FAQs About Denture Billing Practices for Federally Qualified Health Centers

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BACKGROUND

In August 2025, the Wisconsin Primary Health Care Association reached out to the Wisconsin Department of Health Services (DHS) to clarify billing guidance for dentures on behalf of federally qualified health centers (FQHCs).

For the purposes of this document, FQHC means Tribal FQHCs **and** community health centers (CHCs) (non-Tribal FQHCs).

A 2018 ForwardHealth Update explained how to bill the multiple steps of a single arch for a denture but didn't address how to bill for two arches created at the same time, which is often standard practice when a patient requires both an upper and lower denture.

PURPOSE

These FAQs are for FQHC providers and FQHC-contracted billing providers. These FAQs clarify how to bill denture steps under an encounter rate when providers create dentures simultaneously for both maxillary and mandibular arches. Providers may also refer to the ForwardHealth Online Handbook Associated Procedure Codes for Additional Dental Visits topic #21977 for more information.

DENTURE BILLING PRACTICES

Question 1: If I make lower and upper full or partial dentures at the same time, can I get two encounter rates for one date of service (DOS)?

Answer: Claims are denied when they indicate more than one encounter for a given encounter type for the same member, same Tribal FQHC or CHC organization, and same DOS. The FQHC will receive a Remittance Advice that shows one encounter as paid and the second encounter for the same DOS as denied.

Manual claim submission for both upper and lower dentures billed with the same DOS

For denied claims with both the upper (maxillary) and lower (mandibular) dentures billed with the same DOS, FQHCs may resubmit the claim manually. For claims with both the upper denture and the lower denture, FQHCs must submit a single claim that includes:

- The base code and associated Current Dental Terminology (CDT) code D5899 (Unspecified removable prosthodontic procedure, by report) with the respective DOS as separate details.
- The Healthcare Common Procedure Coding System code T1015 (Clinic visit/encounter, all-inclusive) for the base code and the appropriate associated code.

After both upper and lower dentures have been inserted, FQHCs may resubmit the claim manually for review for up to five encounters for each denture. Manual claim resubmissions must include:

- Applicable medical documentation supporting the subsequent encounter.
- The Written Correspondence Inquiry form, F-01170.

The Written Correspondence Inquiry form can be found on the Forms page of the ForwardHealth Portal. Providers should check the "Other" box in the Reason for Inquiry field of the Written Correspondence Inquiry form and indicate "Request for review of medical necessity for subsequent encounter" in the space provided. Providers should follow the instructions on the form for submitting the claim, medical documentation, and form to ForwardHealth. Providers should keep a copy of the claim, medical documentation, and form for their records.

Refer to these Online Handbook topics for more details:

- Medical Records topic #202
- Supporting Clinical Documentation topic #449
- Claim Submission Requirements for Encounters topic #21959

Question 2: Can I wait to drop the base code, and instead submit additional CDT D5899 codes to maximize the number of D5899 (unspecified) codes available per arch, even if I have delivered the denture(s)?
Answer: Providers must follow national coding standards and rules for their claim submissions. Per the Online Handbook Associated Procedure Codes for Additional Dental Visits topic #21977, the base code represents the final prosthesis or dental service.

Billing providers are responsible for the accuracy and completeness of all claims submitted either by the provider or outside billing service or clearinghouse. Additionally, Wis. Admin. Code § DHS 106.02(9) indicates that “a provider shall prepare and maintain truthful, accurate, complete, legible and concise documentation and medical and financial records… .”

Question 3: Do I have to use CDT code D5899 to capture denture steps, or can I utilize a placeholder code in my electronic dental record instead?
Answer: Providers must follow national coding standards and rules for their claim submissions. DHS recommends that you consult with a coding professional experienced in your service area if you have questions about code selection.

Question 4: What happens if our patient stops coming to appointments before the final denture(s) is delivered?
Answer: If a patient stops coming to your office before the final denture is delivered, you can request to be reimbursed for the accrued lab services. Providers can submit a lab bill to ForwardHealth with an explanation of why the final denture(s) was unable to be delivered.

If you have not claimed any dental steps yet, you may attach the lab bill to the claim when you submit it.

If you have claimed dental steps, you may submit an Adjustment/Reconsideration Request form, F-13046, with the lab bill attached and the "medical consultant review requested" box checked on the form to Provider Services Written Correspondence:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Refer to the Claims Denial Adjustment/Review Request topic #22277 for more information.

On a case-by-case basis, ForwardHealth will consider reimbursing providers for these lab fees.

Question 5: My patient lost their ForwardHealth coverage before the final denture could be inserted. Can I still be reimbursed for the denture provided to this patient?
Answer: If you started fabricating a denture that ForwardHealth approved for a member but this member subsequently lost their coverage, ForwardHealth will still reimburse for the approved denture(s) at time of insertion. You should reach out to Provider Services or the dental field representative with the prior authorization (PA) number. ForwardHealth will add a “dental only” note to the active PA request so that dental services may continue for this member.

Refer to these Online Handbook topics:

- Loss of Enrollment — Financial Liability topic #2564 for more information about member loss of enrollment for orthodontic and prosthodontic services.
- Professional Field Representatives topic #473 for the field rep map.

Question 6: What codes should I use to indicate that adjustments were performed post-insertion on a denture(s)?
Answer: Providers must follow national coding standards and rules for their claim submissions. DHS recommends that you consult with a coding professional experienced in your service area if you have questions about code selection. You can refer to:

- BadgerCare Plus/Medicaid Prosthodontics, Maxillofacial Prosthetics, Maxillofacial Surgery, and Orthodontics topic #2818 for a list of all covered prosthodontic, removable codes.
- Prostheses Care Instructions topic #2897 for how to submit claim adjustments six months after the procedure.