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200.000 DENTAL GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Dentists

201.100 Individual Providers of Dental Services in Arkansas and Bordering States 11-1-09

Dental services providers in Arkansas and bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) must meet the Provider Participation and enrollment

requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

Dental providers must be licensed by the State Board of Dental Examiners to practice in their state. A copy of the current dental license must accompany the provider application and Medicaid contract.

201.110 Individual Providers of Oral and Maxillofacial Surgeon Services in Arkansas and Bordering States 11-1-09

Oral and maxillofacial surgery services providers in Arkansas and bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid program as an oral and maxillofacial surgeon specialist:

- A. A copy of certification letter and license from the Arkansas State Board of Dental Examiners or other licensing state verifying completion of all requirements for a specialty license in oral and maxillofacial surgery must be provided.

or

- B. A current copy of annual renewal receipt from the Arkansas State Board of Dental Examiners or other licensing state certification must be provided. Subsequent renewal verification must be provided when issued.
- C. A current copy of the DEA certificate issued by the Drug Enforcement Agency (DEA) must accompany the provider application (DMS-652) and the Medicaid contract (DMS-653). Subsequent certification by the DEA must be provided when issued.

201.200 Individual Providers of Dental or Oral and Maxillofacial Surgeon Services in Non-Bordering States 10-13-03

Individual providers of dental or oral and maxillofacial surgery services in non-bordering states may be enrolled only as limited services providers.

201.210 Individual Limited Services Providers in Non-Bordering States 3-1-11

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file.

To enroll, a non-bordering state provider must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View or print the provider enrollment and contract package \(AppMaterial\). View or print Provider Enrollment Unit Contact information.](#)

- B. Limited services providers remain enrolled for one year.
 - 1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Group Providers of Dental or Oral and Maxillofacial Surgeon Services in Arkansas and Bordering States 11-1-09

Group providers of dental or oral and maxillofacial surgery services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a dentist is a member of a group, each individual dentist and the group must both enroll according to the following criteria:

- A. Each individual dentist within the group must enroll following the criteria established in Sections 201.100 and 201.110.
- B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled licensed dentist within the group.

201.400 Group Providers of Dental or Oral and Maxillofacial Surgeon Services in Non-Bordering States 10-13-03

Group providers of dental services in non-bordering states may be enrolled only as limited services providers.

201.410 Group Limited Services Providers in Non-Bordering States 3-1-11

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file

To enroll, a non-bordering state provider must download an Arkansas Medicaid provider application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View or print the provider enrollment and contract package \(AppMaterial\)](#). [View or print Provider Enrollment Unit Contact information](#).

- B. Limited services providers remain enrolled for one year.
 1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim’s last date of service, if the enrollment file is kept current.
 2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
 3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.500 Dentist Role in the Child Health Services (EPSDT) Program 1-15-11

The Child Health Services (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

- A. Early and periodic screening and diagnosis and treatment (EPSDT) is a health care program designed for (1) health evaluations as soon after birth as possible, (2) repeated at regular recommended times, (3) to detect physical or developmental health problems and (4) health care, treatment and other measures to correct or improve any defects and chronic conditions discovered.

1. Screening

The Arkansas Medicaid Program recommends for **all** eligible EPSDT recipients under 21 years of age, regularly scheduled examinations and evaluations of their general physical and mental health, growth, development and nutritional status.

These screenings must include, but are not limited to:

- a. Comprehensive health and developmental history.
- b. Comprehensive unclothed physical examination.
- c. Appropriate vision testing.
- d. Appropriate hearing testing.
- e. Appropriate laboratory tests.
- f. Dental screening services furnished by direct referral to a dentist for children within six months after the first eruption of the first primary tooth, but no later than twelve months (per the American Academy of Pediatrics).

Screening services must be provided in accordance with reasonable standards of medical and dental practice; as soon as possible in a child's life; and at intervals established for screening by medical, dental, visual and other health care experts.

An age appropriate screening may be performed when a child is being evaluated or treated for an acute or chronic condition and billed as an EPSDT screening. See the EPSDT manual for information regarding EPSDT screenings.

2. Diagnosis

Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health, history, physical, developmental and psychological examination, laboratory tests and X-rays.

3. Treatment

Treatment means physician, hearing, visual services or dental services and any other type of medical care and services recognized under state law to prevent or correct disease and abnormalities detected by screening or by diagnostic procedures.

Physicians and other health professionals who perform a Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment. If immunization is recommended at the time of screening, immunization(s) **must** be provided at that time, **or a direct referral given.**

If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations.

- B. Child Health Services (EPSDT) providers are encouraged to refer to the EPSDT provider manual for additional information. Information can be obtained by going to the Arkansas Medicaid website at www.medicaid.state.ar.us and by checking on provider information.

Dentists interested in becoming a Child Health Services (EPSDT) provider may contact the central Child Health Services Office. [View or print Child Health Services contact information.](#)

201.600 Dentist Role in the Pharmacy Program

8-15-09

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

PRESCRIPTION DRUG INFORMATION

If you have prescription drug prior authorization concerns, please call the Prescription Drug PA Help Desk:

In-state toll free
(800) 707-3854

Local and out-of-state
(501) 374-6609 x 500

Prescribers may also refer to the Arkansas Medicaid website at <https://www.medicaid.state.ar.us/InternetSolution/Provider/pharm/scrinfo.aspx> to obtain the latest information regarding prescription drug coverage.

202.000 Documentation Requirements

11-1-09

Dental providers must keep and properly maintain written records. Along with the required enrollment documentation, which is located in Section 141.000, the following records must be included in the provider's files.

202.100 Dental Records Dentists are Required to Keep

11-1-09

Dentists must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a beneficiary's case file must be signed and dated by the dental provider. The documentation must be kept on the beneficiary's case file.

Documentation must consist of, at a minimum, material that includes:

- A. History and dental examination on initial visit
- B. Chief complaint on each visit

- C. Tests, X-rays and results
- D. Diagnosis
- E. Treatment, including prescriptions
- F. Signature or initials of dentist after each visit
- G. Copies of hospital and/or emergency room records

202.200 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code 25-31-103.

202.300 Reserved 11-1-09

203.000 Monitoring Performance of the Dental Equipment Supplier 7-1-09

The Arkansas Medicaid Program uses a single dental laboratory selected through a competitive bid process to furnish dentures for eligible Medicaid beneficiaries age 21 and over. The Medicaid Program's Medical Assistance Unit depends on dental providers to assist in monitoring the performance of the contractor both in quality of product and timeliness of delivery. The following procedures must be followed:

- A. The Medical Assistance Unit welcomes positive and negative comments regarding the dental laboratory's performance. All comments regarding the dental laboratory's performance must be made on the Vendor Performance Report. [View or print the Vendor Performance Report.](#) The provider will complete the Vendor Performance Report at any time a beneficiary verbally expresses dissatisfaction with his or her dentures.
- B. Vendor Performance Reports should be mailed to the Division of Medical Services, Medical Assistance Unit. [View or print the Division of Medical Services. Medical Assistance Unit contact information.](#)
- C. The Medical Assistance Unit, upon receipt of the Vendor Performance Report, will log and investigate the complaint.
- D. A copy of the report is kept on file and may be a factor in awarding future contracts.

To assist the Medical Assistance Unit in investigating the report, the following guidelines are suggested when submitting a Vendor Performance Report:

- A. Agency and address - enter dental provider agency name, address and phone number
- B. Vendor and address - enter name and address of dental laboratory
- C. Include the date the patient was examined and the date the claim and prescription were submitted
- D. Indicate the date the dentures were delivered
- E. Describe specific problems, e.g., poor quality (explain in detail), failure to deliver in a timely manner, unauthorized substitution, etc.
- F. Give name and ID number of the Medicaid beneficiary

- G. If the provider's staff has previously contacted the dental lab about a problem, note the date of contact, the name of the person who made the contact and the name of the persons contacted. Include any pertinent information related to the contact.

