

**Policy is terminated because coverage is provided under the combined
Medicaid and NCHC 4A, Dental Services**

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1.0 Description of the Procedure, Product, or Service

Routine dental care involves examination and assessment of the teeth and supporting mouth structure in the absence of disease or symptoms, as well as routine prophylactic treatment and care to restore the integrity of the teeth and to maintain current health.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

North Carolina Health Choice (NCHC) covers the following routine dental care:

- a. Routine oral examinations and teeth cleanings twice during a twelve month period.
- b. Topical fluoride treatments twice during a twelve month period.
- c. Sealants from age six to fifteen (6-15) - limited to first and second molars and first and second permanent premolars.
- d. Therapeutic pulpotomy, prefabricated stainless steel crowns and simple tooth extraction.

- e. Panoramic films once every sixty months (five years). Full mouth x-rays (intraoral complete series including bitewings) once every sixty months (five years). Separate reimbursement for full mouth x-rays (CDT code D0210) is not allowed when performed on the same date of service as panoramic films (CDT code D0330). Bitewing x-rays showing the back of the teeth are covered only once during a twelve month period and are not covered if performed within twelve months of full mouth x-rays (i.e. within twelve months of an intraoral complete series including bitewings).
- f. Routine fillings to treat dental caries. Filling composition must be either amalgam or tooth-colored filling material.
- g. Palliative treatment—minor dental treatment of pain such as a toothache. CDT code D9110 includes an emergency exam and any minor treatment administered during this visit.
- h. Effective July 1, 2009, root canal therapy for permanent anterior teeth and permanent first molars when medically necessary.
- i. Effective July 1, 2009, space maintainers are covered; (no benefits are available for space maintainers prior to that date).
- j. Hospital and ambulatory surgical center services for care related to dental surgery only when it is necessary for the care to be received in a hospital setting due to the following:
 - 1. Complex oral procedures with a greater than average incidence of serious complications, such as excessive bleeding or airway obstruction; or
 - 2. Concomitant, systemic conditions for which the recipient is under current medical management and which are not in optimum control, thereby increasing risks; or
 - 3. Mental illness, mental retardation, or behavioral problems, of a severity that precludes management in an office setting; or
 - 4. Dental extractions or restorations for children less than nine (9) years of age. Benefits are subject to the North Carolina Health Choice provisions and limitations for inpatient and outpatient care.
- k. Dental services and materials must meet standards accepted by the American Dental Association as well as receive full, unrestricted approval from the Food and Drug Administration.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or

- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

The routine dental care is not covered for the following:

- a. Braces, bridges, (PFM) porcelain fused to metal crowns, and other dental appliances, except for space maintainers as specifically noted in **Subsection 3.2.i**.
- b. Dental implants, regardless of the reason.
- c. Root canal therapy prior to July 1, 2009. On and after July 1, 2009, benefits for root canal therapy are limited to permanent anterior teeth and permanent first molar teeth; root canal therapy of other teeth is not covered.
- d. Extraction of impacted teeth or for removal of wisdom teeth regardless of the reason.
- e. Although a hospital charge (inpatient or outpatient) may be eligible for benefits based on medical necessity, the dental service(s) provided must otherwise be a covered service to be eligible for benefits.
- f. Services in excess of the following time limitations are not covered:
 - 1. more than two routine oral examinations or teeth cleanings within a twelve-month period;
 - 2. more than two topical fluoride treatments within a twelve-month period;
 - 3. more than one bitewing x-ray showing the back of the mouth in a twelve-month period or a bitewing x-ray performed within the same twelve-month calendar period as a full-mouth x-ray (i.e. within twelve months of an intraoral complete series including bitewings);
 - 4. more than one full-mouth x-ray (intraoral complete series including bitewings) in a sixty-month period (five years); and
 - 5. more than one panorex x-ray in a sixty-month (five year) period.
- g. Dental care not otherwise noted as having specific benefits is not covered.
- h. Periodontal services including periodontal scalings are not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is not required for routine dental care.
- b. Prior approval is required for covered oral surgical procedures.
- c. Preadmission certification and length-of-stay approval are required for inpatient hospital admissions when medically necessary to successfully perform routine dental care.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
07/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
6/15/2011	Subsections 3.2, 4.2, and 7.0; Attachment A.	Updated CDT-2011-2012 copyright; corrected “bitewing” to one word instead of “bite wing”; reformatted CDT Code table; added missing radiograph CDT codes D0210, D0220, D0230, and D0330; and added missing resin-based composite crown CDT code D2390.
06/14/2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Dental (ADA/837D transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity, if applicable.

C. Procedure Code(s)

<u>CDT Codes</u>
<u>Clinical Oral Evaluations: D0120, D0140, D0150, D0160, D0170</u>
<u>Radiographs: D0210, D0220, D0230, D0330, D0270, D0272, D0273, D0274, and D0277</u>
<u>Dental prophylaxis: D1110, D1120</u>
<u>Topical fluoride treatments: D1203, D1204, D1206</u>
<u>Sealants: D1351</u>
<u>Space maintainers: D1510, D1515</u>
<u>Routine fillings to treat dental caries: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394 (Filling composition must be either amalgam or tooth-colored material)</u>
<u>Resin-based composite and prefabricated stainless steel crowns: D2390, D2930, D2931, D2932, D2933, D2934</u>
<u>Therapeutic pulpotomy: D3220, D3221</u>
<u>Root canal therapy: D3310, D3330</u>
<u>Extractions: D7111, D7140, D7210, D7250 (refer to Subsection 3.2.i)</u>
<u>Palliative treatment: D9110</u>

D. Modifiers

Providers are required to follow modifier guidelines, if applicable.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s), if applicable.

F. Place of Service

Office, Outpatient Hospital, ASC, Inpatient hospital

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Date of Termination: 06.14.2012