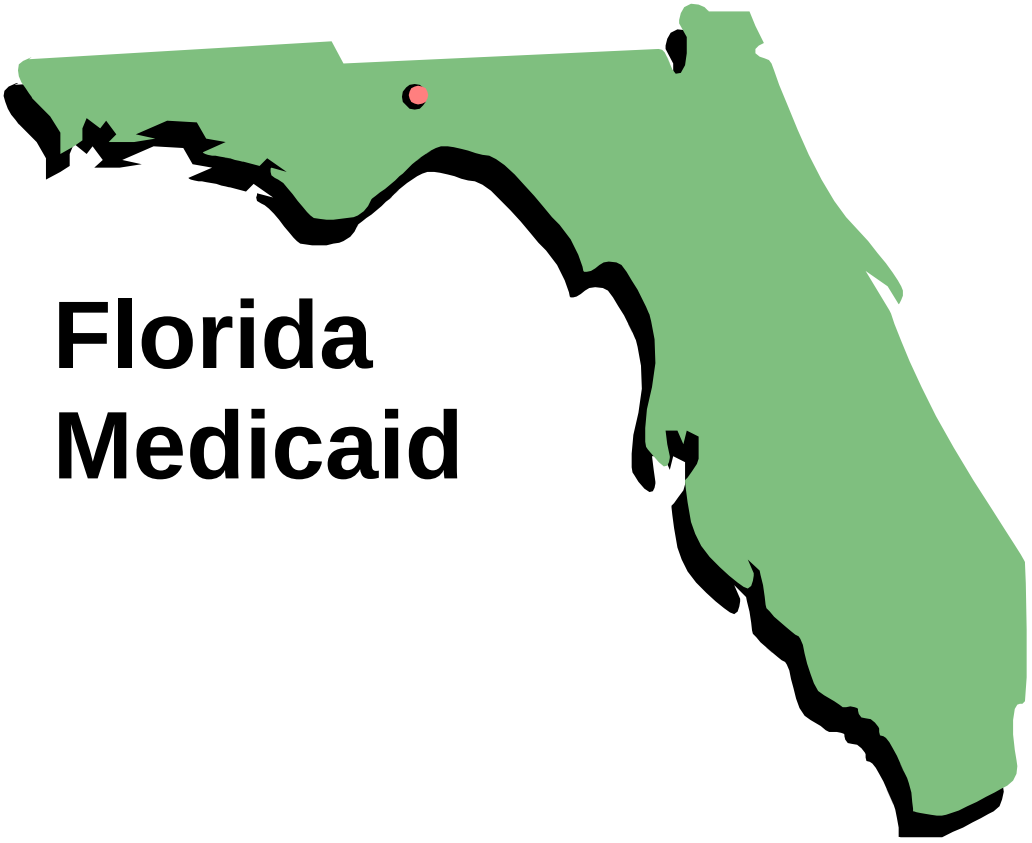

Florida Medicaid

DENTAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
November, 2011

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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UPDATE LOG
DENTAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
Revised Fee Schedule	January 2000
Revised Handbook	January 2000
Revised Handbook	January 2001
Replacement Pages	January 2002
Replacement Pages	April 2002
Replacement Pages	March 2003
Revised Handbook	October 2003
Replacement Pages	January 2004
Replacement Pages	January 2005
Revised Handbook	January 2006
Revised Handbook	November 2011

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DENTAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

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DENTAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

Provider General Handbook describes the Florida Medicaid program. Coverage and limitations handbooks explain covered services, their limits, who are eligible to receive them, and the fee schedules. Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

Title XIX of the Social Security Act.
Title 42 of the Code of Federal Regulations.
Chapter 409, Florida Statutes.
Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook - Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
DENTAL SERVICES
PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes Medicaid dental services, defines the specific authority regulating Florida's Medicaid dental services, defines the types of providers who may provide services, identifies dental specialty providers that may provide specific services, and defines provider record keeping responsibilities

Legal Authority

Dental services are governed by Title 42, Code of Federal Regulations (C.F.R.), Parts 440.100, 440.50, 440.120, and 440.30. This program is implemented through section 409.906, Florida Statutes (F.S.). The Florida Administrative Code (F.A.C.), Rule 59G-4.060, implements the limitations for dental services in Medicaid.

In This Chapter

This chapter contains:

Description and Purpose

Purpose

The purpose of the dental program is to provide dental care to recipients under the age of 21 years, emergency dental services to recipients age 21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all Medicaid-eligible recipients.

Description and Purpose, *continued*

Intended Use

This handbook is intended for use by dentists who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general; the Provider Reimbursement Handbook, ADA Dental and the Provider Reimbursement Handbook, CMS-1500, both of which contain specific procedures for submitting claims for payment. The Dental Provider Reimbursement Schedule contains procedure codes and maximum fees payable for Medicaid dental services.

The Florida Medicaid Provider Reimbursement Handbook, ADA Dental is incorporated by reference in 59G-4.060, Florida Administrative Code (F.A.C.); the Florida Medicaid Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.; and the Florida Medicaid Provider Reimbursement Schedule is incorporated by reference in 59G-4.002, F.A.C.

Adult Dental Services

The adult Medicaid dental services program provides medically-necessary, emergency dental procedures to alleviate pain or infection to eligible Medicaid recipients age 21 and older. Emergency dental care for recipients 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services of the adult dental program.

Children's Dental Services

The children's dental program provides full dental services for all Medicaid eligible children age 20 and below.

Oral And Maxillofacial Surgery Program

The oral and maxillofacial surgery program provides medically necessary coverage for all eligible Medicaid recipients regardless of age.

Copyrighted Dental Codes

All dental procedure codes appearing throughout this handbook are *Current Dental Terminology*, Seventh Edition, (CDT 2009/2010) codes. CDT (including procedure codes and descriptions) is copyrighted by the American Dental Association © 2008 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Provider Qualifications and Enrollment

Dentist Provider Qualifications

Dental providers must be enrolled in the Medicaid program pursuant to the guidelines set forth in Chapter 409, F.S., and Rule 59G-5, F.A.C. Dental providers must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 466, F.S., and Rule 64B5, F.A.C., in order to participate in the Medicaid program. Failure to meet any of these requirements will result in suspension or termination from participating in the Medicaid program.

Medicaid dental providers are assigned the provider type number "35."

Employees of State and County Government Facilities

In accordance with section 466.025 (2) F. S., the Department of Health shall have the authority to issue temporary certificates to dentists to practice in state and county government facilities, working under the general supervision of licensed dentists of this state in the state or county facility, provided such certificates shall be issued only to graduates of schools approved by the Board of Dentistry and further subject to cancellation for just cause. A certificate issued under this section is valid only for such time as the dentist remains employed by a state or county government facility.

Dental Interns and Dental Students

An unlicensed dental intern and dental students of university based dental programs cannot act as a treating provider or bill Medicaid for covered services. The licensed supervising dentist of the clinic acts as the treating provider of a covered service and assumes full responsibility for the work of the student or intern. The clinic may bill Medicaid for covered services provided by these students.

Members of the Public Health Service and Armed Forces

Dentists who perform services in Florida, but are not licensed in Florida, may enroll as Medicaid providers if they are commissioned dental officers of the Public Health Services or Armed Forces of the United States, on active duty, and acting within the scope of their public health service or military responsibilities.

Dental Faculty Certificates

Dentists may enroll as Medicaid providers if they have a teaching permit issued by the Florida Board of Dentistry as outlined in Section 466.002, F.S.

Provider Qualifications and Enrollment, *continued*

Dentist Specialty Requirements

Dentists enrolled in Medicaid may also enroll as a provider of specialty services in:

- **Oral and Maxillofacial Surgery** must be board-eligible or board-certified by the American Board of Oral and Maxillofacial Surgery;
- **Orthodontics** must be board-eligible or board-certified by the American Board of Orthodontics; and
- **Pediatric Dentistry** board-eligible or board-certified by the American Board of Pediatric Dentistry.

If the specialist is not board certified, proof must be provided of completion of a university level post graduate residency program for the particular specialty service being provided.

Proprietorship by Non Dentists

In accordance with section 466.0285, F.S., no person other than a dentist licensed pursuant to Chapter 466, F.S., nor any entity other than a professional corporation or a limited liability company composed of dentists may:

- Employ a dentist or dental hygienist in the operation of a dental office;
- Control the use of any dental equipment or material while such equipment or material is being used for the provision of dental services, whether those services are provided by a dentist, a dental hygienist, or a dental assistant; or
- Direct, control, or interfere with a dentist's clinical judgment.

Health Access Settings

Dentists who practice in health access settings as defined in s. 466.003 (14), must enroll as treating dental providers affiliated with the facility. Health access settings are subject to Medicaid reimbursement limitations.

Health Access Dental License

Dentists who have been issued a health access dental license may enroll as Medicaid treating providers affiliated with a health access facility. Health access facilities are federally qualified health centers, county health departments, rural health clinics, or educational institutions. The dentist acts as a treating provider in the facility. The facility bills Medicaid for covered services rendered by the dentist.

Provider Qualifications and Enrollment, *continued*

Non-Dentists Owned Facilities	A health access facility such as a federally qualified health center, an educational institution, or a rural health center that is owned by an individual or a group other than a licensed dentist may enroll as a Medicaid provider. All dentists affiliated with the facility must enroll in Medicaid as treating providers. Non-dentists at such facilities may not influence, direct, control or interfere with the licensed dentist's independent professional judgment. A state owned facility, such as an intermediate care facility for the developmentally disabled may enroll as a Medicaid provider. Dentists who practice at the facility must enroll as individual treating providers affiliated with the facility. The facility may bill Medicaid for dental services rendered at the facility.
Registered Dental Hygienist (RDH) Practicing in a Health Access Setting	Preventative dental services provided to Medicaid beneficiaries by a RDH employed by or in contractual agreement with a health access facility may be reimbursed when those services are provided under the general supervision as defined in s. 466.003 (10) of a dentist. The Medicaid-enrolled supervising dentist, at the facility where the RDH is employed or in a contractual agreement, will be listed as the treating provider for these services.
General Enrollment Requirements	Dentists must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, dentists must follow the specific enrollment requirements that are listed in this section.
Qualified at the Time of Enrollment	Dentists must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.
Dental Group Providers	Two or more providers practicing together under a single tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.
Individual Provider Responsibilities Within a Group Practice	An individual treating provider must be enrolled as a member of group practices for which he or she performs services. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices with which they are affiliated. Any individual treating provider who is terminating his relationship with a group practice must notify the Medicaid fiscal agent in writing of this termination in order to alter their provider file.

General Requirements

Introduction

In addition to the general provider requirements and responsibilities that are contained in the Medicaid Provider General Handbook, dental providers are also responsible for complying with the provisions contained in this section

Record Keeping Responsibilities

The provider must keep dental treatment records which must contain, at a minimum, the following information about the recipient:

- Current medical history;
- Results of clinical examination and tests conducted, including the identification, or lack thereof, of any oral pathology or diseases;
- Treatment plan proposed by the dental provider; and
- Treatment rendered to the recipient.

Records must be retained for a period of at least 5 years from the date of service.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook, for additional information regarding record keeping and provider responsibilities.

Dental Authorization

Medicaid will reimburse for children's dental services only when those services are duly authorized by the Medicaid recipient's parent or legal representative, except as provided by law.

Transportation to Dental Services

Medicaid transportation by an officially approved Medicaid transportation provider to access covered dental services is a Medicaid compensable service. However, transportation by the parent, guardian, or designee is not a compensable service.

Provider Responsibility Regarding HIPAA

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Mobile Dental Units

Description

A mobile dental unit is a fully operational dental vehicle, trailer or unit that travels to different locations for the provision of dental treatment and is not a stationary dental unit.

