

## National Coverage Provision

### Subject

*Dental Services*

### NCP Number

DENT-002

### Effective Date

\*10/01/2006

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### Indications and Limitations of Coverage

#### A. *Dentists*

*A dentist qualifies as a physician if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.*

#### B. *Inpatient Services in Connection With Dental Services*

*When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an inpatient at a participating hospital. In addition, hospital inpatient services which are necessary because of the patient's underlying medical condition and clinical status or the severity of a non-covered dental procedure, are covered.*

*When the hospital services are covered, all ancillary services such as x-rays, administration of anesthesia, use of the operating room, etc., are covered.*

*Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with non-covered dental services are not covered. The services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.*

C. *Dentures*

*Dentures are excluded from coverage. However, when a denture or a portion of the denture is an integral part (built-in) of a covered prosthesis (e.g., an obturator to fill an opening in the palate), it is covered as part of that prosthesis.*

D. *Dental Services*

*As indicated under the general exclusions from coverage, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.*

*If an otherwise non-covered procedure or service is performed by a dentist as incident to and as an integral part of a covered procedure or service performed by the dentist, the total service performed by the dentist on such an occasion is covered.*

*EXAMPLE 1*

*The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a non-covered procedure. However, when the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes), the totality of surgical procedures is a covered service.*

*EXAMPLE 2*

*Medicare makes payment for the wiring of teeth when this is done in connection with the reduction of a jaw fracture.*

*The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a non-covered procedure or service performed by a dentist must be an incident to and an integral part of a covered procedure or service performed by the dentist. Ordinarily, the dentist extracts the patient's teeth, but another physician, e.g., a radiologist, administers the radiation treatments.*

*When an excluded service is the primary procedure involved, it is not covered, regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. In a like manner, the removal of a torus palatinus (a bony protuberance of the hard palate) may be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, Medicare does not pay for this procedure.*

*Dental splints used to treat a dental condition are excluded from coverage under 1862(a)(12) of the Act. On the other hand, if the treatment is determined to be a covered medical condition (i.e., dislocated upper/lower jaw joints), then the splint can be covered.*

*Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.*

*Medicare makes payment for a covered dental procedure no matter where the service is performed. The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.*

*Payment may also be made for services and supplies furnished incident to covered dental services. For example, the services of a dental technician or nurse who is under the direct supervision of the dentist or physician are covered if the services are included in the dentist's or physician's bill.*

*E. Treatment of Temporomandibular Joint (TMJ) Syndrome*

*There are a wide variety of conditions that can be characterized as TMJ, and an equally wide variety of methods for treating these conditions. Many of the procedures fall within the Medicare program's statutory exclusion that prohibits payment for items and services that have not been demonstrated to be reasonable and necessary for the diagnosis and treatment of illness or injury (§1862(a)(1) of the Act). Other services and appliances used to treat TMJ fall within the Medicare program's statutory exclusion at 1862(a)(12), which prohibits payment "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth..." For these reasons, a diagnosis of TMJ on a claim is insufficient. The actual condition or symptom must be determined.*

*F. Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, Speech-Language Pathology Services) - Definitions*

*PHYSICIAN with respect to outpatient rehabilitation therapy services means a doctor of medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care.*

*G. Dental Services Exclusion*

*Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process. However, payment may be made for certain other services of a dentist.*

*The hospitalization or non-hospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.*

*When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. In like manner, the removal of the torus palatinus (a bony protuberance of the hard palate) could be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement is not made for this purpose.*

*The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a non-covered procedure or service performed by a dentist must be an incident to and an integral part of a covered procedure or service performed by the dentist. Ordinarily, the dentist extracts the patient's teeth, but another physician, e.g., a radiologist, administers the radiation treatments.*

*Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.*

#### **H. Dental Examination Prior to Kidney Transplantation**

*Despite the "dental services exclusion" in §1862(a)(12) of the Act, an oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery is a covered service. This is because the purpose of the examination is not for the care of the teeth or structures directly supporting the teeth. Rather, the examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but would also expose the patient to additional risks in undergoing such surgery.*

*Such a dental or oral examination would be covered under Part A of the program if performed by a dentist on the hospital's staff, or under Part B if performed by a physician. (When performing a dental or oral examination, a dentist is not recognized as a physician under §1861(r) of the Act.)*

### **Coverage Topic**

Dental Services

### **Coding Information**

#### **A. General Information**

The dental exclusion applies to any service, performed in any appropriate place of service by a dentist, physician or qualified NPP, that is defined as services performed for the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth (periodontium, gingivae, dentogingival junction peridontal membrane, cementum and alveolar process).

The dental and related services may be covered for the diagnosis, treatment and/or restoration of teeth and function as a result of facial, oral or neck injury/trauma or malignant tumor removal, effecting the above defined dental structures, and when performed at the same time as the trauma repair or tumor removal. In some cases due to the extent of the injury or tumor it may be necessary to perform these surgical procedures as "staged procedures".

In these situations the initial evaluation and treatment for the restoration of function may be covered. On-going maintenance of these restorations, especially of native oral structures incorporated into the restoration, may be considered routine dental care and is therefore not covered.

Facial/oral prostheses prescribed (L8040-L8049) or custom prepared (21076-21089) following these surgeries are generally considered covered. Dentures or partial dentures BUILT INTO the facial/oral prosthesis would be covered as part of that prosthesis. Subsequent repairs or replacements of these prostheses, including BUILT-IN dentures or partials may also be considered medically necessary.

Endosteal and subperiosteal implants (21245, 21246, 21248, 21249) are considered covered when used to enhance the structure of the jaws in order to support the facial/oral prostheses, as a result of repair or reconstruction due to oral carcinoma or trauma effecting the above defined dental structures.

The extraction of teeth would be covered to prepare the jaw prior to radiation treatment for neoplastic disease. Extractions of the teeth would also be covered as an included part of a facial/oral repair or reconstruction due to injury/trauma or malignant tumor involving the above defined dental structures.

The provision of a tooth guard to protect the teeth prior to radiation therapy may also be covered.

**B. Coding Guidelines**

1. Dental services should be reported with the CPT/HCPCS code, which best describes the service performed; include any necessary modifiers for the service.
2. The dental HCPCS “D” series codes are listed with an “N”, “R” or “I” status code. “N” status codes are non-covered by Medicare. “R” status code represents restricted coverage and the codes may be used to report services. “I” status codes are not valid for Medicare; therefore a CPT code with a matching description should be reported.
3. A consultation CPT code requires the referring physician’s name and UPIN. The referring physician’s name and UPIN should be shown in item 17 and 17a of the CMS 1500 form. This information would be placed in fields 20 and 22 on the electronic claim submission.
4. List the appropriate ICD-9 code that best supports the medical necessity for the service. ICD-9 codes must be present on all Physicians’ Service claims and must be coded to the highest degree of specificity and digit level completeness. (See Documentation Requirements)
5. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. dental care), report an ICD-9 code that best describes the patients condition (see **Non-Covered Diagnosis Codes**) and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit). A Notice of Exclusion from Medicare Benefits (NEMB) may be used with services excluded from Medicare benefits. See [www.cms.hhs.gov/BNI](http://www.cms.hhs.gov/BNI)
6. When reporting extraction of the teeth **prior** to radiation treatment for cancer of the head or neck, report ICD-9 code V07.9 (unspecified prophylactic measures) in the first position in item 21 of the CMS 1500 claim form or equivalent field for electronic submission. Place the cancer diagnosis in the second ICD-9 position.
7. Examinations prior to renal transplant should be coded as one of the following:
  1. Evaluation and Management (E&M) code (99231-99233); or
  2. Consultation code (99251-99255)(See Coding Guidelines); or
  3. D0150 if an E&M or consultation code is not appropriate.
8. List ICD-9 code V42.0 to indicate the examination is being done prior to kidney transplant surgery.
9. The oral examination would be submitted to Part A when performed by a dentist who is employed by the hospital.

