Keystone First - CHIP

Policy No. 152.100CH

Subject: Review Process and Criteria for Dental Services Subject to Prior Authorization (Pre-service) or Retrospective Review

Department: Clinical Services

Original Effective Date: July 1, 2025
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Next Review Date: January1, 2026

Unit: Dental Department

Applicable Party(s):

Review Cycle: Annual

Line(s) of Business: 01CH

Policy:

Dental services requiring authorization are selected on the basis of:

1. Availability of evidenced based guidelines to evaluate the medical necessity of services.
2. Recognition that unexplained variation exists among practitioners in the utilization of selected services.

The Administrator, under the direction of the Dental Director will review all dental services requiring authorization utilizing the definition of Medically Necessary, as outlined by DHS, and adopted by Keystone First (KF) CHIP referred to as "the Health Plan". Review of requests for authorization of dental services are performed by Dentists who are licensed in the Commonwealth of Pennsylvania with a designation of DDS or DMD. Services and categories of dental services which require authorization either pre-service or retrospectively are listed in Attachment A.

A Health Plan Associate may need to use and/or disclose an Enrollee's Protected Health Information (PHI) for the purpose of Treatment, Payment, and Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain an Enrollee's written consent or Authorization prior to using, disclosing, or requesting PHI for purposes of TPO. Therefore, the Health Plan is not required to seek an Enrollee's authorization to release their PHI for any one of the aforementioned purposes (See Policy #669.227, *General Policy – Use and Disclosure of Protected Health Information WithoutEnrollee Consent/Authorization).*

Health Plan Associates may not use, request or disclose to others any PHI that is more than the Minimum Necessary to accomplish the purpose of the Use, request, or Disclosure (with certain exceptions as outlined in Policy #669.217, *Minimum Necessary Standard).* Health Plan Associates are required to comply with specific policies and procedures established to limit Uses of, requests for, or Disclosures of PHI to the minimum amount necessary.

The Health Plan sometimes contracts with other organizations or with individuals who are not members of KF's workforce to perform provider services. This includes Contractors and Consultants. Contractors and Consultants who may require Access to PHI to perform their services for the Health Plan are termed Business Associates (See Policy #669.209, *Disclosure of Protected Health Information to Business Associates and other Contractors).*

The Health Plan will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure in accordance with KFCHIP policies and procedures *(See Policy #669.213- Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data.*

The Health Plan will reasonably safeguard PHI to limit incidental Uses and Disclosures.
An incidental Use or Disclosure is a secondary Use or Disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted Use or Disclosure *(See Policy #669.213- Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data.*

The Health Plan shall retain documents relating to PHI for ten (10) years in accordance with Policy #591.001 Records Retention Policy and Schedule unless otherwise required by Law or regulation.

Health Plan Associates must follow Facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see Policy #669.212, *Facsimile Machines and Transmission of Protected Health Information*).

Purpose: To define a consistent process for authorization of dental services requiring Prior Authorization or Retrospective review including a list of services/ service categories that require authorization.

Definitions: See Policy UM.001CH Glossary of Terms

See Policy # 669.235 HIPAA and ACFC Privacy Definitions

Medically Necessary — A service or benefit that is compensable under the CHIP Program and if it meets any one of the following standards:
● The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
● The service, item, procedure, or level of care will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
● The service, item, procedure, or level of care will assist the Enrollee to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Enrollee and those functional capacities that are appropriate for Enrollees of the same age.

Prior Authorization: A determination made by the Health Plan or its representative to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to an Enrollee prior to the provider's initiating provision of the requested service.

Retrospective Review: A review conducted by the Health Plan or its representative after the delivery of services to determine whether services were delivered as prescribed and consistent with The Health Plan's payment policies and procedures.

Delegate: An entity that has received formal authority to perform a certain function on behalf of the Health Plan. Although the Health Plan can give an entity the authority to perform a function, it retains the responsibility for ensuring that the function is performed appropriately. For the purpose of this document, Delegate refers to an entity that has received formal authority to perform Non-Urgent Care and Urgent Care Prior (Pre- Service) Authorization.

A) Dental Authorization Review Process

1. Requests for Prior or Retrospective Review are submitted electronically, by telephone, fax, or written request to the Health Plan's Utilization Management (UM) department or Delegate.

2. The UM/Delegate staff verifies Enrollee eligibility and Provider participation with the Health Plan and if either Enrollee eligibility or Provider participation with the Health Plan can't be verified, denial notification is made in accordance with Policy #UM.017CH, *Utilization Management Denial Notice Contents and Distribution*.

3. UM/Delegate staff will review the request to determine if the item/services are covered under the Keystone First – CHIP Program. If the item is not covered under the Keystone First – CHIP Program, the request is forwarded to the Dental Reviewer for denial as a non-covered benefit. Denial notification is made in accordance with Policy #UM.017CH, *Utilization Management Denial Notice Contents and Distribution*.

4. The Health Plan provides continuing coverage of care for Enrollees who are engaged in an ongoing course of treatment with a non-participating Practitioner or Provider to promote continuity of care. Continuity care coverage guidelines are outlined in Policy UM.706CH , Continuity of Care. If a request is identified to meet continuity of care, the continuity of care process outlined in Policy UM.706CH will be followed. Orthodontic continuity of care cases will follow the Orthodontic Continuity of Care Process document located under "Dental" , "Resources" on the Health Plan's website.

5. Health Care Providers are not required to submit the numerical diagnosis code to have the service considered for authorization.

6. If there is not sufficient information to make a determination, the UM/Delegate staff will request additional information in accordance with the procedure outlined in Policy #UM.010CH, *Utilization Management Decision Response Time.* Lack of sufficient information is defined as but not limited to:
    - Lack of medically necessary information
    - Lack of consultant findings

7. If the information submitted meets the definition of Medically Necessary as stated in Policy #UM.008CH*, Utilization Management Criteria* and the appropriate Dental Clinical Criteria, as stated in Attachment B, the request is approved. The UM staff notifies the Provider and Enrollee as outlined in Policy #UM.010CH, *Utilization Management Decision Response Time* and enters the authorization information into the appropriate medical management information system.

8. If the request cannot be approved using the applicable Dental Clinical criteria, it is forwarded to a Dental Reviewer for review.

9. A Dental Reviewer may consult a same specialty Dental Reviewer or the Health Plan's Dental Director (who in turn may consult with the Health Plan's Medical Director) if the documentation presented includes information beyond their scope of practice.

10. If the Dental Reviewer determines that the service is Medically Necessary, the Provider and Enrollee are notified in accordance with Policy # UM.010CH, *Utilization Management Decision Response Time.*

11. If the Dental Reviewer determines that the service is not medically necessary the denial is made in accordance with Policy #UM.017CH*, Utilization Management Denial Notice Contents and Distribution* and Policy #UM.010CH, *Utilization Management Decision Response Time.*

12. At the time of the notification of the denial, the Provider is given the opportunity to discuss the denial determination with the Dental Reviewer who made the denial determination or his/her designee (See Policy # UM.105CH, Peer- to-Peer Discussion).

13. Providers and Enrollees who do not agree with the denial determination may appeal the determination in accordance with Policy # AP.102P, *Formal Provider Appeals Process for Medical Necessity Denials and Informal Provider Disputes Not Resolved to the Provider's Satisfaction*and Policy # AP.700CHIP P, *CHIP Enrollee Complaint, Grievance, External Review & DHS Fair Hearing*.

