

Chapter 20

Dental Services

NOTE: Please review the following detail for specific processes and expectations with South Country Health Alliance (South Country). South Country may vary from the MHCP Manual and Minnesota Department of Human Services Guidelines. For additional detail on this chapter, please go to the Minnesota Health Care Programs Provider Manual at [MHCP Provider Manual](#).

South Country uses Delta Dental of Minnesota as our third-party dental administrator. Dental services that require prior authorization are reviewed for medical appropriateness based on evidence-based standards of care, medical necessity criteria, and the member's benefit coverage. The attending or requesting dentist may contact Delta Dental to discuss any dental utilization management denial, reduction or termination of services with Delta Dental's Director or other appropriate reviewers. For a complete list of services that require prior authorization, please refer to the Delta Dental of Minnesota Website (<https://www.deltadentalmn.org/>).

Contact Delta Dental

www.deltadentalmn.org/providers

1-651-406-5907 or toll free 1-800-774-9049 (TTY 711)

Authorization requests may be mailed to:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Claim submission:

Delta Dental of Minnesota
PO Box 9120
Farmington Hills, MI 48333-9120

Electronic Claims Submission – Payer ID 07000

Billing for Dental Services

Before providing dental services, you must verify member eligibility. This can be done using MN Department of Human Services (DHS) MN-ITS. Delta Dental of MN Customer Service (1-800-774-9049 or 1-651-406-5907) is available to assist with eligibility or benefits inquiries. This is not a guarantee that services provided will be covered. Refer to Covered Services to review member's current coverage. Excess services or services noted as non-covered are the member's responsibility. Providers must inform the recipient and discuss all other available covered alternatives before providing a noncovered service for which the recipient is financially responsible using the [Advance Recipient Notice of Noncovered Service/Item \(DHS-3640\) \(PDF\)](#).

A non-contracted provider will be paid at approximately the DHS base rate for services rendered to a South Country member. This payment will be payment in full. In compliance with Minnesota Health Care Programs (MHCP) rules, the provider is unable to balance bill the member. The check will be sent directly to the non-contracted provider.

The Minnesota Department of Human Services (DHS) operates five (5) State-Operated Dental Clinics that provide services to individuals with developmental disabilities, severe/persistent

mental illness and traumatic brain injury who are unable to obtain care from other community providers. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar. The services of State-Operated Dental Clinics will be authorized by and billed directly to the State of Minnesota. Services provided at the State-Operated Dental Clinics will follow MHCP benefit guidelines and authorization requirements.

Dental services provided at Federally Qualified Health Centers (FQHC) will follow the Minnesota Health Care Programs (MHCP) benefit set and authorization guidelines. Dental claims and service authorization requests for services provided at these dental clinics should be submitted to MHCP for processing. For more information, or to check claim and service authorization status, contact the MHCP Provider Contact Center at 1-651-431-2700 or 1-800-366-5411. The following carve out exception applies: South Country will continue to pay claims for MinnesotaCare members.

Covered Services for Non-Pregnant Adults

Adults 21 and older, 19 and older for MinnesotaCare members, receive the following limited set of dental benefits.

The following codes are all the eligible billable codes for non-pregnant adults. Do not provide services without first confirming coverage through MN-ITs or Delta Dental Customer Service.

All covered services must be medically necessary, appropriate and the most cost effective for the medical needs of the patient.

Diagnostic Services

D0120	Periodic exam	<ul style="list-style-type: none"> Twice per calendar year Cannot be performed on same date as limited or comprehensive evaluation (D0140, D0150)
D0140	Limited exam	<ul style="list-style-type: none"> Once per day Cannot be performed on same date as periodic or comprehensive oral evaluation or a prophylaxis (D0120, D0150, D1110) Documentation must include notation of the specific oral health problem or complaint
D0150	Comprehensive exam	<ul style="list-style-type: none"> Once per five (5) years Cannot be performed on same date as periodic or limited evaluation (D0120, D0140)