Copies of the Vendor Performance Report may be obtained by calling the Division of Medical Services, Medical Assistance Unit.

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-09

The Arkansas Medicaid Program covers dental services for Medicaid-eligible recipients under the age of 21 years through the Child Health Services (EPSDT) Program and also has limited coverage of services for individuals age 21 and older.

212.000 Summary of Coverage 7-1-09

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of \$500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the \$500.00 benefit limit for adults.

Medicaid dental procedure codes are listed in Section 262.100 for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in Section 262.200. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. Section 262.200 also lists the procedure codes that are benefit limited.

212.100 Medical and Surgical Services Provided by a Dentist 10-13-03

Recipients age 21 and over are allowed twelve visits per state fiscal year for medical services provided by dentists, physician's services, rural health clinic core services, medical services furnished by optometrists, certified nurse midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Medical services that are provided by a dentist for individuals under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Surgical services are covered for recipients of all ages if the services are medically necessary.

212.200 Oral and Maxillofacial Services 10-13-03

In order to provide oral and maxillofacial surgery services to an Arkansas Medicaid recipient, the dentist must meet the qualifications outlined in Sections 201.110 and 201.300 and enroll as an oral and maxillofacial surgeon. Oral and maxillofacial surgeon services that are medical in nature (e.g., fracture, cyst removal) require a referral by the primary care physician (PCP).

Nitrous oxide/analgesia N₂O is covered when used with a surgical procedure or a procedure other than examination, prophylaxis, fluoride, sealants and X-rays.

212.300 Dental Services Provided by a Mobile Dental Facility 1-1-11

Dental Services Provided by a Mobile Dental Facility

A mobile dental facility is any self-contained, intact facility in which dentistry and dental hygiene are practiced and that may be towed, moved or transported from one location to another.

A mobile dental facility must enroll by completing the Arkansas Medicaid provider application and contract. Mobile dental facilities must meet all criteria of a dental group and submit the same enrollment documentation stated in Section 141.000 and Section 201.000. Additionally, mobile dental facilities must maintain and submit with their Arkansas Medicaid provider application and contract a copy of their mobile facility permit issued by the Arkansas State Board of Dental Examiners. Each individual dentist practicing within the mobile dental facility must also be an Arkansas Medicaid provider and will need to complete Section IV "Group Affiliation" of the Arkansas Medicaid provider application.

NOTE: Mobile providers of Dental or Oral and Maxillofacial Surgeon Services in bordering and non-bordering states cannot enroll.

Billing Procedures

All mobile dental facilities are "pay to" providers only. This service must be performed and billed by a licensed/enrolled dentist with the mobile facility.

NOTE: For providers filing on the paper ADA claim form, mark section 38, select the appropriate POS and complete section 56 (service address).

213.000 Tooth Numbering

4-1-05

Arkansas Medicaid uses an enumeration system to identify regular and supernumerary teeth in children and adults.

- A. The system was devised by the American Dental Association in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- B. It includes a numbering system to identify permanent and permanent supernumerary teeth and an alpha arrangement to identify both regular and deciduous supernumerary teeth.
 1. Valid values for regular permanent teeth include the numbers 1 through 32.
 2. Numbers 51 through 82 indicate supernumerary permanent teeth.
 3. Alpha letters A through T indicate regular deciduous teeth.
 4. AS through TS indicate supernumerary deciduous teeth.

[View or print a description of the tooth numbering method to be used for all Medicaid claims.](#)

214.000 Consultations

4-1-05

A consultation includes services provided by an oral surgeon whose opinion or advice is requested by an oral surgeon or other appropriate source for the further evaluation and/or management of a specific problem. When the consulting oral surgeon assumes responsibility for the continuing care of the patient, any subsequent service provided by him or her is not a consultative service.

Consultations are limited to two per recipient per year in an oral surgeon's or physician's office. This yearly limit is based on the state's fiscal year, July 1 through June 30. Extensions of this benefit are available to recipients under the age of 21 when the consultation is medically necessary.

These procedures must be billed on the American Dental Association (ADA) claim form by oral surgeons enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid recipient and is medically necessary.

215.000 Child Health Services (EPSDT) Dental Screening

3-1-07

~~The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist.~~ The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Service (EPSDT) periodicity schedule.

The dental screening exam is limited to two screening exams per every six (6) months plus one (1) day for individuals under age 19. These benefits may be extended if documentation is provided that verifies medical necessity. See Section 262.100 to view the procedure code for periodic dental screening exams.

~~Individuals under age 19 enrolled in the EPSDT Program may receive an interperiodic dental screening exam as often as is medically necessary.~~ Prior authorization from the Division of Medical Services Dental Care Unit is required for this service and must be requested on the ADA Claim Form. [View or print form ADA-J400](#) or request prior authorization online with a brief narrative through the Provider Electronic Solutions (PES) Application Software or other vendor software. See Section 262.100 for the interperiodic dental screening exam procedure code.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

216.000 Radiographs

10-13-03

Radiographs (X-rays) should be kept to a minimum to be consistent with good diagnostic procedure. **Medicaid dental consultants examine each radiograph before a coverage determination is made; therefore, the radiographs must be of sufficient quality to be readable.** When the radiograph quality is too poor to read, the radiograph must be retaken at no additional charge to the Medicaid Program or the recipient.

Periapical X-rays must be taken to substantiate the need for extractions and/or restorations and endodontia. Periapical X-rays are limited to four per visit without a prior authorization.

When submitting radiographs with a request for authorization, the dentist must ensure that the films are properly mounted, marked R (right) and L (left) and stapled to the ADA claim form. To ensure proper identification, the dentist's name, the patient's name and the date taken must be on the film. Each film must be dated. Any radiographs submitted for review must be mailed to the Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)

Do not mail X-rays to HP Enterprise Services.

All X-rays are returned to the provider. All X-rays pertaining to a Medicaid recipient must be retained for three years and must be made available, upon request, to authorized representatives of the Division of Medical Services.

216.100 Complete Series Radiographs for Beneficiaries of All Ages

7-1-09

A complete series of intraoral radiographs is allowable for beneficiaries of all ages only once every five years. Any limits may be exceeded based on medical necessity (e.g., traumatic accident) for beneficiaries under age 21.

- A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.
- B. Only one complete series is covered. A complete series may be:
 1. Intraoral, including bitewings, or
 2. Panoramic, including bitewings.
- C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.
- D. **Prior authorization (PA) is required for panoramic radiographs of children under age six.**
- E. When referrals are made, the patient's X-rays must be sent to the specialist.
- F. For instructions when billing for a complete series, see Section 262.400.

216.200 Bitewing Radiographs

7-1-09

Bitewing radiographs are covered for beneficiaries of all ages. There are different limitations of coverage for beneficiaries under age 21 and for those beneficiaries age 21 and older.

The ~~EPSDT~~ periodic screening exam must include two bitewing films that cover the distal of the cuspids to the distal of the most posterior tooth.

The ~~EPSDT~~ periodic screening exam must include only two bitewings and is allowed every six (6) months plus one (1) day for beneficiaries under age 21. See Section 262.100 for the appropriate procedure code.

Two bitewing films are allowed once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. See Section 262.200 for appropriate procedure codes.

216.300 Intraoral Film

4-1-05

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form, as noted in Section 216.000.

