

FAQs About Denture Billing Practices for Federally Qualified Health Centers

Created: 12/26/2025

Revised: 03/13/2026



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).

In this document, FQHC refers to both Tribal **and** non-Tribal FQHCs, also known as community health centers.

A 2018 ForwardHealth Update explained how to bill for one denture arch but didn't explain how to bill for two denture arches made 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 the applicable 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.

Topic Category Guide

[Billing for Upper and Lower Dentures on a Single Date of Service](#)

[Provider Responsibilities for Accurate Claim Submission and Documentation](#)

[Reimbursement Process for Undelivered Denture Lab Fees](#)

[Denture Reimbursement Policy After Loss of Coverage](#)

Billing for Upper and Lower Dentures on a Single Date of Service

Date: 03/13/2026

Question: 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: In 2020, ForwardHealth began requiring providers to include the area of oral cavity with Healthcare Common Procedure Coding System (HCPCS) code T1015 to reduce duplicate claims errors when upper (maxillary) and lower (mandibular) dentures are billed the same day.

In 2021, ForwardHealth issued denture guidance for the area of oral cavity. Refer to the Area of Oral Cavity Codes topic [#2806](#). FQHCs no longer need to follow the manual claim resubmission when all criteria are met.

For claims with both the upper and lower dentures billed with the same DOS, 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 HCPCS code T1015 (Clinic visit/encounter, all-inclusive) for the base code and the appropriate associated code.
- The area of oral cavity codes for both the upper and lower denture CDT base codes and HCPCS code T1015. As a reminder, the area of oral cavity codes are "01" for maxillary and "02" for mandibular. The claim will deny if the area of oral cavity is not specified.

After both upper and lower dentures have been inserted, FQHCs may submit claims for up to five encounters for each denture.

Refer to these Online Handbook topics for more details:

- Medical Records topic #[202](#)
- Supporting Clinical Documentation topic #[449](#)
- Claim Submission Requirements for Encounters topics #[21959](#) and #[24125](#)

Provider Responsibilities for Accurate Claim Submission and Documentation

Date: 12/26/2025

Question: 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 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”

Date: 12/26/2025

Question: 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.

Date: 12/26/2025

Question: 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.

Reimbursement Process for Undelivered Denture Lab Fees

Date: 12/26/2025

Question: 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.

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

Denture Reimbursement Policy After Loss of Coverage

Date: 12/26/2025

Question: 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.