14. The Health Plan reimburses Providers for the cost of providing medical information, including copying, only when such payment is required by the Provider's participation agreement with the Health Plan.

15. Written or Faxed documentation received in connection with a request for Authorization Review of Dental services is stored in the appropriate document imaging/storage application. All information with PHI is handled in accordance with Policy #669.213- Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data unless otherwise required by Law or regulation.

Related Procedures:

AP.102P - Formal Provider Appeals Process for Medical Necessity Denials and Informal Provider Disputes Not Resolved to the Provider's Satisfaction
AP.700CHIP P – CHIP Enrollee Complaint, Grievance, External Review and DHS Fair Hearing Policy and Procedures
151.5-Prior Authorization for Prescription Medications
UM.001CH – Glossary of Terms
UM.003CH – Non-Urgent and Urgent Care Prior (Pre-Services) Authorization Process
UM.010CH -- Utilization Management Decision Response Time
UM.008CH – Utilization Management criteria
UM.017CH – Utilization Management Denial Letter Content and Distribution
UM.105CH – Peer to Peer Discussion
UM.200CH – Retrospective Review Process
UM.706 CH – Continuity of Care
669.209-Disclosure of Protected Health Information to Business Associates and Other Contractors
669.212-Facsimile Machines and Transmission of PHI
669.217-Minimum Necessary Standard
669.235-HIPAA and ACFC Privacy Definitions
591.001 Records Retention Policy and Schedule

Source Documents and References:

1. PA CHIP – Eligibility and Benefits Handbook (April 2017 version)
2. Current PA CHIP Agreement

Attachments:

Attachment A: Dental Services for which Prior Authorization or Retrospective Review are Required

Attachment B: Clinical Criteria for Prior and Retro Authorization of Treatment and Emergency Treatment

Attachment C: Procedure Codes and Eligibility Criteria

Approved By:

Date May 19, 2025

Peter Charles Madden, DDS
Chief Dental Director
AmeriHealth Caritas

Attachment A

Dental Services for which Prior Authorization or Retrospective Review are Required

Code	Description
D0470	Diagnostic Models
D2510*	Inlay – metallic – one surface
D2520*	Inlay – metallic – two surfaces
D2530*	Inlay – metallic – three or more surfaces
D2542*	Onlay – metallic – two surfaces
D2543*	Onlay – metallic – three surfaces
D2544	Onlay – metallic – four or more surfaces
D2740	Crown-porcelain / ceramic
D2750	Crown – porcelain fused to high noble metal
D2751	Crown-porcelain fused to predominantly base metal
D2752	Crown-porcelain fused to noble metal
D2780	Crown – 3/4 cast high noble metal
D2781	Crown – 3/4 cast predominantly base metal
D2783	Crown – 3/4 porcelain/ ceramic
D2790	Crown – full cast high noble metal
D2791	Crown-full cast predominantly base metal
D2792	Crown – full cast noble metal
D2794	Crown – titanium and titanium alloys
D2950	Core buildup, including any pins when required
D2954	Prefabricated post and core in addition to crown
D3310	Endodontic therapy, anterior tooth (excluding final restoration)
D3320	Endodontic therapy, premolar tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (excluding final restoration)
D3346	Retreatment of previous root canal therapy - anterior
D3347	Retreatment of previous root canal therapy - premolar
D3348	Retreatment of previous root canal therapy - molar
D3351	Apexification/ recalcification – initial visit
D3352	Apexification/ recalcification – interim medication replacement
D3353	Apexification/ recalcification – final visit (includes completed root canal therapy)
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy - anterior
D3421	Apicoectomy – premolar – first root
D3425	Apicoectomy – molar – first root
D3426	Apicoectomy – each additional root
D3920	Hemisection (including any root removal), not including root canal therapy
D4210	Gingivectomy or gingivoplasty - 4 or more teeth per quadrant

D4211	Gingivectory or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectory or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant
D4249	Clinical crown lengthening - hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft - retained natural tooth - first site in quadrant
D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites)-first tooth, implant or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites)-each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft
D4285	Non-autogenous connective tissue graft procedure (including recipient site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in graft
D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture – resin base
D5212	Mandibular partial denture – resin base
D5213	Maxillary partial denture - cast metal framework
D5214	Mandibular partial denture – cast metal framework
D5221	Immediate maxillary partial denture - resin base
D5222	Immediate mandibular partial denture - resin base
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases
D5282	Removable unilateral partial denture - one piece cast metal, maxillary
D5283	Removable unilateral partial denture - one piece cast metal, mandibular
D6010*	Surgical placemernt of implant body: endosteal implant
D6012*	Surgical placemernt of interim implant body for transitional prosthesis: endosteal implant
D6040*	Surgical placement: eposteal implant

D6050*	Surgical placement: transosteal implant
D6055*	Connecting bar - implant supported or abutment supported
D6056*	Prefabricated abutment - includes modification and placement
D6057*	Custom fabricated abutment - includes placement
D6058*	Abutment supported porcelain/ ceramic crown
D6059*	Abutment supported porcelain fused to metal crown (high noble metal)
D6060*	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061*	Abutment supported porcelain fused to metal crown (noble metal)
D6062*	Abutment supported cast metal crown (high noble metal)
D6063*	Abutment supported cast metal crown (predominantly base metal)
D6064*	Abutment supported cast metal crown (noble metal)
D6065*	Implant supported porcelain/ ceramic crown
D6066*	Implant supported crown - porcelain fused to high noble alloys
D6067*	Implant supported crown - high noble alloys
D6068*	Abutment supported retainer for porcelain/ ceramic FPD
D6069*	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070*	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071*	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072*	Abutment supported retainer for cast metal FPD (high noble metal)
D6073*	Abutment supported retainer for cast metal FPD (predomionantly base metal)
D6074*	Abutment supported retainer for cast metal FPD (noble metal)
D6075*	Implant supported retainer for ceramic FPD
D6076*	Implant supported retainer for FPD - porcelain fused to high noble alloys
D6077*	Implant supported retainer for metal FPD - high noble alloys
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments.
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/ abutment supported prosthesis, per attachment
D6100*	Surgical removal of implant body
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure
D6104	Bone graft at time of implant placement
D6110*	Implant/ abutment supported removable denture for edentulous arch - maxillary
D6111*	Implant/ abutment supported removable denture for edentulous arch - mandibular
D6112*	Implant/ abutment supported removable denture for partially edentulous arch - maxillary
D6113*	Implant/ abutment supported removable denture for partially edentulous arch - mandibular
D6114*	Implant/ abutment supported fixed denture for edentulous arch - maxillary
D6115*	Implant/ abutment supported fixed denture for edentulous arch - mandibular
D6116*	Implant/ abutment supported fixed denture for partially edentulous arch - maxillary
D6117*	Implant/ abutment supported fixed denture for partially edentulous arch - mandibular

