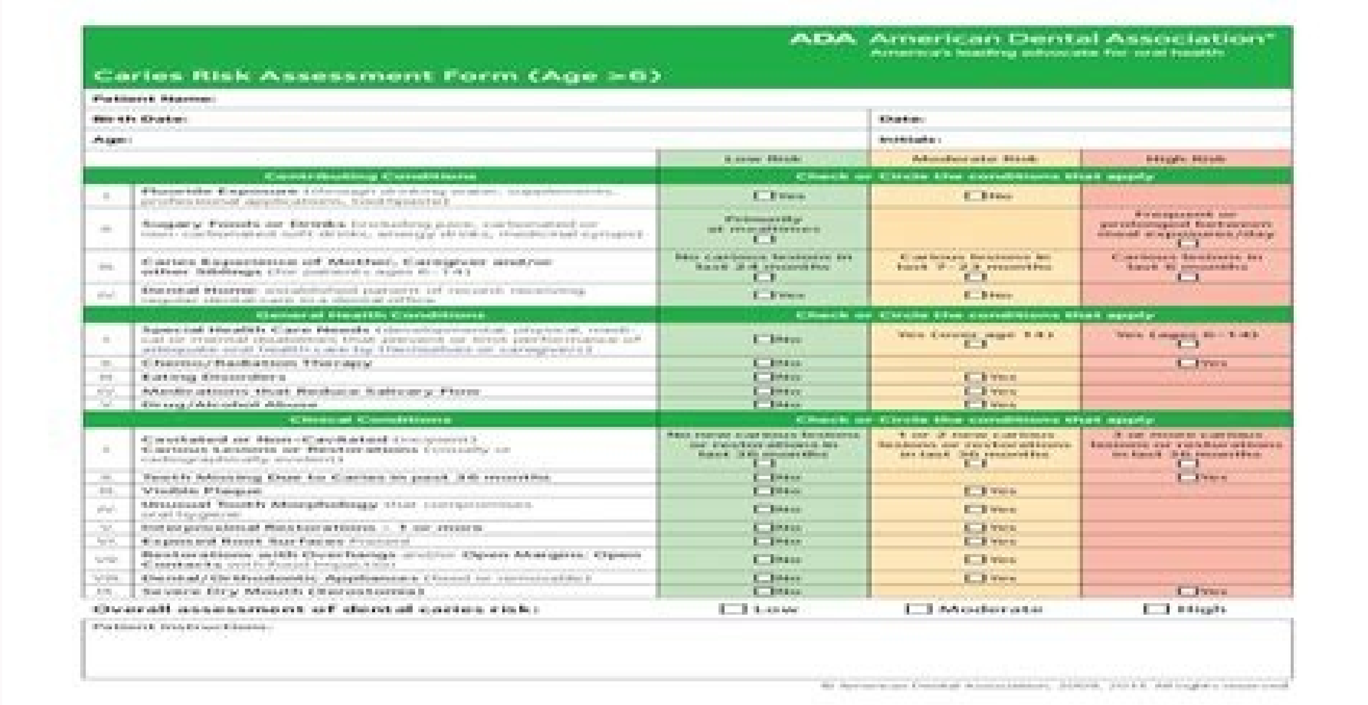
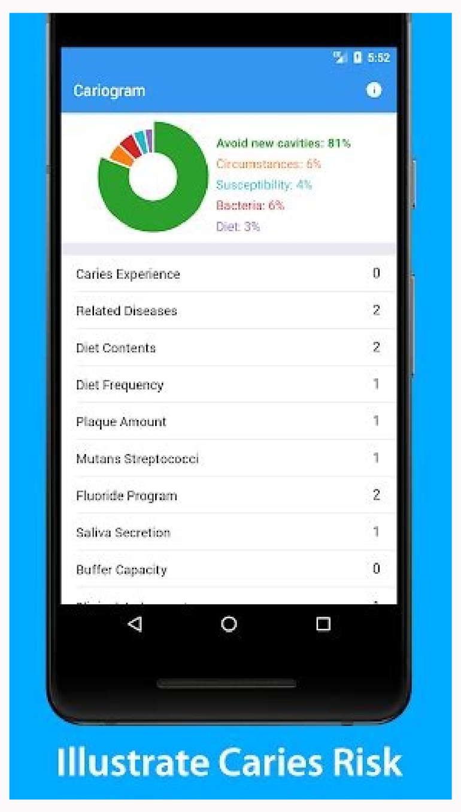
Caries risk assessment form tmhp





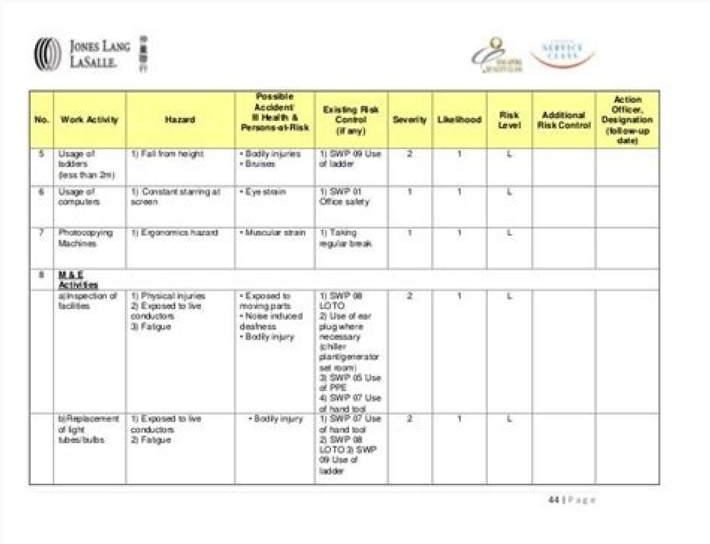
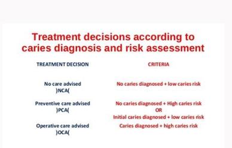


Table 3. Correlation between variables in the Cariogram® and overall caries risk.

	OVERALL CARIES RISK
DMFT index	0.519 ** (0.000)
DMFS index	0.416 ** (0.003)
Caries experience	0.659 ** (0.000)
Related diseases	-0.038 (0.795)
Diet content	0.164 (0.265)
Diet frequency	0.215 (0.143)
Lactobacillus spp count	0.231 (0.114)
Plaque quantity	0.279 (0.055)
Streptococcus mutans count	0.723 ** (0.000)
Plaque index	0.316 * (0.028)
Fluoridation programme	0.298 * (0.040)
Salivary secretion	-0.201 (0.170)
Buffer capacity of saliva	0.303 * (0.037)

Pearson correlation coefficient **: significance level <0.01
*: significance level <0.05



Dental 14.1Enrollment To enroll in the CSHCN Services Program, dental providers must be actively enrolled in Texas Medicaid, maintain an active license status with the Texas State Board of Dental Examiners (TSBDE) (see Title 22 Texas Administrative Code (TAC), §§110.1–110.18), have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state dental providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border. To be eligible to receive reimbursement for dental anesthesia providers must have the following information on file with TMHP: •Current anesthesia permit level issued by the TSBDE (applies to all dental providers) •Proof of an anesthesiology residency recognized by the American Dental Board of Anesthesiology (required to be reimbursed at the enhanced rate for procedure codes D9222 and D9223), if applicable Important:CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid. By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in 26 TAC, but also with knowledge of the adopted Medicaid agency rules published in 1 TAC §§351.1–351.883 and specifically including the fraud and abuse provisions contained in 1 TAC §§371.1–371.1719. CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid. Refer to: Section 2.1, “Provider Enrollment” in Chapter 2, “Provider Enrollment and Responsibilities” for more detailed information about CSHCN Services Program provider enrollment procedures. 14.2Benefits, Limitations, and Authorization Requirements Diagnostic, therapeutic, and preventive dental services are a benefit of the CSHCN Services Program. Orthodontic services, medically necessary dental rehabilitation and restoration services, care of dental emergencies, and medically necessary services provided by doctors of dental surgery (DDS) or doctors of dental medicine (DMD) including, but not limited to, cleft-craniofacial surgery are also a benefit of the CSHCN Services Program. 14.2.1Prior Authorization Requirements Prior authorization is required for all orthodontia services and selected dental services. All requests for prior authorization must be submitted using the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. The TMHP-CSHCN Services Program may require the submission of X-rays, models, etc., for specific prior-authorized services. All prior authorization requests must include specific rationale for the requested service, including documentation of medical necessity and appropriateness of the recommended treatment. Additional documentation, including current periapical radiographs, must be maintained in the client’s medical or dental record and submitted to the CSHCN Services Program on request. Authorization and prior authorization request forms submitted to TMHP must be signed and dated by the dental provider treating the client. If indicated on the form, an authorized representative’s signature is acceptable. All signatures and dates must be current. Stamped signatures are not permitted. Alterations to dates and signatures, such as cross-outs or white-outs, are not allowed. Submitted forms without an original hand-written signature and date will be rejected. Providers must keep the original, signed forms in the client’s medical record as documentation. Important:Refer to each individual section under Benefits and Limitations for specific information about prior authorization requirements. Refer to: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. Tip: Photocopy this form and retain the original for future use. Note:Fax transmittal confirmations are not accepted as proof of timely prior authorization submission. 14.2.2Substitute Dentist The following are conditions for reimbursement of services rendered by a substitute dentist: •Dentists who take a leave of absence for no more than 90 days may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. A locum tenens arrangement is not allowed for dentists. •This arrangement will be limited to no more than 90 consecutive days. Under this temporary basis, the primary dentist (who is the billing agent dentist) may not submit a claim for services furnished by a substitute dentist to address long-term vacancies in a dental practice. The billing agent dentist may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces. CSHCN accept claims from the billing agent dentist for services provided by the substitute dentist for the duration of the billing agent dentist’s active duty as a member of a reserve component of the Armed Forces. •Providers billing for services provided by a substitute dentist must bill with modifier U5 in Block 19 of the American Dental Association (ADA) claim form. •The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by CSHCN. •The billing agent dentist must bill substitute dentist services on a different claim form from his or her own services. The billing agent dentist services cannot be billed on the same claim form as substitute dentist services. •The substitute dentist must be licensed to practice in the state of Texas, must be enrolled in Texas Medicaid before enrolling in the CSHCN Services Program and must not be on the Texas Medicaid provider exclusion list. •The dentist who is temporarily absent from the practice must be indicated on the claim as the billing agent dentist, and his or her name, address, and National Provider Identifier (NPI) must appear in Blocks 53, 54, and 56 of the ADA claim form. •The substitute dentist’s NPI number must be documented in Block 35 of the ADA claim form. Electronic submissions do not require a provider signature. Dentists must familiarize themselves with these requirements and document accordingly. Those services not supported by the required documentation, as detailed above, will be subject to recoupment. Note:Dental services must be filed on the ADA claim form. 14.2.3Diagnostic Services The CSHCN Services Program may reimburse the following diagnostic dental services for CSHCN Services Program eligible clients: •Clinical oral evaluations •Radiographs or diagnostic imaging •Tests or examinations, including oral pathology procedures Based on the American Academy of Pediatric Dentistry’s (AAPD) definition of a dental home, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that is inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, compassionate, culturally competent, and family-centered way. Establishment of a client’s dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate. In providing a dental home for a client, the dentist enhances the ability to assist children and their parents in the quest for optimum oral health care. A First Dental Home (FDH) visit can be initiated as early as 6 months of age and is billed using procedure code D0145. The FDH visit includes, but is not limited to: •Oral examination. •Oral hygiene instruction. •Dental prophylaxis, if appropriate. •Topical fluoride application using fluoride varnish, if appropriate. •Caries risk assessment. •Dental anticipatory guidance. Diagnostic services should be performed for all clients, preferably starting within the first 6 months of the eruption of the first primary tooth, but no later than 1 year of age. Dental home providers should record the oral and physical health history, perform a caries assessment, develop an appropriate preventive oral health regimen, and communicate with and counsel the client’s parent, legal guardian, or primary caregiver. Caries susceptibility tests (procedure code D0425) are used to analyze the acidic level of the oral cavity using acid or alkali sensitive materials to ascertain the client’s likelihood of developing caries. Caries susceptibility tests are considered part of all other dental procedures and are not separately reimbursed. Requesting providers must retain in the client’s medical record all documentation to support the diagnosis and treatment of trauma. 14.2.3.1Prior Authorization Requirements Prior authorization is required for cone-beam imaging (procedure code D0367) and for diagnostic services not adequately described by more specific procedure codes where an unspecified procedure code (D0999) is necessary. To obtain prior authorization, a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted along with documentation supporting medical necessity and appropriateness. Documentation required includes, but is not limited to: •Presenting condition(s). •Medical necessity. •The status of the client’s treatment. Prior authorization is not required for any other diagnostic service. Refer to: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. Section 14.2.3.3, “Cone-Beam Imaging” in this chapter. 14.2.3.2Clinical Oral Evaluations Documentation supporting medical necessity for procedure codes D0140, D0160, D0170, and D0180 must be maintained by the provider in the client’s medical record and must include: •The client complaint supporting medical necessity for the examination. •The area of the mouth that was examined or the tooth involved. •A description of what was done during the treatment. •Supporting documentation of medical necessity, including, but not limited to, radiographs or photographs. The following clinical oral evaluation procedure codes may be considered for reimbursement: Procedure Code Comments and Limitations D0120 •Used for periodic and comprehensive oral evaluations •Limited to once every 6 months by the same provider •Procedure code D8660 will deny when billed for the same date of service by the same provider •Age limitation = NA D0140 •Used only for the initial emergency examination of a specific tooth or area of the mouth •Limited to once per day by the same provider and twice per day for any provider •Provider must document the medical necessity and the specific tooth or area of the mouth on the claim •Denied when billed with procedure code D0160 for the same date of service by the same provider •May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period •Age limitation = NA D0145 •Age limitation = 6 months through 35 months of age D0150 •Used for a comprehensive oral evaluation; limited to one service every three years by the same provider; procedure code D8660 will deny when billed for the same date of service by the same provider •Age limitation = NA D0160 •Used for a problem-focused, detailed, and extensive oral evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim •May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period •Limited to once per day by the same provider •Age limitation = 1 year of age or older D0170 •Used as a follow up to a problem-focused evaluation; provider must document the medical necessity and the specific tooth or area of the mouth on the claim •Denied when billed with procedure code D0140 or D0160 on the same date of service by the same provider •Limited to once per day by any provider •Age limitation = NA D0180 •Used for extensive periodontal evaluation of pain or problems •Denied when billed on the same date of service as procedure code D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider •May be paid in addition to a comprehensive oral examination (procedure code D0150) or a periodic oral examination (procedure code D0120) when billed within a 6-month period •Age limitation = 13 years of age or older A caries risk assessment procedure code (D0601, D0602, or D0603) will be required on the same claim, for the same date of service, by the same provider when dental examination procedure code D0120, D0145, or D0150 is submitted for reimbursement. The client’s dental condition(s) that justifies the risk assessment classification submitted with the claim must be clearly documented and maintained by the provider in the client’s medical record. Professionally developed caries risk assessment tools are available at: •American Dental Association (ADA) •American Academy of Pediatric Dentistry (AAPD) •Department of State Health Services (DSHS), Oral Health Program 14.2.3.3Cone-Beam Imaging Cone-beam imaging is used to determine the best course of treatment for cleft palate repair, skeletal anomalies, post-trauma, implanted or fixed prosthodontics, and orthodontic or orthognathic procedures. Cone-beam imaging is limited to initial treatment planning, surgery, and post-surgical follow-up. Procedure code D0367 must be prior authorized by the TMHP Dental Director. Procedure code D0367 is limited to a combined maximum of three services per calendar year. Additional services may be considered by the TMHP Dental Director with documentation of medical necessity. 