217.000 Preventive Services

217.100 Dental Prophylaxis and Fluoride Treatment

7-1-09

Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis and fluoride treatments are each covered every six (6) months plus one (1) day for beneficiaries under age 21. If further treatment is needed due to severe periodontal problems, the provider must request prior authorization with a brief narrative.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

- A. periodic EPSDT screening exam (for beneficiaries under age 21)
- B. prophylaxis and fluoride
- C. periapical X-rays, amalgam-composite restorations (except four or more surfaces)
- D. pulpotomies for deciduous teeth (Pulpotomies are not a covered service for beneficiaries age 21 and over.)
- E. chrome crowns on deciduous teeth

See Sections 262.100 and 262.200 for applicable codes.

217.200 Dental Sealants

7-1-09

Dental sealants constitute preventive treatments available for eligible beneficiaries under age 21. Coverage is once per lifetime for 1st and 2nd permanent molars only.

Dental sealants are not covered for beneficiaries age 21 and over.

218.000 Space Maintainers

7-1-09

Space maintainers are covered for beneficiaries under age 21 and require prior authorization. X-rays must be submitted with the request for prior authorization. When submitting a treatment plan or claim for space maintainers, identify the missing tooth in the tooth column on the ADA claim form and submit the X-ray to show the tooth for which the space is maintained. See Section 262.100 for applicable procedure codes.

Space maintainers are not covered for beneficiaries age 21 and over.

218.100 Diagnostic Casts (Dental Molds)

7-1-09

Diagnostic casts (dental molds) are covered for beneficiaries of all ages; however, there are benefit limits for beneficiaries age 21 and over. **For more information regarding diagnostic casts, see Sections 226.000, 262.100 and 262.200.**

219.000 Restorations

219.100 Amalgam Restorations

7-1-09

Amalgam restorations are to be used on all teeth distal to the cuspids for beneficiaries of all ages. When submitting a claim for amalgam restorations, the tooth (teeth) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. Amalgam restorations do not require prior authorization. If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate. See Sections 262.100 and 262.200 for applicable procedure codes.

219.200 Composite Resin Restorations

7-1-09

Composite-resin restorations may be performed for anterior teeth for beneficiaries of all ages. Four or more surface composite-resin restoration requires prior authorization. When submitting a claim for composite restorations, the tooth number(s) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. **If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate.** See Sections 262.100 and 262.200 for applicable procedure codes.

220.000 Crowns – Single Restorations Only

7-1-09

Crowns are covered for individuals of all ages.

- A. **Chrome (Stainless Steel) Crowns** - The Medicaid Program will cover chrome (stainless steel) crowns on deciduous posterior teeth only as an alternative to two or three surface alloys. Medicaid will cover chrome crowns on permanent posterior teeth only for loss of cuspal function. Stainless steel crowns on deciduous teeth do not require prior authorization. Prior authorization is required for crowns on all permanent teeth.
- B. **Anterior Crowns** - Prefabricated stainless steel or prefabricated resin crowns may be approved for anterior teeth for beneficiaries under age 14. Prior authorization is required, and X-rays must be submitted to substantiate need.
- C. **Cast Crowns** - Medicaid does not cover cast crowns for posterior teeth.
- D. **Porcelain-to-Metal Crowns** - Porcelain-to-metal crowns may be approved only in unusual cases for anterior incisors and cuspids for beneficiaries under age 21. These cases must be submitted for prior authorization (PA) with complete treatment plans for all teeth and complete series X-rays or panoramic film with bitewings. Photographs are helpful, but are not required.
- E. **Post and Core in Addition to Crown** - Medicaid does not cover core buildups or post and core buildups. This includes an amalgam filling with a stainless steel crown. An exception to this rule may be anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch.

Fillings are not allowed on tooth numbers with crowns within one year of the crown.

See Sections 262.100 and 262.200 for applicable procedure codes.

221.000 Endodontia

7-18-11

Pulpotomy for deciduous teeth may be performed without prior authorization for beneficiaries ~~under age 21~~. **Pulpotomies are not covered for individuals age 21 and over.**

Current indications require carious exposure of the pulp. **Payment for pulp caps is included in the fee for restorations and is not payable separately.**

Endodontic therapy is not covered for individuals age 21 and over.

To be reimbursed, the completed endo-fill should conform to current standards, that is, complete obturation of all canals to within 1mm to 2mm of radiographic apex.

The fee for endodontic therapy does not include restoration to close a root canal access, but does include films for measurement control and post-op.

Medicaid does not cover endodontic retreatment, apexification, retrograde fillings or root amputation. See Section 262.100 for applicable procedure codes.

222.000 Periodontal Procedures

7-1-09

Periodontal treatment is available for beneficiaries of all ages. When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and X-rays are required. Each quadrant to be treated must be indicated on separate lines when requesting prior authorization or payment. Prior authorization will require a report, a periochart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. See Sections 262.100 and 262.200 for applicable procedure codes.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs)

7-18-11

A. Benefits

Full and acrylic partial dentures are covered for beneficiaries of all ages. Full dentures or acrylic partial dentures may be approved for use instead of fixed bridges.

Beneficiaries age 21 and over are allowed only one complete maxillary denture and one complete mandibular denture per lifetime.

Beneficiaries age 21 and over are allowed only one upper and one lower partial per lifetime.

Repairs of dentures and partials are covered ~~but are benefit limited for beneficiaries age 21 and over.~~ See Sections 262.100 and 262.200 for applicable procedure codes.

B. Prior Authorization Requirements

Prior authorization is required for dentures (full or partial) for beneficiaries under the age of 21.

Prior authorization is required for partial dentures for beneficiaries age 21 and over.

Prior authorization is not required for full dentures for beneficiaries age 21 and over.

For dentures that require prior authorization, a complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by partial dentures, must be submitted with prior authorization requests. See Sections 262.100 and 262.200 for further information regarding prior authorization for dentures.

Prior authorization is required for repairs of dentures and partials for eligible beneficiaries of all ages. A history and date of original insertion must be submitted with the prior authorization request. See Sections 262.100 and 262.200 for applicable procedure codes.

C. Required Process for Submitting Adult Dentures and Partial to Dental Lab

For eligible Medicaid beneficiaries age 21 and over, all dentures, whether full or partial, must be manufactured by the Medicaid-contracted dental lab. [View or print contact information for Medicaid Dental Contractor.](#)

When Medicaid issues a prior authorization for partial dentures for a beneficiary age 21 and over, the Dental Lab Request Form with the prior authorization number is returned to the dental provider's office. When the dental provider receives the prior authorization, the authorization will be for a maximum of six (6) (three upper and three lower) limited oral evaluations-problem focused visits (D0140) along with authorization for the diagnostic casts (D0470). The dental provider must then send the Medicaid-contracted dental lab the

completed Dental Lab Request Form with the prior authorization number and models to make the adult partial dentures. **If the dental lab does not receive the Dental Lab Request Form, the lab will make the partial dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** [View or print contact information for Medicaid Dental Contractor.](#)

Though prior authorization is not required for full dentures for beneficiaries age 21 and over, the dental provider must send the Dental Lab Request Form and models directly to the Medicaid-contracted dental lab. The Dental Lab Request Form must clearly indicate that the beneficiary is a Medicaid beneficiary and the dentures are being requested pursuant to the Medicaid benefit plan. **If the dental lab does not receive the request form, the lab will make the full dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** The dental provider will be reimbursed for a maximum of six (6) (three upper and three lower) limited oral evaluations-problem focused (D0140) visits and two (2) (one upper and one lower) diagnostic casts (D0470). [View or print contact information for Medicaid Dental Contractor.](#)

224.000 Adjustments and Relines of Dentures for Beneficiaries Age 21 and Over 7-1-09

Dentures may be relined once every three years and three adjustments of dentures are allowed per lifetime for beneficiaries age 21 and over.

225.000 Oral Surgery

225.100 Simple Extraction 7-1-09

Simple extractions may be performed without prior approval. Simple extractions of 3rd molars do not require prior authorization.