D6190*	Radiographic/ surgical implant index, by report
D6210	Pontic - cast high noble metal
D6211	Pontic - cast predominantly base metal
D6212	Pontic - cast noble metal
D6214	Pontic - titanium and titanium alloys
D6240	Pontic - porcelain fused to high noble metal
D6241	Pontic - porcelain fused to predominantly base metal
D6242	Pontic - porcelain fused to noble metal
D6245	Pontic - porcelain/ ceramic
D6545	Retainer - cast metal for resin bonded fixed prosthesis
D6548	Retainer - porcelain/ ceramic for resin bonded fixed prosthesis
D6549	Resin retainer - for resin bonded fixed prosthesis
D6600*	Retainer inlay – porcelain/ceramic, two surfaces
D6601*	Retainer inlay – porcelain/ceramic, three or more surfaces
D6602*	Retainer inlay – cast high noble metal, two surfaces
D6603*	Retainer inlay – cast high noble metal, three or more surfaces
D6604*	Retainer inlay – cast predominantly base metal, two surfaces
D6605*	Retainer inlay – cast predominantly base metal, three or more surfaces
D6606*	Retainer inlay – cast noble metal, two surfaces
D6607*	Retainer inlay – cast noble metal, three or more surfaces
D6608*	Retainer onlay – porcelain/ceramic, two surfaces
D6609*	Retainer onlay – porcelain/ceramic, three or more surfaces
D6610*	Retainer onlay – cast high noble metal, two surfaces
D6611*	Retainer onlay – cast high noble metal, three or more surfaces
D6612*	Retainer onlay – cast predominantly base metal, two surfaces
D6613*	Retainer onlay – cast predominantly base metal, three or more surfaces
D6614*	Retainer onlay – cast noble metal, two surfaces
D6615*	Retainer inlay – cast noble metal, three or more surfaces
D6740	Retainer crown - porcelain/ ceramic
D6750	Retainer crown - porcelain fused to high noble metal
D6751	Retainer crown - porcelain fused to predominantly base metal
D6752	Retainer crown - porcelain fused to noble metal
D6780	Retainer crown - 3/4 cast high noble metal
D6781	Retainer crown - 3/4 cast predominantly base metal
D6782	Retainer crown - 3/4 cast noble metal
D6783	Retainer crown - 3/4 porcelain/ ceramic
D6790	Retainer crown - full cast high noble metal
D6791	Retainer crown - full cast predominantly base metal
D6792	Retainer crown - full cast noble metal
D7220	Removal of impacted tooth – soft tissue
D7230	Remove of impacted tooth - partially bony
D7240	Remove of impacted tooth – completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed tooth
D7280	Exposure of an unerupted tooth

D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7510	Incision and drainage of abscess-intraoral soft tissue
D7511	Incision and drainage of abscess-intraoral soft tissue- complicated
D7520	Incision and drainage of abscess-extraoral soft tissue
D7521	Incision and drainage of abscess-extraoral soft tissue-complicated
D7953	Bone replacement graft for ridge preservation - per site
D7999	Unspecified oral surgery procedure, by report
D8010*	Limited Orthodontic Treatment of the Primary Dentition
D8020*	Limited Orthodontic Treatment of the Transitional Dentition
D8030*	Limited Orthodontic Treatment of the Adolescent Dentition
D8040*	Limited Orthodontic Treatment of the Adult Dentition
D8070*	Comprehensive Orthodontic Treatment of the Transitional Dentition
D8080*	Comprehensive Orthodontic Treatment of the Adolescent Dentition
D8090*	Comprehensive Orthodontic Treatment of the Adult Dentition
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment
D9224	Administration of general anesthesia with advanced airway – first 15 minutes
D9225	Administration of general anesthesia with advanced airway – each susequent 15 minutes
D9239	Intravenous moderate sedation/analgesia – first 15 minutes
D9243	Intravenous moderate sedation/analgesia – each subsequent 15 minute increment
D9246	Administration of moderate sedation – non-intravenous parenteral – first 15 minutes
D9247	Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minutes
D9610	Therapeutic parenteral drug, single administration
D9930	Treatment of complications (post surgical) – unusual circumstances, by report
D9944	Occlusal guard – hard appliance, full arch
D9945	Occlusal guard – soft appliance, full arch
D9946	Occlusal guard – hard appliance, partial arch

* This service requires prior authorization; retro authorization is not permitted.

ATTACHMENT B

Clinical Criteria for Prior Authorization and/or Retrospective Review of Treatment and EmergencyTreatment

The Keystione First - CHIP Dental Program will provide for the least expensive alternative treatment, as well as require that medical necessity requirements for covered procedures are met.

If a CHIP Enrollee's family wishes to have the Enrollee receive dental services which are not covered by the Keystone First - CHIP Dental benefit package, the family and their dentist may make the appropriate arrangements for care and payment between themselves

The dentist is required to notfy the child's family, in advance, in writing, of the amount the dentist will bill the family.

Inlays and Onlays (D2510, D2520, D2530, D2542, D2543, D2544)

Crowns (D2740, D2750, D2751, D2752, D2780, D2781, D2783, D2790, D2791, D2792, D2794)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth.

Non- abutment teeth: Current periapical x-rays of the tooth/teeth to be restored.

Abutment teeth: Current periapical x-rays of the tooth/teeth and panoramic or full mouth are needed for evaluation.

All criteria below must be met:

- Tooth to be restored (with an inlay, onlay, or crown) must have an opposing tooth in occlusion or be an abutment tooth for a partial denture
- Minimum 50% bone support
- The patient must be free of active periodontal disease and free of advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    1. The tooth is filled within two millimeters of the radiographic apex
    2. The root canal is not filled beyond the radiographic apex
    3. The root canal filling is adequately condensed and/or filled
    4. Healthy periapical tissue (healing PARL or no PARL)
- And 1 of the criteria below must be met:
    1. Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
    2. Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
    3. Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

Core buildups; Posts and cores (D2950, D2954)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    1. The tooth is filled within two millimeters of the radiographic apex
    2. The root canal is not filled beyond the radiographic apex
    3. The root canal filling is adequately condensed and/or filled
    4. Healthy periapical tissue (healing PARL or no PARL)

Root canal therapy (D3310, D3320, D3330)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
    - Evidence of apical pathology/fistula
    - Narrative describing symptoms of irreversible pulpitis

Endodontic Retreatment (D3346, D3347, D3348)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
    - Evidence of apical pathology/fistula
    - Narrative describing symptoms of irreversible pulpitis

Apexification/ Recalcification (D3351, D3352, D3353)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray

- Evidence of apical pathology/fistula
- Narrative describing symptoms of irreversible pulpitis

Pulpal Regeneration (D3355, D3356, D3357)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Deep caries
- Traumatic fracture with near pulpal exposure
- Pain from percussion, temperature
- History of trauma
- Immature permanent tooth (root development)

Apicoectomy (D3410, D3421, D3425, D3426)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Completed root canal
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
  - Evidence of apical pathology/fistula
  - Narrative describing symptoms of irreversible pulpitis

Root Amputation (D3450)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth.

Hemisection (D3920)

Required documentation – Periapical radiograph showing the crown and entire root of the tooth

Gingivectomy or Gingivoplasty (D4210, D4211, D4212)

Required documentation – pre-operative radiographs, periodontal charting, narrative of medical necessity, photo (optional)

1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the periodontal charting

Periodontal surgical services (D4240, D4241, D4249, D4260, D4261, D4263, D4270, D4273, D4275, D4277, D4278, D4283, and D4285)

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated.

Documentation must support medical necessity for the procedure.

Benefits for periodontal services are available only when billed for natural teeth.

Teeth must have a good long-term prognosis to qualify for any periodontal procedures.

All periodontal procedures include routine postoperative care and local anesthesia.

Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.

Services that fail to meet clinical criteria due to prior treatment will be disallowed.

