



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

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January 2010

To: Dental Providers – **For Action**
HMOs for Information

Subject: New Information and Reminders for Dental Services

Effective: January 2010

Purpose: To notify providers with the Division of Medical Assistance and Health Services (DMAHS) of new procedure codes for billing, revisions to existing procedure codes and to give updates and reminders of program policy and regulations.

New Information

New CDT procedure codes for billing services:

The following CDT 2009-10 procedure codes have been added to the NJ Medicaid Program for billing dental services effective January 2010. A cross (+) preceding the procedure code indicates that prior authorization is required.

- +D0417** – Collection and preparation of saliva for laboratory diagnostic testing
- +D2740** – Crown – porcelain/ceramic substrate. Must document rationale for use
- D3222** – Partial pulpotomy for apexogenesis – permanent tooth with incomplete root
- +D5991** – Topical medicament carrier (both arches)

The reimbursement rates for these services are located on www.njmmis.com under Medicaid fee-for-service.

Codes with revisions to prior authorization requirements A single cross hatch (#) preceding the procedure code indicates service can be provided once in a rolling calendar year without prior authorization.

Codes **#D4341 & #D4342**: periodontal scaling and root planning - can be provided once a year without prior authorization for up to four quadrants. Additional services require prior authorization. Request for additional services require submission of detailed description of the condition to include past periodontal services, patient's oral hygiene and motivation level, periodontal charting, recent radiographs, photographs and prognosis. Post treatment evaluation should be available upon request.

Code with revision to frequency: **D1110**- prophylaxis, adult - can be provided twice in a rolling calendar year.

The following procedure codes will require prior authorization:

- +D5710** - rebase complete maxillary denture
- +D5711** – rebase complete mandibular denture
- +D5720** – rebase maxillary partial denture
- +D5721** – rebase mandibular partial denture.

Request shall include denture history, clinical findings with rationale for service, diagnosis and prognosis. This service should be provided with the understanding it will restore denture(s) to a functional state and eliminate the need for a new denture.

Assessment for Comprehensive Orthodontic Treatment-Age Limit

Reimbursement will not be provided for handicapping malocclusion assessment (**D8660**) for clients over the age of 18. The comprehensive orthodontic benefit is through the age of 21. If the client maintains eligibility this will insure the case including retention is completed prior to the 21st birthday.

Third Party Liability (TPL)

Contacting the TPL Unit

The TPL Unit is now in the Office of the Medicaid Inspector General. Questions regarding a client's additional insurance, referred to as TPL coverage, should be directed this office at 609-826-4702.

Claim Submission

The following are requirements for submitting dental claims when a client has TPL:

- The Estimate of Benefits (EOB) statement from the other insurance or documentation the insurance does not include dental benefits **must** be attached to each claim
- All services that have payments from the TPL should be submitted on one claim
- All services that were not paid by the TPL should be submitted on a separate claim.

General Reminders

Medicaid Eligibility

It is the responsibility of the office at each appointment to confirm the identity of the patient and to check their eligibility through one of our verification systems –

REVS 1-800-676-6562

eMEVS through www.njmmis.com

Contact Unisys Provider Services Unit at **800-776-6334** or the County Board of Social Services for the client's county if you have additional eligibility questions.

HMO enrolled clients must be seen by dentist that participate with their HMO and should be referred if you do not participate in their HMO.

Palliative (emergency) treatment of dental pain – D9110

Billing for palliative emergency treatment for dental pain is a per visit code to treat pain and is used when definitive service with a billable code is not available. In general it could be for evaluation for a chief complaint with radiograph taken, providing a prescription or post –op treatment (non-surgical) follow up for pain. As an example, if the service code **D9110** is submitted on a claim with same date of service as a treatment code such as a vital pulpotomy or sedative filling, the service code **D9110** will not be considered for reimbursement.

Oral Evaluations for all patients

All patients can receive up to two oral evaluations a year. The first one will be considered a comprehensive oral evaluation (**D0150**) with the subsequent evaluation being periodic oral evaluation (**D0120**).

Full Mouth Series (FMS) of films

Radiographs to include a panoramic film with bitewings or full mouth series (the number of single film are based on age) can be provided for new patients, regardless of the patient having this provided at a previous office. When a patient indicates a FMS was recently taken, it is expected that the previous office be asked to provide a copy of their films. Reimbursement for the copies can be submitted for prior authorization and pricing. A FMS is reimbursable every three years to the same provider –see section 10:56-2.7 for diagnostic services

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

All Children in the NJ FamilyCare/Medicaid (NJFC) program MUST be referred to the dentist for diagnostic and preventive services by the age of three. As part of Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) participating physicians will be referring high risk children as young as 12 month to participating dentists for these oral evaluations and to begin preventive services. As experts in dental disease prevention and treatment your role should include risk assessment, education to care givers and needed dental treatment. An enhanced rate is provided for oral evaluation of children less than 3 years of age and counseling of primary caregiver using code D0145.

Diagnostic & Preventive services for Individuals with Special Health Care Needs

Diagnostic and preventive services as noted in chapter **10:56-2.9** can be provided up to 4 times a year for patients with special health care needs (SHCN). All SHCN clients can receive these services at least once a year without prior authorization. Additional units needed for a 12 month period must be submitted for prior authorization as follows:

- Codes for periodic oral evaluations and preventive services with total units needed for the year in 17D
- Charting of section 18 for missing teeth
- Associated medical diagnosis noted under “Remarks”

Once approved, the units provided can be submitted under the assigned prior authorization number for payment.

The expectation is that members of the dental team give education and home care instructions to all care givers on appropriate daily oral hygiene for those in their care. Preventive services rendered by the dental team do not eliminate the need for effective daily oral hygiene practices.

Requests for Prior Authorization

For clients that are not edentulous, diagnostic views of all remaining teeth should be submitted with request for services that require prior authorization. This could be a panoramic view with bitewings, bitewings and anterior periapical views or a full mouth series. Films should be recent and demonstrate treatment needs. Forms should be completed for charting to indicate all missing teeth and planned extractions or a separate form may be included.

Total Fee Requested

On the prior authorization form or the dental claim form your total fee requested should be entered in section 17I. The dollar amount **MUST** include the decimal point.

Reimbursement rates in NJ Medicaid

Reimbursement rates provided through the NJ Medicaid Fee for Service Program are located on the www.njmmis.com website. Click on Procedure Codes and Rates located on the left navigator bar and scroll to the bottom of the screen. The three Procedure Code Master Listings to review are:

- Medicaid Fee for Service – for all dental codes used for billing scroll to page 340
- Procedure requiring PA – for dental codes with any prior authorization requirements scroll to page 6
- Children rates – dental codes with rates for children start on page 1.

Note this listing only contains those codes that had a rate increase (rates were increased 01-01-08) for services to children and NOT all codes available, so you must also refer to Medicaid Fee for Service that lists all codes used for billing.

Transition to the 2006 ADA Form

While this project has been delayed, The Division is moving forward with the implementation of using the 2006 ADA form. Implementation of this form is expected to take place in the first half of 2010. A separate newsletter will be sent to advise you on this. Please review **Newsletter Volume 19 No. 2** regarding the transition.

Newsletters

All Newsletters can be located on www.njmmis.com website by clicking on Newsletters and Alerts found on the left navigator bar and completing the required fields.

If you have any questions regarding this information, please call 1-800-776-6334 for assistance.

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