When a simple extraction evolves into a surgical extraction, providers must write a brief explanation of the circumstances if the problem is not indicated on the X-ray. Normally, surgical extractions imply sectioning, suturing and bone removal or any combination of these procedures. Providers must submit the claim, with the X-ray, for authorization and payment to the Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#) See Sections 262.100 and 262.200 for applicable procedure codes.

225.200 Surgical Extractions 7-18-11

Most surgical extractions for beneficiaries under the age of 21 do not require prior authorization. See Section 262.100 for specific instructions regarding surgical extractions for beneficiaries under 21.

All surgical extractions for beneficiaries age 21 and over require prior authorization and X-ray to substantiate need. The dental consultant may require a second opinion when reviewing treatment plans for extractions.

Surgical extractions performed on an emergency basis (See Section 234.000) **for relief of pain** may be reimbursed subject to the approval of the Medicaid's dental consultants. In these cases, the claim with X-ray and a brief explanation should be submitted to the Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)

For beneficiaries under the age of 21, the fee for surgical extraction includes local anesthesia and routine post-operative care. See Sections 262.100 and 262.200 for applicable procedure codes. Anesthesia is not a covered service for beneficiaries 21 and over.

225.300 Traumatic Accident

7-1-09

In cases of traumatic accident and when time is of prime importance, the dental provider may perform the necessary procedure(s) immediately. The procedure code chart found in Sections 262.100 and 262.200 identifies the procedures that may be billed "By Report" and those which must be prior authorized before reimbursement may be made. The chart also indicates the procedures that require submission of X-rays. Pre- and post-operative X-rays, if requested, must be made available to the Division of Medical Services.

225.400 By Report

10-13-03

When "By Report" is indicated on the Medicaid procedure code listings, the dental provider is required to attach a concise report of the procedure to the claim form when submitting the claim for payment. X-rays and hospital records, upon request, must be made available to the Division of Medical Services.

226.000 Orthodontics

7-1-09

Orthodontic treatment is not covered for beneficiaries age 21 and over.

Orthodontic treatment is available for beneficiaries under age 21 with prior authorization on a very selective basis when a handicapping malocclusion is affecting the patient's physical and/or psychological health. The dental provider is responsible for evaluating the attitude of the patient and the parent/guardian toward the treatment and their ability and/or willingness to follow instructions and meet appointments promptly. This evaluation should precede taking orthodontic records. **Note: ARKids First-B does not cover orthodontic treatment, nor is orthodontic treatment available for beneficiaries age 21 and over.**

All orthodontic treatment is classified as either minor treatment for tooth guidance or as comprehensive treatment. Minor treatment for tooth guidance is covered with prior authorization when necessary to correct functional problems.

All orthodontic treatment, including functional appliances, must be requested on the ADA claim form. The ADA claim form must be accompanied by the Request for Orthodontic Treatment form (form DMS-32-0). [View or print form DMS-32-0.](#)

The maximum age of eligibility for full-banded 24-month orthodontic treatment is through age 20. Functional-banded orthopedic appliances require the same diagnostic records as full-banded orthodontics. The minimum total score on a Request for Orthodontic Treatment for consideration of comprehensive orthodontic treatment is 26. This value will be re-scored by a Medicaid dental consultant based on the casts and radiographs provided with the request.

Diagnostic casts (dental molds), cephalometric film, photos, a complete series of X-rays and any information not evident on diagnostic materials must be submitted for review with the ADA claim form. Dental molds must be submitted along with the treatment plan. The dental molds must not be submitted separately, and the provider's and the beneficiary's full names must be clearly inscribed on the upper and lower casts.

If oral surgery is necessary in addition to orthodontic treatment, the oral surgeon must submit his or her treatment plan with the orthodontic treatment plan.

When orthodontic treatment is approved, a procedure code for appliance insertion will be issued. Medicaid coverage includes payment for the appliance, the diagnostic records, casts (dental

molds and X-rays) and the post-treatment retainer. The applicable procedure code and the prior authorization control number will be sent to the provider on the ADA form. The date the treatment is to be completed will also be indicated. Treatment beyond the indicated completion date is not covered. The Authorization for Payment for Services Provided form (form MAP-8) and a copy of the treatment plan must be kept in the patient's file by the provider. [View or print MAP-8 form and instructions.](#)

In order to qualify for Medicaid coverage, treatment that includes the placement of braces must begin within ninety (90) calendar days of prior authorization unless the provider establishes good cause for delay to the satisfaction of the DMS director.

Upon placement of braces, a photograph of the patient must be submitted for payment for orthodontic treatment and is included in the fee. Failure to submit a photo showing placement of braces may result in non-payment of orthodontic treatment. In case of non-payment, the provider will be allowed to submit a claim for the orthodontic records as outlined below.

When treatment is denied or for any reason is not performed, the provider is allowed to submit a claim for the orthodontic records. This includes orthodontic consultation, cephalometric film, diagnostic casts (dental molds), photos and a complete series or panoramic X-ray if taken by the dentist. This claim must be approved by the Medicaid dental consultant.

All claims for orthodontic treatment are to be submitted on the ADA claim form according to directions detailed in Section 262.300 of this manual. Claims must be submitted within 12 months from the date of service.

When a patient is uncooperative for any reason, except for the situation noted in the following paragraph, termination of the treatment will be left to the discretion of the provider. A report must be sent to the Division of Medical Services, Dental Care Unit, with a pro-rated refund to Arkansas Medicaid for the balance of the uncompleted treatment plan. [View or print DMS Dental Care Unit contact information.](#)

When an orthodontic patient moves within the state after initial treatment has begun, the original provider should reimburse the second provider directly for the pro-rated fees remaining. When the second provider submits his or her treatment plan to continue the orthodontic patient's treatment, the provider must submit the orthodontic records of treatment performed by the original provider.

227.000 Professional Visits

7-1-09

Professional visits are payable if prior authorized. Because it is not always possible to plan these calls, the provider should submit a claim with a concise explanation of the circumstances. These visits are subject to review by the dental consultant.

When a treatment is necessary and no procedure code is applicable, a written explanation of the treatment and the usual and customary fee charged to a private patient must be submitted to the Medicaid Program. The dental consultant will stipulate an exact fee to be paid if the treatment is authorized. See Sections 262.100 and 262.200 for applicable procedure codes.

228.000 Hospital Services

7-1-09

All inpatient and outpatient hospitalization for dental treatment requires prior authorization in order for the hospital to receive payment. The dental consultant may request a second opinion when reviewing requests for dental prior authorization.

To request prior authorization, the dental treatment plan must be submitted on the ADA claim form with the appropriate X-rays. A copy of the Additional Information form (DMS-32-A) should

be attached indicating the reason(s) hospitalization is necessary and the name of the hospital. [View or print form DMS-32-A.](#)

In unusual cases, for beneficiaries under age 21, when it is impossible to determine the treatment plan before the patient is anesthetized, indicate the information on the DMS-32-A. Beneficiaries age 21 and over are not covered for general anesthesia, nitrous oxide and non-intravenous conscious sedation.

The provider must complete the first portion of the ADA claim form (the ID of the patient and doctor) and submit both forms together. After the treatment is performed, any procedure(s) requiring prior authorization must be submitted to the dental consultant for authorization.

When hospital services are authorized, it is the dentist's responsibility to provide the hospital with the prior authorization control number in order for the hospital to file a claim. The prior authorization control number must be entered on the claim form. See Sections 262.100 and 262.200 for applicable procedure codes.

228.100 Inpatient Hospital Services

~~7-1-09~~

~~Hospitalization for dental treatment may be approved when the patient's age, medical or mental problems and/or the extensiveness of treatment necessitates hospitalization.~~ Consideration is given in cases of traumatic accidents and extenuating circumstances.