Gingival flap procedure (D4240, D4241)

- Perio classification of Type III or IV
- Lack of attached gingiva

Clinical crown lengthening (D4249)

- Necessary due to coronal fracture or caries
- Not allowable on the same date of service as the restorative procedure

Osseous surgery (D4260, D4261)

- Perio classification of Type III or IV
- History of periodontal scaling and root planing (D4341, D4342)

Bone replacement graft (D4263)

- Documentation demonstrates the need to correct bone defect(s)

Periodontal scaling and root planing (D4341 and D4342)

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated.

All criteria below must be met:

- Pocket depths of 5 mm or greater more on 4 or more teeth in the quadrant indicated on the periodontal charting (for D4341).
- Pocket depths of 5 mm or greater more on 1 to 3 teeth in the quadrant indicated on the periodontal charting (for D4342).
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Complete dentures (D5110, D5120)

Required documentation –Complete series of radiograph images (D0120) or panoramic radiographic image (D0330)

Criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable. If a current denture exists that was not reimbursed by the Plan, it must be non-serviceable for reasons other than tooth loss.

Immediate dentures (D5130, D5140)

Required documentation – Complete series of radiograph images (D0120) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable

Removable partial dentures (D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5282, and D5283)

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable. If a current denture exists that was not reimbursed by the plan, it must be non-serviceable for reasons other than tooth loss.

In addition, 1 of the criteria below must be met:

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)

Implant services (D6010, D6012, D6040, D6050, D6055, D6056, D6057, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6080, D6090, D6091, D6100, D6101, D6102, D6103, D6104, D6110, D6111, D6112, D6113, D6114, D6115, D6116, D6117, D6190)

Note: an implant is a covered procedure of the plan only if determined to be a dental necessity.
If it is determined that an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for any individual implants or implant-related procedures.
The second phase of treatment (the prosthesis phase--placing of the implant crown, bridge, partial denture or denture) may be subject to the alternate benefit provision of the plan.

When indicated, Four Maxillary and Two Mandibular implants are usually sufficient to retain a denture.

Required documentation:

Detailed treatment plan, and

Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review:

Intraoral – comprehensive series of radiographic images (D0210) or;
Panoramic radiographic image (D0330) plus bitewing radiographic images.

All below criteria must be met:
Enrollee has good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where further oral health deterioration is not anticipated.
Implants will be covered only when developmentally and age appropriate.

Note: Implants are considered to be developmentally inappropriate before the cessation of Enrollee's growth.

No pre-existing prosthesis placed within the last 5 years.
There is sufficient space to restore the implant with an anatomically correct crown.

Fixed Prosthodontic services (D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6545, D6548, D6549, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792)

Fixed prosthodontic services are not allowed and are not payable for members under the age of 16.

Fixed partial dentures are covered only for Enrollees with good oral health and hygiene, good periodontal health (AAP Type 1 or 2), and a favorable prognosis where continuous deterioration is not expected.

Procedures that may meet clinical criteria for approval, may be disallowed due to frequency limitations.

Fixed prosthodontic services include routine temporary prosthetics

The date of delivery of a fixed partial denture is the date of service.

If the member is missing more than 2 posterior teeth in the same arch, the allowable benefit will be for a removable partial denture.

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. Non-abutment teeth: Current periapical x-rays of the tooth/teeth to be restored. Also, radiographs which clearly show the adjacent and opposing teeth.

Abutment teeth: Current periapical x-rays of the tooth/teeth and panoramic or full mouth are needed for evaluation. Also, radiographs which clearly show the adjacent and opposing teeth.

All criteria below must be met:

- Tooth to be restored with a retainer crown must have an opposing tooth in occlusion or be an abutment tooth for a fixed partial denture
- Minimum 50% bone support
- The patient must be free of active periodontal disease and of advanced periodontal disease
- No untreated caries on any abutment teeth
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    1. The tooth is filled within two millimeters of the radiographic apex
    2. The root canal is not filled beyond the radiographic apex

3. The root canal filling is adequately condensed and/or filled
4. Healthy periapical tissue (healing PARL or no PARL)

- And 1 of the criteria below must be met:
    1. Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
    2. Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
    3. Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

Impacted teeth (D7220, D7230, D7240, D7241)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
- X-ray matches type of impaction code described
- Documentation of clinical evidence indication impaction, although asymptomatic may not be disease free

Surgical removal of residual tooth roots (D7250)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Tooth root is completely covered by bony tissue on x-ray
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic)

Coronectomy (D7251)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Documentation describes nerve or vascular complication if entire impacted tooth is removed

Tooth reimplantation and / or stabilization (D7270)

Documentation required – Narrative of medical necessity

All criteria below must be met:

- Documentation describes an accident such as playground fall or bicycle injury
- Documentation describes which teeth were avulsed or loosened and treatment necessary to stabilize them through reimplantation and/or stabilization

Exposure of an unerupted tooth (D7280)

Documentation required – Pre-operative radiographs and narrative of medical necessity.

Criteria below must be met:

- Documentation supports impacted/unerupted tooth

Alveoloplasty without extractions (D7320, D7321)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Documentation supports medical necessity for fabrication of a prosthesis

Incision and drainage of abscess (D7510, D7511)

Documentation required – Narrative of medical necessity, radiographs or photos

All criteria below must be met:

For Intraoral incision:

- Documentation describes non-vital tooth or foreign body

Bone replacement graft for ridge preservation – per site (D7953)

Documentation required – Narrative of medical necessity, radiographs

Unspecified oral surgery procedure (D7999)

Documentation required – Narrative of medical necessity and description of procedure; name, license number, and Tax ID of Assistant surgeon required if D7999 is submitted for this purpose

All criteria below must be met:

- Documentation describes medical necessity need for Assistant surgeon

General anesthesia / IV sedation (Dental Office Setting) - (D9222, D9223, D9239, D9243, D9224, D9225)

Documentation required – Narrative of Medical Necessity, Anesthesia Log (retrospective review)

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety

- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of general anesthesia/IV sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

Note that D9222/D9239 may be prior authorized as described above and D9223/D9243 may be retro authorized (with anesthesia log required).

Non-intravenous conscious sedation (Dental Office Setting) (D9245, D9246)

Documentation required – Narrative of medical necessity

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of non-intravenous conscious sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

Therapeutic parenteral drug – single administration – (D9610)

Documentation required – Narrative of Medical Necessity

Must be performed in conjunction with an approved D9222 or D9239.

Treatment of complications (post-surgical) – (D9930)

Documentation required – Narrative of Medical Necessity

- Documentation describes post-surgical condition supporting Medical Necessity for procedure

Occlusal guards – (D9944, D9945, D9946)

Documentation required – Narrative of Medical Necessity

Orthodontics

Fixed or removable appliance therapy (D8210, D8220)

Documentation required – Panoramic and/or cephalometric radiographs, narrative of Medical Necessity

All criteria below must be met:

- Documentation describes thumb sucking or tongue thrusting habit.
- Documentation of existing clinical condition or circumstance making the use of minor orthodontic treatment to control harmful habits a reasonable inclusion as a medically necessary part of the therapeutic regimen.

Limited orthodontic treatment (D8010, D8020, D8030, D8040)

Documentation requirements – Panoramic and /or cephalometric radiograph, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form

All the criteria below must be met:

- Dentition must be free of carious lesions.
- Patient must demonstrate the ability to maintain adequate oral hygiene.

