Questions from SWPT Dental Provider Training

Question #1: Billing for multiple teeth

When billing a partial denture, how do we input multiple teeth on the claim in prism? Or do we just choose one tooth to note? Do we just add one missing tooth number? or how do we input all missing teeth #'s in Prism?

When entering a claim in Prism, and multiple teeth are involved, how do we get all teeth on claim in Prism?

Does it matter if we have all the teeth listed? If it's just in the remarks, does it make a difference on whether the claim is paid or not? Prism doesn't give an option to list more than one tooth in the tooth number spot is the reason I am asking. Specifically, for D5212 and D5211.

When entering a claim in PRISM, the provider will need to check if the code requires the dental attribute and the tooth number/surface/quadrant. For instance, D2330 (Resin-one surface, anterior) and D2331 (Resin-two surfaces, anterior) both require the dental attribute (permanent or primary) as well as the tooth number/surface/quadrant (e.g. 10-Up Lt Lateral Incisor).

However, when billing for a partial denture, specifically for codes D5212 and D5211, there is no requirement to list all the tooth numbers on the claim in PRISM. Reimbursement is the same regardless of how many teeth are involved. For partial dentures, a PA is required. With the PA, Medicaid can ensure the member meets the criteria for a partial denture. (See the Dental, Oral Maxillofacial, and Orthodontia provider manual for more information.)

Question #2: Has D0120 changed for ICF/ID residents?

No, D0120 has not changed for ICF/ID residents. It is still covered as part of the per diem rate paid to the facility. Dental providers will not be reimbursed by Medicaid for these services, as the facility is responsible for payment.

The PRISM Coverage and Reimbursement Code Lookup tool was recently updated to provide existing policy concerning members residing in an ICF/ID. (For code D0120, see the Special Note: LIMITATIONS: #3.)

Question #3: What is covered for those that were on the Non-Traditional Plan?

How do we know what dental benefits they have now? Are you saying that all people who are showing active with medical Medicaid, but there is no dental showing, have emergency dental? How does that come up on eligibility?

All Medicaid members are eligible for emergency dental benefits. Members will receive emergency dental services through the benefit plan they are enrolled in (e.g. EPSDT, Blind/Disabled, Aged, TAM SUD, Emergency Dental). Eligibility for dental benefits can be verified using the Eligibility Lookup tool.

The exception is Dental Emergency. If a member has Dental Emergency, it will not show on the Eligibility Lookup tool or in PRISM. If a member is not receiving dental services through one of the benefit plans, they should be eligible for Emergency Dental. However, to verify if a member has Emergency Dental, please call the Department of Workforce Services at 1-866-608-9422.

Question #4 (Related to #3): Which Dental Codes are covered for all members?

Emergency dental services are covered for all members and are limited to the following codes:

- D0140 - Limited oral evaluation, problem focused
- D0220 - Intraoral periapical, first film
- D0230 - Intraoral periapical, each additional film, if needed
- D7140 - Extraction, erupted tooth or exposed root
- D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7510 - Incision and drainage of abscess, intraoral soft tissue

Question #5: How exactly do we bill the bundling for x-ray and root canal?

For diagnostic purposes, Medicaid allows the reporting of *D0220 - intraoral - periapical first radiographic image* as ancillary to root canal services. All other x-rays performed prior, during, or after root canal procedures are included in the global payment rate.

~~For payment to adjudicate properly, the primary root canal procedure must be billed on the first claim line, and the x-ray must be billed subsequently. In other words, the provider must bill the root canal first and the x-ray second. If the provider's system reorders the codes (meaning the x-ray shows up first), the root canal will not pay. If this is the case, the provider will need to bill the root canal and the x-ray on separate claims.~~

For diagnostic purposes, Medicaid allows the reporting of *D0220 - intraoral - periapical first radiographic image* as ancillary to root canal services. In cases when more than one root canal is performed on the same date of service, CDT D0230 - *intraoral - periapical each additional radiographic image* can also be reported once as ancillary for each additional tooth receiving endodontic services. All other x-rays performed on the tooth/teeth receiving a root canal prior to, during, or after root canal procedures are included in the global payment rate. Please note that this does not prohibit a dental provider from performing needed dental x-rays on other teeth that are not receiving a root canal procedure on the same date of service.

The process for billing root canals and x-rays has recently changed. For x-rays and root canals, the provider will need to bill the root canal first. Once that claim adjudicates, the provider can then bill the x-ray (codes D0220 and D0230) on a separate claim. Providers should not bill the root canal(s) and the x-ray(s) on the same claim. In addition, providers should not bill the x-ray until they have been paid for the root canal. This process will ensure the provider gets paid for the x-ray without any issues.