X-Rays

D0270, D0272, D0273, D0274, D0277	Bitewing x-rays	<ul style="list-style-type: none"> One (1) series per calendar year
D0220, D0230	Periapical x-rays	<ul style="list-style-type: none"> Four (4) per date of service
D0330	Panoramic x-ray	<p>Once per five (5) years except:</p> <ol style="list-style-type: none"> With a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure When medically necessary for the diagnosis and follow up of oral and maxillofacial pathology and trauma Once every two (2) years for patients who cannot cooperate for intraoral film due to disability or medical condition that does not allow for intraoral film placement

Preventive Services

D1110	Prophylaxis	<ul style="list-style-type: none"> Twice per calendar year Authorization is required proving medical necessity for additional prophylaxis performed according to an appropriate individualized treatment plan that meets criteria for covering up to two (2) additional prophylaxis within the calendar year
D1206	Topical application of fluoride varnish	<ul style="list-style-type: none"> Twice per calendar year Cannot be performed on same date as D9910
D1354	Interim Caries Arresting Medicament Application - per tooth	<ul style="list-style-type: none"> Once per tooth per six (6) months Cannot be performed on the same date as D1206 and D9910

Restorative Services

D2330, D2331, D2332, D2335	Anterior composite fillings	<ul style="list-style-type: none"> Limited to once per 90 days for the same tooth
D2140, D2150, D2160, D2161; D2391, D2392, D2393, D2394	Posterior fillings (amalgam or composite)	<ul style="list-style-type: none"> Limited to once per 90 days for the same tooth All reimbursed at amalgam rates South Country prohibits balance billing posterior composites to the member
D2940	Protective restoration	<ul style="list-style-type: none"> Allowed only for relief of pain Cannot be performed on same date as D9110

Endodontics

D3310, D3320	Anterior and Premolar (Including treatment plan, clinical procedures and follow-up care)	<ul style="list-style-type: none"> Once per tooth per lifetime
D3911	Intra-orifice barrier not to be used as final restoration	<ul style="list-style-type: none"> Once per tooth per lifetime Can only be billed with South Country covered endodontic treatment

Periodontics

D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	<ul style="list-style-type: none"> Once per five (5) years Cannot be performed on the same date as D1110, D0150, D0160 or D0180
D4341, D4342	Periodontal Scaling and Root Planing	<ul style="list-style-type: none"> Once every two (2) years per quadrant Requires prior authorization <p>Clinical criteria to be eligible for South Country reimbursement:</p> <ul style="list-style-type: none"> Evidence of bone loss must be present on the current radiographs – panoramic, full mouth series or bitewings – to support the diagnosis of periodontitis There must be current periodontal charting with six point and mobility noted, including presence of pathology and periodontal prognosis The pocket depths must be greater than four millimeters Classification of the periodontology case type must be in accordance with documentation established by the American Academy of Periodontology <p>Prophylaxis or gross debridement cannot be performed on the same day</p>
D4322, D4323	Intra-coronal/Extra- coronal Splint	<ul style="list-style-type: none"> Once per year
D4910	Periodontal Maintenance	<ul style="list-style-type: none"> Four times per year following Scaling and Root Planing

Dentures/Removable Prosthesis

Replacement of a prosthesis is limited to one (1) every six (6) years, unless one of the following conditions applies:

- Replacement of a removable prosthesis in excess of the limit is covered if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the member's control.
- Replacement of a partial prosthesis is covered if the existing prosthesis cannot be modified or altered to meet the member's dental needs.

Service for a removable prosthesis must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six (6) months immediately following the provision of the prosthesis. Document the instruction and the necessary adjustments in the member's dental record.

House calls (D9410) for fitting removable prosthesis is a covered service limited to up to five (5) visits in a calendar year. Bill house calls as D9410 with D5992; D9410 will pay at the current rate and D5992 will pay at \$0.

South Country pays a percentage payment of the allowable for undeliverable removable prostheses. All authorization requirements are still applicable. Submit an attachment for the claims that documents the following:

- Reason for non-delivery noted in the member chart
- Explanation which includes the incurred lab charges and the percent of work completed

Keep the completed prosthesis in the provider's office, in a deliverable condition, for a period of at least two (2) years. Payment will be prorated based on the percentage completed and utilization review.

