Chapter 20

Dental Services

NOTE: *Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at* MHCP Provider Manual.

South Country uses Delta Dental of Minnesota as our third-party dental administrator. Dental services that require prior authorization are reviewed for medical appropriateness based on evidence-based standards of care, medical necessity criteria, and the member's benefit coverage. The attending or requesting dentist may contact Delta Dental to discuss any dental utilization management denial, reduction, or termination of services with Delta Dental's director or other appropriate reviewers. For a complete list of services that require prior authorization, please refer to the Delta Dental of Minnesota website (https://www.deltadentalmn.org/).

Contact Delta Dental

www.deltadentalmn.org/providers

1-651-348-3222 or toll free 1-866-398-9419 (TTY 711)

Authorization requests may be mailed to:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Claim submission:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Electronic Claims Submission – Payer ID 07000

Billing for Dental Services

Before providing dental services, you must verify member eligibility. This can be done using MN Department of Human Services (DHS) MN-ITS. Delta Dental of MN Customer Service (1-866-398-9419) is available to assist with eligibility or benefits inquiries. This is not a guarantee that services provided will be covered. Refer to covered services to review member's current coverage. Excess services or services noted as non-covered are the member's responsibility. Providers must inform the recipient and discuss all other available covered alternatives before providing a non-covered service for which the recipient is financially responsible using the Advance Recipient Notice of Noncovered Service/Item (DHS-3640) (PDF).

A non-contracted provider will be paid at approximately the DHS base rate for services rendered to a South Country member. This payment will be payment in full. In compliance with Minnesota Health Care Programs (MHCP) rules, the provider is unable to balance bill the member. The check will be sent directly to the non-contracted provider.

The Minnesota Department of Human Services (DHS) operates five (5) state-operated dental clinics that provide services to individuals with developmental disabilities, severe/persistent mental illness and traumatic brain injury who are unable to obtain care from other community

providers. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar. The services of state-operated dental clinics will be authorized by and billed directly to the state of Minnesota. Services provided at the state-operated dental clinics will follow MHCP benefit guidelines and authorization requirements.

Dental services provided at federally qualified health centers (FQHC) will follow the Minnesota Health Care Programs (MHCP) benefit set and authorization guidelines. Dental claims and service authorization requests for services provided at these dental clinics should be submitted to MHCP for processing. For more information, or to check claim and service authorization status, contact the MHCP Provider Contact Center at 1-651-431-2700 or 1-800-366-5411. The following carve out exception applies: South Country will continue to pay claims for MinnesotaCare members.

Covered Services

All covered services must be medically necessary, appropriate and the most cost effective for the medical needs of the member. The following list is not all-inclusive. See the MHCP fee schedule for a current list of covered procedure codes.

Please contact Delta Dental Customer Service (1-866-398-9419) for plan specific information. Do not provide services without first confirming eligibility through MN-ITS or Delta Dental Customer Service.

As required by the Centers for Medicare & Medicaid Services (CMS), the Minnesota Child and Teen Checkups (C&TC) Schedule of Age-Related Dental Standards (DHS-5544) (PDF) was developed. Both primary care and dental providers must use this schedule, which is in keeping with recommendations of the American Academy of Pediatric Dentistry.

Clinical Oral Evaluations

D0120	Periodic exam	• Cannot be performed on same date as D0140, D0150, D0160, D0180 or D4355
D0140	Limited exam	• Once per day per facility • Documentation must include notation of specific oral health complaint or problem • Cannot be performed on same date as D0120, D0145, D0150, D0160, D0180, D1120 or D1110
D0145	Oral evaluation of a patient under 3 years of age	• Once per lifetime • Cannot be performed on same date as D1330
D0150	Comprehensive exam	• Once per two (2) years • Cannot be performed on same date as D0120, D0140, D0145, D0160, D0180 or D4355
D0160	Detailed and extensive oral evaluation	• Cannot be performed on same date as D0120, D0140, D0145, D0150, D0180 or D4355
D0180	Comprehensive periodontal evaluation	• Cannot be performed on same date as D0120, D0140, D0145, D0150, D0180 or D4355