10. Covered dental procedures and related service may be furnished by a dentist or a doctor of medicine or osteopathy or other non-physician practitioners acting within their scope of licenses and Medicare requirements.
11. Covered dental procedures and related services may be furnished in any HIPAA/Medicare defined place of service (POS), appropriate, for the procedure/services,

Oral/Facial Prosthetics

12. CPT codes 21076-21089 should be reported when the **physician** prepares the prosthetic impression and constructs the prosthesis. In these instances, the cost of the prosthesis is included in these specific CPT codes.
13. Level II HCPCS codes (L8040-L8049) should be reported when a prosthetist or outside lab constructs the prosthesis, the prosthetist/outside lab should bill the DMERC.
14. When a **physician** makes the prosthetic impression and a prosthetist or outside laboratory constructs the prosthesis, the physician bills using CPT code 21299 (unlisted craniofacial and maxillofacial procedure). Medical documentation containing a complete description of the services must be available or accompany the claim when this unlisted procedure code is used. The non-physician bills the DMERC using the appropriate HCPCS code.
15. Medicare will not make payment for the CPT surgical codes and the Level II HCPCS code when reported on the same claims. The physician and the prosthetist/outside lab must bill separately for the procedures they have performed.
16. The global surgery rules apply to dental surgery and preparation of custom prostheses.

**Coding Table Information**

**Procedure Code**

Any

**Covered Diagnosis Codes**

Malignant Neoplasm of Lip, Oral Cavity, Pharynx

140.0-149.8,

Malignant Neoplasm of Nasal Cavity, Sinuses, Larynx

160.0, 160.2-160.8, 161.0-161.9,

Malignant Neoplasm of Bones of Face, Mandible

170.0-170.1,

Carcinoma in Situ/Neoplasm of Uncertain Behavior of Lip, Oral Cavity, Pharynx

230.0 and 235.1,

Dentofacial Anomalies

524.00-524.12, 524.19

Dentofacial Functional Abnormalities

524.50-524.59

TMJ

524.60-524.64

Loss of Teeth-Trauma

525.11

Conditions of the Jaw

526.0, 526.2, 526.4, 528.9

Fracture of Facial Bones

802.20-802.9,

Open Wounds to the Face/Mouth, Complicated

873.53-873.59, 873.70-873.79,  
Crushing Injury Face, Neck  
925.1, 925.2  
Unspecified Prophylactic Measures  
V07.9  
Kidney Transplant  
V42.0

### **Non-Covered Diagnosis Codes**

#### Bruxism

306.8, 327.53

#### Disorders of tooth development

520.0-520.9,

#### Diseases of hard tissue of teeth

521.00-521.15, 521.20-521.25, 521.30-521.35, 521.40-521.42, 521.49, 521.6, 521.7, 521.81, 521.89, 521.9

#### Pulp and periapical tissues

522.0-522.9,

#### Gingivitis and periodontal disease

101, 523.00, 523.01, 523.10, 523.11, 523.20-523.25, 523.30-523.33, 523.40-523.42, 523.5, 523.6, 523.8, 523.9

#### Disorders of tooth position

524.20-524.4

#### Dental Alveolar conditions

524.70-524.76, 524.79, 524.81, 524.82,

#### Other diseases of teeth and supporting structures

525.0, 525.10, 525.12, 525.13, 525.19, 525.20-525.26, 525.3, 525.40-525.44, 525.50-525.54, 525.60-525.69, 525.8, 525.9,

#### Conditions of the Jaw

526.3, 526.5, 526.61-526.69, 526.81, \*526.89, 526.9, 528.71, 528.72

#### Fluoride administration

V07.31

#### Dental crown/filling

V45.84

#### Dental sealant

V49.82

#### Orthodontic device

V53.4

### **Other Information**

#### **Documentation Requirements**

1. Medical records should be legible, contain the relevant history, physical findings conforming to the criteria stated in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy and must be made available to the Carrier on request.
2. Surgical Procedures: Operative notes for surgical procedures performed in the office location may be contained in the patient's medical record for the date of service or as a separate report maintained within the patient's chart. The operative report for the procedure performed, in any location, must be of significant detail as to support the surgical procedure code reported.