D5110, D5120, D5130, D5140	Complete Denture (including routine post-delivery care)	For each dental arch, removable prostheses are limited to one (1) every six (6) years. A pre-treatment estimate is recommended to ensure a replacement will be covered.
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5820, D5821	Partial Dentures (including routine post-delivery care)	For each dental arch, removable prostheses are limited to one (1) every six (6) years. A pre-treatment estimate is recommended to ensure the replacement will be covered.
D5410, D5411, D5421, D5422, D5511, D5512, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5670, D5671, D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	Denture adjustments, repairs, rebase and relines	D5520, D5640 and D5650 limited to five (5) per 180 days.
D5850, D5851	Tissue Conditioning	<p>Tissue conditioning, limited to once per denture unit:</p> <ol style="list-style-type: none"> 1. As a preparation for taking impressions for the relining of existing dentures 2. For the fabrication of new dentures <p>Bill tissue conditioning once at the completion of treatment, regardless of the number of visits involved.</p>
D5862, D5867, D5875, D5992	Other removable prosthetic service	A pre-treatment estimate is recommended to determine coverage.

Oral Surgery

D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250	Extractions	For all surgical extractions of impacted third molars the tooth must be symptomatic or show evidence of pathology to be covered. Authorization is required for removal of impacted wisdom teeth.
D7285, D7286	Incisional biopsy of oral tissue	
D7510, D7511, D7520, D7521	Incision and drainage of abscesses - intraoral or extraoral soft tissue	

Adjunctive Services

South Country must cover the primary services or procedures for ancillary services to be covered. If the primary procedure is not a covered service, regardless of the complexity or difficulty, coverage of services such as the administration of anesthesia, diagnostic x-rays and other related procedures will not be covered.

D9110	Palliative (emergency) treatment of dental pain	<ul style="list-style-type: none"> Once per day
D9239, D9243 and D9248	Oral and IV sedation	<ul style="list-style-type: none"> Only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center Dentists must be certified by the MN Board of Dentistry to administer general anesthesia and conscious sedation
D9410	House call or extended care facility call	<ul style="list-style-type: none"> Cannot be billed alone Must be used in conjunction with another covered service Cannot be performed on same date as D1330 or D0999
D9920	Behavioral management	<ul style="list-style-type: none"> Once per day when additional staff time is required to accommodate behavioral challenges and sedation is not used A narrative is required on the claim form stating why necessary

Outpatient Dental Surgery Services

When it is medically necessary to provide outpatient dental surgery under general anesthesia, the following additional services may be provided in an outpatient hospital setting or freestanding ambulatory surgical center (ASC) setting as part of the outpatient dental surgery. Indicate the place of service code on the claims and the medical insurance must be billed for a facility fee on the same date of service.

Diagnostic Services for Outpatient Dental Surgery

D0210	Intraoral complete series	<ul style="list-style-type: none"> • Once per five (5) years • Must be performed in outpatient hospital or freestanding ASC • Must indicate the Health Care Service Location Information or place of service code on the claim
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Adjunctive Services

D9222-D9223	General anesthesia	<ul style="list-style-type: none"> • Must be performed in outpatient hospital or freestanding ASC • Must indicate the Health Care Service Location information or place of service code on the claim
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Covered Services for Children and Pregnant Women

The following benefit set is for children under the age of 21 and pregnant women. For MNCare members only: children under the age of 19 receive these benefits. This list is not all-inclusive. Please contact Delta Dental Customer Service (1-800-774-9049) for plan specific information. Do not provide services without first confirming coverage through MN-ITs or Delta Dental Customer Service.

As required by the Centers for Medicare & Medicaid Services (CMS), the [Minnesota Child and Teen Checkups \(C&TC\) Schedule of Age-Related Dental Standards \(DHS-5544\) \(PDF\)](#) was developed. Both primary care and dental providers must use this schedule, which is in keeping with recommendations of the American Academy of Pediatric Dentistry.