Limitations and Exceptions

Medicaid will reimburse for dental services provided through the use of a mobile dental unit, which is owned by, operated by, or having a contractual agreement with a County Health Department (CHD) or Federally Qualified Health Center (FQHC). Medicaid will reimburse the CHD or FQHC for mobile unit dental services. Mobile unit services must be provided and billed in compliance with this handbook and the applicable CHD or FQHC's Services Coverage and Limitations Handbook.

Medicaid will reimburse for dental services provided through the use of a mobile dental unit, which is owned by, operated by, or having a contractual agreement with a state-approved dental educational institution. For Medicaid purposes, a state-approved dental educational institution is defined as a Florida university having a dental school accredited by the American Dental Association.

Medicaid will reimburse a Medicaid dental provider using a mobile dental unit for rendering covered dental services to Medicaid recipients age 21 and older at nursing home facilities.

CHAPTER 2
DENTAL SERVICES
COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter defines the services covered by the dental services programs, the services that are limited and excluded, services that must be prior authorized, and the services that are specialty specific.

This chapter is divided into two sections. Section 1 describes the dental program for Medicaid recipients. Section 2 describes the oral and maxillofacial surgery program available for Medicaid recipients.

Topic Roster for Section 1

This section contains information on the Medicaid adult and children's dental programs.

Overview, continued

Topic Roster for Section 2

This section contains information specific to the oral and maxillofacial surgery program.

SECTION 1: ADULT AND CHILDREN'S DENTAL PROGRAMS

Covered Services

Service Requirements

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- The services cannot be experimental or investigational;
- The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a covered service.

Note: See Appendix D, Glossary, in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

Covered Services, *continued*

Covered Adult Services (Ages 21 and Over)

The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

Note: See the Florida Medicaid Provider Reimbursement Schedule for information on which procedure codes apply to adult recipients. The reimbursement schedule is available on the Medicaid fiscal agent Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Fee Schedules.

Covered Child Services (Ages under 21)

The Medicaid children's dental services program may provide reimbursement for diagnostic services, preventive treatment, restorative, endodontic, periodontal, surgical procedures and extractions, orthodontic treatment, and full and partial dentures (fixed and removable) for recipients under age 21.

Note: See the Florida Medicaid Provider Reimbursement Schedule for information on which dental procedure codes apply to recipients under age 21.

Prior Authorizations

A number of services must be authorized before providing them to the recipient. All requests for prior authorization (PA) of dental procedures must be submitted on the dental "Prior Authorization Request for Treatment Authorization" form (DPA 1041).

Note: See the Florida Medicaid Provider Reimbursement Schedule for dental procedure codes requiring prior authorization. These are identified in the "Spec" column of the fee schedule.

Note: See Chapter 2 in the Florida Medicaid Reimbursement Handbook, ADA Dental for information about prior authorization and a copy of the dental "Prior Authorization Request for Treatment Authorization" form (DPA 1041).

The reimbursement handbook is on the Medicaid fiscal agent Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Handbooks.

Covered Services, *continued*

Five Percent Coinsurance

Medicaid recipients age 21 and older, unless otherwise exempt, are responsible for paying the provider a five percent coinsurance charge for the following procedures related to denture services:D0210, D0290, D5110, D5120, D5211, D5212, D5213, D5214, D5410, D5411, D5421, D5422, D5510, D5520, D5610, D5620, D5630, D5640, D5650, D5660, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, D5820, D7260, D7310, D7320, D7970, D9220, D9221.

Collection of the five percent coinsurance is the responsibility of the provider and is based upon five percent of the Medicaid fee or the provider's charge, whichever is less. Medicaid will automatically deduct the five percent from the provider's payment.

The provider is not required to bill or collect the coinsurance; however, Medicaid will deduct the coinsurance amount from the provider's Medicaid reimbursement regardless of whether or not it was paid.

A provider cannot deny service to a recipient based solely on the recipient's inability to pay a Medicaid coinsurance amount. If the recipient is unable to pay at the time services are rendered, the provider may bill the recipient for the unpaid charge.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information about coinsurance exemptions.

Free Health Care

Medicaid will not reimburse services for Medicaid recipients if non-Medicaid recipients are provided the same services free of charge.

Exceptions are:

- Services provided by agencies that receive federal funds from Title V (Maternal and Child Health) of the Social Security Act;
- Services provided under Part B or C (formerly Part H) of the Individuals with Disabilities Education Act; or
- Services provided in the primary (or non pro bono office or service) office of a provider that participates in a valid pro bono program.

Examples of agencies that receive federal funds are, but not limited to, the Department of Health, County Health Departments, and Children's Medical Services.

Examples of valid pro bono programs are, but not limited to: *We Care*, the *Volunteer Health Care Provider Program*, and *Project Dentists Care*.

Covered Services, *continued*

Solicitation	Providers are not permitted to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

Analgesia

Description	Analgesia is the administration of a drug or agent, primarily nitrous oxide, to temporarily arrest the feeling of pain in a conscious individual.
Documentation	The specific nature of the recipient management problem and the technique(s) utilized must be documented in the recipient's dental record according to guidelines set forth by the Department of Health's Board of Dentistry.
Limitations	Analgesia may be reimbursed only when the recipient has a severe physical or mental disability, or is difficult to manage. Reimbursement is limited to three times per 366 days per recipient. Medicaid does not reimburse for analgesia on the same date of service as behavior management. The use of nitrous oxide may not be billed as non-intravenous conscious sedation.

Behavior Management

Description

Behavior management may be reimbursed for recipients under age 21, who present a management problem that must be controlled by extraordinary means. Without this management, treatment could not be rendered. The specific nature of the recipient management problem and the technique utilized must be documented in writing in the recipient's dental record. Medicaid Behavior Management Report, AHCA Med Serv Form 012, may be used for documenting the recipient management problem.

Note: See Appendix F for a copy of the Medicaid Behavioral Management Report, AHCA-Med Serv Form 012.

Limitations

Reimbursement for behavior management is limited to use with recipients who are developmentally disabled or are uncooperative and difficult to manage. Reimbursement is limited to three times per 366 days per recipient. Behavior management must be billed in conjunction with diagnostic, preventive or treatment codes on the same date of service.

Exclusions

Medicaid does not reimburse for behavior management if:

- Billed routinely every time the recipient visits the office; or
- Billed with either sedation or analgesia on the same date of service.

Consultation Services

Description

A consultation is a service provided by an accredited dental specialist whose opinion or advice regarding the evaluation or management of the specific problem is requested by another dentist. Referrals from other providers are not automatically consultations.

A consultation also occurs when a health practitioner in another discipline, e.g., a physician, requests the advice and opinion of a dentist.

Components

Consultation services include examination of the recipient, evaluation of the recipient's condition, recommendation for treatment, documentation in the recipient's dental record, and a written report to the requesting dentist or physician who will provide the treatment.

Consultation Services, continued

Consultation Versus Referral

If a provider sends a recipient to another provider for specialized care that is not in the referring provider's domain and the referring provider will not participate in the on-going care of the recipient for this problem, this is not a consultation. This is a referral and must be billed as an oral exam or the appropriate procedure code(s) for the treatment rendered.

The distinguishing feature between a consultation and an initial or periodic oral exam will depend on whether the referring provider is going to continue to care for the patient for that particular problem. If this condition can be met, then the referral is billed as a consultation. If this condition cannot be met, then the referral must be billed using the appropriate oral examination code.

Limitations

Consultation services may only be reimbursed to a dentist who limits his practice to a specialty and is enrolled in Medicaid as a specialist.

Exclusions

Consultation services billed with procedure code D9310 are not reimbursable for adult recipients. Consultation services may be reimbursed for recipients under age 21.

Treatment by the consulting dentist on the same day of the consultation is not reimbursable by Medicaid. If treatment is rendered, Medicaid considers that a referral has been made and the dentist may bill for the examination and specific procedures performed, not for the consultation.

Custodial Care Facility Services

Residents of Nursing Facilities and State Mental Hospitals

Dental services are reimbursable for a recipient who resides in a nursing facility or state mental health hospital if the recipient exhibits the need for dental care.

Dental care for Medicaid recipients age 21 and older residing in a nursing facility or state mental health hospital includes:

- Medically-necessary emergency services to alleviate pain or infection. Emergency services are limited to extractions and the incision and drainage of an abscess and
- Full and removable partial dentures and denture-related procedures. Denture services include extractions if the recipient is to receive dentures.

The attending physician or the Director of Nurses must request the oral evaluation.

Custodial Care Facility Services, continued

Residents of Intermediate Care Facility for the Developmentally Disabled (ICF/DD)

Dental services are reimbursable for a recipient who resides in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). However, the ICF/DD must provide each Medicaid recipient with the following dental services that are included in the ICF/DD's per diem rate:

- Periodic, at least annually, oral prophylaxis (cleaning), by a Florida licensed dentist or dental hygienist; and
- Provision of daily oral care including tooth brushing and tooth brushing aids.

Records Requirements

The following information must be included in the recipient's dental record in the dentist's office and in the medical record of the facility where the recipient resides:

- A statement identifying the rationale for the referral to the dentist;
- A statement regarding the recipient's or the guardian's knowledge, understanding, and concurrence with the referral; and
- The duration of the problem, and the anticipated impact on the recipient's health if the problem is unresolved.

The recipient's guardian should understand what procedures will be performed and that the attending physician has concurred with the treatment plan.

Endodontic Services

Description

Endodontic services include pulp capping, therapeutic pulpotomies, root canal therapy, apexification, and apicoectomies.

The prevailing standard of dental care in performing root canal therapy requires a dentist to perform adequate pre- and post-operative diagnosis to support the procedure, to timely and properly perform the procedures, and to re-treat any inadequate procedures when conditions require it.

Endodontic services are only reimbursed for Medicaid eligible recipients under age 21.

Pulp Capping

Pulp capping is a regenerative dressing placed over the exposed (direct pulp cap) or nearly exposed (indirect pulp cap) vital pulp. Pulp capping is differentiated from routine placement of a lining or base under a restoration.

Therapeutic Pulpotomy

Therapeutic pulpotomy is the removal of the coronal portion of the pulp. It may be reimbursed for both deciduous and permanent teeth. The reimbursement fee does not include the final restoration. A pulpotomy may not be billed in conjunction with D3310, D3320, and D3330 by same provider, for the same recipient, same tooth, and same date of service.

Endodontic Services, *continued*

Gross Pulp Debridement	Pulp debridement is for relief of acute pain prior to conventional endodontic therapy. It may be performed on primary and permanent teeth. Reimbursement does not include any necessary diagnostic radiographs. Pulpal debridement is not to be billed by the same provider completing the root canal treatment. The same provider, for the same recipient, same tooth, may not bill it in conjunction with D3310, D3320, and D3330.
Root Canal Therapy	Root canal therapy includes anterior, bicuspid, and molar teeth and is reimbursed by each tooth, not by the number of canals treated. Reimbursement includes extirpation of pulpal tissue, all treatment appointments, filling the root canal(s), and intra-operative radiographs. Reimbursement for the final restoration may be billed separately. Root canal therapy on primary teeth with succedaneous teeth must include the filling of canals with resorbable filling material. Root canal therapy on permanent teeth and primary teeth without succedaneous teeth includes the filling of canals with a non-resorbable filling material.
Root Canal Limitations	Root canal therapy is reimbursable: • For teeth that have restorable crowns; • If the prognosis of the tooth is not questionable for periodontal reasons; and • If exfoliation of a deciduous tooth is not anticipated within eighteen months. A pulpectomy will not be reimbursed separately. It is considered part of the root canal therapy.
Apexification	Apexification is the clinical treatment involving the necrosis of the pulp of incompletely formed deciduous and permanent teeth subsequent to trauma or dental caries. The treatment includes three procedure codes: initial (D3350), interim (D3352), and final visits (D3353). Reimbursement for apexification services does not include the final restoration, which may be billed separately.
Apexification Limitations	Apexification and recalcification therapy is limited to reimbursement of one procedure code per day, per tooth. There may be several interim visits, but only one initial visit and one final visit per treated tooth may be reimbursed.