Diagnostic Imaging

D0210	Intraoral complete series	• Once per two (2) years
D0220 - D0240 D0250	Intraoral - periapical radiographic images Extra-oral - 2D projection radiographic image	• Four (4) per date of service (does not include intraoral-complete series)
D0270 - D0274 D0277	Bitewings - one (1) to four (4) radiographic images Vertical bitewings - seven (7) to eight (8) radiographic images	• One (1) series per calendar year
D0330 D0340	Panoramic radiographic image 2D cephalometric radiographic image	• Once per five (5) years except: 1. With a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure 2. For a medically necessary diagnosis and follow up or oral and maxillofacial pathology and trauma 3. Once every two (2) years for members who cannot cooperate with intraoral film placement due to disability or medical condition
D0364-D0368	Cone Beam CT capture and interpretation	
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	• Once per two (2) years
D0373	Intraoral tomosynthesis Bitewings - one (1) to four (4) radiographic images	• One (1) series per calendar year
D0374	Intraoral tomosynthesis Periapical radiographic image	• Four (4) per date of service (does not include intraoral-complete series)

Preventive Services

Covered services include prophylaxis, topical fluoride treatment, and space maintenance and maintainers.

D1110	Prophylaxis - adult	• Frequency as medically necessary
D1120	Prophylaxis - child	• Frequency as medically necessary
D1206 D1208	Topical fluoride treatment	• Once per six (6) months • Cannot be performed on same date as D9910
D1301-D1321	Prevention counseling	• Once per year
D1330	Oral hygiene instructions	• Once per year • Cannot be performed on same date as D0145
D1351	Sealant - per tooth	• Permanent molars only • Once per tooth per five (5) years
D1354	Application of caries arresting medicament - per tooth	• Once per six (6) months per tooth • Tooth number is required

Restorative Services

Covered services include amalgam restorations, resin-based composite restorations, some crowns, and other restorative services. South Country prohibits balance billing posterior composites to the member.

D2140 - D2161	Amalgam restorations (including polishing)	• Limited to once per ninety (90) days per tooth
D2330 - D2394	Resin-based composite restorations	• Limited to once per ninety (90) days per tooth
D2710 - D2722 D2930 - D2934	Crowns - single restorations Prefabricated stainless steel and/or resin crowns	• Laboratory resin crowns that meet the specifications for utilization review with prior authorization
D2740 D2750	Porcelain crown	• Supplemental benefit for SeniorCare Complete (HMO D-SNP) and Ability Care (HMO D-SNP) members only • One porcelain crown per year
D2940	Protective restoration	• Allowed only for the relief of pain • Cannot be performed on same date as D9110
D2976	Band stabilization - per tooth	• Once per 90 days per tooth
D2989	Excavation of tooth resulting in the determination of non-restorability	• Once per tooth
D2991	Application of hydroxyapatite regeneration medicament - per tooth	• Once per 180 days per tooth

Endodontics

Covered services include pulpotomy, endodontic therapy on primary teeth, endodontic therapy, endodontic retreatment, apexification/recalcification, some apicoectomy/periradicular services, pulpal regeneration, and other endodontic procedures.

South Country covers anterior, premolar, and molar endodontics once per tooth per lifetime.

Periodontics

D4341 and D4342	Periodontal scaling and root planing, per quadrant	• Once per two (2) years • Cannot be performed on same date as D1110 or D4355 • Authorization meeting specifications of utilization criteria is needed • Use oral cavity indicators to designate the quadrants where the service was or will be provided • Bill using appropriate numeric oral cavity designation code: 10 (upper right), 20 (upper left), 30 (lower left) or 40 (lower right)
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	• Once per two (2) years • Cannot be performed on same date as D1110, D0150, D0160, or D0180
D4322	Splint - intra-coronal	• Once per twelve (12) months
D4323	Splint - extra-coronal	• Once per twelve (12) months
D4910	Periodontal maintenance	• Once per 91 days for 24 months following scaling and root planing. After 24 months, D4910 is not payable unless a D4341 or D4342 is performed again under a new prior authorization.