Diagnostic Services

- Periodic oral evaluation
- Limited oral evaluation: Documentation must include notation of the specific oral health problem or complaint
- Oral evaluation for a patient under three years of age and counseling with a primary caregiver: Once per lifetime
- Comprehensive oral evaluation

*Limit of one oral evaluation service per day

X-rays

- Full mouth intraoral complete series
- Intraoral periapical or occlusal x-rays: Four (4) per date of service (does not include intraoral complete series)
- Bitewing x-rays
- Panoramic radiographic image or Cephalometric film, including coverage:
 1. With a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure
 2. For a medically necessary diagnosis and follow-up of oral and maxillofacial pathology and trauma
 3. Once every two (2) years for members who cannot cooperate for intraoral film due to disability or medical condition that does not allow for intraoral film placement

Preventive Services

- Dental prophylaxis
- Topical application of fluoride varnish, topical application of fluoride-excluding varnish: Once per six (6) months
- Oral hygiene instruction: Once per lifetime (prior authorization required for additional service); cannot be performed on same date as D0145
- Sealants: One (1) per five (5) years per permanent molar; children only
- Interim caries arresting medicament application: Once per six (6) months per tooth; cannot be performed on same date as D1206 or D9910
- Space Maintainers

Restorative Services

- Amalgam and composite fillings: Limited to once per 90 days per tooth
- Laboratory resin crowns that meet the specifications of utilization review
- Prefabricated stainless steel or resin crowns
- Protective restoration: Allowed only for the relief of pain, cannot be performed on the same date as D9110

Endodontics

- Pulpotomy, endodontic therapy, endodontic retreatment, apexification/recalcification, some apicoectomy/periradicular services, and other endodontic procedures
- Endodontic treatment

Periodontics

- Scaling and root planing that meets the utilization review criteria
- Full mouth debridement: Once per five (5) years
- Splint - intra-coronal or extra-coronal: Once per year

- Periodontal Maintenance: Four times per year following Scaling and Root Planing

Use oral cavity indicators only for periodontal services to designate the quadrants where the service was or will be provided. Bill using the appropriate numeric oral cavity designation code: 10, 20, 30 or 40.

Prosthodontics

- Removable full and partial dentures, adjustments and repairs, rebase and relines, interim prosthesis, and other prosthetic services
- Fixed partial dentures pontics, some retainers, retainer crowns, and other fixed partial denture services
- Tissue conditioning: As a preparation for taking impressions for the relining of existing dentures or for the fabrication of new dentures
- Maxillofacial prosthetics: Covered services include some prostheses and some carriers
 - Initial placement or replacement of a removable prosthesis is limited to once every six (6) years per member unless the replacement is necessary because it was misplaced, stolen, or damaged due to circumstances beyond the member's control. When applicable, providers must consider the member's degree of physical and mental impairment in determining whether circumstances were beyond a member's control.
 - Replacement of a partial denture is eligible for payment if the existing partial cannot be modified or altered to meet the member's dental needs.
 - Pre-treatment estimate is recommended to ensure that a replacement denture will be covered.
 - Service for a denture must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six (6) months immediately following the provision of the denture. Document the instruction and the necessary adjustments, if any, in the member's dental record.
 - Bill denture identification only for dentures previously made without ID markers. Denture identification for new dentures or partials will deny.
 - House calls for fitting removable prosthesis is covered up to five (5) visits in a calendar year. Bill house calls as D9410 with D5992; D9410 will pay at current rate and D5992 will pay at \$0.
 - Replacement of missing or broken teeth are limited to five (5) teeth per 180 days.
 - South Country pays a percentage payment for undeliverable removable prostheses. All authorization requirements are still applicable. Submit an attachment for the claim that documents the reason for non-delivery as noted in patient chart and an explanation that includes the incurred lab charges and percent of work completed.

Dental Implants

Authorization is always required. Covered services include some pre-surgical services, some implant supported prosthetics, abutment supported single crowns, fixed partial denture retainers, and other implant services.