Endodontic Services, *continued*

Apicoectomy

An apicoectomy is surgery involving the root surface. Reimbursement does not include the retrograde filling material placement.

Apicoectomy Limitations

Apicoectomy therapy is reimbursed only if one or more of the following conditions exist:

- Overfilled canal or canal cannot be filled due to excessive root curvature;
- Fractured root tip is not reachable;
- Broken instrument in canal;
- Perforation of the root in the apical one-third of the canal;
- Root canal filling material lying free in periapical tissues and acting as irritants;
- Root canal therapy is a failure; or
- Periapical pathology not resolved by root canal therapy.

Facility Setting Dental Treatment

Description

Medicaid will reimburse for dental treatment provided in an office, inpatient hospital, outpatient hospital, or ambulatory surgical center (ASC) setting. Any treatment provided in a facility setting, as opposed to a non-facility office setting, must be related to at least one of the following conditions:

- The recipient's health will be so jeopardized that the procedures cannot be performed safely in the office; or
- The recipient is uncontrollable due to emotional instability or developmental disability and sedation has proven to be an ineffective intervention.

The necessity for treatment in a hospital or ASC must be clearly documented in the recipient's dental record.

Injectable Medications

Description

An injectable medication is a medication injected into the body by a dentist in the office in the treatment of illness and disease.

Injectable Medications, *continued*

Reimbursement

Injectable medications can be reimbursed using a J code when a provider purchased the medication and administered the medication in the office. Reimbursement is based on the average wholesale price less 16.4 percent or wholesale acquisition cost plus 5.75 percent.

Note: See the Florida Medicaid Provider Reimbursement Schedule for a list of "J" codes. The reimbursement schedule is available on the Medicaid fiscal agent Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Fee Schedules.

Oral Evaluations

Description

An oral evaluation is a comprehensive diagnostic, visual evaluation of the oral cavity, teeth and supportive structures. Reimbursement includes costs associated with charting and completion of forms.

Any diagnosis for treatment or treatment planning may not be delegated to anyone other than a licensed dentist.

Components

An oral evaluation for children's dental services must include:

- History recording;
- Caries detection;
- Pulp testing when indicated;
- Radiographic studies as appropriate; and
- Written treatment plan.

An oral evaluation for adult dentures must include the review of:

- Tori;
- Anatomical anomalies;
- Pathological degeneration;
- Presence of neoplasm; or
- Any other pathology that would interfere with the success of seating a denture; and a
- Written treatment plan.

A problem focused oral evaluation is limited to the review of:

- A specific oral health problem;
- The presence of an acute dental emergency; or
- The presence of an acute infection.

A written treatment plan must be included.

Oral Evaluations, *continued*

Comprehensive Oral Evaluation

A comprehensive oral evaluation (D0150) is used by a dentist when evaluating a patient comprehensively. This applies to new patients and to established patients who have a significant change in health conditions or who have been absent from treatment for three or more years.

The oral evaluation is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It includes an evaluation for oral cancer when indicated, the evaluation and recording of the patient's dental and medical history, and a general health assessment.

A provider may only be reimbursed for a comprehensive oral evaluation (D0150) once every three years for the same recipient.

No distinction is made between a comprehensive evaluation performed by a general practitioner or specialist.

A comprehensive evaluation may be performed on an adult over the age of 21 for the purpose of determining the need for a partial or full denture. If the recipient is to receive a partial or full denture, the provider may bill Medicaid for the evaluation.

Periodic Oral Evaluation

A periodic oral evaluation is an evaluation performed on an established patient under the age of 21 to determine any changes in the patient's dental and medical status since a previous comprehensive or periodic evaluation. It includes an oral cancer evaluation and periodontal screening when indicated. A periodic evaluation includes charting and history necessary to update and supplement the comprehensive oral evaluation data.

A periodic evaluation may be reimbursed for the same recipient once every 181 days.

Limited Oral Evaluation

A limited oral evaluation, problem focused, is a brief examination limited to a specific oral health problem. This results in the provision of emergency treatment on an episodic basis to relieve pain and suffering. This can be provided to a new patient or a patient of record.

Oral Evaluation for a Patient Under Three Years of Age

Procedure code D0145 is diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth. This type of evaluation should include recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and or primary caregiver.

Oral Evaluations, *continued*

Evaluation Exclusions

A second evaluation will not be reimbursed when the recipient returns on a later date for follow-up treatment subsequent to either a comprehensive or periodic evaluation.

No type of oral evaluation may be billed on the same date of service, same recipient, as another type of evaluation.

Diagnostic casts are included in the orthodontic evaluation and treatment plan and may not be billed as a separate procedure.

Oral Surgery Services

Description

Oral surgery services include extractions as well as surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial regions

Covered Services

For recipients 21 years and older, Medicaid covers extractions and other surgical procedures essential to the preparation of the mouth for dentures. Acute emergency services for the alleviation of pain or infection are also covered and are limited to extraction and the incision and drainage of an abscess.

Surgery services for recipients under age 21 include extractions, surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial areas.

The fee for extractions and surgical procedures includes local anesthesia and routine postoperative care.

Procedures performed as part of a surgical procedure that are secondary, minor or non-essential, and incidental surgery procedures are not separately reimbursable services.

Note: See the Florida Medicaid Provider Reimbursement Schedule for a list of surgical procedures. The reimbursement schedule is available on the Medicaid fiscal agent Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Fee Schedules.

Oral Surgery Services, *continued*

Simple Extraction	A simple extraction is the removal of a permanent or deciduous tooth by the closed method using the elevation and forceps removal technique in which a flap is not retracted. The incidental removal of cyst or lesions attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.
Surgical Extraction	A surgical extraction is the removal of any erupted or unerupted tooth by the open method that includes the retraction of a mucoperiosteal flap and the removal of alveolar bone in order to extract or section a tooth.
Impacted Tooth	An impacted tooth may be imbedded in soft tissue, or the crown of the tooth may be partially or fully covered by bone. The degree of complexity of the impaction must be identified on the claim form by using the appropriate extraction procedure code.
Supernumerary Tooth Extraction	In accordance with American Dental Association guidelines, supernumerary teeth are identified in accordance with the following: • Primary dentition – by the placement of the letter ”S” following the letter identifying the adjacent primary tooth, for example, “AS” is adjacent to “A” and “TS” is adjacent to “T;” or • Permanent dentition – by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar, for example, 51 is adjacent to the upper right molar number 1 and 82 is adjacent to the lower right third molar number 32. The degree of extraction complexity is identified by use of the appropriate extraction procedure code.
Biopsies	Biopsies are the removal of tissue, hard or soft, from the recipient for microscopic examination for the purpose of diagnosis, prognosis and treatment planning.
Alveoloplasty	Alveoloplasty is the surgical preparation of the alveolar ridge for dentures and is indicated in extreme cases without which insertion of dentures would be impossible. The procedures are provided and billed on a quadrant basis, which may or may not be in conjunction with extractions.

Oral Surgery Services, continued

Oral Surgery Limitations

Extractions of all erupted teeth or exposed roots within a quadrant, same recipient and same date of service, are reimbursable with procedure code D7140, using D7140's reimbursement rate for each applicable extraction. This rule does not apply if an extraction within the quadrant is a surgical removal of an erupted tooth or the removal of an impacted tooth, which will be identified by the appropriate extraction procedure code.

Oral Surgery Exclusions

Extractions and surgical procedures not indicated for the preparation of the mouth for full or partial dentures are not reimbursable by Medicaid for recipients 21 years of age or older. The exception to this policy is extractions related to acute emergency services for the alleviation of pain or infection.

Suturing and removal of sutures in association with extractions is not reimbursable as a separate charge.

Alveoloplasty is not reimbursable in conjunction with single tooth extractions.

The procedure code for excision of hyperplastic tissue, D7970, is not reimbursable in conjunction with alveoloplasty on the same date of service.

Orthodontic Services

Description

Orthodontic procedures may be reimbursed for Medicaid recipients under age 21.

Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.

Treatment is routinely accomplished through fixed appliance therapy and monthly maintenance visits. Removable (D8210) or fixed (D8220) appliance therapy may be reimbursed, but is dependent upon individual case circumstances. If requesting a removable (D8210) or fixed (D8220) appliance for thumb sucking or other habit, clinical photos must be submitted with the prior authorization request for the determination of medical necessity.

Note: See Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, ADA Dental for information on obtaining authorization for orthodontic services.

Orthodontic Services, *continued*

Provider Specialty Limitations

Orthodontic procedures may be reimbursed only when provided by specialty trained orthodontists and pediatric dentists who are enrolled in the Medicaid program.

Any surgery related to enhancing the success of the orthodontia may only be reimbursed when provided by a Medicaid enrolled oral surgeon. Related extractions may only be reimbursed when provided by a Medicaid enrolled dentist.

Note: See Chapter 1 of this handbook for information related to specialty requirements.

Limitations

Orthodontic procedures are limited to recipients under age 21 whose handicapping malocclusion creates a disability and impairment to their physical development.

Criteria for approval is limited to one of the following conditions:

- Correction of severe handicapping malocclusion as measured in the Medicaid Orthodontic Initial Assessment Form (IAF) AHCA-Med Serv Form 013;
- Syndromes involving the head and maxillary or mandible jaws such as cleft lip or cleft palate;
- Cross-bite therapy, with the exception of one posterior tooth that is causing no occlusal interferences;
- Head injury involving traumatic deviation; or
- Orthognathic surgery, to include extractions, required or provided in conjunction with the application of braces.

Medicaid will reimburse monthly maintenance visits a maximum of 24 units or 36 months whichever comes first. Extensions beyond 24 units are granted only in the most severe cases such as cleft or surgical cases.

A monthly maintenance fee will only be reimbursed if the recipient is Medicaid eligible on date of service, even though previously authorized.

Note: See Extension of Orthodontia Service Limits in this chapter for more information regarding extension of services.

Orthodontic Services, *continued*

Exclusions

Medicaid will not reimburse for:

- Treatment primarily for cosmetic purposes; or
- Split phase treatment, with exception of cleft palate cases.

Interceptive orthodontic treatment under the Medicaid program will include only treatment for anterior or posterior crossbite and may be considered treatment in full and reimbursed once in a lifetime. The provider should submit a prior authorization request for all orthodontic procedures requesting x-bite therapy and full treatment. The most cost-effective treatment plan may be approved.

Cleft and surgery cases are excluded from the treatment in full" policy and are considered on a case-by-case basis.

Initial Assessment Form

The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.

The IAF is:

- Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
- A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case.

Note: See Appendix A, Medicaid Orthodontic Initial Assessment Form (IAF) AHCA-Med Serv Form 013 located at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Forms.

Note: See Borderline Assessments in this chapter for information about borderline situations.

Completion of The IAF

The conditions listed in the IAF index should be considered in the context of whether they contribute to a disabling malocclusion. The provider scores each applicable condition and totals the recipient's index score.

Special or mitigating circumstances, such as deep bites with palatal trauma or occlusion related temporomandibular joint dysfunction (TMD) must be described in detail. Include description of limited mobility history (locking open or closed) and other severe symptoms of TMD.

Note: See Appendix A, Medicaid Orthodontic Initial Assessment Form (IAF) AHCA-Med Serv Form 013 located at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Forms.

Orthodontic Services, *continued*

Index Score of 26 or Greater

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

The provider must submit the IAF as a diagnostic record component with the prior authorization request.