3. Physicians' Services and diagnostic tests/x-rays must be submitted with an ICD-9 code to support medical necessity and must be coded to the greatest level of specificity and the highest level of digit completeness. This means the precise ICD-9 code that most fully explains the narrative diagnosis contained in the medical record or test interpretation/report including the 4<sup>th</sup> or 5<sup>th</sup> digit sub-classification for the diagnosis category. The ICD-9 code based on the results of the test should be the primary diagnosis. If the test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test/x-ray should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or injury a screening ICD-9 code should be reported, and payment will be denied.

### **Utilization Guidelines**

NA

### **Denial Summary**

The following situations will result in the denial of the initially billed dental and related services or in some cases as a result of a postpayment review.

1. Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Physicians' Services submitted without an ICD-9 code or not coded to the highest level of specificity will be denied as unprocessable.

2. *Anesthesia services provided by the surgeon performing the surgery is considered bundled into the payment for the surgical procedure. Since the payment is bundled, the physician is precluded from billing the beneficiary for this service.*
3. Title XVIII of the Social Security Act section 1862 (a)(12). This section excluded services in connection with the care of teeth or structures directly supporting the teeth

Program exclusion/routine services reported with the GY modifier will be denied as non-covered, the beneficiary is responsible for payment to the provider. The following situations represent Medicare excluded Dental procedures, items and related services:

- a. Routine dental care/examinations/procedures etc. performed on native teeth and their supportive structures following treatment for cancer.
- b. Services that are related to chronic dental disease are not covered and will be denied. Examples of this may include gingivectomy (41820), abscess (41800), etc.
- c. Excision of torus mandibularis (CPT 21031) or the excision of a maxillary torus palatinus (21032) is usually performed to prepare the mouth for dentures. These procedures are dental related and will be denied.
- d. The removal of a radicular cyst, in the mouth or supporting structures of the teeth is also non-covered (ICD-9 Codes 522.8).
- e. Dental appliances (such as dentures, partials, implants), the cost of preparing the mouth for dentures, and the cost of directly repairing the teeth and their supporting structures for retention of the dental appliance, are excluded from coverage.
- f. Osteal implants for cosmetic use or uses other than the retention of a prosthetic are also not covered.
- g. Anesthesia services for any non-covered dental service.
- h. Non-covered dental service (See Non-Covered Diagnosis Codes):
  - Diseases of hard tissue of teeth
  - Pulp and periapical tissues

- Gingivitis and periodontal disease
  - Disorders of tooth development
  - Disorders of tooth position
  - Complete/Partial edentulism
  - Following radiation treatment
  - When the extraction is a component of the tumor resection or trauma repair and is separately billed.
- i. Radiology services for routine dental care or screening are not covered.
  - j. An examination for complaints or symptoms of periodontal disease is excluded from coverage.
  - k. Visits or examinations in connection with the routine care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. Structures directly supporting the teeth include the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum and alveolar process.

**Source**

CMS Pub.100.1 Ch.5 §70.2; CMS Pub.100-2 Ch.1 §70, Ch.15 §§120C, 150-150.1, 220A, Ch.16 §140; CMS Pub.100-3 §260.6

**Notes**

This document replaces the Dental LCD.

[See associated article on Coding and Billing](#)

An asterisk (\*) indicates a revision to that section of the NCP.

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