

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: NV

B. Waiver Title(s): HCBS Waiver for Intellectual and Developmental Disabilities

C. Control Number(s): NV 0125.R07.06

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state’s mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for

each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

This amendment is additive to the previous Appendix K approved on 4/15/2020, 8/19/2020, 6/22/2021, 1/6/2022, 3/14/22, and flexibilities from that Appendix K and amendment remain in place until six (6) months after the end of the federal public health emergency (PHE).

Effective January 1, 2023 – December 31, 2023, DHC FP will temporarily add Dental Services under the Waiver for Individuals with Intellectual and Developmental Disabilities (ID) to the existing waiver services (as “Other”) for ID Waiver Adult recipients.

This expanded service will be funded through the enhanced Federal Funds available per Nevada’s Spending Plan for Section 9817 of the American Rescue Plan Act of 2021 until the specified end date or all section 9817 funds are exhausted, whichever is the earliest.

Prior to Appendix K amendment expiring, this service will be added to ID Waiver through the regular waiver amendment and/or renewal process.

F. Proposed Effective Date: Start Date: January 27, 2020 Anticipated End Date: Six (6) months after the end of the Public Health Emergency (PHE)

G. Description of Transition Plan.

H. Geographic Areas Affected:

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state’s response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. X Services

i. ___ Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

iii. X Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Kirsten
Last Name: Coulombe
Title: Social Services Chief III, LTSS
Agency: Division of Health Care Financing and Policy
Address 1: 1100 E. Williams St
Address 2: Suite 101
City: Carson City
State: NV
Zip Code: 89701
Telephone: (775) 684-3747
E-mail: kirsten.coulombe@dncfp.nv.gov
Fax Number: (775) 687-3893

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name: Jennifer
Last Name Frischmann
Title: Quality Assurance Manager
Agency: Aging and Disability Services Division
Address 1: 3416 Goni Rd.
Address 2: Suite D-132
City Carson City
State NV
Zip Code 89706
Telephone: (775) 687-0528
E-mail jfrischmann@adsd.nv.gov
Fax Number (775) 687-0754

8. Authorizing Signature

Signature:

Date: 09/02/2022

/s/

State Medicaid Director or Designee

First Name: *Suzanne*
Last Name *Biermann*
Title: Administrator
Agency: Division of Health Care Financing and Policy
Address 1: 1210 S. Valley View Blvd
Address 2: Ste 104
City Las Vegas
State NV
Zip Code 89102
Telephone: (702) 668-4277
E-mail suzanne.biermann@dhcfp.nv.gov
Fax Number (702) 668-4280

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification

Service Title:	Dental Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
<p>Oral health has a direct impact on the ID Waiver recipient’s overall health and quality of life. Adults with Intellectual or Developmental Disability (IDD) often have specific challenges during treatment such as the need for behavioral modifications.</p> <p>The scope and nature of this service differs from the State Plan Dental Service for Adults, which only offers emergency extractions and palliative care.</p> <p>Under ID Waiver Services “Other” – Dental Services – services include restoration (e.g. amalgam filling, resin-based composite filling, prefabricated stainless steel crown and resin-crown, core buildup, etc.) and preventative care such as regular check-ups, cleaning, fluoride treatments, x-rays, fillings, periodontal maintenance, periodontal scaling and root planning, crowns/dentures, extractions, and anesthesia.</p> <p>Details on the list of dental services are provided below <i>Service Delivery Method</i> section.</p> <p>The dental service will be effective January 1, 2023 – December 31, 2023.</p> <p>Prior to Appendix K amendment expiring, this service will be added to ID Waiver through the regular waiver amendment and/or renewal process.</p> <p>The dental services under this waiver are only provided for individuals age 21 and over. All Medicaid medically necessary dental services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p>Request for prior authorization (PAR) must be submitted electronically to DHCFP fiscal agent website at https://www.medicaid.nv.gov before rendering dental services.</p> <p>The maximum amount limit is \$2000 per calendar year.</p> <p>The service rates methodology is based on the State Plan Extended Dental Services – Pregnancy Related Services (SPA Attachment 4.19-B Page 2c) 4.19-B Pay for Med Care (nv.gov)</p>	

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Dentist, Periodontics, Emergency Dentistry, Family Dentistry, General Dentistry, Family Dentistry, Maxillofacial Surgery, Prosthodontics, Dental Hygienist, Ordering, Prescribing, Referring (OPR), Endodontics		Dental Group/Facility

Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (<i>provide the following information for each type of provider</i>):			
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
PT22 Dentist, Periodontics, Emergency Dentistry, Family Dentistry, General Dentistry, Family Dentistry, Maxillofacial Surgery, Prosthodontics, Dental Hygienist, Ordering, Prescribing, Referring (OPR), Endodontics Dental Group/Facility	Nevada State Board of Dental Examiners Licensure		Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Nevada Medicaid Services Manual.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
PT22	DHCFP Fiscal Agent		Upon enrollment and every 5 years thereafter for revalidation
Service Delivery Method			
Service Delivery Method (<i>check each that applies</i>):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

The list of dental services that will be provided to ID Waiver Adult Recipients are as follows:

Codes	Title	Description	Service Limit
D0120	Periodic oral examination- Patient of Record		1 service unit per 6 rolling months
D0150	Comprehensive oral examination- New Patient		1 service unit per 12 rolling months
D0210	Intraoral- Complete series of radiographic images		D0210 may not be billed on the same date of service as D0220 and/or D0230. Use code D0210 when providing 14 or more intraoral exams on the same date of service. 1 service unit (complete series) per 36 rolling months
D0220	Intraoral- Periapical first radiographic image		1 service unit per 12 rolling months. D0220 may not be billed on the same date of service as D0210.
D0230	Intraoral- Periapical each additional radiographic image		12 units per rolling year D0230 may not be billed on the same date of service as D0210. No more than 13 units of any combination of D0220 and /or D0230 may be billed within any
D0240	Intraoral- Occlusal radiographic image		2 units per 12 rolling months
D0272	Bitewings- 2 Radiographic images		1 unit per 6 months
D0330	Panoramic radiographic image		1 service unit per 36 months
D0350	Oral/facial images		1 service unit per 12 rolling months, 1 unit covers an unlimited number of photos
D0470	Diagnostic casts		1 service unit per 12 rolling months
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report		Coverage is limited to 1 of any of these procedures per 12 month(s). Coverage is limited to 1 examination per biopsy/excision.
D0474	Accession of tissue, gross and microscopic examination; including assessment of surgical margins for presence of disease, preparation and transmission of written report		Coverage is limited to 1 of any of these procedures per 12 month(s). Coverage is limited to 1 examination per biopsy/excision.
D1110	Prophylaxis - Adult	This procedure is reimbursable once per 6 months. More frequent prophylaxis may be approved if deemed medically necessary.	1 unit per 6 months.
D1208	Topical application of fluoride	excluding varnish	1 unit per 6 months

Codes	Title	Description	Service Limit
D1354	Interim caries arresting medicament application per tooth	Reimbursed per tooth every 6 months. Total of four (4) times per lifetime of the tooth, which may be increased if the caries risk remains high or extremely high. Limited to Silver Diamine Fluoride	1 service unit per 6 months per tooth
D2140	Amalgam-one surface only posterior permanent teeth	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	1 unit per 36 months per tooth
D2150	Amalgam-two surfaces posterior - permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	1 unit per 36 months per tooth
D2150	Amalgam- two surfaces posterior - permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	1 unit per 36 months per tooth
D2160	Amalgam-three surfaces posterior -permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	1 unit per 36 months per tooth
D2160	Amalgam- three surfaces posterior - permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	1 unit per 36 months per tooth
D2161	Amalgam-four surfaces posterior - permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	1 unit per 36 months per tooth
D2330	Resin-based composite, one surface, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	1 unit per 36 months per tooth
D2331	Resin-based composite, two surfaces, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo except MI or DI.	1 unit per 36 months per tooth
D2331	Resin-based composite, two surfaces, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo of MI or DI.	1 unit per 36 months per tooth
D2332	Resin-based composite, three surfaces, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	1 unit per 36 months per tooth
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with four surfaces, including the surface I.	1 unit per 36 months per tooth