14.2.3.4First Dental Home Based on the American Academy of Pediatric Dentistry’s definition, the CSHCN Services Program defines a dental home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. In providing a dental home for a client, the dental provider enhances the ability to assist clients and their parents in obtaining optimum oral health care. The first dental home visit can be initiated as early as 6 months of age and must include, but is not limited to, the following: •Comprehensive oral examination •Oral hygiene instruction with primary caregiver •Dental prophylaxis, if appropriate •Topical fluoride varnish application when teeth are present •Caries risk assessment •Dental anticipatory guidance The dental home provider must keep supporting documentation for procedure code D0145 in the client’s medical record. The supporting documentation must include, but is not limited to, the following: •Oral and physical health history review •Dental history review •Primary caregiver’s oral health •Oral evaluation •An appropriate preventive oral health regimen •Caries risk assessment •Dental prophylaxis, which may include a toothbrush prophylaxis •Oral hygiene instruction with parent or caregiver •Anticipatory guidance communicated to the client’s parent, legal guardian, or primary caregiver, to include the following: •Oral health and home care •Oral health of primary caregiver or other family members •Development of mouth and teeth •Oral habits •Diet, nutrition, and food choices •Fluoride needs •Injury prevention •Medications and oral health •Fluoride varnish application •Any referrals, including dental specialist’s name Procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, and D8660 will be denied when billed on the same date of service, for any provider as D0145. A First Dental Home examination is limited to ten services per client lifetime with at least 60 days between visits by any provider. Reimbursement for procedure code D0145 is limited to dentists certified by the Texas Department of State Health Services (DSHS). Providers can complete a free continuing education course online or attend classroom training to be certified to provide First Dental Home services. For information about training, refer to the Department of State Health Services (DSHS) Oral Health Program web page at hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/dental-providers/first-dental-home. 14.2.3.5Radiographs or Diagnostic Imaging The number of radiograph films required for a complete intraoral series is dependent on the age of the client. An intraoral series requires at least eight films. Adults and children older than 12 years of age require 12 to 20 films to be considered an intraoral series. A panoramic radiographic image (procedure code D0330) plus a minimum of four bitewing radiographic images (procedure code D0274) may be considered equivalent to a complete intraoral series including radiographic images (procedure code D0210). Supporting documentation must be kept in the client’s dental record when medical necessity is not evident on radiographs. The following radiographs or diagnostic imaging procedure codes may be considered for reimbursement: Procedure Code Limitations D0210 •Limited to one service every three years by the same provider •Denied when submitted on an emergency claim •Age limitation = 2 years or older D0220 •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0230 •Age limitation = 1 year of age or older D0240 •Limited to two per day by the same provider •Age limitation = NA D0250 •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0270 •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0272 •Denied when billed with procedure code D0210 same day, by the same provider •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0273 •Denied when billed with procedure code D0210 same day, by the same provider •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0274 •Denied when billed with procedure code D0210 same day, by the same provider •Limited to one per day by the same provider •Age limitation = 2 years of age or older D0277 •Denied when billed with procedure code D0210 same day, by the same provider •Denied when billed with procedure code D0330 same day, by the same provider •Limited to one per day by the same provider •Age limitation = 2 years of age or older D0310 •Age limitation = 1 year of age or older D0320 •Age limitation = 1 year of age or older D0321 •Age limitation = 1 year of age or older D0322 •Age limitation = 1 year of age or older D0330 •Limited to one per day by any provider •Limited to one service every 3 years by the same provider •Age limitation = 3 years of age or older D0340 •Denied when billed with procedure code D8080 •Limited to one per day by the same provider •Age limitation = 1 year of age or older D0350 •Must be used when billing for photographs •Accepted only when diagnostic quality radiographs cannot be taken •Documentation of medical necessity must be submitted with the claim •Limited to one per day by the same provider •Age limitation = NA D0367 •Age limitation = NA 14.2.3.6Tests and Oral Pathology Procedures The following procedure codes may be considered for reimbursement and are limited to clients who are 1 year of age or older: Procedure Codes D0415 D0460 D0470 D0502 Procedure code D0460: •Includes multiple teeth and contralateral comparisons based on medical necessity. •Is considered part of any endodontic procedure and is not separately reimbursed when billed on the same date of service as any endodontic procedure. •Is not payable when billed for primary teeth. •Is limited to one service per day by the same provider. Refer to: Section 14.2.6, “Therapeutic Services” in this chapter for additional information about endodontic procedures. When billing for diagnostic procedures not adequately described by other procedure codes, providers should use procedure code D0999. Only one emergency or trauma claim per client, per day may be submitted. Separate services may be submitted for the same client on the same date of service, one for emergency or trauma and one for nonemergency or routine care. When billing electronically for emergency or trauma-related dental services, use the ET modifier to indicate emergency. 14.2.4Orthodontia Services Orthodontia services are benefits of the CSHCN Services Program for clients with prior authorization and an appropriate diagnosis code that indicates cleft lip, cleft palate, congenital anomalies of skull and face bones, dentofacial functional abnormalaties, or major anomalies of jaw size. Orthodontia for cosmetic purposes only is not a benefit of the CSHCN Services Program. All removable or fixed orthodontic appliances must be billed with procedure codes D8210 or D8220. 14.2.4.1Prior Authorization Requirements Prior authorization is required for all orthodontic services except for the initial orthodontic visit. Prior authorization is only approved for a complete orthodontic treatment plan, and all active orthodontic treatments must be completed within 36 months. Prior authorization is not transferable to another dentist. The new provider must request prior authorization to complete the orthodontic treatment initiated by the previous provider. Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) require prior authorization and the time frame may be considered for extension not to exceed 36 months of actual treatment. Refer to: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. 14.2.4.2Required Documentation To obtain prior authorization, the provider must submit the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. The following documentation must accompany the form, and must include the date of service the documentation was obtained: •A complete orthodontia treatment plan including all the procedures required to complete full treatment such as: •Extractions •Orthognathic surgery •Upper and lower appliances •Monthly adjustments •Appliance removal (if needed) •Special appliances •All diagnostic models •A cephalometric radiograph with tracing •Facial photographs •A full series or radiographs or a panoramic radiograph Note:Diagnostic models, radiographs, and any other paper diagnostic tools submitted to TMHP will be returned to the submitting provider. Requests submitted with damaged diagnostic models will be returned to the provider as an incomplete request. A prior authorization request for orthodontia services must include one of the following indications: •Cleft lip •Cleft palate •Congenital anomalies of skull and face bones •Dentofacial functional abnormalities •Major anomalies of jaw size A prior authorization request for comprehensive orthodontic treatment or crossbite therapy submitted without the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form, diagnostic model, radiographs (X-rays), and any other necessary supporting documentation will not be considered and will be returned to the provider as incomplete. The following information must be provided in the case of a transfer of care from one provider to another: •A request for prior authorization as outlined above •Explanation of why the client left the previous provider •Explanation of the client’s treatment status 14.2.4.3Submitting Local Codes for Orthodontic Procedures To ensure appropriate claims processing, the local code reflecting the specific service is required on the claim. For electronic submissions other than TexMedConnect submissions, providers must follow the steps below to ensure the correct local code is accurately applied to the appropriate claim detail: 1)Submit the DPC prefix in the first three bytes of NTE02 at the 2400 loop. Submit the DPC prefix only once. 2)Submit the remark code (local code) in bytes 4–8, based on the order of the claim detail. Do not enter any spaces or punctuation between remark codes, unless to designate that the detail is not billed with D8210 or D8220. Example:For a claim with three details, where details 1 and 3 are submitted with procedure code W-D8210 and detail 2 is not, enter the following information in the NTE02 at the 2400 loop: DPC1014D 1046D(The space shows that detail 2 needs no local code.) Example:If all three details require a local code, enter DPC and the appropriate local codes in sequence without any spaces between the codes: DPC1024D1055D1056D(The absence of spaces indicates that local codes are needed for all three details.) To submit using TexMedConnect, enter the local code into the Remarks Code field, located under the Details header. The Remarks Code field is the field following the Procedure Code field. TexMedConnect submitters are not required to enter the DPC prefix, because it is automatically placed in the appropriate field on the TexMedConnect electronic claim. For paper claim submissions, providers must enter the local code in the Remarks section of the claim form. Failure to follow the above steps does not cause the claim to deny; however, manual intervention is required to process the claim and a delay of payment may be the result. Orthodontic procedure codes that were local codes used for prior authorization and reimbursement have been converted to Current Dental Terminology (CDT) (national) procedure codes. The following procedures are not included in comprehensive treatment: CDT Procedure Code Remarks Code Description D8660 Z2009 Initial orthodontic visit D8670 Z2013 Orthodontic adjustments, per month D7997* Z2016 Premature appliance removal, per arch Only one retainer per arch per lifetime (procedure code D8680) is allowed. The delivery of a retainer includes any visits for retainer adjustments. Retainer adjustments are not reimbursed separately. Procedure code D8080 is a comprehensive code and includes a diagnostic workup as well as all upper and lower orthodontic appliances (braces) necessary to treat the client. CDT Procedure Code Remarks Code Description D8080 Z2009 or Z2011 or Z2012 Diagnostic workup, approved or Orthodontic appliance, upper (braces) or Orthodontic appliance, lower (braces) When a diagnostic workup is not approved, individual components may be considered for separate reimbursement. Use the following procedure codes: CDT Procedure Code Remarks Code Description D0330 Z2010 Diagnostic workup, not approved D0340 D0350 D0470 Diagnostic