Requests for authorization for dental implants must be submitted with the following dental history, case information, and documentation:

- Medical and dental history that supports the medical necessity

- Copies of current radiographs that show the current dental condition
- Complete treatment plan, including prosthesis and all related services
- The [Dental Implants Authorization Form \(DHS-3538\) \(PDF\)](#) must be completed and included with the necessary documentation requirements sent to Delta Dental

The following criteria must be met to receive payment for dental implants and related services:

- Bone and tooth loss that compromises chewing or breathing
- The implants must be medically necessary and cost-effective
- A complete treatment plan, including prosthesis and all related services, must be approved prior to the start of treatment

Oral Surgery

- Oral surgery services are covered including extractions, other surgical procedures, excision of soft tissue lesions, excision of intra-osseous lesions, excision of bone tissue, some surgical incision, and other repair procedures.
 - Authorization is always required for removal of impacted third molars. Submit requests for authorization with documentation of any of the following for each tooth to be extracted:
 - Documentation that third molar extractions are symptomatic or show evidence of pathology
 - Presence of severe pain or swelling
 - Documented recurrent episodes of pericoronitis
 - An episode of cellulitis
 - An episode of abscess formation or untreatable pulpal or periapical pathology
 - Active current periodontal disease due to the position of the third molar and its association with the second molar, periodontal charting required
 - External resorption of the third molar or of the second molar where this would reasonably appear to be caused by the third molar
 - A non-restorable carious lesion on a partially erupted third molar or a carious lesion on the distal of the second molar due to the position of the third molar
 - A pathological condition such as a dentigerous cyst or other related pathology

Orthodontic Treatment

South Country covers orthodontic treatment that meets the specifications of utilization criteria for children through the age of 20 and for those 18 and under on MNCare. All orthodontic treatment requires prior authorization review for medical necessity.

When submitting an authorization, the following documentation must be included:

- Description of classification of occlusion (e.g., angle class, arch crowding or spacing, etc.)
- Functional problems (e.g., over bite, overjet, cross bites, etc.)

- Disfiguring characteristics (e.g., facial asymmetry, etc.)
- Contributing factors (e.g., missing teeth, impacted teeth, etc.)
- Measurements in millimeters (mm) of all admissible crowding, crossbites, overbite, overjet or open bite
- Description of conditions that deem medical necessity for the treatment
- Specific treatment plan and appliances (enter the appropriate procedure code)
- Five (5) intraoral photographs; upper and lower occlusal; prints or mounted slides are acceptable; include profile photos
- Appropriate radiographs (panorex or full mouth and cephalometric)

Comprehensive or interceptive orthodontic treatment is considered medically necessary when one or more of the following criteria is met:

- Overjet greater than 9 mm
- Reverse overjet greater than 3.5 mm
- Anterior or posterior crossbite, or both, of three or more teeth per arch
- Lateral or anterior open bite 2 mm or more, of four or more teeth per arch
- Impinging overbite with evidence of occlusal contact into the opposing soft tissue
- Impactions where eruption is impeded but extraction is not indicated (excluding third molars)
- Jaws or dentition, or both, which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology
- Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant
- Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars)
- Other conditions as deemed medically necessary (must include narrative)

Orthodontic care usually requires lengthy treatment. South Country recommends that the provider discuss the expected eligibility period with the family and the county human services agency before initiating treatment. This will clarify the eligibility policies and help reduce denial of payment due to subsequent ineligibility. A member's eligibility can terminate or may go from fee-for-service to a managed care organization on a month-to-month basis.

Providers are encouraged to consult with parents or guardian regarding noncompliance and disregard for instructions. Providers may terminate treatment if not compliant with instructions.

For comprehensive orthodontic treatment:

- Use D8999 for initial banding and write "initial banding" in the narrative
- Bill adjustments utilizing the appropriate comprehensive code (D8070, D8080, D8090)

For **noncomprehensive** orthodontic treatment, South Country does not authorize or reimburse for initial banding. Request limited and interceptive treatment based on the number of expected visits utilizing either of the following:

- The appropriate limited orthodontic treatment code
- The appropriate interceptive orthodontic treatment code

Replacement or re-cementing of one (1) or two (2) brackets due to reasonable wear and tear is considered a part of the total orthodontic treatment. Re-cementing of brackets due to a failure of the patient to comply with the provider instructions is a noncovered service and the provider may bill the member for the cost. Since re-cementation of brackets is not a covered service, the provider is not required to submit charges to South Country.

The retention phase of orthodontic treatment is a component of the total orthodontic care for which the provider is reimbursed. The type of retention is a choice made by the provider. Do not bill the member.