Index Score of Less Than 26

A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

Borderline Assessments

When the IAF score is less than 26, but the strategical positioning of the malocclusion constitutes a serious impediment or threat to normal growth, development and function of the jaws or dentition, the provider must submit a completed prior authorization, IAF, diagnostic photographs, panoramic x-ray and study models to the Medicaid orthodontic consultant for determination of medical necessity.

Note: See Prior Authorization Diagnostic Record Components in this chapter for more information regarding required photos.

Orthodontic Services, *continued*

General Considerations

Orthodontic services will not be denied based on the type of treatment proposed by a provider unless the consultant considers the treatment to be radically inappropriate. The consultant may temporarily disapprove services based on the age of the recipient or the eruption state of permanent teeth. If the prior authorization request is returned to provider (RTP), the provider should submit the original records and a new panorex taken after further eruption has occurred. The provider may bill Medicaid for the panorex, however, the provider cannot bill for procedure code D8660.

A thorough, well conceived and articulated treatment plan may aid in possible approval, especially in borderline situations.

The determination of whether or not a particular case qualifies under the Medicaid Orthodontic Program is based primarily on Medicaid criteria for "most severely handicapping malocclusion."

Prior Authorization Diagnostic Record Components

Orthodontic services must be authorized by Medicaid prior to the services being rendered. The prior authorization (PA) request must include the following diagnostic record components:

- Completed and signed dental Prior Authorization Request for Treatment Form (DPA 1041);
- Completed and signed Initial Assessment Form (Appendix A);
- Clinical photographs (prints or slides) showing:
  - frontal view, relaxed, teeth in occlusion;
  - profile, right or left;
  - intraoral, right or left sides, teeth in occlusion;
  - intraoral, frontal, teeth in occlusion; and
  - occlusal view (if photos are submitted without complete records);
- Panoramic type radiograph;
- Study models; and
- Lateral cephalometric radiograph.

Trimmed and articulated or "rough-trimmed" models should indicate the proper occlusion, either with lines or a wax bite. Models that are unable to be articulated or are too damaged in shipping will not be evaluated.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook for a copy of the prior authorization request form.

Orthodontic Services, *continued*

Submitting Diagnostic Records

The record components must be mailed in a single package with the prior authorization request. If any one of the components is omitted from the records, all records will be returned with a letter stating what is necessary to complete the request. Records will be returned separate from the prior authorization disposition.

Before submission, wax bites and models must be disinfected, sterilized and dried to prevent mold during shipping.

Prior Authorization Mailing Address

All orthodontic PA requests, along with the diagnostic record components or other orthodontic consultant correspondence, must be sent to:

Medicaid Orthodontic Program
Bureau of Medicaid Services
2727 Mahan Drive
Mail Stop # 20
Tallahassee, Florida 32308-5403

Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment is the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction or dentofacial deformity including anatomical and functional relationships. Comprehensive orthodontic treatment utilizes fixed orthodontic appliances through procedure codes D8070, D8080 or D8090 in conjunction with the appropriate stage of dentition development.

The fee for orthodontic treatment does not include related extractions or oral or orthognathic surgery, which must be billed separately.

The overall fee for orthodontic appliances procedure codes (D8070, D8080, and D8090) includes the removal of the appliances and retainers at the end of treatment.

Orthodontic Services, *continued*

Dentition Stages

The stages of dentition development incorporated within comprehensive orthodontic treatment along with the specified procedure code are as follows:

- Transitional dentition is the final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging. Use procedure code D8070;
- Adolescent dentition is the dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment. Use procedure code D8080; and
- Adult dentition is the dentition that is present after the cessation of growth that would affect orthodontic treatment. Use procedure code D8090.

Number of Units Requested

If the maxillary and mandibular arches are to be treated concurrently, two units may be requested for procedure codes D8070, D8080, or D8090.

The number of units requested for procedure code D8670 may not exceed 24 units.

Reimbursement Restrictions

The fixed appliance reimbursement at the start of treatment covers the cost of appliances and materials throughout treatment, including the removal of appliances and fabrication of retainers upon completion of treatment.

Procedure code D8999 may be used for reimbursement of debanding and retainers when appliances were placed by a different provider with an unaffiliated practice (not a partner sharing or office-sharing arrangement).

The provider may pass on the costs of broken brackets or bands to the recipient when breakage exceeds a quantity of five.

A flat adjustment fee may be reimbursed for each visit the recipient is seen during active treatment, not to exceed a maximum of 24 payments. This fee may be billed each visit that the child is seen and is Medicaid eligible.

Medicaid regulations prohibit reimbursement when the child misses an appointment, did not receive a service, or was ineligible for Medicaid.

Orthodontic Services, *continued*

Premature Removal of Appliances

Removal of braces is recommended when:

- There is documentation of a lack of cooperation from the patient; or
- The patient requests premature removal and a release form has been signed by the parent, guardian, or patient if he is age 18 or older.

If appliances are removed prematurely due to one of the circumstances above and treatment has not been completed (12 units or more), the treating provider should provide retainers. If treatment is not near completion (less than 12 units) and tooth movement has not occurred, retainers should not be provided.

Pre-treatment Exam and Treatment Plan

Reimbursement for the pre-orthodontic treatment visit, procedure code D8660, includes study models, photographs, radiographs (panoramic and cephalometric), and the diagnosis and treatment plan.

Medicaid reimburses for code D8660 only if a request for prior authorization, along with diagnostic record components, has been submitted to the Medicaid orthodontic consultant for review. Procedure code D8660 itself does not require prior authorization. When requesting prior authorization for orthodontic services, list only the services that require prior authorization.

Extension of Service Limits

A request for extension of services beyond 24 units must be submitted with justification for the extension. The request must be made on a prior authorization request form (DPA 1041), submitted with current photos and panoramic x-ray showing progress to date and sent to Medicaid for consideration of medical necessity. Extensions are granted only in the most severe cases, such as surgical or cleft cases.

Lost or Broken Retainer

Medicaid may reimburse replacement retainer(s) one per arch per lifetime for either a lost or broken retainer if Medicaid reimbursed for any of the active orthodontic treatment. A replacement appliance requires prior authorization and is billed using procedure code D8692.

Orthodontic Services, *continued*

Relocation of Patient and Unused Portion of Prior Authorization	If a recipient under age 21, who is receiving active orthodontic treatment that is reimbursed by Medicaid, moves to an area of the state located outside the treating provider's service area, the unused portion of the prior authorization may be transferred to another provider for the continuation of treatment. The new provider must request the remaining units of procedure code D8670 on a prior authorization request form and submit the request to the Medicaid orthodontic consultant.
Continuation of Cases From Out-of-State	If a child moves to Florida from another state while undergoing active orthodontic treatment that was reimbursed through that state's Medicaid program, the Florida provider may request continuation of treatment through Florida Medicaid. The Florida provider must submit a prior authorization request to provide continuation of treatment and include diagnostic record components reflecting the present level of treatment. Note: See Prior Authorization Diagnostic Record Components in this chapter for more information.
Appliance Replacement	When a recipient changes orthodontic providers and needs a replacement appliance(s), it must be explained on the IAF.

Palliative Treatment

Description	Palliative treatment is limited to Medicaid recipients under age 21 to relieve pain and discomfort on an emergency basis when time and circumstances contraindicate more definitive treatment and services, such as opening up the pulpal chamber for drainage, removal of high spots to relieve traumatic occlusion, treatment of apthous ulcers or herpetic lesions. The dental record must contain complete justification for billing this procedure. Palliative treatment may be used in conjunction with a problem focused limited oral evaluation and only once per office visit.

***Palliative Treatment*,** continued

Exclusions	Palliative treatment and non-emergency treatment may not be reimbursed by Medicaid for the same recipient on the same day. Writing a prescription(s) for analgesics or antibiotics without any definitive treatment will not be reimbursed by Medicaid as palliative treatment.

Periodontal Services

Description	Periodontal services may be reimbursed only for eligible recipients under 21 years of age who exhibit generalized periodontal pockets in excess of the 4-5 mm range. The fee for the service includes postoperative care. The nature of any condition must be documented on the periodontal chart (Appendix E) of the dental record. Note: See Appendix E in this handbook for an example of a periodontal chart.
Gingivectomy	A gingivectomy is the excision of the soft tissue wall of the periodontal pocket in shallow to moderate suprabony pockets. It is usually performed on suprabony pockets that need access for restorative dentistry or when moderate gingival enlargements are present.
Gingival Flap Procedure	A gingival flap procedure is the surgical debridement of the root surface and the removal of granulation tissue following resection of the soft tissue flap and includes root planning. Osseous recontouring is not reimbursable in conjunction with this procedure.
Scaling and Root Planing	Scaling and root planing involves instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus and stains. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. This is a definitive, meticulous treatment procedure designed to remove cementum or dentin that is rough, and may be permeated by calculus, or contaminated with toxins or microorganisms. It may be used as a definitive treatment in some stages of periodontal disease or a part of pre-surgical procedures in others. Scaling and root planing procedures are limited to beneficiaries under 21 years of age who exhibit generalized periodontal pocket depths in the 4-5 mm range. Significant periodontal pockets must be indicated in the patient's dental record. The provider may use Appendix E, Sample Periodontal Chart, or the tooth chart in the patient's record for charting periodontal pockets.

Periodontal Services, *continued*

Full Mouth Debridement	Full mouth debridement (D4355) is the gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation on a Medicaid recipient under age 21. Debridement can be billed once in a 366 day period and may not be billed with procedure codes D4341 or D4342 on the same date of service, same recipient. Full mouth debridement may be billed one time for the entire mouth on the same date of service. Procedure code D4355 may not be billed by the quadrant or by the arch.
Osseous Surgery	Osseous surgery is a procedure in which the teeth's supporting bone is altered to achieve a more physiologic form and function. The surgery may include removing supporting or non-supporting bone.
Periodontal Limitations	Periodontal scaling is therapeutic treatment and may be reimbursed for recipients under age 21 with periodontal disease.
Periodontal Exclusions	Periodontal scaling used prophylactically is not reimbursable by Medicaid. Periodontal scaling may not be reimbursed for the same recipient on the same date of service as a prophylaxis, except in circumstances when all procedures are performed in a hospital or ambulatory surgical center with the child under general anesthesia. Gingivectomy procedure codes D4210 and D4211 may not be billed for the same quadrant on the same date of service, same recipient, or the same provider. Gingival flap procedure codes D4240 and D4241 may not be billed for the same quadrant on the same date of service, same recipient, or the same provider. Periodontal scaling procedure codes D4341 and D4342 may not be billed for the same quadrant, on the same date of service, same recipient, or the same provider. Osseous Surgery procedure codes D4260 and D4261 may not be billed for the same quadrant on the same date of service, same recipient, or the same provider.

Preventive Services

Description	For eligible recipients under the age of 21, preventive services, including oral prophylaxis, topical fluoride application, oral hygiene instruction, sealants, and space maintainers, are reimbursable services.
Video Teleconference	Medicaid will reimburse a Medicaid-enrolled dental services provider for an oral prophylaxis, topical fluoride application, and oral hygiene instructions performed by a Registered Dental Hygienist in a satellite office or clinic via video teleconferencing with a supervising licensed dentist located in a hub office or clinic.
Oral Prophylaxis	Oral prophylaxis may be reimbursed for recipients in normal or good periodontal health. An oral prophylaxis involves removing bacterial plaque, food debris, stains, and calculus from the crowns and roots with hand scaling or ultrasonic scaling instruments and or electric polishers. Tooth brushing does not replace polishing the teeth with a prophy angle or air polishing prophylaxis system. Procedure code D0110 may be reimbursed on recipients ages 12 through 20 in transitional or permanent dentition. Since pockets are absent in a completely normal periodontium, scaling and polishing are performed on the anatomic or clinical crowns and into very shallow, healthy sulci.
Oral Prophylaxis Limitations	An oral prophylaxis will be reimbursed once in a 181 day period, per recipient under the age of 21.
Oral Prophylaxis Exclusions	Periodontal scaling (D4341 or D4342) will not be reimbursed with a prophylaxis on the same date of service.
Topical Fluoride Application	Topical fluoride application includes fluoride gel, liquid, foam, or varnish, which is applied separately from prophylaxis paste by means of a tray, swabs, brush or rinse. Incorporating fluoride with the polishing compound is part of the prophylaxis procedure and is not separately reimbursable. Fluoride varnish may not be applied with the application of a fluoride gel, liquid, or foam on the same date of service, same recipient.