Because of the cost of a hospital stay, providers are encouraged to use outpatient hospital care whenever feasible. The length of hospitalization should be kept to a minimum.

Request for hospitalization should be made only when other methods such as premedication, delay of treatment, limited in office treatment, sedation, etc., have been evaluated. See Sections 262.100 and 262.200 for the applicable inpatient hospitalization code.

228.200 Outpatient Hospital Services

7-1-09

When a primary procedure to be performed in outpatient surgery is medical in nature, Arkansas Medicaid will not cover a dental procedure that is incidental to the primary procedure (e.g., the removal of a wisdom tooth when a tonsillectomy is being performed). When the primary procedure is medical, and it is cancelled, the provider may request a prior authorization for the dental procedure to be performed as outpatient surgery.

Information that should be included in the request for prior authorization for outpatient surgery includes the following.

- A. An explanation for the reason the dental procedure cannot be performed in the provider's office.
- B. An explanation for the reason a dental procedure cannot be postponed. (e.g., a procedure that cannot be postponed until a child matures and becomes receptive to a dental office environment and treatment.)
- C. The provider should also state whether sedation or general anesthesia will be used during the procedure for beneficiaries under age 21. **Note: General anesthesia, nitrous oxide and non-intravenous conscious sedation are not covered for beneficiaries age 21 and over.**
- D. A copy of the dental plan must be included with the prior authorization request.

For outpatient hospitalization, the Medicaid dental consultant will assign one of four addendum codes. The extent and type of treatment are used in determining the code; thus all procedures

involved must be indicated on the treatment plan. See Sections 262.100 and 262.200 for applicable procedure codes.

These addendum codes are for hospital use only. If the dentist submits a claim using one of these codes, the claim will be denied. In the event payment is made in error, the amount paid will be recouped through post-payment review.

229.000**Adult Services****4-30-10**

Effective for dates of service on and after July 1, 2009, Arkansas Medicaid covers dental treatment for beneficiaries who are 21 years of age and older.

Treatment for beneficiaries age 21 and over includes:

- A. Dental screenings
- B. Radiographs – periapical (first and additional film) and bitewings
- C. Prophylaxis and fluoride treatment
- D. Amalgam restorations
- E. Composite resin restorations
- F. Diagnostic Casts
- G. Prefabricated stainless steel permanent crowns and re-cementing crowns
- H. Periodontal scaling, root planning and other maintenance procedures
- I. Complete and partial dentures and certain repairs for dentures
- J. Simple extractions
- K. Surgical extractions
- L. Treatment of dental pain
- M. Biopsies of oral tissue
- N. Incision and drainage of abscesses
- O. Tobacco counseling

Treatment does not include:

- A. Dental sealants
- B. Space maintainers/orthodontic treatment
- C. Resin or porcelain-ceramic substrate crowns
- D. Pulpotomies
- E. Root canal therapy
- F. Tooth reimplantation/stabilization
- G. Consultations

H. General anesthesia, nitrous oxide and non-intravenous conscious sedation

In general, Arkansas Medicaid does not cover dental treatment not specified above for adults who are 21 years of age and older. An exception to this general rule is dental treatment that is medically necessary.

Medically necessary dental treatment is defined as dental care that will stabilize a life-threatening medical condition or dental care for a condition that, if not treated, could result in death.

The above exception is limited to services related to extractions only.

All medically necessary dental care must be pre-approved by medical and dental consultants at the Division of Medical Services. All adult dental care services claims may be submitted electronically or on paper.

The review process must include:

- A. The identification of a life-threatening medical problem affected by oral health. Some examples of such conditions are:
 1. HIV/AIDS patients with infections the immune system is unable to fight
 2. Transplant patients with infected teeth or gums
 3. Cancer radiation treatments to the head/neck/jaw
- B. Letters of medical necessity must be submitted by the primary care physician and the dentist who will perform the dental services detailing the medical condition and the effects the oral health problems have on the overall health of the beneficiary. Any supporting information, including x-rays, to further substantiate medically necessary treatment must also be submitted.
- C. Upon receipt, the Division of Medical Services medical and dental consultants will evaluate the information submitted and authorize the dental treatment, if any, that Medicaid will reimburse. After the review process is completed, the panel will return to the dental provider any x-rays, along with an approval or denial, to perform the requested services.
- D. The office of the dental provider will notify the beneficiary regarding the decision of the Division of Medical Services consultants, and, if appropriate, arrange to begin dental care.

The medical and dental consultants will only approve dental treatment for adults who strictly meet the medical necessity criteria.

Reconstructive surgery for cosmetic purposes and dental implants are not covered services.

230.000 PRIOR AUTHORIZATION

231.000 Procedure for Obtaining Prior Authorization

4-15-09

Certain dental and surgical procedures require prior authorization (PA). The prior authorization may be required because of federal requirements, the elective nature of the service or other reasons.

All requests for prior authorization should be submitted to the Dental Care Unit of the Arkansas Division of Medical Services by the attending dentist/orthodontist on the ADA claim form.

Procedures requiring prior authorization must be approved by the Dental Care Unit before the procedure is performed.

Payment is subject to verification of the beneficiary's eligibility at the time of the service. Prior authorization does NOT guarantee payment. It is the provider's responsibility to verify and print the beneficiary's eligibility for benefits on the date of service PRIOR to rendering authorized services.

232.000 Duration of Authorization

4-15-09

Prior authorizations are valid for one (1) year provided the beneficiary remains eligible for services. Because Medicaid eligibility may vary from month to month, the Medicaid Program cannot predict whether a beneficiary for whom authorization has been given will remain eligible.

The Medicaid Program provides reimbursement for services for eligible beneficiaries only. Prior authorization does not guarantee payment. The beneficiary must be eligible on the date of service and the claim must meet all applicable requirements. If the beneficiary becomes ineligible for Medicaid benefits, the authorization is void.

The Medicaid beneficiary is responsible for informing the dental care provider on the initial visit that he or she is eligible for Medicaid and must present his or her Medicaid card to the provider. However, the Medicaid card, alone, is insufficient for verification of eligibility. The provider must also review the Medicaid system to verify current eligibility.

The dental care provider has the option whether or not to provide dental care to the Medicaid beneficiary. If the dental care provider chooses to treat the Medicaid beneficiary, the provider is not obligated to bill Medicaid; however, the provider should inform the Medicaid beneficiary if he or she is willing to bill Medicaid before services are provided. Billing Medicaid for covered services provided to an eligible beneficiary obligates the dental care provider to accept the Medicaid determined payment amount as payment-in-full for those services. See Section I of this manual for complete information of provider and beneficiary responsibilities.

If the beneficiary's Medicaid identification number changes, the authorization must be updated with the new identification number. Providers must return the treatment plan to Medicaid with a notation of the new number. The provider may proceed with treatment while the update is being processed.

If the authorized treatment cannot be completed in one (1) year and the beneficiary is still eligible for Medicaid benefits, the provider may return the treatment plan and request an update. The provider may request an update and proceed with treatment while the update is being processed.

233.000 Standard Prior Authorization Procedures

4-15-09

After examining a beneficiary and verifying his or her eligibility under the Medicaid Program, the provider should complete the ADA claim form as described in Section 262.300 and mail all copies of the form with X-rays, if required, to the Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)

If the treatment plan outlined on the ADA claim form is not self-explanatory, the provider must complete and attach the form DMS-32-A to the treatment plan. The X-rays should be properly identified with both the name of the dentist and the beneficiary and must be stapled to the ADA claim form. All X-rays must be dated and labeled with the name of the dentist and the beneficiary. [View or print DMS-32-A form and instructions for completion.](#)

233.100 Review of Treatment Plan

6-1-06

The treatment plan will be reviewed by a dental consultant with the Division of Medical Services' Dental Care Unit.