Third Party Liability (TPL) or other insurance information for billing for orthodontics

When South Country approves orthodontic treatment:

- When TPL or other insurance pays an initial down payment and subsequent payments over the course of the treatment (monthly, quarterly, semi-annual or annual payments):
 - Bill the approved initial appliance placement code and indicate the TPL or other insurance initial down payment amount on the claim
 - A physical copy of the Primary EOB with estimated full payment amount must be submitted with the claim

Other Services

- Palliative care for the relief of pain
- Anesthesia, which includes the following:
 - Deep sedation or general anesthesia. Regardless of the age of the child, the determination of medical necessity for general anesthesia in conjunction with dental service must consider the information related to general anesthesia established by the American Academy of Pediatric Dentistry
 - Intravenous conscious sedation or analgesia
 - Nitrous oxide analgesia, anxiolysis
- House or extended care facility call. Extended care facilities are long-term care facilities. These include: nursing facilities, skilled nursing facilities, boarding care homes, IMDs, ICF/DDs, hospices, and swing beds. Services performed in a school or Head Start program are considered house calls
 - Billing house calls or extended-care facility calls must be reported along with the appropriate code(s) for the actual service(s) performed and can only be billed for on-sight delivery of covered services; cannot be performed on same date as D1330 or D0999
- Behavior management when additional staff time is required to accommodate behavioral challenges and sedation is not used
- Occlusal adjustment limited to once per day and includes only those services defined by the most current edition of the CDT
- Therapeutic parenteral drugs and other drugs by report (D9610, D9612 and D9630): enter additional information in the notes section of the claim form, including:
 - Name of drug
 - NDC of drug

- Dosage

Teledentistry

Teledentistry is the delivery of dental care services or consultations while the patient is at an originating site and the dentist is at a distant site. For additional information see MHCP [Telehealth Services](#).

South Country allows payment for teledentistry services. Reimbursement for teledentistry is the same as face-to-face encounters and only a distant site can bill for services.

To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the MHCP telehealth policy by completing the [Provider Assurance Statement for Telehealth \(DHS-6806\)](#).

Originating Sites for Teledentistry

The originating site is the location of an eligible South Country member at the time the service is being furnished via a telecommunication system.

Affiliate practice or originator within Minnesota Board of Dentistry defined scope of practice must be present at origination site:

- Dentist
- Advanced dental therapists
- Dental therapists
- Dental hygienists
- Licensed dental assistants
- Other licensed health care professionals

List of Teledentistry Services

South Country will cover teledentistry claims for diagnostic services. Coverage is limited to children, pregnant woman and limited adult benefits as specified in [Minnesota Statutes 256B.0625](#), subd 9 (covered services).

South Country allows the following CDT codes for these diagnostic services when performed via teledentistry:

- D0120: Periodic oral evaluation – established patient
- D0140: Limited oral exam
- D0145: Oral evaluation for patient under three years of age
- D0150: Comprehensive oral evaluation – new or established patient
- D0210: Intraoral – complete series of radiographic images
- D0220: Intraoral – periapical first radiographic image
- D0230: Intraoral – periapical each additional radiographic image
- D0270: Bitewing – single radiographic image
- D0272: Bitewings – two radiographic images
- D0274: Bitewings – four radiographic images
- D0240: Intraoral – occlusal radiographic image

- D0330: Panoramic radiographic image
- D9310: Medical dental consultation

Billing Teledentistry Services

South Country dental providers who self-attest that they meet all of the conditions of the MHCP telemedicine policy by completing the [Provider Assurance Statement for Telehealth \(DHS-6806\)](#) can submit claims for teledentistry services using the CDT code that describes the services rendered with place of service (POS) 02. By using POS 02 you are certifying that you are rendering services to a patient located in an eligible originating site via an interactive audio and visual telecommunications system. The following limitations apply:

- Payment will be made for only one (1) reading or interpretation of diagnostic tests such as x-rays, lab tests and diagnostic assessment
- Payment is not available for providers for sending materials
- Out-of-state coverage policy applies for services provided via teledentistry
- Consultations performed by providers who are not located in Minnesota and contiguous counties, require prior authorization prior to the service being provided

Dental Procedures Reported with CPT Coding

Note: The services below are not payable if submitted to Delta Dental of MN on an ADA (837D) claim form. They must be billed on an 837P form and submitted to South Country's medical claims system. To receive reimbursement for CPT procedure codes, you must be individually enrolled with South Country. For instructions see [South Country's Provider Manual Chapter 4 Provider Billing](#). Contact South Country's Provider Contact Center at 1-888-633-4055 for assistance.

