# Attention Dental Providers

# CDT Code Policy Changes

1. **Effective for dates of service on or after November 1, 2016, please note the Frequency Limitations for the following procedure codes have changed:**

    - **D0350** 2D Oral/facial photographic image obtained intra-orally or extra-orally. Frequency reduced from two (2) times within three (3) months to two (2) times within six (6) months.
    - **D7210** Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated. Frequency **without prior approval (PA)** reduced from six (6) to four (4) times within twelve (12) months from date of first surgical extraction.

2. **Effective for dates of service on or after November 1, 2016, please note the Site Designation requirement for the following procedure code has changed:**

    - **D5610** Repair resin denture base. The site designation requirement has changed from quadrant (QUAD) to arch (ARCH).

3. **Effective for dates of service on or after November 1, 2016, please note the following procedure codes no longer have a set fee and have been designated as "By Report" (BR):**

    - **D7413** – Excision of malignant lesion up to 1.25 cm
    - **D7471** – Removal of lateral exostosis (maxilla or mandible),
    - **D7490** – Radical resection of maxilla or mandible
    - **D7540** – Removal of reaction-producing foreign bodies – musculoskeletal system
    - **D7550** – Partial ostectomy / sequestrectomy for removal of non-vital bone

4. **Effective for dates of service on or after November 1, 2016, please note the following procedure codes have been designated as "Report Needed". The existing set fees have not been changed:**

    - **D7285** – Biopsy of oral tissue – hard (bone, tooth),
    - **D7286** – Biopsy of oral tissue – soft,
    - **D7410** – Excision of benign lesion up to 1.25 cm
    - **D7450** – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
    - **D7460** – Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
    - **D7510** – Incision and drainage of abscess – intraoral soft tissue

5. **Effective for dates of service on or after November 1, 2016, please note these changes in prior approval requirements:**

- **D7350** – Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) requires prior approval (PA).
- **D8010, D8020, D8030, D8040, D8050, and D8060** are no longer "By Report, PA optional" codes. These codes require prior approval (PA).

"(REPORT NEEDED)" / "BY REPORT (BR)" PROCEDURES:
All claims for these procedures must be submitted with supporting documentation.

Information concerning the nature, extent and need for the procedure or service, the time, the skill and the equipment necessary, must be furnished. Appropriate documentation (e.g., operative report, procedure description, and/or itemized invoices and name/dosage of therapeutic agents) is required. To ensure appropriate payment in the context of current Medicaid fees, bill your usual and customary fee charged to the general public. Claims should only be submitted **AFTER** treatment is completed.

Operative reports must include the following information:

a. Diagnosis;
b. Size, location and number of lesion(s) or procedure(s) where appropriate;
c. Major surgical procedure and supplementary procedure(s);
d. Whenever possible, list the nearest similar procedure by code number;
e. Estimated follow-up period;
f. Operative time;
g. Specific details regarding any anesthesia provided (this should include start - stop times and all medications administered).

If documentation needs to be submitted in support of any "(REPORT NEEDED)" / "By Report (BR)" procedure, the claim **MUST** be submitted on a **paper claim form 'A'** with the documentation as an attachment. Attachments must be on paper the same size as the claim form. This documentation must be maintained in the member's record and made available upon request.

**DO NOT SEND RADIOGRAPHIC IMAGES AS A CLAIM ATTACHMENT**

If radiographs are needed DOH or OMIG will request that you submit them directly to the reviewing unit.

Claim Form 'A' can be obtained from eMedNY by calling (800) 343-9000.

For questions about these changes, contact the Bureau of Dental Review at 1-800-342-3005 or by email at DENTAL@health.ny.gov.