- A. If the treatment plan is denied, the ADA claim form will be returned to the provider with an explanation of the denial on form DMS-2635 (Dental Disposition Form). [View or print form DMS-2635.](#)
- B. If additional information is needed, the treatment plan will be returned with the disposition form detailing the reason for return. The prior authorization request may be resubmitted with the required information.
- C. If the request is approved in full, each procedure code will be checked in blue. The original and one copy of the ADA claim form will be returned to the provider with the assigned prior authorization number. Service may then be provided.
- D. If the request is only partially approved, those procedures of the treatment plan denied will be marked "NO" on the ADA claim form and those procedures approved will be marked in red. The prior authorization number will apply only to those procedures of the treatment plan shown as being approved.
- E. The prior authorization number will be indicated in Section 9 of the ADA claim form if the treatment plan is completely or partially approved.

234.000 Emergency Procedures

10-13-03

For services that require prior authorization, the services must be approved by the Division of Medical Services Dental Care Unit prior to the provision of the services in order to be reimbursed by Medicaid. However, in certain medical emergencies, services may be reimbursed when authorization is made after the provision of services. In such emergency cases, the treatment plan and services must still be approved by the Medicaid Program's dental consultants PRIOR TO PAYMENT.

The provider may contact the Dental Care Unit for technical advice on Medicaid payment policies in such medical emergencies. [View or print the Division of Medical Services Dental Unit contact information.](#)

235.000 Orthodontia Prior Authorization

10-13-03

Section 226.000 contains information regarding the Medicaid coverage of orthodontia services.

The ADA claim form is used to request prior authorization for orthodontic services. The ADA claim form must be accompanied by form DMS-32-0, titled, Request for Orthodontic Treatment. [View or print the ADA claim form.](#) [View or print DMS-32-0 form and instructions.](#)

Models, cephalometric films and photo should be submitted with the completed ADA claim form to the Division of Medical Services Dental Care Unit.

[View or print the Division of Medical Services Dental Care Unit contact information.](#)

The treatment should not begin until approval has been received.

If the treatment plan is approved, a prior authorization control number will be issued and must be used on all claims submitted for payment. Payment may be made for the full amount of the orthodontic treatment (or less if indicated). Records are included in the overall fee for orthodontia.

If treatment is denied, the reason for denial will be indicated. The provider may then submit a claim for cephalometric film, study models, full-mouth X-rays and photo to the Dental Care Unit for approval and payment.

236.000 Prescription Prior Authorization 4-15-09

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program pursuant to an order from an authorized prescriber. Certain prescription drugs may require prior authorization.

The dental provider must request prior authorization before prescribing a prescription drug to an eligible Medicaid beneficiary.

Dental providers must refer to the Pharmacy Section of the Medicaid website at www.medicaid.state.ar.us for information relative to:

- A. Prescription drugs requiring prior authorization
- B. Drugs subject to specific prescribing requirements
- C. Criteria for drugs requiring prior authorization

To request prior authorization, the provider must complete form DMS-2694, titled Medicaid Prior Authorization and Extension of Benefit Requests. [View or print form DMS-2694.](#)

240.000 REIMBURSEMENT

241.000 Method of Reimbursement 7-1-06

Arkansas Medicaid reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

242.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.

The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days

after receipt of a request for such appeal. The panel will hear the questions and will submit a recommendation to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing

7-1-07

Dental providers must use the American Dental Association (ADA) form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

262.000 ADA Billing Procedures

262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21

7-18-11

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21.

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

* Revenue code

**(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

** Prior authorization is required for panoramic x-rays performed on children under six years of age (See Section 216.100).

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Child Health Services (EPSDT) Dental Screening (See Section 215.000)			
D0120	** (CHS/EPSDT Dental Screening Exam)	No	No
D0140	** (CHS/EPSDT Interperiodic Dental Screening Exam)	No	No
Radiographs (See Sections 216.000 – 216.300)			
D0210	Intraoral – complete series (including bitewings)	No	No
D0220	Intraoral – periapical – first film	No	No
D0230	Intraoral – periapical – each additional film	No	No
D0240	Intraoral – occlusal film	No	No
D0250	Extraoral – first film	No	No
D0260	Extraoral – each additional film	No	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D0272	Bitewings – two films	No	No
D0330	Panoramic film	No**	No
D0340	Cephalometric film	Yes	No
Tests and Laboratory			
D0350	Oral/facial photographic images	Yes	No
D0470	Diagnostic casts	Yes	No
Preventive			
Dental Prophylaxis (See Section 217.100)			
D1120	Prophylaxis – child ** (ages 0-9)	No	No
D1110	Prophylaxis – adult ** (ages 10-20)	No	No
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)			
D1203	Topical application of fluoride (prophylaxis not included) – child ** (ages 0-20)	No	No
Dental Sealants (See Section 217.200)			
D1351	Sealant per tooth ** (1st and 2nd permanent molars only)	No	No
Space Maintainers (See Section 218.000)			
D1510	Space maintainer – fixed – unilateral	Yes	Yes
D1515	Space maintainer – fixed – bilateral	Yes	Yes
D1525	Space maintainer – removable-bilateral	Yes	Yes
Restorations (See Sections 219.000 – 219.200)			
Amalgam Restorations (including polishing) (See Section 219.100)			
D2140	Amalgam – one surface	No	No
D2150	Amalgam – two surfaces	No	No
D2160	Amalgam – three surfaces	No	No
D2161	Amalgam – four or more surfaces	No	No
Composite Resin Restorations (See Section 219.200)			
D2330	Resin – one surface, anterior, permanent	No	No
D2331	Resin – two surfaces, anterior, permanent	No	No
D2332	Resin – three surfaces, anterior, permanent	No	No
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Crowns – Single Restoration Only (See Section 220.000)			
D2710	Crown – resin (laboratory)	Yes	Yes
D2752	Crown – porcelain -ceramic substrate	Yes	Yes
D2920	Re-cement crown	No	Yes
D2930	Prefabricated stainless steel crown – primary	No	No
D2931	Prefabricated stainless steel crown – permanent	Yes	Yes
Endodontia (See Section 221.000)			
Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration)	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes	No
Endodontic (Root Canal) therapy (including treatment plan, clinical procedures and follow-up care)			
D3310	Anterior tooth (excluding final restoration)	No	No
D3320	Bicuspid tooth (excluding final restoration)	No	No
D3330	Molar (excluding final restoration)	No	No
Periapical Services			
D3410	Apicoectomy (per tooth) – first root	Yes	Yes
Periodontal Procedures (See Section 222.000)			
Surgical Services (including usual postoperative services)			
D4341	Periodontal scaling and root planing	Yes	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes
Complete dentures (Removable Prosthetics Services) (See Section 223.000)			
D5110	Complete denture – maxillary	Yes	Yes
D5120	Complete denture – mandibular	Yes	Yes
Partial Dentures (Removable Prosthetic Services) (See Section 223.000)			
D5211	Upper partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
D5212	Lower partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
Repairs to Partial Denture (See Section 223.000)			
D5610	Repair acrylic saddle or base	Yes	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D5620	Repair cast framework	Yes	No
D5640	Replace broken teeth – per tooth	Yes	No
D5650	Add tooth to existing partial denture	Yes	No
Fixed Prosthodontic Services (See Section 224.000)			
D6930	Re-cement bridge	Yes	No
Oral Surgery (See Section 225.000)			
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)			
D7111	Extraction, coronal remnants-deciduous tooth	No	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No	No
D7220	Removal of impacted tooth – soft tissue	No	No
D7230	Removal of impacted tooth – partially bony	No	No
D7240	Removal of impacted tooth – completely bony	No	No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes
Other Surgical Procedures			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes	Yes
D7280	Surgical exposure of impacted or un-erupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	Yes
D7285	Biopsy of oral tissue – hard	Yes	Yes
D7286	Biopsy of oral tissue – soft	Yes	Yes
Osteoplasty for Prognathism, Micrognathism or Apertognathism			
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Frenulectomy			
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes	Yes
Orthodontics (See Section 226.000)			
Minor Treatment of Control Harmful Habits			
D8210	Removable appliance therapy	Yes	Yes
D8220	Fixed appliance therapy	Yes	Yes
Comprehensive Orthodontic Treatment – Permanent Dentition			
D8070	Class I Malocclusion	Yes	Yes
D8080	Class II Malocclusion	Yes	Yes
D8090	Class III Malocclusion	Yes	Yes
Other Orthodontic Devices			
D8999	Unspecified orthodontic procedure, by report	Yes	Yes
Anesthesia			
D9220	General Anesthesia – first 30 minutes	Yes, but no PA required when billed with D7210, D7220, D7230, D7240.	Yes
D9221	General Anesthesia – each 15 minutes	Yes, but no PA required when billed with D7210, D7220, D7230, D7240.	No
D9230	Analgesia N ₂ O	No, but requires report for request for more than 1 unit per day	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D9248	Non-I.V. Conscious Sedation	Yes and requires report	No
Consultations (See Section 214.000)			
D9310	** (Second opinion examination) Consultation, diagnostic service provided by dentist or physician other than practitioner providing treatment	Yes	No
Outpatient Hospital Services (See Section 228.200)			
0361*	Outpatient hospitalization – for hospital only	Yes	No
0360*	Outpatient hospitalization – for hospital only	Yes	No
0369*	Outpatient hospitalization – for hospital only	Yes	No
0509*	Outpatient hospitalization – for hospital only	Yes	No
Smoking Cessation			
D1320	Tobacco counseling for the control and prevention of oral disease	No	No
D9920	Behavior management, by report ** (tobacco counseling)	No	No
Unclassified Treatment			
D9110	Palliative treatment with dental pain	Yes	No