model (procedure code D0470) are included in procedure codes (D8010 or D8020). The orthodontic diagnostic work-up procedures are considered inclusive to procedure codes D8010 or D8020 and are not reimbursed separately. Panoramic radiographic images (procedure code D0330), cephalometric radiographic images (procedure code D0340), oral/facial photographic images obtained intraorally or extraorally (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when billed with any one of the following procedure codes: D8010 or D8020. Procedure code D8680 includes all retainers necessary to treat the client. Use the following remarks codes according to the services provided: Remarks Code Description 1033D Mandibular, fixed, 2x4 retainer 1034D Mandibular, fixed, 3x3 retainer 1035D Mandibular, fixed, 4x4 retainer Z2014 Orthodontic retainer, upper Z2015 Orthodontic retainer, lower Procedure code D8010 includes a crossbite workup and removable appliance. Use the following remarks codes according to the services provided: Remarks Code Description 8110D Crossbite therapy, removable appliance Z2018 Crossbite, workup Procedure code D8020 includes a crossbite workup and the fixed appliance. Use the following remarks codes according to the services provided: Remarks Code Description 8120D Crossbite therapy, fixed appliance Z2018 Crossbite, workup The orthodontic diagnostic work up procedures are considered inclusive procedures. Procedure codes D0330, D0340, D0350, and D0470 are denied when billed with a diagnostic work up procedure. The following tables display the special fixed and removable orthodontic appliances. Under the current provisions of the Health Insurance Portability and Accountability Act (HIPAA), all fixed appliances are designated as procedure code D8220, and all removable appliances are designated as procedure code D8210. These are entered as a line item on the paper American Dental Association (ADA) Dental Claim Form with the appropriate fee. However, the remarks codes (former local procedure codes), as appropriate and listed below, also need to be entered on the authorization request form and in the Remarks field of the dental claim form (paper and electronic) to ensure correct authorization, accurate records, and reimbursement. Failure to bill the correct procedure codes may result in claim processing delays. Note:Prior authorization must be requested using both the CDT procedure code and the remarks codes for orthodontia services. Use the following remarks codes in the Remarks field for fixed appliances (procedure code D8220): Remarks Code Fixed Appliances Description 1000D Appliance for horizontal projections 1001D Appliance for recurved springs 1002D Arch wires for crossbite correction, for total treatment 1003D Banded maxillary expansion appliance 1008D Bonded expansion device 1012D Crib 1015D Distalizing appliance with springs 1016D Expansion device 1018D Fixed expansion device 1019D Fixed lingual arch 1020D Fixed mandibular holding arch 1021D Fixed rapid palatal expander 1025D Herbst appliance, fixed or removable 1026D Interocclusal cast cap surgical splints 1028D Jasper jumpers 1029D Lingual appliance with hooks 1030D Mandibular anterior bridge 1031D Mandibular bihelix, similar to a quad helix for mandibular expansion to attempt nonextraction treatment 1036D Mandibular lingual, 6x6, arch wire 1042D Maxillary lingual arch with spurs 1043D Maxillary and mandibular distalizing appliance 1044D Maxillary quad helix with finger springs 1045D Maxillary and mandibular retainer with pontics 1049D Modified quad helix appliance 1050D Modified quad helix appliance, with appliance 1051D Nance stent 1052D Nasal stent 1057D Palatal bar 1058D Post surgical retainer 1059D Quad helix appliance held with transpalatal arch horizontal projections 1060D Quad helix maintainer 1061D Rapid palatal expander (RPE), i.e., quad helix, haas, or menne 1068D Stapled palatal expansion appliance 1072D Thumb sucking appliance, requires submission of models 1076D Transpalatal arch 1077D Two bands with transpalatal arch and horizontal projections forward 1078D W-appliance Use the following remarks codes in the Remarks field for removable appliances (procedure code D8210): Remarks Code Removable Appliances Description 1004D Bite plate/bite plane 1005D Bionator 1006D Bite block 1007D Bite plate with push springs 1010D Chateau appliance (face mask, palatal expander, and hawley) 1011D Coffin spring appliance 1013D Dental obturator, definitive (obturator) 1014D Dental obturator, surgical (obturator, surgical stayplate, immediate temporary obturator) 1017D Face mask (protraction mask) 1022D Frankel appliance 1023D Functional appliance for reduction of anterior open bite and crossbite 1024D Head gear (face bow) 1027D Intrusion arch 1032D Mandibular lip bumper 1037D Mandibular removable expander with bite plane (crozat) 1038D Mandibular ricketts rest position splint 1039D Mandibular splint 1040D Maxillary anterior bridge 1041D Maxillary bite-opening appliance with anterior springs 1046D Maxillary Schwarz 1047D Maxillary splint 1048D Mobile intraoral arch (MIA), similar to a bihelix for nonextraction treatment 1053D Occlusal orthotic device 1054D Orthopedic appliance 1055D Other mandibular utilities 1056D Other maxillary utilities 1062D Removable bite plane 1063D Removable mandibular retainer 1064D Removable maxillary retainer 1065D Removable prosthesis 1066D Sagittal appliance, 2-way 1067D Sagittal appliance, 3-way 1069D Surgical arch wires 1070D Surgical splints (surgical stent/wafer) 1071D Surgical stabilizing appliance 1073D Tongue thrust appliance, requires submission of models 1074D Tooth positioner, full maxillary and mandibular 1075D Tooth positioner with arch The following procedure codes are used to bill orthodontic services: ADA Procedure Codes D5951 D5952 D5953 D5954 D5955 D5958 D5959 D5960 D7280 D7997 D8010 D8020 D8080 D8210 D8220 D8660 D8670 D8680 D8999 The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims. 14.2.5Preventive Services The following dental preventive services are benefits of the CSHCN Services Program: •Oral hygiene instruction •Dental prophylaxis and topical fluoride treatment •Dental sealants •Space maintainers, including recementation and removal 14.2.5.1Authorization Requirements Authorization or prior authorization is not required for preventive dental services. 14.2.5.2Oral Hygiene Instruction Procedure code D1330 may be considered for reimbursement for clients who are 1 year of age or older when the services are above and beyond the routine brushing and flossing instructions included in the prophylaxis procedure codes and when additional time and expertise is directed toward the client's care. Procedure code D1330 is limited to once per year by any provider and is denied when billed on the same day as procedure codes D1110, D1120, D1206, or D1208 by any provider. Procedure code D1330 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims. 14.2.5.3Dental Prophylaxis and Topical Fluoride Treatment When performing fluoride treatments, procedure code D1120 and D1208 or procedure code D1110 and D1208 must be billed on the same date of service. Procedure codes D1110 and D1120 include oral health instructions, and are limited to one prophylaxis per 6 calendar months, by any provider. Procedure codes D1110 and D1120 will be denied when submitted on an emergency claim. The following procedure codes may be considered for reimbursement but are not payable on the same date of service as any D4000 series (periodontal) procedure codes: Procedure Code Age Limitation D1110 13 years of age or older D1120 6 months through 12 years of age D1206 NA D1208 NA The procedure codes in the table above are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims. 14.2.5.4Dental Sealants Dental sealants may be considered for reimbursement when applied to the deciduous (baby or primary) teeth or permanent teeth for clients who are 1 year of age or older. Dental sealants may be applied by a dentist or dental hygienist. Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth. The tooth must be at risk for dental decay and be free of proximal caries and restorations on the surface to be sealed. Each tooth must be billed separately using procedure code D1351. Reimbursement is on a per tooth basis, regardless of the number of surfaces sealed. Tooth numbers and surfaces must be indicated on the claim form. Dental sealants and replacement sealants are limited to one every 3 years, per tooth, for the same provider. Procedure code D1351 is not payable on the same date of service as any of D4000 series (periodontal) procedure codes. During claims processing or retrospective review, if the claim, narrative, documentation, or charting by a provider includes language, terms, or acronyms indicating a preventative resin was applied, the procedure will be reimbursed as a dental sealant, not as a restorative procedure. Procedure code D1351 is not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims. Procedure code D1352 may be reimbursed for posterior permanent teeth only to clients who are 5 years of age or older. Procedure code D1352 will be denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior to procedure code D1352. 14.2.5.5Space Maintainers One space maintainer per tooth ID may be reimbursed per lifetime, per client. Replacement space maintainers may be considered on appeal with documentation supporting medical or dental necessity. Space maintainers may be reimbursed with procedure codes D1510, D1516, D1517, D1520, D1526, D1527, and D1575. Procedure codes D1551, D1552, D1553, D1556, D1557, and D1558 may be reimbursed to clients who are 1 through 20 years of age. Removal of a space maintainer (procedure code D1556, D1557, or D1558) is not payable to the provider or dental group practice that originally placed the device. Procedure codes D1553 and D1556 are limited to once per quadrant, per day, same provider. When procedure codes D1510, D1516, or D1517 have been previously reimbursed, the recementation of space maintainers may be considered for reimbursement to either the same or a different CSHCN Services Program dental provider when billed with procedure codes D1551, D1552, or D1553. Procedure codes D1510, D1516, D1517, D1520, D1526, and D1527 may be reimbursed for clients who are 1 year of age or older. These procedure codes are not reimbursed to orthodontists or oral maxillofacial surgeons. These providers may be reimbursed by the CSHCN Services Program as a dentist or dentistry group provider type by using the appropriate provider identifier when billing claims. Space maintainers are designed to prevent tooth movement and are a benefit in the following situations: •After premature loss of a deciduous (primary) tooth, first or second molars (tooth identification) (TID): A, B, I, and J for clients who are 1 through 12 years of age. •After premature loss of deciduous (primary) tooth, first or second molars (tooth identification) (TID): K, L, S, and T for clients who are 1 through 12 years of age. •After loss of a permanent first molar (TID: 3 and 14) for clients who are 3 years of age or older. •After loss of a permanent first molar (TID: 19 and 30) or clients who are 3 years of age or older. •After premature loss of a deciduous (primary) second molar (TID: A, J, K, and T) for clients who are 3 through 7 years of age billed with (procedure code D1575). Space maintainers submitted with procedure code D1575 are limited to one per tooth ID, per client. 14.2.5.6Noncovered Counseling Services 14.2.5.6.1Dental Nutrition Counseling Procedure code D1310 is not a benefit of the CSHCN Services Program as a separate procedure. Dental nutrition counseling is included as part of all preventive, therapeutic, and diagnostic dental procedures. A client requiring more involved nutrition counseling may be referred to their primary care physician. The provider can refer the client to a CSHCN Services Program-enrolled licensed dietitian for further nutrition counseling. 14.2.5.6.2Tobacco Counseling Procedure code D1320 is not a benefit of the CSHCN Services Program as a separate procedure. Tobacco counseling may be reimbursed as a part of all preventive, therapeutic, and diagnostic dental procedures. 14.2.6Therapeutic Services The following therapeutic dental services are benefits of the CSHCN Services Program: •Restorations •Endodontics •Periodontics •Prosthodontics, both fixed and removable •Maxillofacial prosthetics •Implants •Oral and maxillofacial surgery •Adjunctive general services, including, but not limited to: •Dental anesthesia •Dental hospital call •Desensitizing medicaments •Dental behavior management •Internal bleaching of discolored tooth •Occlusal adjustments 14.2.6.1Prior Authorization Requirements Prior authorization requirements for specific procedures are contained within each section below. Prior authorization for therapeutic services is valid up to 90 days (this does not apply to orthodontic services). To obtain prior authorization, the following must be submitted: •The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form •Provider documentation supporting the medical necessity and appropriateness of the recommended treatment Each distinct dental procedure code to be performed that requires prior authorization must be listed on the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. Repetitive dental procedure codes must be listed to indicate the total quantity to be performed. Additional documentation, including current periapical radiographs, must be maintained in the client's medical record and submitted to the CSHCN Services Program on request. Refer to: Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. 