Prosthodontics

- Covered services include removable full and partial dentures, adjustments, and repairs, rebase and relines, interim prosthesis, and other prosthetic services.
- Service Limits:
    - Initial placement or replacement of a removable prosthesis is limited to once every three (3) years unless one or more of these conditions apply:
        - Replacement of a removable prosthesis in excess of this limit is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen or damaged due to circumstances beyond the member's control. When applicable, providers must consider the member's degree of physical and mental impairment in determining whether the circumstances were beyond a member's control.
        - Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's dental needs.

D5110 - D5140 D5810 and D5811	Complete dentures (including routine post-delivery care)	• One removable appliance per dental arch per three (3) years • Authorization is required for replacement
D5211 - D5226 D5820 and D5821	Partial dentures (including routine post-delivery care)	• Initial placement is or replacement is limited to every three (3) years
D5410 - D5422 D5511 - D5520 D5611 - D5671	Adjustments and repairs to complete and partial dentures	• D5520, D5640 and D5650 are limited to five (5) teeth per 180 days
D5710 - D5721 D5730 - D5761	Denture rebase and reline procedures	

D5850 and D5851	Tissue conditioning, maxillary or mandibular	• Insertion of tissue conditioning liners are limited to once per denture unit:
		  • As a preparation for taking impressions for the relining of existing dentures
		  • For the fabrication of new dentures
		• Bill tissue conditioning once at the completion of treatment, regardless of the number of visits involved

D5863 - D5856	Overdenture	• For each dental arch, removable prostheses are limited to one every three (3) years

- Service for a denture must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six (6) months immediately following the provision of the denture. Document the instruction and the necessary adjustments, if any, in the member's dental record;
- House calls for fitting removable prosthesis is covered up to five (5) visits in a calendar year. Bill house calls as D9410 with D5992; D9410 will pay at current rate and D5992 will pay at $0;
- South Country pays a percentage payment for undeliverable removable prostheses. All authorization requirements are still applicable. Submit an attachment for the claim that documents the reason for non-delivery as noted in patient chart and an explanation that includes the incurred lab charges and percentage of work completed. Keep the completed prosthesis in the provider's office, in a deliverable condition, for a period of at least two (2) years. Payment will be prorated based on the percentage completed and utilization review; and
- Maxillofacial prosthetics: covered services include some prostheses and some carriers.

Dental Implants

Authorization is always required. Covered services include some pre-surgical services, some implant supported prosthetics, abutment supported single crowns, fixed partial denture retainers, and other implant services.

Requests for authorization for dental implants must be submitted with the following dental history, case information, and documentation:

- Medical and dental history that supports the medical necessity;
- Copies of current radiographs that show the current dental condition;
- Complete treatment plan, including prosthesis and all related services; and
- The Dental Implants Authorization Form (DHS-3538) (PDF) must be completed and included with the necessary documentation requirements sent to Delta Dental.

The following criteria must be met to receive payment for dental implants and related services:

- Bone and tooth loss that compromises chewing or breathing;
- The implants must be medically necessary and cost-effective; and
- A complete treatment plan, including prosthesis and all related services, must be approved prior to the start of treatment.

D6092 and D6093	Re-cement or re-bond implant/abutment supported crown or fixed partial denture	• Subject to utilization review
D6058 - D6094	Single crowns, abutment supported	• Authorization required
D6068 - D6194	Fixed partial denture (FPD) retainer, abutment supported	• Authorization required

Oral and Maxillofacial Surgery

- Oral surgery services are covered including extractions, other surgical procedures, excision of soft tissue lesions, excision of intra-osseous lesions, excision of bone tissue, some surgical incision, and other repair procedures.
    - Authorization is always required for removal of impacted third molars. Submit requests for authorization with documentation of any of the following for each tooth to be extracted:
        - Documentation that third molar extractions are symptomatic or show evidence of pathology;
        - Presence of severe pain or swelling;
        - Documented recurrent episodes of pericoronitis;
        - An episode of cellulitis;
        - An episode of abscess formation or untreatable pulpal or periapical pathology;
        - Active current periodontal disease due to the position of the third molar and its association with the second molar, periodontal charting required;
        - External resorption of the third molar or of the second molar where this would reasonably appear to be caused by the third molar;

- A non-restorable carious lesion on a partially erupted third molar or a carious lesion on the distal of the second molar due to the position of the third molar; and
- A pathological condition such as a dentigerous cyst or other related pathology.