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older

7-18-11

The following list shows the procedure code, procedure code description, whether or not prior authorization is required, whether an X-ray should be submitted with a treatment plan, and if there is a benefit limit on a procedure.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates “**Yes, \$500.00**”, then that item, when used in combination with other items listed, cannot exceed the \$500.00 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If “**No**” is shown, the item is not benefit limited.

Note: The use of the symbol, **, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
Dental Screening (See Section 215.000)				
D0120	Periodic oral evaluation	No	No	Yes-\$500 Yes-1 per year
D0140	Limited oral evaluation-problem focused	No	No	Yes-\$500 Yes-12 per year
Radiographs (See Sections 216.000 – 216.300)				
D0210	Intraoral – complete series (including bitewings)	No	No	Yes-\$500 Yes-1 per 5 years
D0220	Intraoral – periapical – first film	No	No	Yes-\$500
D0230	Intraoral – periapical – each additional film	No	No	Yes-\$500
D0272	Bitewings – two films	No	No	Yes-\$500 Yes-1 per year
D0330	Panoramic film	No	No	Yes-\$500 Yes-1 per 5 years
Tests and Laboratory				
D0470	Diagnostic Casts (full denture)	No	No	Yes-\$500
	Diagnostic Casts (partial denture)	Yes	Yes	Yes- 4 per lifetime
Dental Prophylaxis (See Section 217.100)				
D1110	Prophylaxis – adult	No	No	Yes-\$500 Yes-1 per year
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)				
D1203	Topical application of fluoride (prophylaxis not included) – adult	No	No	Yes-\$500 Yes-1 per year
Restorations (See Sections 219.000 – 219.200)				
Amalgam Restorations (including polishing) (See Section 219.100)				
D2140	Amalgam – one surface, primary or permanent	No	No	Yes-\$500
D2150	Amalgam – two surfaces, primary or permanent	No	No	Yes-\$500
D2160	Amalgam – three surfaces, primary or permanent	No	No	Yes-\$500

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
D2161	Amalgam – four or more surfaces, primary or permanent	No	No	Yes-\$500
Composite Resin Restorations (See Section 219.200)				
D2330	Resin – one surface, anterior, permanent	No	No	Yes-\$500
D2331	Resin – two surfaces, anterior, permanent	No	No	Yes-\$500
D2332	Resin – three surfaces, anterior, permanent	No	No	Yes-\$500
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes	Yes-\$500
Crowns – Single Restoration Only (See Section 220.000)				
D2920	Re-cement crown	No	Yes	Yes-\$500
D2931	Prefabricated stainless steel crown – permanent	Yes	Yes	Yes-\$500
Surgical Services (including usual postoperative services)				
D4341	Periodontal scaling and root planing-four or more contiguous	Yes	Yes	Yes-\$500
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Yes	Yes	Yes-\$500
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes	Yes-\$500
Repairs to Complete and Partial Dentures (See Section 223.000)				
D5410	Adjust complete denture-maxillary	No	No	Yes-\$500 Yes-3 per lifetime
D5411	Adjust complete denture-mandibular	No	No	Yes-\$500 Yes-3 per lifetime
D5610	Repair acrylic saddle or base	Yes	No	Yes-\$500
D5640	Replace broken teeth – per tooth	Yes	No	Yes-\$500
D5650	Add tooth to existing partial denture	Yes	No	Yes-\$500
D5730	Reline complete maxillary denture (chairside)	No	No	Yes-\$500 Yes-1 every 3 years

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
D5731	Reline lower complete mandibular denture (chairside)	No	No	Yes-\$500 Yes-1 every 3 years
Fixed Prosthodontic Services (See Section 224.000)				
D6930	Re-cement bridge	Yes	No	Yes-\$500
Oral Surgery (See Section 225.000)				
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)				
D7140	Single tooth	No	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)				
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes	No
D7220	Removal of impacted tooth – soft tissue	Yes	Yes	No
D7230	Removal of impacted tooth – partially bony	Yes	Yes	No
D7240	Removal of impacted tooth – completely bony	Yes	Yes	No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes	No
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes	Yes-\$500
Other Surgical Procedures				
D7285	Biopsy of oral tissue – hard	Yes	Yes	Yes-\$500
D7286	Biopsy of oral tissue – soft	Yes	Yes	Yes-\$500
D7310	Alveoplasty in conjunction with extractions-four or more teeth	Yes	No	Yes-\$500
D7472	Removal of torus palatinus	Yes	No	Yes-\$500 1 per lifetime

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
D7473	Removal of torus mandibularis	Yes	No	Yes-\$500 1 per lifetime
Osteoplasty for Prognathism, Micrognathism or Apertognathism				
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No	Yes-\$500
Unclassified Treatment				
D9110	Palliative treatment with dental pain	Yes	No	Yes-\$500
Smoking Cessation				
D1320	Tobacco counseling for the control and prevention of oral disease	No	No	Yes-\$500
D9920	Behavior management, by report ** (tobacco counseling)	Yes	No	Yes-\$500

262.300 ADA National Place of Service (POS) Codes

7-1-07

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office/Clinic	11
Other location	99

262.400 Billing Instructions - ADA Claim Form - Paper Claims Only

00-00-00

Dental providers must complete the ADA Claim form when:

- A. Billing for services when using the ADA procedure codes
- B. Requesting prior authorization
- C. Approving prior authorization
- D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. [View or print the Division of Medical Services Dental Unit contact information.](#)

Completed claim forms should be forwarded to the HP Enterprise Services Claims Department. [View or print the HP Enterprise Services Claims Department contact information.](#)

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. [View or print ADA-J400.](#)

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Other Dental or Medical Coverage?	Check No or Yes. If No, skip items 5 through 11.
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.