And in addition, one or more of the following criteria must be met:

- Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors
- Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)
- Documentation demonstrates a large anterior – posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth class II or Class III)
- Documentation shows anterior cross bite which involves more than two teeth in cross bite
- Documentation shows posterior transverse discrepancies which involves several posterior teeth in cross bite (not a single tooth in cross bite), one of which must be a molar
- Documentation shows significant posterior open bite (not involving partially erupted teeth or one or two teeth slightly out of occlusion)
- Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically)
- Salzmann Criteria Index Form score meets requirements of 25 or greater. This requirement only applies to D8030 and D8040.

Comprehensive orthodontic treatment (D8070, D8080, D8090)

Documentation requirements – Panoramic and /or cephalometric radiographs, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form.

All the criteria below must be met:

- Dentition must be free of carious lesions.
- Patient must demonstrate the ability to maintain adequate oral hygiene.

And in addition, one or more of the following criteria must be met:

- Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors
- Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)
- Documentation demonstrates a large anterior – posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth class II or Class III)
- Documentation shows anterior cross bite which (involves more than two teeth in cross bite
- Documentation shows posterior transverse discrepancies which involves several posterior teeth in cross bite (not a single tooth in cross bite), one of which must be a molar
- Documentation shows significant posterior open bite (not involving partially erupted teeth or one or two teeth slightly out of occlusion)
- Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically)
- Salzmann Criteria Index Form score meets requirements of 25 or greater. This requirement only applies to D8080 and D8090.

Periodic orthodontic treatment visit (D8670)

Documentation requirements – Completed Keystone First Orthodontic Continuation of Care Form.

Photos of current orthodontic status.

The criteria below must be met:

Ongoing active comprehensive orthodontic treatment.

Orthodontic Retention (D8680)

Documentation required – diagnostic quality photos

All criteria below must be met:

- Photos show completed orthodontic case.

ATTACHMENT C

Procedure Codes And Eligibility Criteria

Services not listed in this Dental Benefit Grid are not benefits of this plan, and are not covered.

The Keystone First - CHIP Dental Program will provide for the least expensive alternative treatment, as well as require that medical necessity requirements for covered procedures are met.

If a CHIP Enrollee's family wishes to have the Enrollee receive dental services which are not covered by the Keystone First - CHIP Dental benefit package, the family and their dentist may make the appropriate arrangements for care and payment between themselves

The dentist is required to notfy the CHIP Enrollee's family, in advance, in writing, of the amount the dentist will bill the family.

GENERAL INFORMATION
All benefits are subject to the definitions, limitations, and exclusions given below and are payable only when the service is necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
The following is a list of services most commonly provided to covered individuals. It is not an all-inclusive list. Benefits for ADA codes not listed below will be provided, subject to exclusions and limitations shown in this plan.
Some services may be subject to dental review. The dentist should submit a pre-determination/pre-certification request prior to start of service.
Exclusions and limitations shown in this plan. services or medically necessary orthodontic dental services. There are no deductibles, copayments or coinsurance for PA CHIP covered dental benefits.
All exams, oral evaluations and treatments, such as fluorides and some images are combined under one limitation under the plan. Periodic oral exam (D0120) oral evaluations (D0145), and comprehensive oral exam (D0150, D0180) are combined and limited to one exam every 6 months from the date services were last rendered. There must be a 6 month separation between services, even if the separation of services enters a new benefit year.
All services requiring more than one visit are payable once all visits are completed.
All major prosthodontic services are combined under one replacement limitation under the plan. Benefits for prosthodontic services are combined and limited to one every 60 months
The periodicity scheduled used for the CHIP dental package is the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.
N = No Reporting Requirements T = Tooth Reporting Requirement Q = Quadrant Reporting Requirement

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D0120	Periodic oral evaluation-established patient	No				N	0	18	1	180	Days Per patient per dentist/dental group. (A combined total of one D0120, D0145, D0150, D0160, or D0180 per patient per 180 days.)
D0140	Limited oral evaluation-problem focused	No				N	0	18	1	1	Days Per patient.
D0150	Comprehensive oral evaluation- new or established patient	No				N	0	18	1	180	Days Per patient per dentist/dental group. (A combined total of one D0120, D0145, D0150, D0160, or D0180 per patient per 180 days.)
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No				N	0	2	1	180	Days per patient per dentist/ dental group. (A combined total of one D0120, D0145, D0150, D0160, or D0180 per patient per 180 days.)
D0160	Detailed and extensive oral evaluation – problem focused, by report	No				N	0	18	1	180	Days per patient per dentist/ dental group. (A combined total of one D0120, D0145, D0150, D0160, or D0180 per patient per 180 days.) Not payable with TMJ.
D0170	Limited oral evaluation-problem focused	No				N	0	18	1	1	. Days per patient. One D0170 per 30 Days, per Patient per provider.
D0180	Comprehensive periodontal evaluation – new or established patient	No				N	0	18	1	180	Days per patient per dentist/ dental group. (A combined total of one D0120, D0145, D0150, or D0180 per patient per 180 days.)
D0210	Intraoral – comprehensive series of radiographic images	No				N	0	18	1	5	Years per patient. A combined total of one D0210 or D0330 is eligible in a 5 year period.

D0220	Intraoral- periapical first radiographic image	No				N	0	18	1	1	Day per patient. Not payable if billed with D0210. Ten in any 12 month period.
D0230	Intraoral – periapical each additional radiographic image	No				N	0	18	10	1	Year per patient. Not payable if billed with D0210.
D0240	Intraoral -occlusal radiographic image	No				N	0	18	1	1	Year per patient
D0270	Bitewing - single radiographic image	No				N	0	18	1	180	Days per patient. A combined total of one D0270, D0272, D0273, D0274, or D0277 is eligible in a 180 day period. Not payable if billed with D0210.
D0272	Bitewings -two radiographic images	No				N	0	18	1	180	Days per patient. A combined total of one D0270, D0272, D0273, D0274, or D0277 is eligible in a 180 day period. Not payable if billed with D0210.
D0273	Bitewings - three radiographic images	No				N	0	18	1	180	Days per patient. A combined total of one D0270, D0272, D0273, D0274, or D0277 is eligible in a 180 day period. Not payable if billed with D0210.
D0274	Bitewings – four radiographic images	No				N	0	18	1	180	Days per patient. A combined total of one D0270, D0272, D0273, D0274, or D0277 is eligible in a 180 day period. Not payable if billed with D0210.
D0277	Vertical bitewings - 7 to 8 radiographic images	No				N	0	18	1	180	Days per patient. A combined total of one D0270, D0272, D0273, D0274, or D0277 is eligible in a 180 day period. Not payable if billed with D0210.
D0330	Panoramic radiographic image	No				N	0	18	1	5	Years per patient. A combined total of one D0210 or D0330 is eligible in a 5 year period
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis.	No				N	0	18	1	1	Per Year per patient
D0350	2D oral/ facial photographic image obtained intra-orally or extra-orally	No				N	0	18			
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No				N	0	18	1	1	Per Year per patient.

D0415	Collection of microorganisms for culture and sensitivity	No				N	0	18	1	1	Per Lifetime per patient.
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	No				N	0	18	1	1	Per Lifetime per patient.
D0423	Genetic test for susceptibility to disease - specimen analysis	No				N	0	18	1	1	Per Lifetime per patient.
D0460	Pulp vitality tests	No				N	0	18	1	30	Days per patient.
D0470	Diagnostic casts	Yes	0	18	Narrative of medical nessity	N	0	18	1	1	Per lifetime per patient. Not payable with orthodontia.