Orthodontic Treatment

South Country covers orthodontic treatment that meets the specifications of utilization criteria. All orthodontic treatment requires prior authorization review for medical necessity.

When submitting an authorization, the following documentation must be included:

- Description of classification of occlusion (e.g., angle class, arch crowding or spacing, etc.);
- Functional problems (e.g., over bite, overjet, cross bites, etc.);
- Disfiguring characteristics (e.g., facial asymmetry, etc.);
- Contributing factors (e.g., missing teeth, impacted teeth, etc.);
- Measurements in millimeters (mm) of all admissible crowding, crossbites, overbite, overjet, or open bite;
- Description of conditions that deem medical necessity for the treatment;
- Specific treatment plan and appliances (enter the appropriate procedure code);
- Five (5) intraoral photographs; upper and lower occlusal; prints or mounted slides are acceptable; include profile photos; and
- Appropriate radiographs (panorex or full mouth and cephalometric).

Comprehensive or interceptive orthodontic treatment is considered medically necessary when one or more of the following criteria is met:

- Overjet greater than 9 mm;
- Reverse overjet greater than 3.5 mm;
- Anterior or posterior crossbite, or both, of three or more teeth per arch;
- Lateral or anterior open bite 2 mm or more, of four or more teeth per arch;
- Impinging overbite with evidence of occlusal contact into the opposing soft tissue;
- Impactions where eruption is impeded but extraction is not indicated (excluding third molars);
- Jaws or dentition, or both, which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology;
- Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant;
- Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars); and
- Other conditions as deemed medically necessary (must include narrative).

Orthodontic care usually requires lengthy treatment. South Country recommends that the provider discuss the expected eligibility period with the member and the county human services agency before initiating treatment. This will clarify the eligibility policies and help reduce denial

of payment due to subsequent ineligibility. A member's eligibility can terminate or may go from fee-for-service to a managed care organization on a month-to-month basis.

Providers are encouraged to consult with members, parents or guardian regarding noncompliance and disregard for instructions. Providers may terminate treatment if not compliant with instructions. If treatment stops for any reason, please notify Delta Dental.

Replacement or re-cementing of one (1) or two (2) brackets due to reasonable wear and tear is considered a part of the total orthodontic treatment. Re-cementing of brackets due to a failure of the patient to comply with the provider instructions is a noncovered service and the provider may bill the member for the cost. Since re-cementation of brackets is not a covered service, the provider is not required to submit charges to South Country.

The retention phase of orthodontic treatment is a component of the total orthodontic care for which the provider is reimbursed. The type of retention is a choice made by the provider. Do not bill the member.

Third Party Liability (TPL) or other insurance information for billing for orthodontics

When South Country approves orthodontic treatment:

- When TPL or other insurance pays an initial down payment and subsequent payments over the course of the treatment (monthly, quarterly, semi-annual, or annual payments):
    - Bill the approved initial appliance placement code and indicate the TPL or other insurance initial down payment amount on the claim.
    - A physical copy of the Primary EOB with estimated full payment amount must be submitted with the claim.