Preventive Services, *continued*

Topical Fluoride Limitations	Topical fluoride application may be reimbursed once in a 181 day period per recipient. The application of fluoride varnish is delivered in a single visit and involves the entire oral cavity. Varnish may be applied to a child's teeth up to age three and a half every 90 days. Children over the age of three and a half are allowed a fluoride varnish treatment every 6 months.
Topical Fluoride Exclusions	Applying topical fluoride including fluoride varnish to the prepared portion of a tooth prior to restoration is not reimbursable as a topical fluoride application. Fluoride varnish should not be used as a desensitizer or filling material.
Oral Hygiene Instructions and Education	Preventive dental care instructions and education must include: • Education to the parent and or child on how dental plaque and oral hygiene relate to dental disease; • Instructions to the parent and or child in the proper methods of oral hygiene and the removal of plaque; and • Nutritional counseling of the parent and child on the relationship of diet and dental disease.
Sealants	Sealants are applied to pits and fissures of permanent teeth to prevent caries. The enamel surface of the tooth may be mechanically or chemically prepared. Buccal and lingual grooves are included in the fee. Products used must be classified as acceptable by the American Dental Association.
Limitations On Sealants	Sealants may be reimbursed once per three years, per tooth, on the following teeth: • Permanent 1st molars – tooth #s 3, 14, 19, 30; and • Permanent 2nd molars – tooth #s 2, 15, 18, 31 Sealants applied to deciduous teeth will not be reimbursed by Medicaid.
Sealant Exclusions	No caries or existing amalgam or resin restoration may be present on the surface of the tooth on which a sealant is applied.

Preventive Services, continued

Space Maintainers

Space maintainers (Procedure codes D1510 and D1515) may be reimbursed for necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth.

Space maintainers are limited to fixed appliances, including unilateral and bilateral, and must be passive in nature.

Procedure codes D1510 and D1515 do not require prior authorization.

Space Maintainer Exclusions

A space maintainer will not be reimbursed by Medicaid if the space will be maintained for less than six months.

Preventive Services in FQHCs and CHDs

Medicaid will reimburse Federally Qualified Health Centers (FQHCs) and County Health Department (CHDs) one encounter rate for preventative dental services for recipients under age 21. Services described below must be provided on the same date of service and billed as one encounter rate using either procedure code D0120 (periodic oral evaluation) or D0150 (comprehensive oral evaluation), whichever is appropriate.

- Prophylaxis;
- Topical application of fluoride; and
- Oral hygiene instructions.

Unbundling of the services noted above is prohibited. If more than one encounter occurs to complete the services listed above, the provider must bill one encounter on the date of service that the procedures were completed.

Radiographs

Description

Radiographs that confirm the need for extractions or other procedures essential to the preparation of the mouth for dentures and in conjunction with acute emergency dental services may be reimbursed for eligible recipients 21 years of age and older.

Medicaid may reimburse for intraoral, extraoral, and panoramic radiographs essential to making a diagnosis of dental disease, or trauma for eligible recipients under age 21.

All radiographs must be of diagnostic quality.

The quality of panographic-type radiographs is not sufficient for diagnosis in periodontics, endodontics, and restorative.

Radiographs, continued

Components

Radiographs used in the preparation of the mouth for adult dentures or acute emergency dental services must determine if any of the following are present:

- Retained roots;
- Unerupted teeth;
- Foreign bodies; or
- Periapical or periodontal pathology.

Radiographs for recipients under age 21 must determine if any of the following are present:

- Caries;
- Retained roots;
- Unerupted teeth;
- Foreign bodies; or
- Periapical and other pathology.

Intraoral – Complete Series

An intraoral, complete series requires a minimum of 12 periapical radiographs.

Limitations

For eligible adults, radiograph reimbursement is limited to intraoral periapicals and panoramic radiographs required to make a diagnosis and to develop a treatment plan for the seating of full or partial dentures or for use in conjunction with acute emergency dental services.

For eligible recipients under age 21, radiograph reimbursement is limited to intraoral periapical, bitewing, occlusal, and panoramic radiographs required to make a diagnosis and to develop a treatment plan.

The total amount reimbursed for individual periapicals must not exceed the fee for a complete series (D0210) for the same recipient on the same date of service.

Reimbursement Frequency

Reimbursement for a complete series of intraoral radiographs including bitewings (if indicated) is limited to once in a three (3) year period, per recipient.

Bitewing radiographs billed as a separate procedure are limited to once in a 181 day period per recipient.

A panoramic film is limited to once in a three (3) year period, per recipient.

Radiographs, *continued*

Radiology Exclusions

All bitewing radiographs are excluded from reimbursement for ages 21 and older except when taken in conjunction with a full mouth series.

The following radiographs will not be reimbursed for caries detection:

- Occlusal film;
- Extraoral film; or
- Panoramic film.

Medicaid will reimburse for either an intraoral-complete series or a panoramic film, but not both, for the same recipient on the same date of service by the same provider.

Removable Prosthodontics

Description

Removable prosthodontics involves the fabrication, repairing, relining and adjusting of an appliance for the replacement of extracted teeth, by and under the direction of a dentist. This appliance is removed from the mouth by the patient.

Services Covered

For all eligible Medicaid recipients, Medicaid may reimburse for the fabrication of full and removable partial dentures, the relining of dentures, the repair of dentures, and the use of all-acrylic interim partial dentures.

The standard for all dentures, whether seated immediately after extractions or following alveolar healing, is that the dentures be fully functional.

Prior to the fabrication of complete or partial dentures, the provider must ascertain from the recipient if he presently has dentures; and if so, did Medicaid provide those dentures and when.

Non-Immediate Dentures

A non-immediate denture procedure must include:

- The reimbursement for seating; and
- All necessary adjustments and corrections, including relines, for six months after seating.

An immediate and a non-immediate denture are billed using the same procedure code.

Removable Prosthodontics, *continued*

Immediate Dentures

An immediate denture procedure includes:

- The reimbursement for seating; and
- All necessary adjustments and corrections, including relines, for three months after seating.

If the dentist fabricating the immediate denture is different than the dentist removing the teeth, the dentist who fabricated the dentures may bill for the dentures when he delivers the dentures to the patient.

An immediate denture is billed using the same procedure code as a non-immediate denture

Partial Dentures

Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.

Removable partial dentures are reimbursable for all eligible Medicaid recipients regardless of age.

Procedure code D6985 includes fixed partial dentures (pedo partials) for pediatric use only. Procedure code D6985 is not covered for adults age 21 and older.

The provider must have an approved prior authorization before billing Medicaid for the services.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, ADA Dental Claim Form, for a copy of the form and instructions about prior authorization.

Denture Billing Date

A claim for dentures may not be submitted until the dentures are actually seated. Use the date the dentures were seated as the date of service.

In some cases, fabrication of dentures could possibly extend into a month for which the recipient is not Medicaid eligible. In that event, use the date the denture was ordered for fabrication as the denture's date of service when submitting the claim.

In the event the provider has ordered a denture and incurred a lab expense but is unable to complete the seating, a provider may submit a claim for reimbursement. The date the denture was ordered may be used as the date of service.

Information regarding the dentures must be accurately documented in the patient's dental record.

Removable Prosthodontics, continued

Relines

All relines must reflect measurable improvement toward the unit's optimal function. This includes both chair side and laboratory techniques.

Relines may be reimbursable regardless of whether Medicaid paid for the dentures. The fee for a reline includes all necessary corrections and adjustments for a period of six months from the date of the reline.

A reline using a "light-cured" technique is a chair side reline.

Initial Reline

To receive Medicaid reimbursement, immediate dentures may be relined no earlier than three months after date of insertion and non-immediate dentures no earlier than six months after seating.

Denture Repairs

All repairs must render the denture unit measurably improved; or, if in conjunction with a reline, the repair and reline will make the unit optimally functional.

Repairs may be processed in either a commercial or office dental laboratory.

Limitations

Full and removable partial dentures may be reimbursed once for an upper, a lower or a complete set per the lifetime of the recipient.

Medicaid does not reimburse the replacement of lost partial or full dentures.

Relines may be reimbursed once per denture per 366 days.

Reimbursement for an all-acrylic interim partial (flipper) is limited to the replacement of anterior teeth and is covered for children under age 21.

Exception to Limitations

Exceptions to the limitation of one set of dentures per lifetime of the recipient, may be considered for dentures if the dental provider determines the:

- Full or partial dentures are no longer functional, because of the physical condition of the recipient; or
- Full or partial dentures are no longer functional, because of the condition of the denture.

Requesting Exceptions

Requests for exceptions to the once per lifetime rule must be made to the Medicaid area office. Area Medicaid staff will formally notify the provider of the decision and if granted, what forms to use and how a claim is to be submitted.

Note: See Appendix C in the Florida Medicaid Provider General Handbook for area Medicaid office addresses.

Removable Prosthodontics, continued

Exclusions

Medicaid will not reimburse for:

- Partial dentures where there are at least eight posterior teeth in occlusion;
- Partial dentures for single tooth replacement unless it is a missing anterior tooth;
- Claims for relines and denture adjustments with the same date of service for the same recipient;
- Claims for repairs and denture adjustments with the same date of service for the same recipient; and
- The use of tissue conditioning relines.

Denture Enhancements

Denture enhancements, such as gold inlays, gold teeth, jewels in teeth, etc., are neither reimbursable by Medicaid nor billable to the recipient. Medicaid reimbursement for the denture(s) is considered payment in full for the covered service of the complete, fully functional denture(s), and the necessary corrections and adjustments (listed previously).

The total provision of the functional denture(s) to the recipient is the service covered by Medicaid. There is no part of the service that is not covered. Providers cannot accept any payment from the recipient for the denture(s).

Restorative Services

Description

Restorations may be reimbursed for eligible recipients under age 21 to eliminate carious or post-traumatic lesions from teeth and to restore the anatomic shape, function and aesthetics of teeth.

Restorative Services, *continued*

Covered Services

Medicaid may reimburse for:

- Amalgam restorations;
- Resin restorations, including composite and glass-ionomers;
- Prefabricated stainless steel crowns for both deciduous and permanent teeth;
- Porcelain fused to predominantly base metal crowns for permanent posterior or anterior teeth when the tooth has been endodontically treated and cannot be adequately restored with a stainless steel crown, amalgam or resin restoration; and
- Porcelain/ceramic substrate crowns for permanent anterior teeth when the tooth has been treated endodontically and cannot be adequately restored with a resin restoration.

The fee for amalgam restorations includes local anesthesia, tooth preparation, routine lining and base, polishing, and the use of any adhesive, such as amalgam bonding agents.

The fee for resin restorations includes local anesthesia, tooth preparation, routine lining and base, etching, an adhesive, such as resin bonding agents, and curing the restoration.

Note: See the Florida Medicaid Provider Reimbursement Schedule for the Medicaid reimbursable crown types. The reimbursement schedule is available on the Medicaid fiscal agent Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Fee Schedules.

Note: See Appendix C in this handbook for a list of dental procedure codes that require entry of a tooth number, tooth surface, or mouth quadrant on the ADA Dental.