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D1110	Prophylaxis -adult	No				N	12	18	1	180	Days per patient. Only one D1110 or D1120 is eligible in a 180 day period.
D1120	Prophylaxis - child	No				N	0	11	1	180	Days per patient. Only one D1110 or D1120 is eligible in a 180 day period.
D1206	Topical application of fluoride varnish	No				N	0	18	2	1	Year per patient. A combined total of two (D1206 and/or D1208) are eligible in a one year period.
D1208	Topical application of fluoride – excluding varnish	No				N	0	18	2	1	Year per patient. A combined total of two (D1206 and/or D1208) re eligible in a one year period.
D1351	Sealant - per tooth	No				T	0	18	1	36	Months per tooth. Allowable on 1st and 2nd premolars. Allowable on 1st and second molars.
D1353	Sealant repair – per tooth	No				T	0	18	1	36	Months per tooth.
D1354	Application of caries arresting medicament – per tooth	No				T	0	18	2	1	Per arch per year
D1354	Application of caries arresting medicament – per tooth	No				T	0	18	1	36	Months per tooth per patient. Premolars, first molars, and second molars ohly
D1354	Application of caries arresting medicament – per tooth	No				T	0	18	6	1	Lifetime per tooth per patient
D1510	Space maintainer – fixed, unilateral, per quadrant	No				Q	0	18			
D1516	Space maintainer – fixed - bilateral, maxillary	No				T	0	18			
D1517	Space maintainer – fixed - bilateral, mandibular	No				T	0	18			
D1520	Space maintainer – removable, unilateral, per quadrant	No				Q	0	18			
D1526	Space maintainer – removable – bilateral, maxillary	No				T	0	18			
D1527	Space maintainer – removable – bilateral, mandibular	No				T	0	18			
		Authorization Requirements				**Benefit Details**					

Code	Code Description	Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No				N	0	18			
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No				N	0	18			
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No				N	0	18			
D1556	Removal of fixed unilateral space maintainer – per quadrant	No				N	0	18			
D1557	Removal of fixed bilateral space maintainer – maxillary	No				N	0	18			
D1558	Removal of fixed bilateral space maintainer – mandibular	No				N	0	18			
D2140	Amalgam – one surface, primary or permanent	No				T	0	18	1	24	Months per tooth per patient.
D2150	Amalgam – two surfaces, primary or permanent	No				T	0	18	1	24	Months per tooth per patient.
D2160	Amalgam – three surfaces, primary or permanent	No				T	0	18	1	24	Months per tooth per patient.
D2161	Amalgam – four or more surfaces, primary or permanent	No				T	0	18	1	24	Months per tooth per patient.
D2330	Resin-based composite - one surface, anterior	No				T	0	18	1	24	Months per tooth per patient.
D2331	Resin-based composite two surfaces, anterior	No				T	0	18	1	24	Months per tooth per patient.
D2332	Resin-based composite three surfaces, anterior	No				T	0	18	1	24	Months per tooth per patient.
D2335	Resin- based composite four or surfaces or involving incisal angle (anterior)	No				T	0	18	1	24	Months per tooth per patient.
		Authorization Requirements				**Benefit Details**					

Code	Code Description	Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D2391	Resin - based Composite - one surface, posterior	No				T	0	18	1	24	Months per tooth per patient. No reimbursement if performed within 30 days of a crown.
D2392	Resin - based Composite - two surfaces, posterior	No				T	0	18	1	24	Months per tooth per patient. No reimbursement if performed within 30 days of a crown.
D2393	Resin - based Composite - three surfaces, posterior	No				T	0	18	1	24	Months per tooth per patient. No reimbursement if performed within 30 days of a crown.
D2394	Resin - based composite-four or more surfaces, posterior	No				T	0	18	1	24	Months per tooth per patient. No reimbursement if performed within 30 days of a crown.
D2510	Inlay – metallic – one surface	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. An alternate benefit of D2140 will be provided.
D2520	Inlay – metallic – two surfaces	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. An alternate benefit of D2150 will be provided.
D2530	Inlay – metallic – three or more surfaces	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. An alternate benefit of D2160 will be provided.
D2542	Onlay – metallic – two surfaces	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. Not payable if the tooth can be restored with an amalgam restoration or with a resin-based composite direct placement restoration.
D2543	Onlay – metallic – three surfaces	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. Not payable if the tooth can be restored with an amalgam restoration or with a resin-based composite direct placement restoration.
D2544	Onlay – metallic – four or more surfaces	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	60	Months per tooth. Not payable if the tooth can be restored with an amalgam restoration or with a resin-based composite direct placement restoration.

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D2740	Crown-porcelain/ceramic	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient 1 per tooth every 5 years regardless of crown procedure code.
D2750	Crown – porcelain fused to high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient 1 per tooth every 5 years regardless of crown procedure code.
D2751	Crown-porcelain fused to predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient 1 per tooth every 5 years regardless of crown procedure code.
D2752	Crown-porcelain fused to noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient 1 per tooth every 5 years regardless of crown procedure code.
D2780	Crown – 3/4 cast high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2781	Crown – 3/4 cast predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2783	Crown – 3/4 porcelain/ ceramic	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2790	Crown – full cast high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2791	Crown - full cast predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient 1 per tooth every 5 years regardless of crown procedure code.

D2792	Crown – full cast noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2794	Crown – titanium and titanium alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	12	18	1	5	Years per tooth per patient. 1 per tooth every 5 years regardless of crown procedure code.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No				T	0	18	1	1	Day per tooth per patient
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No				T	0	18	1	1	Day per tooth per patient
D2920	Re-cement or re-bond crown	No				T	0	18	1	1	Day per tooth per patient
D2929	Prefabricated porcelain/ ceramic crown – primary tooth	No				T	0	14	1	60	Months per tooth per patieht. Under age 15 where no permanent successor exists.
D2930	Prefabricated stainless steel crown - primary tooth	No				T	0	14	1	60	Months per tooth per patient. Under age 15.
D2931	Prefabricated stainless steel crown - permanent tooth	No				T	0	14	1	60	Months per tooth per patient. Under age 15.
D2940	Protective restoration	No				T	0	18	1	1	Day per tooth per patient.
D2950	Core buildup, including any pins when required	Yes	0	18	Narrative of medical necessity; pre-op x-rays	T	0	18	1	5	Years per tooth
D2951	Pin retention – per tooth, in addition to restoration	No				T	0	18	1	2	Years per tooth per patient

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D2954	Prefabricated post and core in addition to crown	Yes	0	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	18	1	1	Per lifetime per tooth
D2980	Crown repair necessitated by restorative material failure	No			Narrative of medical necessity	T	0	18	1	12	Months per tooth per patient. By report.
D2981	Inlay repair necessitated by restorative material failure	No			Narrative of medical necessity	T	0	18	1	12	Months per tooth per patient. By report.
D2983	Veneer repair necessitated by restorative material failure	No			Narrative of medical necessity	T	0	18	1	12	Months per tooth per patient. By report.
D2991	Application of hydroxyappetite regeneration medicament – per tooth	No			Narrative of medical necessity	T	0	18	1	1	LIFETIME/PER TOOTH/PER PATIENT. NOT ALLOWED IF TOOTH WAS PREVIOUSLY RESTORED (D2140-D2161, D2391-D2394, D2330-D2335)
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No				T	0	18	1	1	Per Day/ per Tooth/ Per Patient “If a root canal is performed within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure ad benefits are not payable separately.
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	No				T	0	18	1	1	Per Day/ Per Tooth/ Per Patient “If a root canal is performed 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	No				T	0	11	1	1	Per Lifetime per tooth “Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11.”
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	No				T	0	18	1	1	Per Lifetime per tooth “Incompete endodontic treatment when you discontinue treatment. Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11.”