Other Services

D9110	Palliative (emergency) treatment of dental pain	• Once per day
D9222 - D9248	Anesthesia, deep sedation, nitrous oxide/analgesia, anxiolysis	• When applicable, regardless of the age of the patient, the determination of medical necessity for general anesthesia in conjunction with dental service must consider the information related to general anesthesia established by the American Academy of Pediatric Dentistry
D9311	Medical consultation	• Once per date of service
D9410	House or extended care facility call	• Cannot be billed alone. Must be used in conjunction with another covered service • Cannot be performed on the same date as D0999

D9610, D9612 and D9630	Therapeutic parenteral drug
	Drugs or medicaments dispensed in the office for home use
		• Enter additional information in the notes section of the claim form, including:
		  • Name of drug
		  • NDC of drug
		  • Dosage

D9910	Application of desensitizing medicament	
D9920	Behavior management	• When additional staff time is required to accommodate behavioral challenges
D9951	Occlusal adjustment - limited	• Once per day
D9952	Occlusal adjustment - complete	

Teledentistry

Teledentistry is the delivery of dental care services or consultations while the patient is at an originating site and the dentist is at a distant site. For additional information see MHCP Telehealth Services.

South Country allows payment for teledentistry services. Reimbursement for teledentistry is the same as face-to-face encounters and only a distant site can bill for services.

To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the MHCP telehealth policy by completing the Provider Assurance Statement for Telehealth (DHS-6806).

Originating Sites for Teledentistry

The originating site is the location of an eligible South Country member at the time the service is being furnished via a telecommunication system.

Affiliate practice or originator within Minnesota Board of Dentistry defined scope of practice must be present at origination site:

- Dentist;
- Advanced dental therapists;
- Dental therapists;
- Dental hygienists;
- Licensed dental assistants; and
- Other licensed health care professionals.

List of Teledentistry Services

South Country will cover teledentistry claims for diagnostic services. Coverage is limited to children, pregnant woman and limited adult benefits as specified in Minnesota Statutes 256B.0625, subd 9 (covered services).

South Country allows the following CDT codes for these diagnostic services when performed via teledentistry:

- D0120: Periodic oral evaluation – established patient;
- D0140: Limited oral exam;
- D0145: Oral evaluation for patient under three years of age;
- D0150: Comprehensive oral evaluation – new or established patient;
- D0210: Intraoral – complete series of radiographic images;
- D0220: Intraoral – periapical first radiographic image;
- D0230: Intraoral – periapical each additional radiographic image;
- D0270: Bitewing – single radiographic image;
- D0272: Bitewings – two radiographic images;
- D0274: Bitewings – four radiographic images;
- D0240: Intraoral – occlusal radiographic image;
- D0330: Panoramic radiographic image; and
- D9310: Medical dental consultation.

Billing Teledentistry Services

South Country dental providers who self-attest that they meet all of the conditions of the MHCP telemedicine policy by completing the Provider Assurance Statement for Telehealth (DHS-6806) can submit claims for teledentistry services using the CDT code that describes the services rendered with place of service (POS) 02. By using POS 02 you are certifying that you are rendering services to a patient located in an eligible originating site other than the patients home via an interactive audio and visual telecommunications system. POS 10 should be used when the originating sight is the patient's home. The following limitations apply:

- Payment will be made for only one (1) reading or interpretation of diagnostic tests such as x-rays, lab tests and diagnostic assessment;
- Payment is not available to providers for sending materials;

- Out-of-state coverage policy applies for services provided via teledentistry; and
- Consultations performed by providers who are not located in Minnesota and contiguous counties, require prior authorization prior to the service being provided.

Dental Procedures Reported with CPT Coding

Note: The services below are not payable if submitted to Delta Dental of MN on an ADA (837D) claim form. They must be billed on an 837P form and submitted to South Country's medical claims system. To receive reimbursement for CPT procedure codes, you must be individually enrolled with South Country. For instructions see South Country's Provider Manual Chapter 4 Provider Billing. Contact South Country's Provider Contact Center at 1-888-633-4055 for assistance.

Temporomandibular Joint Disorder (TMD)

Treatment for TMD is considered a medical service when the underlying pain and dysfunction is caused by 1) pain related TMD including myalgia, myofascial pain, arthralgia, arthritis, or headache attributed to TMD or 2) temporomandibular joint (TMJ) intra-articular disorders, including disk displacement with and without reduction, degenerative joint disease, osteoarthritis, or subluxation. Document that the history and physical exam support the diagnosis.

Providers should submit a medical claim (837P) via the medical provider portal. The ICD diagnosis code and the associated CPT code for the occlusal orthotic device (41899 unlisted procedure, dentoalveolar structures) must be included on the claim.