14.2.6.2Anesthesia Requirements for Clients who are Six Years of Age or Younger For clients who are six years of age or younger, the following will apply: •All Level 4 sedation/general anesthesia services provided by a dentist (procedure codes D9222 and D9223), and any anesthesia services provided by an anesthesiologist (M.D./D.O.) or certified registered nurse anesthetist (CRNA) (procedure code 00170 with modifier U3) provided in conjunction with dental therapeutic services must be prior authorized. •The dentist performing the therapeutic dental procedure is responsible for obtaining prior authorization and is also responsible for providing the anesthesia prior authorization information to the anesthesiology provider. •The current process of scoring 22 points on the Criteria for Dental Therapy Under General Anesthesia form does not guarantee authorization or reimbursement for clients who are six years of age and younger. Procedure code 00170 with modifier U3, and procedure codes D9222 and D9223 is limited to once per six calendar months by any provider. Requests for prior authorization must include, but is not limited to, the following client-specific documents and information: •A completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form •A completed CSHCN Services Program Prior Authorization Request for Dental of Orthodontia Services form •The location of where the procedure(s) will be performed (office, inpatient hospital, or outpatient hospital) •Name of the group providing the Level 4 anesthesia services •A narrative unique to the client, detailing the reasons for the proposed level of sedation (indicate procedure code D9222, D9223, or 00170 with modifier U3). The narrative must include a history of prior treatment, information about failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and any relevant medical condition(s). •Diagnostic quality radiographs or photographs •When appropriate radiographs or photographs cannot be taken prior to general anesthesia. The narrative must support the reasons for an inability to perform diagnostic services. For special cases that receive authorization, diagnostic quality radiographs or photographs will be required for payment and will be reviewed by the TMHP dental director. Note:In cases of an emergency medical condition, accident, or trauma, prior authorization is not necessary. However, a narrative and appropriate pre- and post-treatment radiographs or photographs must be submitted with the claim, which will be reviewed by the TMHP dental director. 14.2.6.3Interrupted Treatment Plan Prior authorization for an incomplete treatment plan is not transferable to the new provider. The new provider must obtain prior authorization to complete the treatment plan initiated by the original provider. 14.2.6.4Restorations Restorations do not require prior authorization except for onlays and crowns. Procedure code D2999 requires prior authorization. Consideration of restoration reimbursement is contingent on compliance with the following limitations: •Restorations on primary teeth and permanent posterior teeth may be reimbursed on the basis of the surface or surfaces restored and are paid as a total maximum fee per tooth. •More than one restoration on a single surface is considered a single restoration. A multiple surface restoration cannot be billed as two or more separate one-surface restorations. •The restorations must show definite crossing of the plane of each surface listed for primary and permanent tooth restoration completed to be considered for reimbursement as a multiple surface restoration. •All reimbursement for tooth restorations include local anesthesia and pulp protection media, where indicated, without additional charges. These services will deny as part of another service if billed separately. •The CSHCN Services Program may reimburse restorations and therapeutic care based on medical necessity. Therapeutic procedures are not reimbursed for preventive purposes. Inlay or onlay restorations and crowns–single restorations only may be reimbursed a maximum fee when performed on permanent teeth. This fee includes the actual inlay or onlay or crown, and any provisional crown, and any preparatory work before the seating of the permanent crown. Reimbursement for crowns and onlay restorations are payable once per client, per tooth every ten years. Additional crowns and onlays may be considered with prior authorization and documentation of medical necessity. Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth) or post-operative periapical radiograph(s) (for anterior teeth) with the claim to verify that the restoration meets the standard of care. Single restoration only crown procedure codes are limited to CSHCN Services Program clients who are 13 years of age or older. Procedure code D2799 is denied as part of the global fee for a crown. Use the following procedure codes for restoration services: Procedure Codes Limitations Amalgam Restorations D2140 A = NA D2150 A = NA D2160 A = 1 year of age or older D2161 A = 1 year of age or older Resin-Based Composite Restorations D2330 A = NA D2331 A = NA D2332 A = 1 year of age or older D2335 A = 1 year of age or older D2390 A = NA D2391 A = NA D2392 A = NA D2393 A = 1 year of age or older D2394 A = 1 year of age or older Inlay or Onlay Restorations D2510 A = 13 years of age or older D2520 A = 13 years of age or older D2530 A = 13 years of age or older D2542 A = 13 years of age or older D2543 A = 13 years of age or older D2544 A = 13 years of age or older D2650 A = 13 years of age or older D2651 A = 13 years of age or older D2652 A = 13 years of age or older D2662 A = 13 years of age or older D2663 A = 13 years of age or older D2664 A = 13 years of age or older D2710 A = 13 years of age or older D2720 A = 13 years of age or older D2721 A = 13 years of age or older D2722 A = 13 years of age or older D2740 A = 16 years of age or older, limited to TID #4-13 and 20-29 only. D2750 A = 16 years of age or older, limited to TID #4-13 and 20-29 only. D2751 A = 16 years of age or older, limited to TID #4-13 and 20-29 only. D2752 A = 16 years of age or older, limited to TID #4-13 and 20-29 only. D2780 A = 13 years of age or older D2781 A = 13 years of age or older D2782 A = 13 years of age or older D2783 A = 13 years of age or older D2790 A = 13 years of age or older D2791 A = 13 years of age or older D2792 A = 13 years of age or older D2794 A = 13 years of age or older D2910 A = 13 years of age or older D2915 A = 6 years of age or older D2920 A = 1 year of age or older, payable to any CSHCN Services Program dental provider, including the same provider that performed the original crown cementation D2930 A = NA D2931 A = 6 years of age or older D2932 A = 1 year of age or older, limited to TID C-H, M-R, and all permanent teeth. D2933 A = NA, limited to TID C-H and M-R primary teeth. D2934 A = NA D2940 A = NA D2950 A = 6 years of age or older D2952 A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2952 for the same tooth, for the same date of service, by the same provider D2953 A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2953 for the same tooth, for the same date of service, by the same provider D2954 A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2954 for the same tooth, for the same date of service, by the same provider D2955 A = 4 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2955 for the same tooth, for the same date of service, by the same provider D2957 A = 13 years of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2957 for the same tooth, for the same date of service, by the same provider D2960 A = 13 years of age or older D2961 A = 13 years of age or older D2962 A = 13 years of age or older D2971 A = 13 years of age or older, limited to four services per lifetime for each tooth by any provider D2980 A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2980 for the same tooth, for the same date of service, by the same provider D2999 A = 1 year of age or older; procedure codes D3110 and D3120 may not be reimbursed when billed with procedure code D2999 for the same tooth, for the same date of service, by the same provider, prior authorization Other Restorative Services D2951 Limited to two times per lifetime for permanent teeth, same TID, any provider. Additional services will be considered with documentation of medical necessity. A = 6 years of age or older The following dental restoration procedure codes will be limited to once per rolling year, for the same TID, by the same provider: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2391 D2392 D2393 D2394 Procedure codes D2335 and D2390 when provided to primary teeth will be limited to once per lifetime, same TID, any provider, and will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as the following procedure codes: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2335 D2390 D2932 D2933 D2934 Total reimbursement for direct restorations on primary teeth cannot exceed the total dollar amount allowed for a stainless steel crown, per TID, per date of service. This limitation does not apply to procedure code D2335. 14.2.6.4.1Direct Restorations and Other Restorative Services Direct restoration of a primary tooth with the use of a prefabricated crown will be considered as a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the replacement of the prefabricated crown procedure codes D2930, D2932, D2933, and D2934 during pre-payment review. Procedure code D2930 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2335 D2390 D2391 D2392 D2393 D2394 Procedure codes D2933 and D2934 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2335 D2390 Procedure codes D2931 and D2932 will be denied if the following procedure codes have been billed within a rolling year, for the same TID, by the same provider: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2335 D2390 D2391 D2392 D2393 D2394 D2931 D2932 14.2.6.5Endodontics The following procedures are limited to four permanent teeth without prior authorization: •Initial endodontic therapy (procedure codes D3310, D3320, and D3330) •Retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348) Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately. 14.2.6.5.1Prior Authorization Prior authorization is required for root canal therapy and retreatment of previous root canal therapy (procedure codes D3346, D3347, and D3348) in excess of four root canals. To obtain prior authorization, the CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form must be submitted with documentation of medical necessity. Documentation supporting medical necessity must be maintained in the client's dental record and include the following: •The medical necessity before treatment, during treatment, and post treatment •Periapical radiographs •The final size of the file to which the canal was enlarged and the type of filling material used •Any reason that the root canal may appear radiographically unacceptable must be documented in the client's dental record Prior authorization is required for procedure code D3460. Documentation of medical necessity must include the following: •The client is 16 years of age or older. •Regular treatment failed. •The client's anatomy is such that no other fixed or removable prosthodontic alternatives are available, including, but not limited to anodontia, a result of trauma, or birth defect. Prior authorization is required for an unspecified endodontic procedure, procedure code D3999. Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter for more information about prior authorization requirements. Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. 14.2.6.5.2Pulp Caps and Pulpotomy Procedure Code Limitations D3110 A = 1 year and older D3120 A = 1 year and older D3220 •A = NA. •Limited to once per lifetime, per primary tooth (TID A through T) •Will be denied when performed within 6 months of pulpal therapy (procedure codes D3230 and D3240) on the same primary TID, by the same provider •Will be denied when performed within 6 months of root canal therapy (procedure codes D3310, D3320, and D3330) on the same permanent TID by the same provider D3230 A = 1 year and older D3240 A = 1 year and older Direct pulp caps (procedure code D3110) and indirect pulp caps (procedure code D3120) are a benefit for permanent teeth only (TID 1-32). Direct pulp caps (procedure code D3110) may be reimbursed when billed with the following procedure codes for the same tooth ID, on the same date of service, by the same provider: Procedure Codes D2140 D2150 D2160 D2161 D2330 D2331 D2332 D2335 D2390 D2391 D2392 D2393 D2394 D2510 D2520 D2530 D2542 D2543 D2544 D2650 D2651 D2652 D2662 D2663 D2664 D2710 D2720 D2721 D2722 D2740 D2750 D2751 D2752 D2780 D2781 D2782 D2783 D2790 D2791 D2792 D2794 D2931 D2932 Indirect pulp caps (procedure code D3120) may be reimbursed when billed with procedure code D2940 for the same tooth ID, on the same date of service by the same provider. Procedure code D3221 is considered part of all endodontic procedures and will not be reimbursed separately. 