Codes	Title	Description	Service Limit
D2390	Resin-based composite crown, anterior	This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	1 unit per 36 months per tooth
D2391	Resin-based composite - one surface, posterior	This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	1 unit per 36 months per tooth
D2392	Resin-based composite, two surfaces, posterior	This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32.	1 unit per 36 months per tooth
D2392	Resin-based composite, two surfaces, posterior	This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	1 unit per 36 months per tooth
D2392	Resin-based composite - two surfaces, posterior	This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	1 unit per 36 months per tooth
D2393	Resin-based composite - three surfaces, posterior	This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	1 unit per 36 months per tooth
D2393	Resin-based composite - three surfaces, posterior	This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	1 unit per 36 months per tooth
D2394	Resin-based composite - four surfaces, posterior - permanent teeth only	This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	1 unit per 36 months per tooth
D2920	Recement crown	This procedure is reimbursable for tooth number 1 through 32.	1 unit per 12 months per tooth
D2931	Prefabricated stainless steel crown, permanent tooth	This procedure is reimbursable for tooth number 1 through 32.	Once in lifetime per tooth
D2931	Prefabricated stainless steel crown - permanent teeth only	This procedure is reimbursable for Tooth Number 1 through 32.	Once in lifetime per tooth
D2932	Prefabricated resin crown (permanent teeth)	This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.	1 unit per 36 months per tooth
D2950	Core buildup, including any pins, in addition to crown	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	1 unit per 36 months per tooth
D2951	Pin retention, per tooth, in addition to restoration	This procedure is reimbursable for tooth number 2 through 5; 12 through 15; 18 through 21; and 28 through 31.	2 units per 36 months per tooth

Codes	Title	Description	Service Limit
D2954	Prefabricated post and core in addition to crown	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	Once in a lifetime per tooth
D2999	Unspecified restorative procedure, by report	This procedure is reimbursable for tooth number 1 through 32.	None
D3110	Pulp cap – direct (excluding final restoration)	This procedure is reimbursable for tooth number 1 through 32.	1 unit per 36 months per tooth
D3220	Therapeutic pulpotomy (excluding final restoration)- permanent teeth only	This procedure is reimbursable for tooth numbers 1 through 32	1 unit per 36 months per tooth
D3222	Partial pulpotomy for apexogenesis	This procedure is reimbursable for tooth numbers 2 through 15 and 18 through 31.	Once in a lifetime per tooth
D3310	Endodontic Therapy, anterior (excluding final restoration)	This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.	Once in a lifetime per tooth
D3320	Endodontic Therapy, bicuspid (excluding final restoration)	This procedure is reimbursable for tooth number 4, 5, 12, 13, 20, 21, 28 and 29.	Once in a lifetime per tooth
D3330	Endodontic Therapy, molar (excluding final restoration)	This procedure is reimbursable for tooth number 2, 3, 14, 15, 18, 19, 30 and 31.	Once in a lifetime per tooth
D3346	Retreatment of previous root canal therapy, anterior	This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.	Once in a lifetime per tooth
D3352	Apexification/recalcification, Interim Medication Replacement	This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	Once in a lifetime per tooth
D3410	Apicoectomy, anterior	This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.	Once in a lifetime per tooth
D3430	Retrograde filling, per root	This procedure is reimbursable for tooth number 6 through 11 and 22 through 27.	Once in a lifetime per tooth - multiple roots may be claimed; you must attach documentation to claim if multiple roots are involved on the same tooth
D3999	Unspecified endodontic procedure, by report	This procedure is reimbursable for tooth number 1 through 32.	None
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.	4 units per 60 months
D4341	Periodontal scaling and root planning, four or more teeth per quadrant	This procedure is reimbursable for oral cavity designator 10, 20, 30, and 40.	4 units per 12 months
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		1 unit per 12 rolling months
D4999	Unspecified periodontal procedure, by report		None
D5110	Complete denture, maxillary		1 unit per 60 months
D5120	Complete denture, mandibular		1 unit per 60 months
D5130	Immediate denture, maxillary		1 unit per 60 months

Codes	Title	Description	Service Limit
D5140	Immediate denture, mandibular		1 unit per 60 months
D5211	Maxillary partial denture, resin base (including retentive/clasping materials, rests and teeth)		1 unit per 60 months
D5212	Mandibular partial denture, resin base (including retentive/clasping materials, rests and teeth)		1 unit per 60 months
D5511	Repair broken complete denture base, mandibular	Total of \$175.00 limit in denture repairs per arch, see manual for details.	1 unit per 60 months
D5512	Repair broken complete denture base, maxillary	Total of \$175.00 limit in denture repairs per arch, see manual for details.	1 unit per 60 months
D5520	Replace missing or broken tooth, complete denture/per tooth	1st Tooth = \$65.00; Each additional tooth = \$33.00 This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	1 unit per 60 months
D5611	Repair resin denture base, partial denture, mandibular		1 unit per 60 months
D5612	Repair resin partial denture base, maxillary		1 unit per 60 months
D5630	Repair or replace broken retentive/clasping materials, partial denture – per tooth	This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.	Contraindicated any provider, within 91 days
D5640	Replace missing or broken teeth, partial denture, per tooth	1st Tooth = \$65.00; Each additional tooth = \$33.00 This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	Contraindicated any provider, within 91 days
D5650	Add tooth to existing partial denture	1st Tooth = \$65.00; Each additional tooth = \$33.00 This procedure is reimbursable for tooth number 2 through 15 and 18 through 31.	Contraindicated any provider, within 91 days
D5660	Add clasp to existing partial denture – per tooth	This procedure is reimbursable for oral cavity designator 10, 20, 30 and 40.	Contraindicated any provider, within 91 days
D5750	Reline complete maxillary denture (indirect)		1 unit per 6 months with a maximum of 6 units per 60 months
D5751	Reline complete mandibular denture (indirect)		1 unit per 6 months with a maximum of 6 units per 60 months
D5760	Reline maxillary partial denture (indirect)		1 unit per 6 months with a maximum of 6 units per 60 months
D5761	Reline mandibular partial denture (indirect)		1 unit per 6 months with a maximum of 6 units per 60 months
D5899	Unspecified removable prosthodontic procedure, by report		2 units per 60 months