Sleep Apnea Appliances

For South Country members who cannot tolerate a continuous positive airway pressure (CPAP) machine, a physician may prescribe an oral appliance. The oral appliance is considered durable medical equipment. Dentists assure the proper fit of the appliance. Most appliances require that a dentist take necessary impressions and a bite registration.

Criteria for coverage of a custom fabricated oral appliance (E0486) can be found in the MHCP Provider Manual - Dental Services (Overview).

Alveoloplasty or Gingivectomy

Report medical procedure codes 41820, 41828, 41872 and 41874 with the appropriate oral cavity designation code as required by the Minnesota Administrative Uniformity Committee (AUC).

Alveoloplasty and gingivectomy services do not require a denial from Medicare before billing South Country. Use Physician's Current Procedural Terminology (CPT) procedure codes when billing complex oral surgery, including alveoloplasty.

Fluoride Varnish Application (FVA) in Primary Care Settings

Fluoride varnish application is required at all C&TC visits, starting at the eruption of the first tooth or no later than 12 months of age, and continuing through five (5) years of age. FVA may also be applied for children 6 years and older based on their risk factors for dental caries. This can be done as often as four (4) times per 365 days in the clinic setting. South Country provides reimbursement for FVA during a C&TC visit on children from birth to 21 years of age. Providers must be qualified health care professionals or clinical staff who are trained and successfully completed an approved FVA training on oral screenings, fluoride varnish indications and application, and office implementation. Additional training resources are available through Oral

Health Initiative, a program of the American Academy of Pediatrics (AAP). AAP oral health training activities offer continuing medical education (CME) credits.

Head start agencies, WIC programs and public health agencies may bill for FVA after fulfilling the training requirement above.

South Country covers fluoride varnish application for children in primary care settings from birth to age 21 for up to four times per 365 days. Members 21 years of age and over may receive two fluoride varnish applications per year in a medical setting. Qualified health care professionals and trained clinical staff must bill using the CPT code 99188. This code replaces HCPS Code D1206. You may bill FVA at three (3) to six (6)-month intervals.

Dental providers must bill using CDT code D1206 and may bill South Country once per six months.

Silver Diamine Fluoride (SDF) in Primary Care Settings

The American Medical Association (AMA) approved a code for health care professionals to receive reimbursement for the application of SDF to arrest dental caries lesions without the provision of restorative care. Treatment is indicated where this is a visible need identified during the open-mouth exam at a C&TC visit. The provider must obtain informed consent and provide SDF education.

Primary care providers (physicians or other qualified health care professionals) and trained clinical staff) may perform service and should use CPT code 0792T for billing.

The payment for SDF, when applied during a C&TC visit, is in addition to other C&TC services. Primary care providers bill SDF on the same claim as other C&TC services. South Country reimbursement rate is per given tooth number billed once per six months. There is no limit on the number of teeth that may be treated per day.

Dental Procedures billed on an Institutional Claim

Dental providers must make a contractual arrangement with the hospital to be reimbursed for providing dental services. Bill medical services provided using an 837I claim. Report dental services using the appropriate CDT code. The 837I claim must be submitted to South Country's medical claims system as described above. An 837D claim may be submitted to Delta Dental for payment of services rendered using CDT procedure codes.

Non-Covered Services

The following services are not covered. Separate billing either to South Country or the member/enrollee for these services is prohibited. This is not an all-inclusive list.

- Barriers;
- Disposable equipment/supplies;
- Drapes;
- Eye protection;
- Fluoride trays or rinses;
- Gauze or sterile packing;
- Gloves;
- Infection control procedures;
- Needles;

- Periodontal charting (separate from codes D0150 or D0180);
- Prescriptions dispensed in office;
- Pulp caps (direct D3110 and indirect D3120);
- Prosthetic cleaning;
- Sterilization solutions/equipment;
- Surgical supplies;
- Suture material;
- Syringes; and
- Treatment deemed to be cosmetic or for aesthetic reasons.