Temporomandibular Joint Disorder (TMD)

Treatment for TMD is considered a medical service when the underlying pain and dysfunction is caused by 1) pain related TMD including myalgia, myofascial pain, arthralgia, arthritis or headache attributed to TMD or 2) temporomandibular joint intra-articular disorders, including disk displacement with and without reduction, degenerative joint disease, osteoarthritis or subluxation. Document that the history and physical exam support the diagnosis.

Providers should submit a medical claim (837P) via the [medical provider portal](#). The ICD diagnosis code and the associated CPT code for the occlusal orthotic device (41899 unlisted procedure, dentoalveolar structures) must be included on the claim.

Sleep Apnea Appliances

For South Country members who cannot tolerate a continuous positive airway pressure (CPAP) machine, a physician may prescribe an oral appliance. The oral appliance is considered Durable Medical Equipment. Dentists assure the proper fit of the appliance. Most appliances require that a dentist take necessary impressions and a bite registration.

Criteria for coverage of a custom fabricated oral appliance (E0486) can be found in the [MHCP Provider Manual - Dental Services \(Overview\)](#).

Alveoloplasty or Gingivectomy

Report medical procedure codes 41820, 41828, 41872 and 41874 with the appropriate oral cavity designation code as required by the Minnesota Administrative Uniformity Committee (AUC).

Alveoloplasty services do not require a denial from Medicare before billing South Country. Use Physician's Current Procedural Terminology (CPT) procedure codes when billing complex oral surgery, including alveoloplasty.

Fluoride Varnish Application (FVA) in Primary Care Settings

Fluoride varnish application is required at all C&TC visits, starting at the eruption of the first tooth or no later than 12 months of age, and continuing through five (5) years of age. This can be done as often as four (4) times per 365 days in the clinic setting. South Country provides reimbursement for FVA during a C&TC visit on children from birth to 21 years of age. Providers must be qualified health care professionals or clinical staff who are trained and successfully completed an approved [FVA training](#) on oral screenings, fluoride varnish indications and application, and office implementation. Additional training resources are available through [Oral Health Initiative](#), a program of the American Academy of Pediatrics (AAP). AAP oral health training activities offer Continuing Medical Education (CME) credits.

Head start agencies, WIC programs and public health agencies may bill for FVA after fulfilling the training requirement above.

South Country covers fluoride varnish application for children in primary care settings from birth to age 21 for up to four times per 365 days. Qualified health care professionals and trained clinical staff must bill using the CPT code 99188. This code replaces HCPS Code D1206. You may bill FVA at three (3) to six (6)-month intervals.

Dental providers must bill using CDT code D1206 and may bill South Country once per six months.

Dental Procedures billed on an Institutional Claim

Dental providers must make a contractual arrangement with the hospital to be reimbursed for providing dental services. Bill medical services provided using an 837I claim. Report dental services using the appropriate CDT code. The 837I claim must be submitted to South Country's medical claims system as described above. An 837D claim may be submitted to Delta Dental for payment of services rendered using CDT procedure codes.

Non-Covered Services

The following services are not covered. Separate billing either to South Country or the member/enrollee for these services is prohibited. This is not an all-inclusive list.

- Barriers
- Disposable equipment/supplies
- Drapes
- Eye protection
- Fluoride trays or rinses
- Gauze or sterile packing
- Gloves
- Infection control procedures
- Needles
- Periodontal charting (separate from codes D0150 or D0180)
- Prescriptions dispensed in office

- Prosthetic cleaning
- Sterilization solutions/equipment
- Surgical supplies
- Suture material
- Syringes
- Treatment deemed to be cosmetic or for aesthetic reasons