia.
- ◆ Clarification that replacement of dentures due to resorption in less than 5 years is not covered.
- ◆ Removal of the \$125 limit for tooth guidance. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required.

Chapter F is revised to update the sample of form 470-0829, *Request for Prior Authorization*.

Date Effective

July 1, 2002

Material Superseded

Remove the following pages from *DENTAL SERVICES MANUAL* and destroy them:

<u>Page</u>	<u>Date</u>
Table of Contents (page 4)	July 1, 1998
Table of Contents (page 5)	January 1, 2000
Chapter E	
1	January 1, 1994
2-4	July 1, 1998
5, 6	January 1, 1994
7	July 1, 1998
8-12	January 1, 1994
13-39	July 1, 1998
40-46	January 1, 1994
47, 48	July 1, 1998
49-51	January 1, 1995
Chapter F	
3	7/97

Additional Information

The updated provider manual containing the revised pages can be found at:

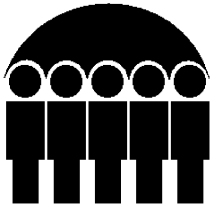
www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:

General Letter No. 8-AP-214

Employees' Manual, Title 8
Medicaid Appendix

June 23, 2003

DENTAL PROVIDER MANUAL TRANSMITTAL NO. 03-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: ***DENTAL PROVIDER MANUAL***, Chapter E, *Coverage and Limitations*, pages 26, 30 through 41, 43 through 48, 50, and 52, revised; and Chapter F, *Billing and Payment*, pages 20, 21, 23, and 25, revised.

This revision incorporates:

- ◆ Procedure code and nomenclature changes.
- ◆ Revisions in the CDT-4.

The following new codes are covered effective March 1, 2003:

D0180	Comprehensive periodontal exam
D2390	Resin based composite crown, anterior (age 20 and under)
D2391	Resin based composite-one surface posterior
D2392	Resin based composite-two surfaces posterior
D2393	Resin based composite-three surfaces posterior
D2394	Resin based composite-four or more surfaces posterior
D7111	Coronal remnants, deciduous tooth
D7140	Extraction, erupted tooth or exposed root
D7261	Primary closure of a sinus perforation
D7287	Cytology sample collection
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion complicated
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7671	Alveolus-open reduction, may include stabilization
D7771	Alveolus-closed reduction, stabilization of teeth
D7972	Surgical reduction of fibrous tuberosity

The following new codes are covered effective March 1, 2003, when prior authorization has been obtained.

- D4261 Osseous surgery (including flap entry and closure)-one to three teeth per quadrant (covered for age 20 and under)
- D4275 Soft tissue allograft (covered for age 20 and under)
- D4342 Periodontal scaling and root planing 1-3 teeth, per quadrant (covered age 20 and under)

The following CDT-3 codes were eliminated from the CDT-4 and are not covered effective July 31, 2003. Use the cross-walked CDT-4 codes.

<u>Deleted Code</u>	<u>Cross-walk Code</u>
D2110	D2140
D2120	D2150
D2130	D2160
D2131	D2161
D2380	D2391
D2385	D2391
D2386	D2392
D6250	NONE
D6530	NONE
D6544	NONE
D7110	D7111
D7120	D7111
D7130	D7140
D7420	D7411
D7430	NONE
D7431	D7411
D7480	D7485
D7992	NONE

Date Effective

Immediately

Material Superseded

Remove the following pages from *DENTAL PROVIDER MANUAL* and destroy them:

<u>Page</u>	<u>Date</u>
Chapter E 26, 30-41, 43-48, 50, 52	July 1, 2002

Chapter F

20, 21	January 1, 2000
23 (470-3744)	4/00
25 (470-0040)	4/00

Additional Information

The updated provider manual containing the revised pages can be found at:

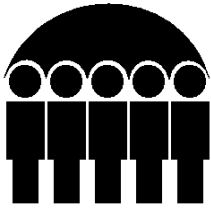
www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.



Iowa Department of Human Services

For Human Services use only:
General Letter No. 8-AP-242
Employees' Manual, Title 8
Medicaid Appendix

January 13, 2004

DENTAL SERVICES MANUAL TRANSMITTAL NO. 04-1

ISSUED BY: Bureau of Managed Care and Clinical Services

SUBJECT: **DENTAL SERVICES MANUAL**, Chapter E, *Coverage and Limitations*, pages 4, 7, 8, 23, 26, 34, 51, and 52, revised, and Chapter F, *Billing and Payment*, page 23, revised.

Chapter E is revised to:

- ◆ Include necessary crowns on permanent anterior teeth that have received root canal treatment.
- ◆ Clarify coverage of additional diagnostic and definitive procedures with a limited oral evaluation.
- ◆ Update orthodontia procedure codes. Orthodontia providers are reminded that a one-time, lump-sum payment for orthodontia treatment can be billed when form 470-3174, *Addendum to Dental Provider Agreement*, has been completed and submitted to the fiscal agent. Procedure code D8690 should be billed when treatment is transferred to another provider before completion.
- ◆ Correct typographical errors.

Date Effective

July 1, 2003

Material Superseded

Remove the following pages from **DENTAL SERVICES MANUAL** and destroy them:

<u>Page</u>	<u>Date</u>
Chapter E	
4, 7, 8, 23	July 1, 2002
26, 34	June 1, 2003
51	July 1, 2002
52	June 1, 2003
Chapter F	
23	10/02

Additional Information

The updated provider manual containing the revised pages can be found at:

www.dhs.state.ia.us/policyanalysis

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

ACS
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to ACS, fiscal agent for the Department of Human Services.