14.2.6.5.3Root Canals Root canals may only be reimbursed when performed on permanent teeth. Reimbursement for endodontic therapy (procedure codes D3310, D3320, and D3330), or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348) includes all appointments, radiographs, and procedures necessary to complete the treatment, including, but not limited to: •Pulpotomy •Radiographs performed pre-, intra-, and postoperatively Re-treatment claims for an incomplete pulpotomy performed by a dentist not associated with the original treating dentist or dental group will be considered for reimbursement upon appeal. Documentation of medical necessity and the incomplete initial pulpotomy must be submitted with the appeal. The appeal must also include a written narrative and pre- and post-treatment X-rays, which will be reviewed by a Texas licensed dentist. Note:The identified, original treating dentist or dental group will not be considered for reimbursement. The following services are not considered part of the endodontic therapy procedures or the retreatment procedures of a previous root canal and may be reimbursed separately: •Diagnostic evaluation •Radiographs performed at the initial, periodic, or emergency service visits Root canal therapy not carried to completion with a final filling should not be billed using a root canal therapy procedure code. It must be billed using procedure code D3999. Providers must file the claim with a narrative description of the procedures that were completed. The date of service for a root canal is the date when the service was initiated. Procedure codes D3220, D3351, D3352, and D3353 performed on a tooth within the 6 months preceding a root canal is considered part of the root canal. The total amount reimbursed will not exceed the total dollar amount allowed for procedure codes D3310, D3320, and D3330, or D3346, D3347, and D3348. Apicoectomy (procedure codes D3410, D3421, D3425, and D3426) billed after root canal therapy or retreatment of a previous root canal may be reimbursed separately. Refer to the following table for additional limitations for endodontic services: Procedure Codes Limitations D3110 A = 1 year of age or older, refer to Section 14.2.6.4, “Restorations” in this chapter for additional limitations D3120 A = 1 year of age or older D3220 A = NA; see additional restrictions in Section 14.2.6.5.2, “Pulp Caps and Pulpotomy” in this chapter D3230 A = 1 year of age or older D3240 A = 1 year of age or older D3310 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3320 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3330 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3346 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3347 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3348 A = 6 years of age or older, limited to 4 teeth without prior authorization, #1–32 only D3351 A = 6 years of age or older D3352 A = 6 years of age or older D3353 A = 6 years of age or older D3410 A = 6 years of age or older D3421 A = 6 years of age or older D3425 A = 6 years of age or older D3426 A = 6 years of age or older D3430 A = 6 years of age or older D3450 A = 6 years of age or older D3460 A = 16 years of age or older, prior authorization D3470 A = 6 years of age or older D3910 A = 1 years of age or older D3920 A = 6 years of age or older D3950 A = 6 years of age or older D3999 A = 1 year of age or older, prior authorization 14.2.6.6Periodontics Medical necessity for third-molar sites includes, but is not limited to: •Medical or dental history documenting need due to inadequate healing of bone following third-molar extraction, including date of third-molar extraction. •Secondary procedure several months postextraction. •Position of the third molar preoperatively. •Postextraction probing depths to document continuing bony defect. •Postextraction radiographs documenting continuing bony defect. •Bone graft and barrier material used. Medical necessity for other than third-molar sites, includes, but is not limited to: •Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injury). •Intra- or extra-oral radiographs of treatment sites. •If medical necessity is not radiographically evident, intraoral photographs would be appropriate to request; otherwise, intraoral photographs would be optional unless requested preoperatively by the Health and Human Services Commission (HHSC) or its agent. •Periodontal probing depths. •Number of intact walls associated with an angular bony defect. •Bone graft and barrier material used. The preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when billed on the same date of service as any D4000 series periodontal procedure code. Periodontal scaling and root planing (procedure codes D4341 and D4342) will be denied when submitted for the same date of service as other D4000 series codes, except D4341 and D4342, any provider. Full mouth debridement (procedure code D4355) will be denied when submitted for the same date of service as the following procedure codes by any provider: Procedure Codes D4210 D4211 D4230 D4231 D4240 D4241 D4245 D4249 D4260 D4261 D4266 D4267 D4270 D4273 D4274 D4275 D4276 D4277 D4278 D4283 D4285 D4381 D4910 D4920 D4999 Periodontal medicaments (procedure code D4381) must be applied to all affected teeth at the same visit to be effective, and are limited to one service per client per year for clients who are 13 years of age or older. Periodontal maintenance (procedure code D4910) may be reimbursed only if one of the following occurs: •A periodontal surgery or nonsurgical periodontal service (procedure code (D4240, D4241, D4260, or D4261) is billed for the same client by any provider. •There is documented evidence of periodontal therapy while the client was not CSHCN Services Program eligible in the client's dental record within 90 days before the periodontal maintenance. Periodontal maintenance may be reimbursed no more than 3 times within this 90-day period for the same client, by any provider. The periodontic procedure codes in the following table that are limited to clients who are 13 years of age or older may also be considered for younger clients based on the medical condition with supporting documentation of medical necessity. Procedure Codes Limitations D4210 A = 13 years of age or older, DOC, PP1 D4211 A = 13 years of age or older, DOC, PP1 D4230 A = 13 years of age or older D4231 A = 13 years of age or older D4240 A = 13 years of age or older, DOC, PP2 D4241 A = 13 years of age or older, DOC, PP2 D4245 A = 13 years of age or older, prior authorization, DOC, PP2 D4249 A = 13 years of age or older, prior authorization D4260 A = 13 years of age or older, limited to once per quadrant, per day, same provider D4261 A = 13 years of age or older, limited to once per quadrant, per day, same provider D4266 A = 13 years of age or older, prior authorization, DOC, PP2 D4267 A = 13 years of age or older, prior authorization, DOC, PP2 D4270 A = 13 years of age or older, prior authorization, DOC, PP1 D4273 A = 13 years of age or older, prior authorization, DOC, PP1 D4274 A = 13 years of age or older, prior authorization D4275 A = 13 years of age or older, DOC, PP1, limited to one service per day, same provider D4276 A = 13 years of age or older, prior authorization, DOC, PP1 D4277 A = 13 years of age or older, prior authorization, DOC, PP1 D4278 A = 13 years of age or older, prior authorization, DOC, PP1; procedure code D4278 must be billed on the same date of service as procedure code D4277 or it will be denied D4283 A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4283 must be billed with primary procedure code D4273 on the same claim, for the same date of service, by the same provider D4285 A = 13 years of age or older, limited to three teeth per site, DOC, PP1; procedure code D4285 must be billed with primary procedure code D4275 on the same claim, for the same date of service, by the same provider D4341 A = 13 years of age or older, prior authorization, denied when submitted on the same date of service as D4355; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity. D4342 A = 13 years of age or older, prior authorization; Current periodontal charting, a current full mouth radiograph, and a narrative describing the periodontal diagnosis must be submitted with the prior authorization request to determine medical necessity. D4355 A = 13 years of age or older, DOC, PP1 D4381 A = 13 years of age or older, limited to one service per client, per year D4910 A = 13 years of age or older, denied if billed within 90 days after a full mouth debridement, additional limitations, DOC, PP1 D4920 A = 13 years of age or older D4999 A = 13 years of age or older, prior authorization Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter. 14.2.6.7Prosthodontics (Removable) and Maxillofacial Prosthetics Local anesthesia is denied as part of removable prosthodontics procedures. Denture reline procedures are allowed if the reline makes the denture serviceable. Denture reline and rebase procedures are denied if billed within 1 rolling year of a complete or partial denture. •Maxillary reline and rebase procedure codes D5710, D5720, D5730, D5740, D5750, and D5760 are denied as part of complete or partial maxillary denture procedures D5110, D5130, D5211, and D5213. •Mandibular reline and rebase procedure codes D5711, D5721, D5731, D5741, D5751, and D5761 are denied as part of complete or partial mandibular denture procedures D5120, D5140, D5212, and D5214. Repairs to partial maxillary dentures (procedure code D5670) are denied as part of maxillary procedure codes D5211, D5213, and D5640. Repairs to partial mandibular dentures (procedure code D5671) are denied as part of mandibular procedure codes D5212, D5214, and D5640. The cost of repairs cannot exceed replacement costs. Procedure codes D5867 and D5875 are denied as part of any repair or modification of any removable prosthetic. Use the following procedure codes for prosthodontic (removable) services: Procedure Codes Limitations D5110 A = 1 year of age or older, prior authorization D5120 A = 1 year of age or older, prior authorization D5130 A = 3 years of age or older, prior authorization D5140 A = 3 years of age or older, prior authorization D5211 A = 6 years of age or older, prior authorization D5212 A = 6 years of age or older, prior authorization D5213 A = 6 years of age or older, prior authorization D5214 A = 6 years of age or older, prior authorization D5410 A = 1 year of age or older D5411 A = 1 year of age or older D5421 A = 6 years of age or older D5422 A = 6 years of age or older D5511 A = 1 year of age or older, prior authorization D5512 A = 1 year of age or older, prior authorization D5520 A = 3 years of age or older, prior authorization D5611 A = 3 years of age or older D5612 A = 3 years of age or older D5630 A = 6 years of age or older D5640 A = 6 years of age or older D5650 A = 6 years of age or older D5660 A = 6 years of age or older D5670 A = 6 years of age or older D5671 A = 6 years of age or older D5710 •A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider. D5711 •A = 1 year of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider. D5720 •A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider. D5721 •A = 6 years of age or older, prior authorization. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider. D5730 •A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider. D5731 •A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider. D5740 •A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5750, and D5760, same provider. D5741 •A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider. D5750 •A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider. D5751 •A = 1 year of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider. D5760 •A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider. D5761 •A = 6 years of age or older. Limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider. D5810 A = 1 year of age or older, prior authorization D5811 A = 1 year of age or older, prior authorization D5820 A = 6 years of age or older, prior authorization D5821 A = 6 years of age or older, prior authorization D5850 A = 1 year of age or older, prior authorization D5851 A = 1 year of age or older, prior authorization D5862 A = 13 years of age or older, prior authorization D5863 A = 6 years of age or older, prior authorization D5864 A = 6 years of age or older, prior authorization D5865 A = 6 years of age or older, prior authorization D5866 A = 6 years of age or older, prior authorization D5899 A = 1 year of age or older, prior authorization Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter. 14.2.6.7.1Maxillofacial Prosthetics Use the following procedure codes for maxillofacial prosthetic services: Procedure Codes Limitations D5911 A = NA, prior authorization D5912 A = NA, prior authorization D5913 A = NA, prior authorization D5914 A = NA, prior authorization D5915 A = NA, prior authorization D5916 A = NA, prior authorization D5919 A = NA, prior authorization D5922 A = NA, prior authorization D5923 A = NA, prior authorization D5924 A = NA, prior authorization D5925 A = NA, prior authorization D5926 A = NA, prior authorization D5927 A = NA, prior authorization D5928 A = 1 year of age or older, prior authorization D5929 A = 1 year of age or older, prior authorization D5931 A = 1 year of age or older, prior authorization D5932 A = NA, prior authorization D5933 A = NA, prior authorization D5934 A = 1 year of age or older, prior authorization D5935 A = 1 year of age or older, prior authorization D5936 A = 1 year of age or older, prior authorization D5937 A = NA, prior authorization D5951 A = NA, prior authorization D5952 A = birth through 12 years of age, prior authorization D5953 A = 13 years of age or older, prior authorization D5954 A = NA, prior authorization D5955 A = 13 years of age or older, prior authorization D5958 A = NA, prior authorization D5959 A = NA, prior authorization D5960 A = NA, prior authorization D5982 A = NA, prior authorization D5983 A = NA, prior authorization D5984 A = NA, prior authorization D5985 A = NA, prior authorization D5986 A = NA, prior authorization D5987 A = NA, prior authorization D5988 A = NA, prior authorization D5999 A = NA, prior authorization Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter. 14.2.6.7.2Implants Implants require prior authorization. Use the following procedure codes for implant services: Procedure Codes Limitations D6010 A = 16 years of age or older, prior authorization D6040 A = 16 years of age or older, prior authorization D6050 A = 16 years of age or older, prior authorization D6055 A = 16 years of age or older, prior authorization D6056 A = 16 years of age or older, prior authorization D6057 A = 16 years of age or older, prior authorization D6080 A = 16 years of age or older, prior authorization D6090 A = 16 years of age or older, prior authorization D6092 A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider D6093 A = 16 years of age or older, prior authorization, limited to one service per tooth, once per calendar year, by any provider D6095 A = 16 years of age or older, prior authorization D6100 A = 16 years of age or older, prior authorization D6199 A = 16 years of age or older, prior authorization Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter for more information about prior authorization requirements. 14.2.6.7.3Fixed Prosthodontics Prior authorization is required for fixed prosthodontics. Fixed prosthodontics are limited to CSHCN Services Program clients who are 16 years of age or older, as the client must be old enough to have mature teeth and minimal jaw growth remaining. Required documentation for prior authorization includes, but is not limited to: •The CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services form. •Documentation of medical necessity for the requested procedure includes, but is not limited to: •Documentation supporting that the mouth is free of disease; no untreated periodontal, endodontic disease, or rampant caries. •Documentation supporting only one virgin abutment tooth; at least one tooth must require a crown, except when a Maryland bridge is placed. •Tooth Identification (TID) System noting only permanent teeth. •Documentation supporting that a removable partial is not a viable option to fill the space between the teeth. •Appropriate pretreatment radiographs of each involved tooth, such as periapical views must be maintained in the client's medical record and submitted to the CSHCN Services Program on request. Panoramic films are inadequate to detect caries or tooth structure necessary to evaluate the request. Prior authorization will not be given when: •Films show two good abutment teeth, except when a Maryland bridge will be replaced. •There is untreated periodontal or the presence of endodontic disease, or rampant caries which would contraindicate the treatment. Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter. The following fixed prosthetics (pontics, retainers, and abutments), may be reimbursed with a maximum fee and include any preparatory work before placement of the fixed prosthetic. Procedure Codes D6210 D6211 D6212 D6240 D6241 D6242 D6245 D6250 D6251 D6252 D6545 D6548 D6549 D6720 D6721 D6722 D6740 D6750 D6751 D6752 D6780 D6781 D6782 D6783 D6790 D6791 D6792 Each abutment and each pontic constitutes a unit in a fixed partial-denture bridge (bridgework). The following procedure codes are considered part of any other service and are not reimbursed separately: Procedure Codes D6600 D6601 D6602 D6603 D6604 D6605 D6606 D6607 D6608 D6609 D6610 D6611 D6612 D6613 D6614 D6615 Use the following procedure codes for fixed prosthodontics services. These codes require prior authorization: Procedure Codes Limitations Fixed Partial Denture Pontics D6210 D6211 D6212 D6240 D6241 D6242 D6245 D6250 D6251 D6252 Fixed Partial Denture Retainers—Inlays or Onlays D6545 D6548 D6549 Fixed Partial Denture Retainers—Crowns D6720 D6721 D6722 D6740 D6750 D6751 D6752 D6780 D6781 D6782 D6783 D6790 D6791 D6792 Other Fixed Partial Denture Services D6920 D6930 D6940 D6950 D6980 D6999 14.2.6.8Oral and Maxillofacial Surgery Prior authorization is required for most oral and maxillofacial surgery, including, but not limited to, invasive procedures for clients with cleft lip, cleft palate, or craniofacial anomalies, which must be performed by a cleft and craniofacial team or a coordinated multidisciplinary team. All oral surgery procedures include local anesthesia and visits for routine postoperative care. Use the following table for oral and maxillofacial surgery procedure codes and prior authorization requirements. Procedure Codes Limitations D7111 A = NA D7140 A = NA D7210 A = NA D7220 A = NA D7230 A = NA D7240 A = NA D7241 A = 1 year of age or older D7250 A = 1 year of age or older D7260 A = NA, prior authorization D7261 A = NA, prior authorization D7270 A = NA D7272 A = 1 year of age or older, prior authorization D7280 A = 1 year of age or older. Procedure code D7280 will be denied unless billed with an authorized procedure code D7283 for the same tooth, on the same day, by the same provider. D7282 A = 1 year of age or older D7283 A = 1 year of age or older, prior authorization, permanent dentition only (tooth identification [TID] 2-15 and 18-31). To obtain prior authorization, a copy of the orthodontic treatment plan must be submitted along with a current panoramic radiograph to determine medical necessity and a CSHCN Services Program Prior Authorization Request for Dental or Orthodontia Services Form. D7285 A = NA, prior authorization D7286 A = NA, prior authorization D7290 A = NA, prior authorization D7291 A = 1 year of age or older, prior authorization D7310 A = 1 year of age or older, prior authorization D7320 A = 1 year of age or older, prior authorization D7340 A = 1 year of age or older, prior authorization D7350 A = 1 year of age or older, prior authorization D7410 A = NA, prior authorization D7411 A = NA, prior authorization D7413 A = NA, prior authorization D7414 A = NA, prior authorization D7440 A = NA, prior authorization D7441 A = NA, prior authorization D7450 A = NA, prior authorization D7451 A = NA, prior authorization D7460 A = NA, prior authorization D7461 A = NA, prior authorization D7465 A = NA, prior authorization D7471 A = NA, prior authorization D7472 A = NA, prior authorization D7510 A = NA D7520 A = NA D7530 A = NA, prior authorization D7540 A = NA, prior authorization D7550 A = NA, prior authorization D7560 A = NA, prior authorization D7670 A = NA D7820 A = NA, prior authorization D7880 A = NA, prior authorization D7899 A = 1 year of age or older, prior authorization D7910 A = NA D7911 A = NA D7912 A = NA D7955 A = NA, prior authorization D7961 A = 12 through 20 years of age, prior authorization D7962 A = NA, prior authorization D7970 A = NA, prior authorization D7971 A = NA, prior authorization D7972 A = 1 year of age or older, prior authorization D7980 A = NA, prior authorization D7983 A = NA, prior authorization D7997 A = NA, prior authorization D7999 A = NA, prior authorization Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter. 14.2.6.9Adjunctive General Services Refer to individual procedure codes in the following table for prior authorization requirements: Procedure Code Limitations D9110 A = NA, see additional benefit information listed below table D9120 A = 13 years of age or older, prior authorization D9210 A = NA, denied when billed for the same date of service as procedure code D9248 D9211 A = NA, denied when billed for the same date of service as procedure code D9248 D9212 A = NA, denied when billed for the same date of service as procedure code D9248 D9222 A = NA, prior authorization, DOC, limited to 15 minutes (1 unit) per day, denied when billed for the same date of service as procedure code D9248 D9223 A = NA, prior authorization, DOC, limited to 2 hours and 45 minutes (11 units) per day must be billed with primary procedure code D9222, same provider D9230 A = NA, denied when billed for the same date of service as procedure code D9248 D9239 A = NA, limited to 15 minutes (1 unit) per day, any provider, denied when billed on the same date of service as procedure code D9222 or D9248 D9243 A = NA, limited to 1 hour and 15 minutes per day (5 units), must be billed with primary procedure code D9239, same provider D9248 A = NA, DOC, limited to one service per day and two services per 12 months, refer to Section 14.2.6.10, “Dental Anesthesia” in this chapter. Denied when billed for the same date of service as procedure code D9420, any provider. D9310 A = NA, prior authorization D9420 A = NA, prior authorization, DOC, refer to Section 14.2.7.1, “Dental Hospital Calls” in this chapter. D9430 A = NA D9440 A = NA D9610 A = NA, prior authorization, limited to once per client per day, DOC D9612 A = NA, prior authorization, limited to once per client per day, DOC D9630 A = NA, prior authorization, DOC D9910 A = NA, limited to once per six months, any provider, not to be used for bases, liners, or adhesives D9920 A = 1 year of age or older, prior authorization, denied when billed on the same day as procedure code D9222, D9230, D9239, or D9248 or with an evaluation, prophylactic treatment, or radiographic procedure, DOC; claim must include diagnosis of intellectual disability, refer to Section 14.2.6.11, “Dental Behavior Management” in this chapter. D9930 A = NA D9944 A = NA D9950 A = 13 years of age or older, prior authorization D9951 A = 13 years of age or older, prior authorization, may be reimbursed once every three rolling years per client, any provider, considered full-mouth procedure D9952 A = 13 years of age or older, prior authorization, may be reimbursed once per lifetime per provider, considered full-mouth procedure D9970 A = NA, one service per day, any provider D9974 A = 13 years of age or older, DOC, refer to Section 14.2.6.12, “Internal Bleaching of Discolored Tooth” in this chapter D9999 A = NA, prior authorization, DOC Note:For those procedures requiring prior authorization, the prior authorization is valid up to 90 days from the date it is issued. Refer to: Section 14.2.6.1, “Prior Authorization Requirements” in this chapter for more information about prior authorization requirements. Section 4.4, “Prior Authorizations” in Chapter 4, “Prior Authorizations and Authorizations” for detailed information about prior authorization requirements. 14.2.6.9.1Emergency Dental Treatment Services Procedure code D9110 is an emergency service only. The type of treatment rendered and tooth identification must be indicated. It must be for a service other than a prescription or topical medication. The reason for the emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked on the claim form. Procedure code D9110 is a benefit for the following: •Sedative or periodontal dressing •Starting root canal procedure; (i.e.:, open and drain tooth or re-medication of previously opened tooth) •Smoothing fractured tooth that is cutting lips or cheek •Debridement or curettage of wound •Excision of operculum over an erupting tooth •Limited gingivectomy •Suture removal by dentist other than the dentist who placed suture(s) •Placement of a temporary crown by other than the patient's regular dentist and one who is not in the process, has not previously, or does not in the future intend to perform an acrylic, polycarbonate, stainless steel or cast crown on this same tooth •Tissue conditioning of a full or partial denture •Removal of spontaneously or post-surgically sequested bone spicule •Spot or limited scaling and root planing •Procedures necessary to treat a dry socket •Procedures necessary to control bleeding •Non-surgical reduction of TMJ dislocation •Procedures necessary to relieve pain associated with pericoronitis, particularly third molars Procedure code D9110 is not a benefit for the following: •Prescription written •Medication given or administered •Application of topical medication to teeth or gums •Occlusal adjustments •Oral hygiene instructions 14.2.6.10Dental Anesthesia All dental providers must comply with the American Academy of Pediatric Dentistry (AAPD) guidelines and TSBDE rules and regulations, including the standards for documentation and record maintenance for dental anesthesia. Providers must have a level 4 permit and an anesthesiology residency recognized by the American Dental Board of Anesthesiology to receive an enhanced rate for procedure codes D9222 and D9223. All levels of sedation must have clinical documentation and a narrative in the client's dental record to support medical necessity of the service. The client's dental record must be available for review by representatives of HHSC or it's designee. 