Resin Restorations

Direct resin-based restorations may be reimbursed for restoring:

- Anterior teeth, cuspid to cuspid, all surfaces; and
- Posterior teeth, primary and permanent, one, two, and three surfaces.

Medicaid will reimburse for a resin restoration only if the tooth has been mechanically prepared for the restoration. Resin restorations may be used to restore carious lesions that extend into the dentin or areas that are deeply eroded into dentin.

A resin-based composite restoration is not a preventive procedure.

Restorative Services, *continued*

Resin Restoration

Direct resin-based restorations may be reimbursed for restoring:

- Anterior teeth, cuspid to cuspid, all surfaces; and
- Posterior teeth, primary and permanent, one, two, and three surfaces.

Medicaid will reimburse for a resin restoration only if the tooth has been mechanically prepared for the restoration. Resin restorations may be used to restore carious lesions that extend into the dentin or areas that are deeply eroded into dentin.

A resin-based composite restoration is not a preventive procedure.

Limitations

Reimbursement for restorative services is limited to:

- Essential services necessary to restore and maintain dental health;
- One restoration per tooth surface except for the occlusal surface of permanent maxillary 1st and 2nd molars;
- One restoration for a mesial or distal lesion; and
- One posterior one-surface resin restoration every three years per tooth number or letter per tooth surface. Both primary and permanent teeth are included using procedure code D2391.

Exclusions

Medicaid will not reimburse for:

- Restoration on primary teeth when loss is expected within six months;
- Crowns provided solely for aesthetic reasons; or
- Fixed bridges (except for procedure code D6985).

Sedation

Intravenous Conscious Sedation

Intravenous conscious sedation (Procedure codes D9241and D9242) is the intravenous administration of a drug or agent to produce a controlled state of consciousness and a reduced stress or excitement level. It may be accompanied by partial loss of protective reflexes, including either or both the inability to continually maintain an airway independently or to respond appropriately to physical stimulation or verbal command.

Intravenous conscious sedation must be administered in accordance with Rule 64B5-14, F.A.C.

Sedation, *continued*

Non-Intravenous Conscious Sedation	Non-intravenous conscious sedation (Procedure code D9248) is a depressed level of consciousness produced by the administration of pharmacologic substances that retains an individual's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command. This modality includes administration of medication via intramuscular, subcutaneous, submucosal, inhalation, oral, rectal, or transmucosal and appropriate monitoring. Non-Intravenous conscious sedation does not include nitrous oxide administration. Non-intravenous conscious sedation must be administered in accordance with Rule 64B5-14, F.A.C.
Sedation Limitations	Non-intravenous conscious sedation is limited to three times per 366-day period, per recipient. Medicaid does not reimburse for sedation if billed on the same date of service as behavior management.
Sedation Exclusions	The writing of a prescription for a non-intravenous conscious sedative is excluded as a claim. The use of general anesthesia procedure code(s), D9220 and D9221, for either intravenous or non-intravenous sedation modalities is not reimbursable for Medicaid eligible dental services.

SECTION 2: ORAL AND MAXILLOFACIAL SURGERY PROGRAM

General Information

Description	The oral and maxillofacial surgery program provides medically necessary treatment for disease or injury to the jaw or any structure contiguous to the jaw, and the reduction of any fracture of the jaw or facial bone. The surgery may be reimbursed for a Medicaid recipient of any age, subject to certain limitations as set forth below.

General Information, *continued*

Age Restrictions

For recipients 21 years of age or older, oral and maxillofacial surgery services are limited to the following:

- Surgery for injury or disease when provided by a qualified dentist; or
- Medically necessary acute emergency dental services to relieve pain or infection.

Recipients under age 21 are eligible for the following services:

- All the oral and maxillofacial surgery services available to recipients 21 years and older; and
- Surgery for relief of pain or infection and the maintenance of dental health.

Procedure Fees

The fees paid are the same as fees paid to physicians who perform these procedures. Services furnished by a dentist would be considered physician services if those services had been furnished by a physician.

The fee for any procedure performed in a hospital setting includes admission, preoperative visits and examination, completion of records, and postoperative care.

Reimbursable Services

Medicaid payment for oral and maxillofacial surgery is limited to those covered procedures listed on the Florida Medicaid Provider Reimbursement Schedule. The reimbursement schedule is available on the Medicaid fiscal agent Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Fee Schedules.

Specialty Restricted Codes

The following procedure codes are restricted to use by Medicaid enrolled oral surgeons, provider type 35, specialty code 72:

- Radiology, codes 70100 through 77334; and
- Evaluation and management, codes 99201 through 99285.

Prior Authorizations

Description

Some procedures must be authorized prior to being provided to the recipient. All requests for prior authorization (PA) of dental procedures must be submitted on the dental "Prior Authorization Request for Treatment Authorization" form (DPA 1041). Medicaid will notify the provider in writing of the disposition of the request.

Surgery that requires prior authorization when performed in a setting outside the inpatient hospital is identified in the Oral and Maxillofacial Surgery Fee Schedule, which is included in the Florida Medicaid Provider Reimbursement Schedule, by "PA" in the "Spec" column.

Note: See the Florida Medicaid Provider Reimbursement Schedule for oral and maxillofacial surgery procedure codes requiring prior authorization. These are identified by a "PA" in the "Spec" column.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook CMS 1500 for instructions about prior authorization.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook CMS 1500 for information about prior authorization for inpatient hospital admissions.

Supporting Documentation

Any technical data, reports, history, and physical findings that support the request should be attached to the PA request.

Post Authorizations

Surgical procedures performed as an emergency may be authorized after the fact, but the authorization must be requested and approved before submitting a claim.

Authorization Longevity

A procedure that is prior authorized must be performed within 120 days from the Prior Authorization Notice date.

Consultation Services

Description

A consultation is a type of service provided by an accredited dental specialist whose opinion or advice regarding the evaluation or management of the specific problem is requested by another dentist.

A consultation may also occur when a health practitioner in another discipline requests the advice of a dentist. Referrals from other providers are not automatically consultations.

These services may be rendered in an inpatient, outpatient, or office setting.

Consultation Services, *continued*

Consultation Versus Referral

If a provider sends a recipient to another provider for specialized care that is not in the referring provider's domain, and the referring provider will not participate in the on-going care of the recipient for this problem, this is not a consultation. This is a referral and should be billed as an examination or appropriate evaluation and management code.

The distinguishing feature between a consultation and an established or new patient visit will depend on whether the referring provider is going to continue to care for the patient for that particular problem. If this condition can be met, then the referral should be billed as a consultation. If this condition cannot be met, then the referral should be billed as a new or established patient.

Consultation Components

The following must be recorded in the recipient's dental record:

- Request and need for consultation from the attending or requesting provider;
- Consultant's opinion and any services ordered or performed; and
- A written report of the findings and recommendations provided to the attending or requesting provider.

Hospital Inpatient Consultation Visits

One initial consultation per hospitalization, per recipient, per provider specialty may be reimbursed.

If a partial or complete transfer of care ensues following the initial hospital consultation, all follow-up visits are considered subsequent hospital visits.

A follow-up inpatient consultation can be billed only if it is requested by the attending provider to recommend management modification or advise a new plan of care in response to changes in the recipient's status. This request must be documented.

Office or Other Outpatient Consultation Visits

Medicaid reimbursement is limited to one initial consult visit, per provider specialty, per 366 days for a non-hospitalized recipient.

If a partial or complete transfer of care ensues following the initial office or outpatient consultation visit, all follow-up visits are considered subsequent evaluation and management services.

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending provider, the appropriate evaluation and management code should be used.

Consultation Services, continued

Non-reimbursable Consultation Visits	A consultation visit in addition to an office or hospital visit on the same day of service by the same provider will not be reimbursed. Consultations rendered in nursing or custodial care facilities are not reimbursable.

Evaluation and Management Services

Description	Evaluation and Management (E&M) services include office or other outpatient visits for new and established patients, initial and subsequent hospital care, office and inpatient consultations, and emergency department visits. Medicaid will reimburse only oral and maxillofacial surgery trained specialists for E&M services that are enrolled in Medicaid with that specialty. Note: See the Evaluation and Management Services guidelines section of the *Physicians' Current Procedural Terminology* (CPT) for the E & M code levels.
Visit Frequency	Office and hospital visits are limited to one visit per recipient, per day, per provider subspecialty.
New Patient Visit	One new patient visit may be reimbursed once per recipient, per provider or provider group. A new patient is one who has not received any professional services from the provider or provider group within the past three years.
Established Patient Visit	An established patient is one who has received professional care within the past three years from the provider or provider group. Providers sharing practice coverage and treating established patients of the primary provider must bill established patient visits.
Office Visits	Office visits may be reimbursed for services provided in a provider's office, an outpatient facility, or ambulatory facility.

Evaluation and Management Services, continued

Hospital Visits

Hospital visits for an inpatient recipient may be reimbursed when the provider completes:

- A non-surgical service; and
- A significant, separately identifiable evaluation and management procedure is clearly documented in the medical record.

Hospital visits to a recipient are not reimbursed if the visits are related to a procedure not covered by Medicaid. Visits during the global post-operative period are not reimbursable if related to the surgical procedure.

Emergency Care Visits

Emergency care services may be reimbursed when the services are provided in the emergency facility of a hospital. There is no distinction between new and established patients in the emergency department, only levels of care.

Reimbursement may be made to a private practicing oral surgeon or a hospital-based oral surgeon.

Visit Reimbursement Limitations

The following codes are considered visit codes and are not reimbursable in addition to an office or hospital visit: 99238, 99241-99245, D0120, D0140, and D0150.

If an office or emergency room visit is rendered on the same day as an initial hospital visit, the provider can be reimbursed for one or the other but not both.

Use the appropriate evaluation and management code to indicate a significant, separately identifiable service above and beyond the usual pre and postoperative care associated with the procedure was performed. A report must be attached to the claim. This modifier requires the claim to be reviewed by a Medicaid consultant for justification of the evaluation and management service and appropriate pricing.

Visits to the same recipient by more than one specialty provider on the same day for different diagnoses may be reimbursed if documented in the recipient's record as being medically necessary.

Non-reimbursable Visits

Visits for second opinions are not reimbursable.

Services furnished to Florida recipients when they are out of the country are not reimbursable.

Procedure code D9420, Hospital Call, is not reimbursable for any procedure listed in the Oral and Maxillofacial Surgery Fee Schedule, which is included in the Florida Medicaid Provider Reimbursement Schedule.

Radiology Services

Description	Radiology services include diagnostic radiology and oncology procedures.
Maximum Fee	The maximum fee that may be reimbursed to an oral surgeon or an oral surgery group includes both the technical and professional components of a radiology service performed in the office setting.
Professional Component	The professional component is the provider interpretation and reporting of the radiological exam, and is identified by adding a modifier 26 to the procedure code on the claim form. The professional component can be reimbursed for services provided only in the inpatient and outpatient hospital setting. If the professional service component is provided for an emergency room recipient, use “22,” outpatient hospital, as the place of service on the claim.
Diagnostic Radiology	Diagnostic Radiology includes: • Limited exam which includes anterior, posterior and lateral views and is only part of a complete exam; or • Complete exam that includes all necessary views for optimal examination. All procedures are considered complete unless indicated differently. The procedure is done by a single provider and includes injection of contrast media.
Computerized Tomography	Computerized Tomography (CT) requires specific diagnosis codes to justify the necessity of the test. The Max Fee is the maximum allowable for a scan without contrast and with contrast media. Reimbursement for follow-up visits on the same day is included in the fee for the scan. Note: See Appendix B of this handbook for the diagnosis codes applicable to CT scans.
CT Scan Frequency	A repeat computerized tomography scan on the same day is not reimbursable.