D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Yes	0	18	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	T	0	18	1	1	Per Lifetime Per Tooth Per Patient
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Yes	0	18	Pre-operative x-rays (excluding bitewings). Narrative of medical necessity	T	0	18	1	1	Per Lifetime Per Tooth Per Patient
D3330	Endodontic therapy, molar tooth (excluding final restoration))	Yes	0	18	Pre-operative x-rays (excluding bitewings), narrative of medical necessity	T	0	18	1	1	Per Lifetime Per Tooth Per Patient
D3346	Retreatment of previous root canal therapy - anterior	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3347	Retreatment of previous root canal therapy - premolar	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3348	Retreatment of previous root canal therapy - molar	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3351	Apexification/ recalcification – initial visit (apical closure/ calcific repair of perforatiohs, root resorption, et .)	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3352	Apexification/ recalcification -interim medication replacement	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3353	Apexification/ recalcification -final visit (includes completed root canal therapy – apical cloure/ calcific repair of perforations, root resdorption, etc.)	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth
D3355	Pulpal regeneration – initial visit	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth. Does not include final restoration.
D3356	Pulpal regeneration - interim medication replacement	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth. Does not include final restoration.
D3357	Pulpal regeneration - completion of treatment	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18	1	1	Per Lifetime per tooth. Does not include final restoration.
D3410	Apicoectomy - anterior	Yes	0	18		T	0	18	2 teeth	1	Day Per Tooth Per Patient

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D3421	Apicoectomy - premolar – (first root)	Yes	0	18		T	0	18	2 teeth	1	Day Per Tooth Per Patient
D3425	Apicoectomy - molar – first root	Yes	0	18		T	0	18	2 teeth	1	Day Per Tooth Per Patient
D3426	Apicoectomy-(each additional root)	Yes	0	18		T	0	18	2 teeth	1	Day Per Patient
D3450	Root amputation – per root	Yes	0	18		T	0	18			
D3920	Hemisection (including any root removal)	Yes	0	18	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	18			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months Per Quadrant Per Patient (A combined total of one D4210 or D4211 per quadant is eligible in a 36 month period.)
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months Per Quadrant Per Patient (A combined total of one D4210 or D4211 per quadant is eligible in a 36 month period.)
D4212	Gingivectory or gingivoplasty to allow access for restorative procedure, per tooth	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per tooth. With restorative procedures.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months per quadrant. (A combined total of one D4240 or D4241 per quadant is eligible in a 36 month period.)
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months per quadrant. (A combined total of one D4240 or D4241 per quadant is eligible in a 36 month period.)

D4249	Clinical crown lengthening - hard tissue	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	1	Per Lifetime per tooth.
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months per quadrant. (A combined total of one D4260 or D4261 per quadant is eligible in a 36 month period.)
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months per quadrant. (A combined total of one D4260 or D4261 per quadant is eligible in a 36 month period.)
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant. (A combined total of one D4263 or D4270 per quadant is eligible in a 36 month period.)
D4270	Pedicle soft tissue graft procedure	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	18	1	36	Months per quadrant. (A combined total of one D4263 or D4270 per quadant is eligible in a 36 month period.)
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant.
D4275	Non-autogenous connective tissue graft procedure (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant.
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites)-first tooth, implant or edentulous tooth position in graft	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant. (A combined total of one D4277 or D4278 per quadrant is eligible in a 36 month period.)

D4278	Free soft tissue graft procedure (including recipient and donor surgical sites)-each additional tooth, implant or edentulous tooth position in same graft site.	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant. (A combined total of one D4277 or D4278 per quadrant is eligible in a 36 month period.)
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth, implant or edentulous tooth position in graft	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant.
D4285	Non-autogenous connective tissue graft procedure (including recipient site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in graft	Yes	0	18	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	T	0	18	1	36	Months per quadrant.
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	18	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	18	2 different quadrants	1	Per day per patient.
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	18	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	18	1	24	Months per quadrant. (A combined total of one D4341 or D4342 per quadant is eligible in a 24 month period.)
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Yes	0	18	Periodontal charting and pre- op x-rays. Narrative o medical necessity	Q	0	18	1	24	Months per quadrant. (A combined total of one D4341 or D4342 per quadant is eligible in a 24 month period.)
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	No				N	0	18	1	1	Lifetime per patient. No history of prophylaxis or periodontal treatment in past 12 months. .

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D4910	Periodontal maintenance	No				N	0	18	1	90	Days per patient with past history of therapeutic periodontal treatment or periodontal maintenance.
D5110	Complete denture - maxillary	Yes	0	18	Full mouth or panorex x-rays. Narrative of medical necessity),	N	0	18	1	5	Years (A combined total of one D5110 or D5130 is eligible in a 5 year period)
D5120	Complete denture - mandibular	Yes	0	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	18	1	5	Years (A combined total of one D5120 or D5140 is eligible in a 5 year period)
D5130	Immediate denture - maxillary	Yes	0	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	18	1	5	Years (A combined total of one D5110 or D5130 is eligible in a 5 year period)
D5140	Immediate denture - mandibular	Yes	0	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	18	1	5	Years (A combined total of one D5120 or D5140 is eligible in a 5 year period.)
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	18	1	5	Years (A combined total of one D5211, D5213, D5221 or D5223 is eligible in a 5 year period.)
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity	N	6	18	1	5	Years (A combined total of one D5212, D5214, D5222, or D5224 is eligible in a 5 year period.)

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D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	18 n	1	5	Years (A combined total of one D5211, D5213, D5221, or D5223 is eligible in a 5 year period.)
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	18	1	5	Years (A combined total of one D5212, D5214, D5222, or D5224 is eligible in a 5 year period.)
D5221	Immediate maxillary partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years (A combined total of one D5211, D5213, D5221, or D5223 is eligible in a 5 year period.)
D5222	Immediate mandibular partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years (A combined total of one D5212, D5214, D5222, or D5224 is elgibile in a 5 year period.)
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years (A combined total of one D5211, D5213, D5221, or D5223 is eligible in a 5 year period.)
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests, and teeth)	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years (A combined total of one D5212, D5214, D5222, or D5224 is eligible in a 5 year period.)
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), maxillary	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years One of (D5282) per 60 months
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/ clasping materials, rests, and teeth), mandibular	Yes	6	18	Full mouth or panorex x-rays. Narrative of medical necessity,		6	18	1	5	Years One of (D5283) per 60 months
D5410	Adjust complete denture – maxillary	No				N	0	18	1	1	Day per patient. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5411	Adjust complete denture – mandibular	No				N	0	18	1	1	Day per patient. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.