Codes	Title	Description	Service Limit
D6241	Pontic - porcelain fused to predominantly base metal		None
D6545	Retainer - cast metal for resin bonded fixed prosthesis		None
D6999	Unspecified, fixed prosthodontic procedure, by report		1 unit per 60 months
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in a lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in a lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7220	Removal of impacted tooth – soft tissue	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in a lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7230	Removal of impacted tooth – partially bony	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in a lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7240	Removal of impacted tooth- completely bony	This procedure is reimbursable for Tooth Number 1 through 32; and for Supernumerary Teeth 51 through 82.	Once in a lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in lifetime, same tooth. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider. D7241 and D7261 are contraindicated against each other - within 90 days, same recipient, any provider.
D7250	Surgical removal of residual tooth roots (cutting procedure)	This procedure is reimbursable for tooth number 1 through 32; and for supernumerary teeth 51 through 82.	Once in a lifetime. D7111, D7140, D7210, D7220, D7230, D7240, D7241 and D7250 are contraindicated in conjunction with D9215 - same day, same recipient, any provider.
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	This procedure is reimbursable for oral cavity designator 01 and 02.	Contraindicated any provider, within 91 days
D7280	Surgical access of an unerupted tooth	This procedure is reimbursable for tooth number 2 through 15; and 18 through 31.	Once in a lifetime, same tooth

Codes	Title	Description	Service Limit
D7285	Biopsy of oral tissue – hard (bone, tooth)		None
D7286	Biopsy of oral tissue - soft (all others)		None
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report		None
D7310	Alveoloplasty in conjunction with extractions – per quadrant		Four in a lifetime, contraindicated any provider within 60 days from extraction date.
D7510	Incision and drainage of abscess – intraoral soft tissue	This procedure is reimbursable for tooth number 1 through 32.	Incidental already part of another procedure
D7910	Suture of recent small wounds up to 5 cm		None
D7961	Buccal / Labial Frenectomy (Frenulectomy)	This procedure is reimbursable for oral cavity designator 01, 02, 10, 20, 30 and 40.	Three in a lifetime
D7962	Lingual Frenectomy (Frenulectomy)		Three in a lifetime
D9110	Palliative (emergency) treatment of dental pain		1 service unit per patient, per day, same provider, and 2 units per 6 months
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis		6 units per 12 rolling months
D9239	Intravenous moderate conscious sedation/analgesia – first 15 minutes		1 unit per day
D9243	Intravenous moderate conscious sedation/analgesia – each additional 15 minute increment		4 units per day
D9248	Non-intravenous conscious sedation		6 units per 12 rolling months
D9420	Hospital call		None
D9440	Office visit – after regularly scheduled hours		None
D9944	Occlusal guard – hard appliance, full arch	This procedure reimbursable for oral cavity designator 01 and 02. This procedure reimbursable for oral cavity designator 01 and 02.	1 unit per 36 months
D9945	Occlusal guard – soft appliance, full arch	This procedure reimbursable for oral cavity designator 01 and 02.	1 unit per 36 months
D9946	Occlusal guard – hard appliance, partial arch	This procedure reimbursable for oral cavity designator 01 and 02.	1 unit per 36 months
D9951	Occlusal adjustment – limited		Once in a lifetime

Codes	Title	Description	Service Limit
D9997	Dental case management – patients with special health care needs	A maximum of four dental case management services, per beneficiary, are available annually by the same billing provider or another Medicaid provider located in the same office as the billing provider.	1 unit per 3 months
D9999	Unspecified adjunctive procedure, by report		1 unit per 6 months



ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.