To:

Dentists

HMOs and Other Managed Care Programs

Changes to dental procedure codes

The American Dental Association (ADA) has changed its dental procedure codes to eliminate duplication of codes contained in medical or other coding systems. To remain consistent with the changes made by the ADA, Wisconsin Medicaid began recognizing the new dental procedure codes on **July 1, 2000**.

"0" to "D" code change

In the new American Dental Association (ADA) *Current Dental Terminology, Third Edition, Version 2000* (CDT-3/2000) coding system, all procedure codes start with a "D" instead of a "0" (zero). All updates and modifications to ADA procedure codes, descriptors, and common dental terms can be found in the CDT-3/2000 manual.

Transition period

At the request of the Wisconsin Dental Association (WDA), Wisconsin Medicaid will allow a transition period during which dentists can use either the "0" *or* the "D" codes. This transition period will provide dental offices, software vendors, and business partners time to make the necessary technical and software modifications before the complete conversion to "D" codes becomes mandatory.

The transition period will end **July 1, 2001**. Therefore, providers submitting claims on and after July 1, 2001, are required to use the new ADA CDT-3/2000 procedure codes ("D"codes) when billing Wisconsin Medicaid.

Before switching to "D" codes, the appropriate software must be installed. Therefore, before beginning to use the new codes, dentists should contact their software vendor(s) and other business partners to ensure that they are prepared for the change.

Dentists can begin using the new "D" codes at any time during the transition period; however, once the transition has been made, the new set of codes must be used exclusively from that point forward. For example, if a dentist has transitioned to use "D" codes and needs to bill for the "removal of exostosis – per site," that dentist is required to use procedure code D7471.

Exceptions

In most cases only the first character of the procedure code was changed (i.e., "0" to "D"). There are, however, two exceptions where the ADA changed both the first *and* the last character of the procedure code. These exceptions are detailed in Table 1 of the Attachment to this *Update*.

Procedure codes added

Several procedure codes have been added to the list of Medicaid-covered basic dental services. A list of the added procedure codes can be found in Table 2 of the Attachment.

Special note for orthodontic procedures

Orthodontic providers who choose to use "0" codes during the transition period must use the orthodontic codes listed on pages B115 and B116 of the Dental Handbook (issued 11/98) when completing prior authorization (PA) requests or when billing for orthodontic procedures. Providers who choose to use the new "D" codes are required to use the orthodontic procedures (D8010–D8692) as listed in Table 2 of the Attachment when completing PA requests or when billing for orthodontic procedures.

Procedure code deleted

Local procedure code W7117, Treatment of ANUG (acute necrotizing ulcerative gingivitis/Vincent's disease), has been deleted as a Medicaid-covered basic dental service. Wisconsin Medicaid will not reimburse for this procedure code for services provided on and after July 1, 2000.

Prior authorization

In situations where a procedure requires PA, the procedure code submitted on the claim form should exactly match the procedure code that was approved on the PA request. Wisconsin Medicaid understands that software limitations may make it difficult for providers to ensure that these codes agree. Therefore, if a "0" code appears on the approved PA request and the corresponding "D" code is on the subsequent claim, Wisconsin Medicaid will manually

correct the procedure code on the claim and continue it through the claims process.

Medicaid HMO network providers

This *Update* applies to fee-for-service Medicaid dental providers only. If you are a Medicaid HMO dental network provider, contact your managed care organization for more information about its billing procedures. Wisconsin Medicaid HMOs are required to provide at least the same benefits for enrollees as those provided under fee-for-service arrangements.

ATTACHMENT

Table 1 - Exceptions

Oral Surgery					
"0" Code	**"D" Code**	**Description of Service**	**PA Required**	**Allowable Age**	**Limitations**
07470	D7471	Removal of exostosis – per site	Yes	All	None.

Adjunctive General Services					
"0" Code	**"D" Code**	**Description of Service**	**PA Required**	**Allowable Age**	**Limitations**
09240	D9241	Intravenous sedation/analgesia	Yes	All	PA not required in an emergency. Not billable with D9220, D9248, 09220, 09248.

Table 2 - Procedure codes <u>added</u>

Procedure Codes <u>Added</u>				
Procedure Code*	**Description of Service**	**PA Required**	**Allowable Age**	**Limitations**
D0350 and 00350	Oral/facial images (includes intra- and extra-oral images)	Yes	<21	HealthCheck referral required.
D2952 and 02952	Cast post and core in addition to crown	No	All	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, SN only. Cannot be billed with D2954, 02954.
D2954 and 02954	Prefabricated post and core in addition to crown	No	All	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, SN only. Cannot be billed with D2952, 02952.
D3221 and 03221	Gross pulpal debridement permanent teeth only	No	All	Tooth numbers 2-15, 18-31, SN only. Not to be used by provider completing endodontic treatment.

(Continue Table 2)

Procedure Codes Added				
Procedure Code*	**Description of Service**	**PA Required**	**Allowable Age**	**Limitations**
D7871 and 07871	Non-arthroscopic lysis and lavage	Yes	All	Allowable only once per side (right and left), per three years.
D7997 and 07997	Appliance removal (not by a dentist who placed appliances), includes removal of archbar	No	All	Operative report required.
D8010	Limited orthodontic treatment of the primary dentition	Yes	<21	HealthCheck referral required.
D8020	Limited orthodontic treatment of the transitional dentition	Yes	<21	HealthCheck referral required.
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	<21	HealthCheck referral required.
D8040	Limited orthodontic treatment of the adult dentition	Yes	<21	HealthCheck referral required.
D8050	Interceptive orthodontic treatment of the primary dentition	Yes	<21	HealthCheck referral required.
D8060	Interceptive orthodontic treatment of the transitional dentition	Yes	<21	HealthCheck referral required.
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	<21	HealthCheck referral required.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Yes	<21	HealthCheck referral required.
D8090	Comprehensive orthodontic treatment of the adult dentition	Yes	<21	HealthCheck referral required.
D8670	Periodic orthodontic treatment visit (monthly adjustments)	Yes	<21	HealthCheck referral required.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer)	Yes	<21	HealthCheck referral required.
D8692	Replacement of lost or broken retainer	Yes	<21	HealthCheck referral required.
D9248 and 09248	Non-intravenous conscious sedation (oral conscious sedation)	Yes	All	Not analgesia. Not billable with D9220, D9241, 09240, 09220. Not inhalation of nitrous oxide.

* If more than one procedure code is listed, use the procedure code that is consistent with the code set you use to bill Wisconsin Medicaid for other dental procedures.