Radiology Services, *continued*

Magnetic Resonance Imaging	A diagnosis code is required to justify the medical necessity for magnetic resonance imaging (MRI). Reimbursement for follow-up visits on the same day is included in the fee for the scan. Note: See Appendix B of this handbook for the diagnosis codes applicable to MRI.
MRI Frequency	No more than two body areas per day or up to three procedures in 30 days may be reimbursed per recipient for MRIs.
Radiology Frequency	Only one interpretation (reading) per radiology procedure may be reimbursable.
Service Exclusions	Radiology services by mobile units are not reimbursable. When an X-ray is taken in the hospital Emergency Department (ED), either the ED physician or the oral and maxillofacial surgeon is reimbursed for the interpretation, but not both.

Surgery Services

Description	Surgical services are manual and operative procedures for correction of deformities and defects repair of injuries, and diagnosis and cure of certain diseases.

Surgery Services, *continued*

Global Surgical Services Components

The following services are included in the payment amount for a global surgery:

- The preoperative visit on day one (the day of surgery);
- Intraoperative Services – Intraoperative services are a usual and necessary part of a surgical procedure; examples are local anesthesia and topical anesthesia;
- Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery, because of complications that do not require additional trips to the operating room;
- Post Surgical Pain Management – By the surgeon;
- Miscellaneous Services and Supplies – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, splints; routine peripheral intravenous lines, nasogastric tubes; and changes and removal of tracheostomy tubes; and
- Postoperative Visits – Follow-up visits within the postoperative period of the surgery that are related to recovery from the surgery.

Note: See the Florida Medicaid Provider Reimbursement Schedule for the number of follow-up days that are included in the surgical fee. The reimbursement schedule is available on the Medicaid fiscal agent's Web site at: www.mymedicaid–florida.com. Select Public Information for Providers, then Provider support, then Fee Schedules.

Global Surgical Services Exclusions

The following services are not included in the payment amount for a global surgery:

- Diagnostic tests and procedures, including diagnostic radiological procedures; or
- Treatment for postoperative complications, which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. It does not include a patient's room, a minor treatment room, a post-anesthesia care unit, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).

Unlisted Procedures

Unlisted procedures or procedure codes ending in 99 may be billed only when there is no available procedure code. If the provider bills an unlisted procedure code when there is an appropriate procedure code, the claim will be denied.

An unlisted procedure code requires that a report documenting the service provided be attached to the claim for medical review and pricing.

Surgery Services, *continued*

Incidental Procedures	Procedures performed as part of a surgical procedure that are secondary, minor, non-essential, and incidental surgical procedures are not separately reimbursable services.
Assistant Surgeon	Only one assistant surgeon can be reimbursed per operative session.
Surgical Trays	Surgical trays used for office surgery are not reimbursed separately from the surgical procedure.
Cosmetic Surgery	Cosmetic surgery is not reimbursable.
Endosteal Implants	Medicaid will reimburse for endosteal implants only when used in conjunction with reconstructive types of surgeries. Both partial and complete endosteal implants require prior authorization. Medicaid will not reimburse for replacement of individual teeth via implants. Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook for the prior authorization procedures.

APPENDIX A

MEDICAID ORTHODONTIC INITIAL ASSESSMENT FORM (IAF)

You will need this score sheet and a disposable ruler (or a Boley Gauge)

Name: _____ I. D. Number: _____

Conditions:

			HLD Score
1.	Cleft palate deformities (Indicate an "X" if present and score no further)		_____
2.	Deep impinging overbite**. When lower incisors are destroying the soft tissue** (Indicate an "X" if present and score no further)		_____
3.	Crossbite of individual anterior teeth. **When destruction of soft tissue is present** (Indicate an "X" if present and score no further)		_____
4.	Severe traumatic deviations. (Attach description of condition. For example, loss of a premaxilla segment by burns or accident, the result of osteomyelitis or other gross pathology) (Indicate an "X" if present and score no further)		_____
5A.	Overjet greater than 9 mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties. (Indicate an "X" if present and score no further)		_____
5B.	Overjet in mm		_____
6.	Overbite in mm		_____
7.	Mandibular protrusion in mm	_____ x 5=	_____
8.	Open bite in mm	_____ x 4=	_____

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVERE CONDITION. DO NOT SCORE BOTH CONDITIONS.

9.	Ectopic eruption (Count each tooth, excluding third molars).	_____ x 3=	_____
10.	Anterior crowding (Score one point for MAXILLA and one point for MANDIBLE, two points for maximum anterior crowding).	_____ x 5=	_____
11.	Labio-Lingual spread in mm		_____
12.	Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar)	Score 4	_____
		Total Score	_____

Patient name: _____Medicaid I.D. # _____

Please describe these and any other problems:

Please describe tentative treatment plan:

Use additional sheets as required.

_____

Date Provider's signature

For Medicaid use:

___ Patient does not meet Medicaid criteria for "most severely handicapped"

___ Patient not eligible

___ Send additional materials, as per handbook

_____

_____

Consultant_____Date_____

***Appendix A*, continued**

How to Score the Initial Assessment Form

Cleft Palate – Submit a cleft palate case in the mixed dentition only if you can justify in a narrative why there should be treatment before the client is in full dentition.

Severe Traumatic Deviation – Refers to facial accidents only. Points cannot be awarded for congenital deformity. It does not include traumatic occlusions for crossbites.

Overjet in Millimeters – Score the case exactly as measured, then subtract 2mm (considered the norm) and enter the difference as the score.

Overbite in Millimeters – Score the case exactly as measured, then subtract 3mm (considered the norm) and enter the difference as the score. This would be double counting.

Mandibular Protrusion in Millimeters – Score the case by measurement in mm by the distance from the labial surface of the mandibular incisors to the labial surface of the maxillary incisor. Do not score both overbite and open bite.

Open Bite in Millimeters – Score the case exactly as measured. Measurement should be recorded from the "line of occlusion" of the permanent teeth-not from ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers, because of the frequency of relapse.

Ectopic Eruption – An unusual pattern of eruption, such as high labial cuspids or teeth that are grossly out of the long axis of the alveolar ridge. Do **not** include (score) teeth from an arch if that arch is to be counted in the following category of "Anterior crowding." For each arch, you may score either the ectopic eruption **or** anterior crowding but **not** both.

Anterior Crowding – Anterior teeth that require extractions as a prerequisite to gain adequate room to treat the case. If the arch expansion is to be implemented as an alternative to extraction, provide an estimated number of appointments required to attain adequate stabilization. Arch length insufficiency must exceed 3.5 mm to score for crowding on any arch. Mild rotations that may react favorably to stripping or moderate expansion procedures are not to be scored as "crowded."

Labio-Lingual Spread in millimeters –The measurement of the lower incisors in millimeters in the deviation from the normal arch of the lower teeth.

Providers should be conservative in scoring. Liberal scoring will not be helpful in the evaluation and approval of the case. The case **must** be considered **dysfunctional** and have a minimum of **26** points on the IAF to qualify for any orthodontic care other than crossbite correction.

The intent of the program is to provide orthodontic care to recipients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily for aesthetics are not within the scope of benefits of this program.

If attaining a qualifying score of 26 points is uncertain, provide a brief narrative when submitting the case. The narrative may reduce the time necessary to gain final approval and reduce shipping costs incurred to resubmit records.

Directions for Using the Handicapping Labio-Lingual Deviation (HLD) Index

Instructions for HLD Index Measurements

Procedure:

1. Position the patient's teeth in centric occlusion.
2. Record all measurements in the order given and round off to the nearest millimeter (mm).
3. Enter score "0" if condition is absent.
4. The use of a recorder is recommended.

Conditions:

1. Cleft palate deformities---automatic qualification; however if the deformity cannot be demonstrated on the study mode, the condition must be diagnosed by properly credentialed experts and that diagnosis must be supported by documentation. If present, enter an "X" and score no further.

2. Deep impinging overbite---tissue destruction of the palate must be clearly visible in mouth. On study models, the lower teeth must be clearly touching the palate and there must be clear evidence of damage visible on the submitted models; touching or slight indentations do not qualify. If present, enter an "X" and score no further.

3. Crossbite of individual anterior teeth---destruction of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. A minimum of 1.5mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases. If present, enter an "X" and score no further.

4. Severe traumatic deviations---these might include, for example, loss of premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. Traumatic deviation does not mean loss of anterior teeth due to gross destruction or evulsion. If present, enter an "X" and score no further.

5. Overjet---this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plane. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Reverse overjet may be measured in the same manner. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient. If the overjet is greater than 9mm or reverse overjet is greater than 3.5mm, enter an "X" and score no further. Otherwise, enter the measurement in mm x 1.

6. Overbite---a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do not use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor-from the incisal edge to the pencil mark. Do not record overbite and openbite on the same patient. Enter the measurement in mm x 1.

7. Mandibular (dental) protrusion or reverse overjet---measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Mandibular incisors in crossbite do not count as mandibular (dental) protrusion or reverse overjet. Skeletal mandibular protrusion must be present. Do not use the upper lateral incisors or cuspids for this measurement. Do not record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).

Directions For Using The Handicapping Labio-Lingual Deviation (HLD) Index, continued

8. Open bite---measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do not use the upper lateral incisors or cuspids for this measurement. In some situations, one has to make an approximation by measuring perpendicular to the occlusal plane as illustrated in Fig. 1. Do not record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).

9. Ectopic eruption---count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If condition No. 10, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **Do not score both conditions**.

10. Anterior crowding---anterior arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points for maxillary arch with anterior crowding and (5) points for mandibular arch with anterior crowding. If condition. No.9, ectopic eruption is also present in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). **Do not score both conditions.**

11. Labiolingual spread---use a disposable ruler (or a Boley gauge) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch line. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth. In the event that multiple anterior crowding is observed, all deviations should be measured for labiolingual spread but only the most severe individual measurement should be entered on the score sheet. Enter the measurement in millimeters on the score sheet.

12. Posterior unilateral crossbite---this condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the two maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet.

APPENDIX B
ORAL AND MAXILLOFACIAL SURGERY
DIAGNOSIS CODE LISTS FOR MRIs AND CT SCANS

MRI Orbit, Face and Neck

170.0	Malignant Neoplasm, Bone, Skin, Breast
171.0	
190.0-192.3	Malignant Neoplasm, Other Unspecified
194.3-194.4	
196.0	
200.21	Malignant Neoplasm Hematopoietic/ Lymphatic
201.01	
201.08	
201.11	
201.18	
201.21	
201.28	
201.41	
201.48	
201.51	
201.58	
201.61	
201.68	
224.0-224.7	Benign Neoplasms
225.0-225.2	
226	
227.1-227.5	
235.0-235.1	Neoplasms on Uncertain Behavior
237.0-237.1	
240.0	Disorders of Thyroid Gland
241.0-242.21	
243-244.3	
252.0-252.1	Diseases of Other Endocrine Glands
255.4-255.6	
352.0-352.6	
382.00-382.2	Diseases of Ear and Mastoid
383.00-383.33	
385.0-385.13	
385.31-385.35	
386.0-386.03	
386.2-386.56	
387.0-387.2	
388.2	
388.61	
756.0	
781.0-781.4	
781.6	
784.2-784.5	
850.0-851.79	Intracranial Injury W/O Skull Fracture
852.01-854.19	
870.4-872.74	Open Wound of Head, Neck and Trunk
874.00-874.5	
925	Crushing Injury
950.0-951.7	Injury to Nerves and Spinal Cord

