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Medicaid Alert

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TO: Providers of Dental Services – **For Action**
Health Maintenance Organizations **For Information Only**

SUBJECT: CDT Procedure Codes - FAQs

EFFECTIVE: Immediately for CDT4 Codes Effective July 1, 2003

PURPOSE: This Medicaid Alert is intended to provide providers of dental services responses to commonly-asked questions regarding the CDT4 procedure codes adopted by the New Jersey Division of Medical Assistance and Health Services (DMAHS), effective July 1, 2003.

ACTION: DMAHS has compiled commonly asked questions concerning the adoption of CDT4 procedure codes, effective July 1, 2003. Providers of dental services are encouraged to review DMAHS's responses to these questions in order to better understand use of the CDT4 procedure codes and related billing procedures. **Please share this information with your billing staff.**

Frequently Asked Procedure Code Questions

1. When should a provider report CDT4 Procedure codes for Medicaid-covered dental services?

Response: The new CDT4 procedure codes must be reported for dental services provided on or after July 1, 2003. If Unisys previously issued a prior authorization using the prior dental procedure codes, you must report a corresponding CDT4 procedure code for the dental service provided. The Unisys claims processing system will automatically recognize the new CDT4 procedure code and match this information to the previously authorized dental procedure code.

2. How should a dental provider correct prior authorization for a new CDT4 procedure code assigned to a dental service with a service date prior to July 1, 2003?

Response: The provider must contact the Medicaid Dental Bureau, provide the prior authorization number, and indicate that dental treatment was provided prior to July 1, 2003. The Dental Bureau will request that the procedure code be changed to the old procedure code and verify the date of service to be certain that this date is covered by the prior authorization.

3. What are the procedure codes for diagnostic services?

D0150	Comprehensive oral evaluation
D0150 76	Comprehensive oral evaluation for developmentally disabled or neurologically impaired
D0150EP	Comprehensive oral evaluation for children through the age of 20
D0140	Limited oral evaluation
D0160	Detailed and extensive oral evaluation- problem focused

4. What are the procedure codes for composite restorations?

D2390	Resin-based composite crown, anterior
D2391	Resin-based composite-one surface
D2392	Resin-based composite - two surfaces
D2393	Resin-based composite - three surfaces
D2394	Resin-based composite - four or more surfaces

5. What are the procedure codes for amalgams for primary and permanent teeth?

D2140	Amalgam -one surface
D2150	Amalgam - two surfaces
D2160	Amalgam - three surfaces
D2161	Amalgam - four or more surfaces

6. What is the procedure code for more frequent additional scaling?

D4355-76	Full mouth debridement
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Note: This code was previously reported as Y2105 for developmentally disabled and neurologically impaired.

7. What are the procedure code changes for extractions and torus removal?

D7111	Coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis

8. What are the procedure codes for orthodontic treatment?

D8080	Comprehensive orthodontic - appliance placement
D8080-22	Monthly adjustment visits 1 st through 24 th months
D8080-52	Monthly adjustment visits 25 th through 35 th months

9. What is the procedure code for general anesthesia?

D9220-22	General Anesthesia
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Note: To be reported when the dentist providing dental services is also administering general anesthesia.

10. What replaces procedure codes that had a value of "Y" in the first position?

They have been replaced as follows:

D1510-52 (Y2115) Tooth processed to arch bar
D5899-22 (Y2505) Add tooth immediate replacement

11. Are procedure codes with modifiers still being used?

Note: Nationally accepted modifiers, as noted in the HCPC and CPT manuals, can be reported with the new CDT4 procedure code. The State cannot establish State-specific procedure code modifiers for billing purposes.

12. What are HIPAA regulations concerning claim forms?

HIPAA standards only apply to electronic claims submissions. HIPAA standards do not apply to dental claims submitted as hard copy or paper claims or to related prior authorizations.

Common Billing Errors and Solutions

1. All by report (B.R.) priced dental procedure codes must be submitted for prior authorization with documentation of services attached. There are many procedure codes that were previously priced B.R. that have been assigned new specific CDT4 procedure codes and may or may not require prior authorization.

2. Claim payments denied by UNISYS for a previously extracted tooth (i.e. Error Code 742) must be submitted to the Medicaid Dental Bureau, P.O. Box 713, Trenton, NJ 08625 for prior authorization. A film of the tooth in question must be attached for the override of Error Code 742 to be considered and for the claim to be priced.

3. "To" and "From" dates and Medicaid Recipient Identification Numbers included in previously approved prior authorizations can be corrected by the Dental Bureau. Please contact the Dental Bureau to request these changes. The prior authorization number and the information to be changed must be provided to the Dental Bureau.

4. The Medicaid Newsletter Volume 13, No. 47 uses the term "NO CROSSWALK". This is a systemic term used to indicate a procedure code has not been assigned to a dental service by the State. This procedure code cannot be billed to UNISYS and cannot be "matched" with another code. This dental service may have been incorporated into another CDT4 procedure code, or the previous code may have changed completely, or the previous code may no longer be a valid code.

Examples:

- Restorative services are still a Medicaid-covered dental benefit, however there have been procedure code revisions.
- The Medicaid program's old dental procedure code 04220 (gingival curettage) AND CDT3 procedure code D4220 were **eliminated** with the CDT4 changes and as a result are no longer Medicaid-covered dental benefits.
- Oral and maxillofacial surgery services are still Medicaid-covered benefits, however there are procedure code revisions.

5. UNISYS uses Error Codes to provide the reason(s) for payment denials. Please contact UNISYS first at 1-800-776-6334 concerning denials. If they are unable to assist you, they will advise you to contact the Dental Bureau. The Dental Bureau may be reached at 1-800-782-0181. When calling the Dental Bureau, you must have your Remittance Advice available to provide the Bureau with patient and treatment information, as well as the denial code(s) and description so Bureau staff can better assist you with your concerns.

6. When you receive the notification letter from UNISYS (FD-362) concerning your approved prior authorization number, carefully verify all information with your dental claim for accuracy and to ensure the prior authorization is active. A suspended prior authorization number will not allow payment and must be corrected before any treatment can be provided. The most common reasons for authorization suspensions are errors in Medicaid Recipient Identification Number or Person Number; incorrect procedure codes or conflicts between Medicaid eligibility for services and the To/From prior authorization dates. Once you have identified the error(s) or if you need assistance, contact the Dental Bureau for assistance.

If you have any questions concerning this Newsletter, please contact the Medicaid Dental Bureau at 1-800-782-0181.

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