Field Number and Name	Instructions for Completion
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
<i>POLICYHOLDER/SUBSCRIBER INFORMATION</i>	
12. Policyholder/Subscriber Name...Address, city, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
<i>PATIENT INFORMATION</i>	
18. Relationship to Policyholder/Subscriber in #12 above.	Check one of the following: Self Spouse Dependent Child Other
19. Student Status	Check one of the following, if applicable: FTS – Full-time student PTS – Part-time student
20. Name...Address, City, State, Zip Code	Enter last name, first name on first line of field 20. Enter address, city, state, and zip code on second and third lines.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account #	Enter the 10-digit patient Medicaid identification number.
<i>RECORD OF SERVICES PROVIDED</i>	

Field Number and Name	Instructions for Completion
24. Procedure date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F – Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
32. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
33. Total Fee	Required for Medicaid. Enter the total fee charged.
MISSING TEETH INFORMATION	
34. (Place an 'X' on each missing tooth)	Draw an X through the number or letter of each missing permanent and primary tooth.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment	Check one of the following: Provider's Office Hospital ECF Other
39. Number of Enclosures	Enter the number of radiographs, oral images, and models in the applicable boxes.

Field Number and Name	Instructions for Completion
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis?	Check No or Yes. If Yes, complete item 44.
44. Date Prior Placement?	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident
	If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
<i>BILLING DENTIST OR DENTAL ENTITY</i>	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Not required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52A. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
<i>TREATING DENTIST AND TREATMENT LOCATION INFORMATION</i>	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Not required.
55. License Number	Optional.

Field Number and Name	Instructions for Completion
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56A. Provider Specialty Code	Not required.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52A is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

262.500 Special Billing Procedures for ADA Claim Form

7-1-09

- A. Each procedure must be shown on a separate line, such as:
1. Extractions
 2. Upper partials
 3. Lower partials
 4. Upper denture relines
 5. Lower denture relines
- B. When a complete intraoral series is made for beneficiaries under age 21, the dentist must use procedure code D0210 rather than indicating each intraoral film on a separate line.
- C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form.
- D. Post-operative X-rays must accompany all claims with root canals for beneficiaries under age 21. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)
- E. Prophylaxis and fluoride must be indicated on the same line of the form using code D1201. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.
- F. Indicate the tooth number when submitting claims for code D0220 and D0230, intraoral single film. When a complete series is made for beneficiaries under age 21, providers must use code D0210 rather than indicating each tooth on a separate line.
- G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

- H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.
- I. Use procedure code D1110 for prophylaxis-adult, ages 10 through 99, and procedure code D1120 for prophylaxis-child, ages 0 through 9.

263.000 CMS-1500 Billing Procedures

4-1-05

Oral surgeons billing CPT procedure codes must use the CMS-1500 form.

263.100 CPT Procedure Codes

12-9-11

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

- A. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter “E” in Field 24H.
- B. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor’s office, patient’s home, nursing home and skilled nursing facility.
- C. Radiology procedures are payable only in the dentist’s office. The place of service (POS) codes may be found in Section 262.300 of this manual. **These services require a PCP referral.**

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each service must be billed on a separate form. See Section 263.300 for complete billing instructions.

- A. When billing for extractions (procedure code 41899), a listing of teeth extracted by date, tooth number and ADA code number must be attached.
- B. Recipients in the Child Health Services (EPSDT) Program are not benefit limited.

See the Arkansas Medicaid Dental Fee Schedule for covered procedure codes.

263.110 CPT Procedure Codes that Require Prior Authorization Before Performing the Procedure

12-9-11

11960	11970	11971	21079	21080	21081	21082	21083
21084	21085	21086	21087	21088	21089	21120	21121
21122	21123	21125	21127	21137	21138	21139	21145
21146	21147	21150	21151	21154	21155	21159	21160
21172	21175	21179	21180	21181	21182	21183	21184
21188	21193	21194	21195	21196	21198	21208	21209

21244	21245	21246	21247	21248	21249	21255	21256
30400	30410	30420	30430	30435	30450	30462	67900
69300							

263.120 **Reserved** **10-1-09**

263.200 **National Place of Service (POS) Codes** **7-1-07**

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office/Clinic	11
Other location	99
Ambulatory Surgical Center	24

263.300 **Billing Instructions - CMS-1500 - Paper Claims Only** **7-1-07**

HP Enterprise Services offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help HP Enterprise Services efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the HP Enterprise Services Claims Department. [View or print the HP Enterprise Services Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

263.310 **Completion of CMS-1500 Claim Form** **6-1-08**

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.

Field Name and Number	Instructions for Completion
3. PATIENT'S BIRTH DATE SEX	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY. Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box). Name of the city in which the beneficiary or participant resides. Two-letter postal code for the state in which the beneficiary or participant resides. Five-digit zip code; nine digits for post office box. The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8. PATIENT STATUS	Not required.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH SEX c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial. Policy and/or group number of the insured individual. Not required. Not required. Required when items 9 a-d are required. Name of the insured individual's employer and/or school. Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	

Field Name and Number	Instructions for Completion
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
10d. RESERVED FOR LOCAL USE	Not used.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not used.
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding current as of the date of service.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	<p>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</p> <ol style="list-style-type: none"> 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Not required.
D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 262.100.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.

Field Name and Number	Instructions for Completion
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid ARKids First-B co-payments.
30. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.

Field Name and Number	Instructions for Completion
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

263.400 Special Billing Procedure for the CMS-1500 Claim Form

7-1-07

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary. [View a CMS-1500 sample form.](#) These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: Procedure code 99238 (Hospital Discharge Day Management) is payable for medical services. Procedure code 99238 may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes 99221 through 99233). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible beneficiaries of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible beneficiaries under the age of 21 years participating in the Child Health Services (EPSDT) Program.

263.410 Multiple Quadrants Billing Instructions

7-1-07

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a patient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

D1110	D1120	41872	41874
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263.420 Anesthesia Services

7-1-07

Anesthesia services are billed using the CMS-1500 claim format.

- A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the Current Procedural Terminology (CPT-4) code book.
- B. Providers must bill anesthesia time.
- C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.
- D. Providers may bill electronically unless paper attachments are required.
- E. When providers bill on paper, any applicable modifier(s) are also required.

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G.

The procedure code listed under the “Qualifying Circumstances” in the Anesthesia Guidelines in the CPT requires medical care services. When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, and must bill “1” unit of service.

Procedure code 00170 may be billed by oral surgeons for anesthesia for inpatient or outpatient dental surgery using place of service code 24, 21, 22, or 11, as appropriate. The code does not require prior approval for anesthesia claims.

263.421 Anesthesia Procedure Codes 7-1-07

Oral surgeons must use the following anesthesia procedure codes when billing on paper.

00100	00102	00103	00140	00160	00162	00164	00170
00172	00174	00176	00190	00192	00300		

263.422 Reserved 7-1-07

263.423 Guidelines for Anesthesia Values 10-13-03

All anesthesia values are determined by adding a Basic Value, which is related to the complexity of the service, plus Modifiers (P1 through P5), qualifying circumstances and Time Units.

A Basic Value includes the value of all anesthetic services except the time actually spent administering the anesthesia, modifiers and any qualifying circumstance. The Basic Value includes usual pre-operative and post-operative visits and the administration of fluids and/or blood incident to the anesthesia. The Basic Value for anesthesia when multiple surgical procedures are performed is the Basic Value for the procedure with the highest unit value.

Enter only the time points in the units of service Field 24G on the claim. The system will automatically assign the correct number of base points and modifiers.

263.424 Time Units 10-13-03

Time units will be automatically added to the Basic Value, the Anesthesia Modifier and qualifying circumstances for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision. Enter the time units in Field 24G.