CT Head and Neck

036.0-036.8	Other Bacterial Diseases
047.0-047.8	Poliomyelitis & Other Viral of CNS
049.0-049.8	
053.0-053.13	Viral Disease Accompanied by Exanthem
062.0-063.2	Arthropod Borne Viral Disease
070.0-070.4	Other Diseases from Viruses
090.4	Syphilis and Other Venereal Disease
094.0-094.89	
130.0	Helminthiase
147.0-149.9	Malignant Neoplasm of Lip, Oral, Pharynx
160.0-161.3	Malignant Neoplasm, Respiratory, Thoracic
170.0-170.1	Malignant Neoplasm, Bone, Skin, Breast
171.0	
190.0-192.3	Malignant Neoplasm Other & Unspecified

194.1-194.4
195.0
196.0
198.3-198.4
200.01 ..... Malignant Neoplasm, Lymphatic/ Hematopoietic
200.08
200.11
200.18
200.2
200.28
201.01
201.08
201.11
201.18
201.21
201.28
201.41
201.48
201.61
201.68
215.0 ..... Benign Neoplasms
215.8
224.0-224.8
225.0-225.2
226
227.1-227.5
228.02-228.03
230.0 ..... Carcinoma in Situ
231.0-231.1
231.8
235.0-235.1 ..... Neoplasms of Uncertain Behavior
235.6
237.0-237.1
237.5-237.6
239.1-239.2 ..... Neoplasms of Unspecified Nature
239.6-239.8
241.0-242.21 ..... Disorders of Thyroid
244.0-244.3
250.20-250.31..... Diseases of Other Endocrine Glands
250.60-250.61
252.0-253.8
255.4-255.6
320.0-320.3 ..... Inflammatory Diseases of CNS
321.0-324.1
331.3-331.4 ..... Hereditary & Degenerative Disease, CNS
332.0
333.0-333.7
334.0-334.2
340-341.8 ..... Other Disorders of CNS
343.0-345.7
348.3
352.0-352.6 ..... Disorders of the Peripheral Nerves
430-436 ..... Cerebrovascular Disease Congenital Anomalies
741.00-741.03
742.0-742.4
744.05
748.2
779.2 ..... Other Conditions Orig In Perinatal Symptoms
780.3
784.2
850.0-851.79..... Intracranial Injury W/O Skull Fracture
852.00-854.19
870.3-872.74..... Open Wound of Head, Neck and Trunk
874.00-874.5
925 ..... Crushing Injury
950.0-951.7 ..... Injury to Nerves and Spinal Cord

APPENDIX C

PROCEDURES REQUIRING A TOOTH NUMBER, TOOTH SURFACE OR A MOUTH QUADRANT CODE

The following is a list of dental procedure codes that require a tooth number or letter code be entered in field 27 on the ADA Dental claim form.

D1351	D2392	D2951	D3330	D7220
D2140	D2393	D2954	D3331	D7230
D2150	D2710	D2970	D3333	D7240
D2160	D2721	D3110	D3351	D7241
D2161	D2751	D3120	D3352	D7250
D2330	D2920	D3220	D3353	D7270
D2331	D2930	D3221	D3410	D7280
D2332	D2931	D3230	D3430	D7281
D2335	D2932	D3240	D7111	
D2390	D2940	D3310	D7140	
D2391	D2950	D3320	D7210	

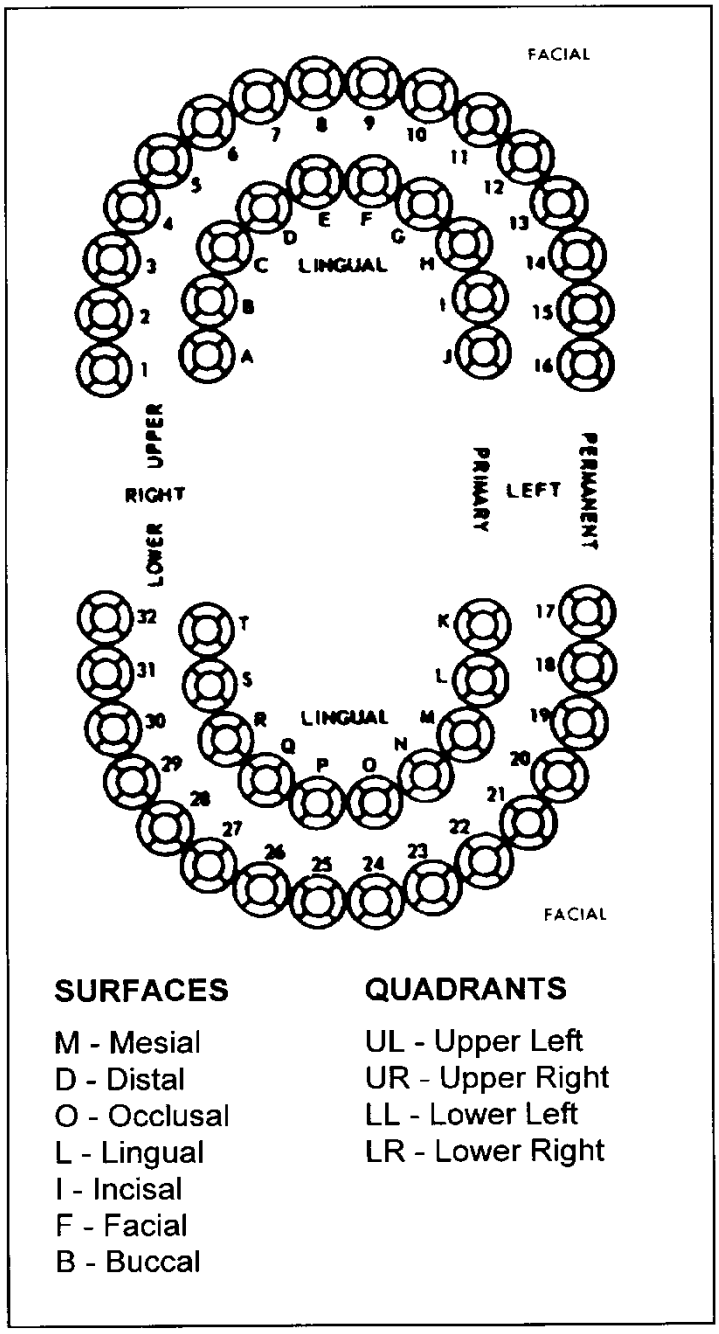
The following is a list of dental procedure codes that require a tooth surface code be entered in field 28 on the ADA Dental claim form. Acceptable tooth surface codes are: M, O, D, F, B, L or I, or combinations thereof.

D2140	D2330	D2391
D2150	D2331	D2392
D2160	D2332	D2393
D2161	D2335	

The following is a list of dental procedure codes that require a mouth quadrant code be entered in field 25 on the ADA Dental claim form. Acceptable mouth quadrant codes are: UR-10, UL-20, LR-30 or LL-40.

D4210
D4211
D4240
D4241
D4260
D4261
D4341
D4342
D7310
D7320

APPENDIX D
ADA TOOTH CHART



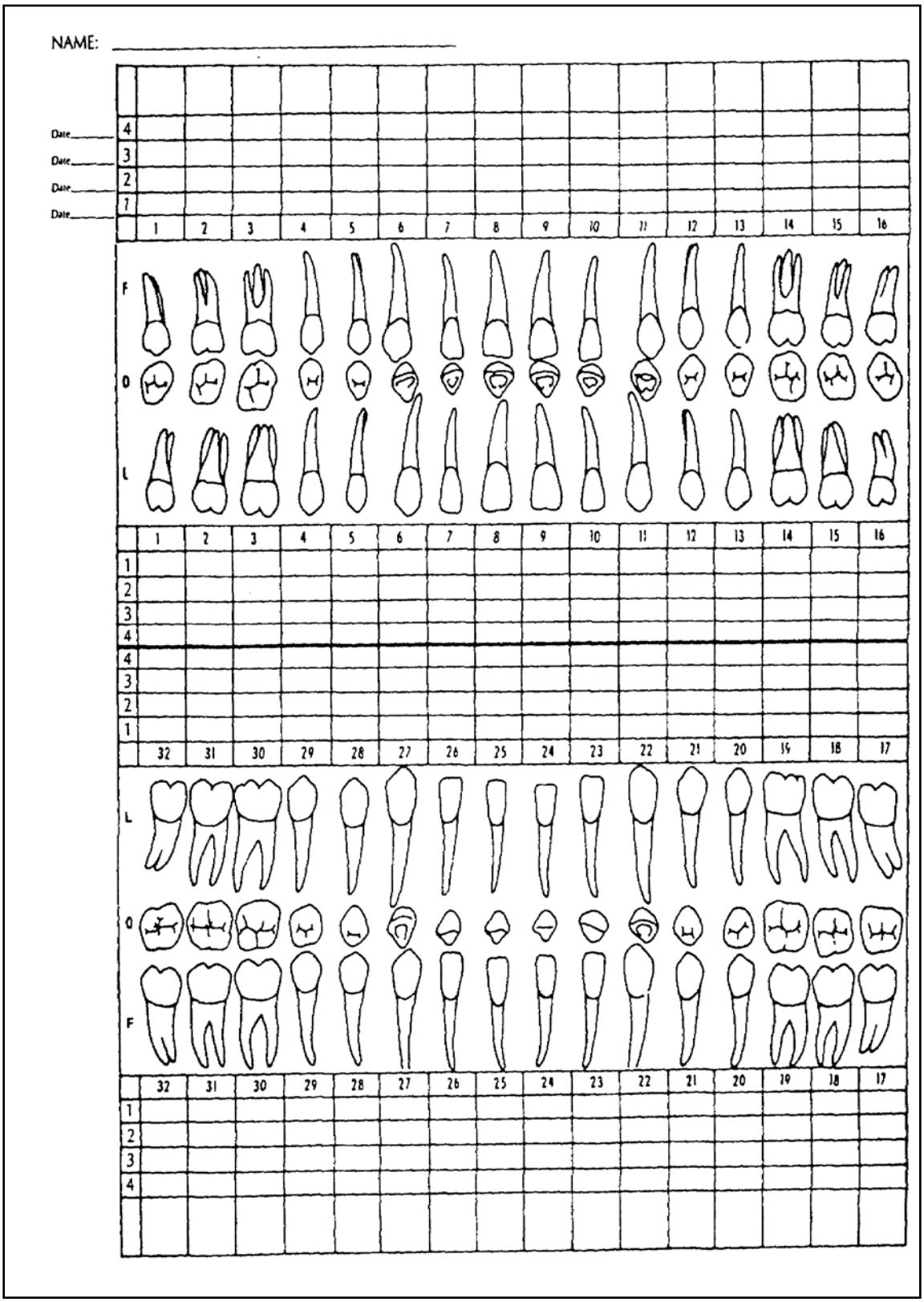
SURFACES

M - Mesial
D - Distal
O - Occlusal
L - Lingual
I - Incisal
F - Facial
B - Buccal

QUADRANTS

UL - Upper Left
UR - Upper Right
LL - Lower Left
LR - Lower Right

APPENDIX E
SAMPLE PERIODONTAL CHART



APPENDIX F

MEDICAID BEHAVIOR MANAGEMENT REPORT

Date of Service: _____

Recipient Name: _____

Recently, this child was seen in our dental office. Because of the misbehavior of the child during the dental visit, he/she could not have been worked on without behavior management techniques. The child exhibited the following behavior during his/her dental treatment:

___Crying or Fearful ___Defiance ___Thrashing around

___Hitting or kicking ___Apprehensive ___Grabbing instruments

___Difficulty getting into chair ___Uncooperative (due to physical or mental impairment)
Will not lean back
Will not stay in chair

Verbal communications were insufficient in accomplishing our goals and behavior management techniques had to be employed with _____.
(Child's First Name)

Techniques used to manage the behavior:

___Tell-show-do

___Positive reinforcement or abnormal amount of time consumed

___Required two or more personnel to assure safety of child and staff

___Papoose or Pedi-wrap

Other Comments:

_____

PROVIDER NAME DATE