14.2.6.10.1Anesthesia Permit Levels The following table shows the levels of anesthesia permits that are issued by the TSBDE: Permit Level Description of Level Permit Privileges Nitrous oxide/oxygen inhalation conscious sedation Stand-alone permit Level 1 Minimal sedation Stand-alone permit Level 2 Moderate enteral Automatically qualifies for Level 1 and Level 2 permit privileges Level 3 Moderate parenteral Automatically qualifies for Level 1, Level 2, and Level 3 permit privileges Level 4 Deep sedation/general anesthesia Automatically qualifies for Level 1, Level 2, Level 3, and Level 4 permit privileges Providers will be reimbursed only for those procedure codes that are covered by their anesthesia permit level. The following procedure codes may be used to bill dental anesthesia and indicates the minimum anesthesia permit level to be reimbursed for these procedure codes: Procedure Codes Level of Sedation D9211 Level 3 D9212 Level 3 D9222 Level 4 D9223 Level 4 D9230 Level 1 D9239 Level 3 D9243 Level 3 D9248 Level 2 Dental anesthesia is not age-restricted. Local anesthesia in conjunction with operative or surgical services (procedure code D9215) is all inclusive with any other dental service and is not reimbursed separately. Procedure codes D9239 is limited to 15 minutes (1 unit) per day. Procedure code D9243 is limited to 1 hour and 15 minutes per day (5 units). Reimbursement of procedure code D9248 is limited to one service per client per day. Procedure code D9248 is limited to two times per year, per client. If more than two nonintravenous (IV) conscious sedation services are required by the same provider in a 12 month period, prior authorization is required. Any dentist providing nonintravenous (IV) conscious sedation must comply with all TSBDE Rules and American Academy of Pediatric Dentistry (AAPD) Guidelines, including maintaining a current permit to provide non-IV conscious sedation. Claims must include a provider statement indicating that the procedure was provided in full compliance with these guidelines. Documentation supporting medical necessity and appropriateness for the use of non-IV conscious sedation must be maintained in the client's records and is subject to retrospective review. Supporting documentation includes, but is not limited to the following: •Narrative addressing the reason non-IV conscious sedation was necessary •Medications used to provide the non-IV conscious sedation •The duration of the non-IV conscious sedation, including the start and end times •Monitored statistics, such as vital signs and oxygen saturation levels •Any resuscitative measures that may have been necessary The following procedure codes are denied when billed for the same date of service as procedure code D9248: Procedure Codes D9210 D9211 D9212 D9222 D9230 D9239 D9920 Refer to: Section 14.2.7.3, “Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services)” in this chapter. 14.2.6.10.2Method for Counting Minutes for Timed Procedure Codes All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour. Time intervals for 1 through 12 units are as follows: Units Number of Minutes 0 units 0 minutes through 7 minutes 1 unit 8 minutes through 22 minutes 2 units 23 minutes through 37 minutes 3 units 38 minutes through 52 minutes 4 units 53 minutes through 67 minutes 5 units 68 minutes through 82 minutes 6 units 83 minutes through 97 minutes 7 units 98 minutes through 112 minutes 8 units 113 minutes through 127 minutes 9 units 128 minutes through 142 minutes 10 units 143 minutes through 157 minutes 11 units 158 minutes through 172 minutes 12 units 173 minutes through 187 minutes All levels of sedation must have clinical documentation and a narrative in the client's dental record to support the necessity of the service. Documentation must include the sedation record that indicates sedation start and end times in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines. The client's dental record must be available for review by representatives of HHSC or its designee. 14.2.6.11Dental Behavior Management Procedure code D9920 is considered for prior authorization in addition to therapeutic procedures when provided in the office and when the client has a diagnosis of an intellectual disability described as mild, moderate, severe, profound, or unspecified. Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the client's chart and is subject to retrospective review. Supporting documentation includes, but is not limited to, the following: •A current physician statement addressing the intellectual disability, signed and dated within 1 year before the dental behavior management •The client's diagnosis of intellectual disability •A description of the service performed, including the specific problem and the behavior management technique applied •Personnel and supplies required to provide the behavioral management •The duration of the behavior management, including the start and end times Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Except for those procedures requiring prior authorization, admission to an outpatient or freestanding ambulatory surgical center (ASC) for the purpose of performing dentistry services must be authorized. Refer to: Section 24.5.1, “Benefits, Limitations, and Authorization Requirements” in Chapter 24, “Hospital” for more information about prior authorization in an ASC. 14.2.6.12Internal Bleaching of Discolored Tooth Internal bleaching of a discolored tooth is an accepted endodontic treatment for clients who are 13 years of age or older. It is intended to remove and change the organic material in the enamel of an infected or traumatized tooth. It is considered medically necessary when chemical change of the contents in the interior of the tooth is judged necessary to complete an endodontic treatment to the tooth for therapeutic, not cosmetic purposes. Prior authorization is not required. Procedure code D9974 may be considered for reimbursement when the claim is filed with documentation supporting medical necessity. Claims that are filed without documentation supporting medical necessity are denied as incomplete. 14.2.6.13Noncovered Services The following therapeutic services are not benefits of the CSHCN Services Program. Procedure Codes D3331 D3332 D3333 D6058 D6059 D6060 D6061 D6062 D6063 D6064 D6065 D6066 D6067 D6068 D6069 D6070 D6071 D6072 D6073 D6074 D6075 D6076 D6077 D6094 D6194 D7412 D7671 D7771 D7830 D9972 D9973 14.2.7Dental Treatment in Hospitals and ASCs Dental rehabilitation and restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting. 14.2.7.1Dental Hospital Calls Dental hospital calls may be reimbursed for clients of any age that require medically necessary general anesthesia or dental treatment in the inpatient or outpatient hospital setting. Providers may bill procedure code D9420 in addition to the dental services performed in the inpatient or outpatient setting. Documentation supporting the medical necessity of the dental hospital call must be retained in the client's dental record and is subject to retrospective review. Procedure code D9420 is limited to twice per rolling year, per client, any provider. Refer to: Chapter 24, “Hospital” for more information about requirements for inpatient and outpatient services. 14.2.7.2Authorization and Prior Authorization Requirements All inpatient hospital admissions for dental services require prior authorization. Except for those specific procedures that require prior authorization, admission to freestanding ASCs or outpatient hospital ambulatory surgical centers (HASCs) for the purpose of performing dentistry services require authorization. The CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia must be submitted to the TMHP-CSHCN Services Program with supporting documentation of medical necessity. Refer to: Chapter 4, “Prior Authorizations and Authorizations” for additional information. Chapter 24, “Hospital.” Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Hospital Admission—For Use by Facilities Only form Refer to: CSHCN Services Program Prior Authorization Request for Inpatient Surgery—For Surgeons Only form. 14.2.7.3Dental General Anesthesia Provided in the Inpatient or Outpatient Setting (Medically Necessary Dental Rehabilitation or Restoration Services) Dental rehabilitation or restoration services requiring general anesthesia may be performed in the inpatient or outpatient setting. CSHCN Services Program dental services should be billed using the following Current Procedural Terminology (CPT) procedure codes and modifier where appropriate: •Anesthesia services for general dental anesthesia, procedure code 00170 with modifier U3 •ASC or HASC dental rehabilitation or restoration, procedure code 41899 with modifier U3 •Physical examinations before dental restorations under anesthesia, procedure codes 99202, 99222, and 99282 •Restorations under anesthesia, procedure codes 99222 and 99282 Supporting documentation must be retained in the client's chart and must reflect compliance with the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia and the CSHCN Services Program Policy About the Criteria for Dental Therapy Under General Anesthesia, Attachment 1. Dental general anesthesia may be reimbursed once every 6 months per client any provider. All supporting documentation must be maintained in the client's medical record. The client's record must be available for review by representatives of the CSHCN Services Program, the Department of State Health Services (DSHS), the CSHCN Services Program claims contractor, and HHSC. The dental provider is required to maintain the following documentation in the client's dental record: •The medical evaluation justifying the need for anesthesia •Description of relevant behavior and reference scale •Other relevant narrative justifying the need for general anesthesia •Client's demographics, including date of birth •Relevant dental and medical history •Dental radiographs, intraora or perioral photography, or diagram of dental pathology •Proposed dental plan of care •Consent signed by parent or guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained •Completed CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form •The parent or guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that the parent or guardian understands and agrees with the dentist's assessment of their child's behavior •Dentist's attestation statement and signature, which is put on the bottom of the CSHCN Services Program Criteria for Dental Therapy Under General Anesthesia form or included in the client's dental record as a separate form Hospital and outpatient facility admissions are subject to medical necessity review. 14.2.8Doctor of Dentistry Services as a Limited Physician The CSHCN Services Program covers services provided by a DDS or DMD if the services are a benefit and furnished within the dentist's scope of practice as defined by Texas state law. To participate in the CSHCN Services Program as a dentist practicing as a limited physician, a dentist (DDS or DMD) must be enrolled separately as a dentist practicing as a limited physician. The CSHCN Services Program recognizes the standards of care needed to appropriately address the repair of cleft and craniofacial anomalies as outlined in the guidelines prepared by the American Cleft Palate - Craniofacial Association (acpa-cpf.org). A comprehensive, multidisciplinary approach is medically necessary to meet all of the needs of clients with complex medical conditions who require treatment by a broad range of medical specialists. Standard of care for the comprehensive repair or reconstruction of craniofacial anomalies for CSHCN Services Program clients requires a team approach either by a C/C team or by an equivalent coordinated multidisciplinary team. The following exceptions may be considered to this requirement: •A C/C or equivalent multidisciplinary team is not available in the area and the client is unable to travel. (Medical record documentation must explain the reasons the client is unable to travel.) •A C/C or equivalent multidisciplinary team is not available in the area, or the team approach cannot be coordinated over multiple locations. (Medical record documentation must describe attempts to coordinate a team approach.) •A C/C or equivalent multidisciplinary team is available but the client or the client's parent/ guardian refuses to receive care from the team. (Medical record documentation must explain the reason for the refusal of the care offered by the team.) Refer to: Section 31.2.39.11, “Cleft/Craniofacial Procedures” in Chapter 31, “Physician” for more detailed information. If a client has third-party insurance coverage available that requires reconstructive facial surgery involving the bony skeleton of the face (including midface osteotomies and cleft lip and palate repairs performed by a physician), the CSHCN Services Program cannot consider a claim for payment unless all third-party payer requirements are met. 14.2.8.1Authorization Requirements The following procedure codes require prior authorization and may be considered with medical review of documentation of medical necessity. These procedures may be considered cosmetic and are not a benefit except when the procedure is performed as a result of trauma or injury to reconstruct tissues or body structures, or to repair damaged tissues. Procedure Codes 11950 11951 11952 11954 15630 15780 15781 15788 15789 15876 Documentation of medical necessity indication that the procedure was performed due to trauma or injury must be submitted with the authorization request. Unless otherwise noted in the following tables, all other procedure codes in this section do not require authorization or prior authorization. 14.2.8.2Surgery The following surgery CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist

physician: Procedure Codes 10060 10061 10140 10160 10180 11000 11010 11011 11012 11042 11043 11044 11102 11103 11104 11105 11106 11107 11200 11201 11305 11306 11307 11308 11310 11311 11312 11313 11420 11421 11422 11423 11424 11426 11440 11441 11442 11443 11444 11446 11620 11621 11622 11623 11624 11626 11640 11641 11642 11643 11644 11646 11900 11901 11950** 11951** 11952** 11954** 11960 11970 11971 12001 12002 12004 12005 12006 12007 12011 12013 12014 12015 12016 12017 12018 12020 12021 12031 12032 12034 12035 12036 12037 12051 12052 12053 12054 12055 12056 12057 13120 13121 13122 13131 13132 13133 13151 13152 13153 13160 14020 14021 14040* 14041* 14060* 14061* 14301 14302 15004 15005 15115 15116 15120* 15121* 15135* 15136* 15155* 15156* 15157* 15240* 15241* 15260* 15261* 15275 15276 15277 15278 15574 15576* 15620 15630** 15730 15733 15740 15750 15756 15757 15758 15760 15769 15770 15780** 15781** 15786 15787 15788** 15789** 15819 15820* 15821* 15850 15851 15852 15876** 17250 20100 20525 20551 20552 20600 20604 20605 20606 20615 20660 20670 20680 20690 20692 20693 20694 20696 20697 20900 20902* 20910 20912 20920 20922 20955 20956 20957 20962 20969 20970 20972 20973 20999* 21010 21011 21012 21013 21014 21025 21026 21029 21030 21031 21032 21040 21046 21047 21048 21049 21050 21060 21070 21073 21076* 21077* 21079* 21080* 21081* 21082* 21083* 21084* 21085* 21086* 21087* 21088* 21089* 21100* 21110* 21116 21120* 21121* 21122* 21123* 21125* 21127* 21137* 21138* 21139* 21141* 21142* 21143* 21145* 21146* 21147* 21150* 21151* 21154* 21155* 21159* 21160* 21172* 21175* 21179* 21180* 21181* 21182* 21183* 21184* 21188* 21193* 21194* 21195* 21196* 21198* 21199* 21206* 21208* 21209* 21210* 21215* 21230* 21235* 21240 21242 21243 21244* 21245* 21246* 21247* 21248* 21249* 21255* 21256* 21260* 21261* 21263* 21267* 21268* 21270* 21275* 21280* 21282* 21295* 21296* 21299* 21315 21320 21325 21330 21335 21336 21337 21338 21339 21340 21343 21344 21345 21346 21347 21348 21355 21356 21360 21365 21366 21385 21386 21387 21390 21395 21400 21401 21406 21407 21408 21421 21422 21423 21431 21432 21433 21435 21436 21440 21445 21450 21452 21453 21454 21461 21462 21465 21470 21480 21485 21490 21497* 21499* 21685 29800 29804 29999* 30000 30020 30120 30124 30125 30130 30140 30150 30160 30200 30300 30310 30460* 30462* 30580* 30600* 30620* 30630* 30801 30802 30901 30903 30905 30906 30930 30999* 31020 31080 31081 31084 31085 31086 31087 31090 31200* 31201 31603 31605 31830 40490 40500 40510 40520 40525 40527* 40530* 40650* 40652* 40654* 40700* 40701* 40702* 40720* 40761* 40799* 40800 40801 40804 40805 40806 40808 40810 40812 40814 40816 40818 40819 40820 40830 40831 40840 40842 40843 40844 40845 40899* 41000 41005 41006 41007 41008 41009 41010 41015 41016 41017 41018 41100 41105 41108 41110 41112 41113 41114 41115 41116 41120 41130 41250 41251 41252 41510 41520 41599* 41800 41805 41806 41820 41821 41822 41823 41825 41826 41827 41828 41830 41850 41870 41872 41874 41899* 42000 42100 42104 42106 42107 42120 42140 42145* 42160 42180 42182 42200* 42205* 42210* 42215* 42220* 42225* 42226* 42227* 42235* 42260* 42280* 42281* 42299* 42300 42305 42310 42320 42330 42335 42340 42400 42405 42408 42409 42410 42415 42420 42425 42426 42440 42450 42500 42505 42507 42509 42510 42550 42600 42650 42660 42665 42699* 42700 42720 42725 42800 42804 42806 42808 42809 42810 42815 42890 42892 42894 42900 42950 42960 42961 42962 42970 42999* 61501 61559* 62147 64400 64640 64681 64722 64736 64738 64740 64742 67900 67914 67915 67916 67917 67921 67922 67923 67924 67930 67935 67950* 67961* 67966* 67971 67973 67974 67975 J0558 J0561 14.2.8.3Cleft/Craniofacial Surgery by a Dentist Physician The following additional codes may be reimbursed to a provider enrolled as a cleft/craniofacial surgeon. Prior authorization is required. Procedure Codes 30540 30545 30560 61550 61552 61556 61557 61558 62115 62117 Septoplasty (procedure code 30520) for nonrelated repair or reconstruction of cleft lip, cleft palate, or craniofacial anomalies may be prior authorized with documentation to support medical necessity. 14.2.8.4Evaluation and Management or Consultation The following evaluation and management or consultation service procedure codes are payable to a dentist physician: Procedure Codes 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99218 99219 99220 99221 99222 99223 99231 99232 99233 99238 99241 99242 99243 99244 99245 99251 99252 99253 99254 99255 99281 99282 99283 99284 99285 Evaluation and management codes for home services are not reimbursed to dentists or dentistry groups. 14.2.8.5Radiology and Laboratory Procedures The following diagnostic radiology and laboratory procedure codes are payable to a dentist physician: Procedure Codes 70100 70110 70120 70130 70140 70150 70160 70170 70190 70200 70250 70260 70300 70310 70320 70328 70330 70332 70336 70350 70355 70370 70371 70380 70390 73100 76942 88305 88331 88332 Refer to: The CMS website at www.cms.gov/CLIA/10 Categorization of Tests.asp for information about procedure codes and modifier QW requirements. The CSHCN Services Program follows the Medicare categorization of tests for CLIA certificate-holders. 14.2.8.6Other Procedures Payable to a Dentist Physician The following additional CPT procedure codes are payable to a dentist enrolled in the CSHCN Services Program as a dentist physician: Procedure Codes 90284 92511 96369 96370 96372 96374 J0121 J0290 J0295 J0330 J0558 J0561 J0690 J0692 J0694 J0696 J0697 J0698 J0702 J0720 J0744 J1020 J1030 J1040 J1100 J1165 J1170 J1200 J1364 J1580 J1631 J1720 J1790 J1810 J1840 J1850 J1885 J1940 J2010 J2060 J2400 J2510 J2540 J2560 J2700 J2770 J2920 J2930 J3000 J3260 J3300 J3301 J3303 J3370 J3430 J3480 J3490 T1013 Providers must use procedure code T1013 with modifier U1 for the first hour of service, and modifier UA for each additional 15 minutes of service. Procedure code T1013 billed with modifier U1 is limited to once per day, per provider; procedure code T1013 billed with modifier UA is limited to a quantity of 28 per day. Procedure codes 90284, J1459, J1561, J1568, J1569, and J1572 will be denied if billed with the same date of service by any provider as the following procedure codes (unless otherwise indicated): Procedure Codes 90284 J1459* J1460 J1560 J1561* J1566 J1568* J1569* J1572* J7504 J7511 *These procedure codes may be billed more than once per day but will not be reimbursed if billed in combination with any other procedure code in this table. 14.2.8.7Anesthesia by Dentist Physician In addition to the procedure codes discussed under “Benefits and Limitations” in this chapter, the following anesthesia CPT procedure codes are payable to a dentist physician: Procedure Codes 00100 00102 00160 00162 00164 00170 00190 00192 00300 99100 99116 99135 99140 14.3Claims Information Dental services must be submitted to TMHP in an approved electronic format or on a paper ADA Dental Claim Form. Providers can obtain copies of this form by contacting the ADA at 1-800-947-4746 or ordering online from the ADA website at www.ada.org. TMHP does not supply the forms. Any paper dental claim submitted using any other version of the dental claim form is not processed and is returned to the submitter. When completing a paper ADA Dental Claim Form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements. Providers billing electronically must submit dental claims in American National Standards Institute (ANSI) ASC X12 837D format. Specifications are available to providers developing in-house systems, software developers, and vendors. Because each software package is different, field locations may vary. Providers should contact the software developer or vendor for information about their software. Providers or software vendors may direct questions about development requirements to the TMHP EDI Help Desk at 1-888-863-3638. Claims must contain the billing provider’s full name, address, and provider identifier. The billing provider’s full name and address must be entered in Block 48 of the paper ADA Dental Claim Form, and the ten-digit NPI must be entered in Block 49. A claim without a provider name, address, and NPI cannot be processed. The Healthcare Common Procedure Coding System (HCPCS)/CPT codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page at www.cms.gov/medicare/coding/ncci-coding-edits or correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails. Refer to: Chapter 41, “TMHP Electronic Data Interchange (EDI)” for information on electronic claims submissions. Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for general information about claims filing. Section 5.7.2.13, “Instructions for Completing the Paper ADA Dental Claim Form” in Chapter 5, “Claims Filing, Third-Party Resources, and Reimbursement” for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank. 14.3.1Dental Emergency Claims The Emergency Indicator field has been removed from the HIPAA-approved 837D electronic transaction. Dental providers submitting electronic claims in the 837D format must use modifier ET to report emergency services. Modifier ET must be placed in the SVC01 section of the 837D format. Additionally, the Comments field should be used to document the specific nature of the emergency. The Comments field in the HIPAA-approved 837D electronic transaction is 80 bytes long. To indicate a dental emergency on a paper claim submission (ADA Dental Claim Form), check Block 45, Treatment Resulting From (check the applicable box), and check the Other Accident box for emergency claim reimbursement. If the Other Accident box is checked, information about the emergency must be provided in Block 35, Remarks. Only one emergency or trauma claim per client, per day may be submitted. Separate services (one for emergency or trauma and one for nonemergency or routine) may be submitted for the same client on the same day, any provider, for separate services and procedure codes. 14.3.2Tooth Identification (TID) and Surface Identification (SID) Systems Claims are denied if the procedure code is not compatible with TID or SID. Use the alpha characters to describe tooth surfaces or any combination of surfaces. Anterior teeth have facial and incisal surfaces only. Posterior teeth have buccal and occlusal surfaces only. 14.3.3Supernumerary Tooth Identification Each identified permanent tooth and each identified primary tooth has its own identifiable supernumerary number. This developed system can be found in the CDT published by the ADA. The TID for each identified supernumerary tooth is used for paper and electronic claims and can only be billed with the following codes: •For primary teeth only: D7111 •For both primary and permanent teeth the following codes are billable: D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7285, D7286, and D7510 Permanent Teeth Upper Arch Tooth # 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Super # 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 Permanent Teeth Lower Arch Tooth # 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 Super # 82 81 80 79 78 77 76 75 74 73 72 71 70 69 68 67 Primary Teeth Upper Arch Tooth # A B C D E F G H I J Super # AS BS CS DS ES FS GS HS IS JS Primary Teeth Lower Arch Tooth # T S R Q P O N M L K Super # TS SS RS QS PS OS NS MS LS KS 14.4Reimbursement Dental services may be reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid. For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com. The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled “Adjusted Fee” to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes. Note:Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column. 14.5TMHP-CSHCN Services Program Contact Center The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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