D5421	Adjust partial denture – maxillary	No				N	0	18	1	1	Day per patient Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5422	Adjust partial denture – maxillary	No				N	0	18n	1	1	Day per patient Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5511	Repair broken complete denture base, mandibular	No				N	6	18	1	1	Day per patient
D5512	Repair broken complete denture base, maxillary	No				N	6	18	1	1	Day per patient
D5520	Replace missing or broken teeth – complete denture (each tooth)	No				T	0	18	3	1	Day per patient
D5611	Repair resin partial denture base, mandibular	No				N	0	18	1	1	Day per patient
D5612	Repair resin partial denture base, maxillary	No				N	0	18	1	1	Day per patient
D5621	Repair cast partial framework, mandibular	No				N	0	18	1	1	Day per patient
D5622	Repair cast partial framework, maxillary	No				N	0	18	1	1	Day per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	18	1 clasp per tooth	1	Day per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	18	4 clasps	1	Year per patient

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D5640	Replace broken teeth - per tooth	No				T	0	18	3 teeth	1	6 months per patient
D5650	Add tooth to existing partial denture	No				T	0	18	2 teeth	1	6 months per patient
D5660	Add clasp to existing partial denture - per tooth	No				T	0	18	1 per tooth	1	Lifetime per patient
D5710	Rebase complete maxillary denture	No					0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5711	Rebase complete mandibular denture	No					0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5720	Rebase maxillary partial denture	No					0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5721	Rebase mandibular partial denture	No					0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5730	Reline complete maxillary denture (direct)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5731	Reline complete mandibular denture (direct)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5740	Reline maxillary partial denture (direct)	NO				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5741	Reline mandibular partial denture (direct)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.

D5750	Reline complete maxillary denture (indirect)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5751	Reline complete mandibular denture (indirect)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5760	Reline maxillary partial denture (indirect)	No				N	0	18	1	36	\Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5761	Reline mandibular partial denture (indirect)	No				N	0	18	1	36	Months. 6 Months after initial installation. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the denture.
D5850	Tissue conditioning, maxillary	No					0	18	1	6	Months per patient
D5851	Tissue conditioning, mandibular	No					0	18	1	6	Months per patient.
D6010	Surgical placemernt of implant body: endosteal implant	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity.		12	18	1	60	Months per tooth.
D6012	Surgical placemernt of interim implant body for transitional prosthesis: endosteal implant	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity.		12	18	1	60	Months per tooth.
D6040	Surgical placement: eposteal implant	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity.		12	18	1	60	Months per tooth.
D6050	Surgical placement: transosteal implant	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6055	Connecting bar - implant supported or abutment supported	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6056	Prefabricated abutment - includes modification and placement	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6057	Custom fabricated abutment - includes placement	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6058	Abutment supported porcelain/ ceramic crown	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.

D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6062	Abutment supported cast metal crown (high noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6063	Abutment supported cast metal crown (predominantly base metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6064	Abutment supported cast metal crown (noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6065	Implant supported porcelain/ ceramic crown	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6066	Implant supported crown - porcelain fused to high noble alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6067	Implant supported crown - high noble alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6068	Abutment supported retainer for porcelain/ ceramic FPD	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6073	Abutment supported retainer for cast metal FPD (predomionantly base metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.

D6075	Implant supported retainer for ceramic FPD	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6077	Implant supported retainer for metal FPD - high noble alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6090	Repair implant supported prosthesis, by report	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/ abutment supported	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6095	Repair implant abutment, by report	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6100	Surgical removal of implant body	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6104	Bone graft at time of implant placement	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6110	Implant/ abutment supported removable denture for edentulous arch - maxillary	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.
D6111	Implant/ abutment supported removable denture for edentulous arch - mandibular	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch,
D6112	Implant/ abutment supported removable denture for partially edentulous arch - maxillary	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.
D6113	Implant/ abutment supported removable denture for partially edentulous arch - mandibular	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.

D6114	Implant/ abutment supported fixed denture for edentulous arch - maxillary	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.
D6115	Implant/ abutment supported fixed denture for edentulous arch - mandibular	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.
D6116	Implant/ abutment supported fixed denture for partially edentulous arch - maxillary	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch.
D6117	Implant/ abutment supported fixed denture for partially edentulous arch - mandibular	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per arch,
D6190	Radiographic/ surgical implant index, by report	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6210	Pontic - cast high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6211	Pontic - cast predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6212	Pontic - cast noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6214	Pontic - titanium and titanium alloys	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6240	Pontic - porcelain fused to high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6241	Pontic - porcelain fused to predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6242	Pontic - porcelain fused to noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6245	Pontic - porcelain/ ceramic	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6548	Retainer - porcelain/ ceramic for resin bonded fixed prosthesis	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6549	Resin retainer - for resin bonded fixed prosthesis	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.

D6600	Retainer inlay – porcelain/ceramic, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6601	Retainer inlay – porcelain/ceramic, tthree or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6602	Retainer inlay – cast high noble metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6603	Retainer inlay – cast high noble metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6604	Retainer inlay – cast predominantly base metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6606	Retainer inlay – cast noble metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6607	Retainer inlay – cast noble metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6608	Retainer onlay – porcelain/ceramic, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6609	Retainer onlay – porcelain/ceramic, tthree or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6610	Retainer onlay – cast high noble metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6611	Retainer onlay – cast high noble metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6612	Retainer onlay – cast predominantly base metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6614	Retainer onlay – cast noble metal, two surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6615	Retainer onlay – cast noble metal, three or more surfaces	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.

D6740	Retainer crown - porcelain/ ceramic	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6750	Retainer crown - porcelain fused to high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6751	Retainer crown - porcelain fused to predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6752	Retainer crown - porcelain fused to noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6780	Retainer crown - 3/4 cast high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6781	Retainer crown - 3/4 cast predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6782	Retainer crown - 3/4 cast noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6783	Retainer crown - 3/4 porcelain/ ceramic	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6790	Retainer crown - full cast high noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6791	Retainer crown - full cast predominantly base metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.
D6792	Retainer crown - full cast noble metal	Yes	12	18	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity		12	18	1	60	Months per tooth.

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D6930	Re-cement or re-bond fixed partial denture	No				N	0	18	1	6	Months per patient. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the fixed partial denture.
D6980	Fixed partial denture repair necessitated by restorative material failure	No				N	0	18	1	6	Months per patient. Not payable within six (6) months of initial delivery to the dentist or dental group that initially delivered the fixed partial denture.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No				T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No				T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7220	Removal impacted tooth-soft tissue	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7230	Removal of impacted tooth- partially bony	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7240	Removal of impacted tooth– completely bony	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.

D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7250	Removal of residual tooth roots (cutting procedure)	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth. Not payable to the dentist or dental group that originally extracted the tooth.
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Yes	0	20	Narrative of medical necessity	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7280	Exposure of unerupted tooth	Yes	0	23	Pre-operative x-ray	T	0	18	1 per tooth	1	Per Lifetime per tooth.
D7288	Brush biopsy – transepithelial sample collection	No				N	o	18	1	6	Months per patient
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	No				Q	0	18	1 per quadrant	1	Per Lifetime per quadrant per patient
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	No				Q	0	18	1 per quadrant	1	Per Lifetime per quadrant per patient
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	Q	0	18	1 per quadrant	1	Per Lifetime per quadrant per patient

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Yes	0	18	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	Q	0	18	1 per quadrant	1	Per Lifetime per quadrant per patient.
D7471	Removal of lateral exostosis – maxilla or mandible-	No				N	0	18n	2	1	Per Lifetime per patient
D7510	Incision and drainage of abscess - intraoral soft tissue	Yes	0	18	Narrative of medical necessity, xrays or photos optional	N	0	18	2	1	Per Day per patient
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Yes	0	18	Narrative of medical necessity, x-rays or photos optional	T	0	18	1	1	Per Day per patient.
D7520	Incision and drainage of abscess - extraoral soft tissue	Yes	0	18	Narrative of medical necessity, x-rays or photos optional	T	0	18	1	1	Day per patient.
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Yes	0	18	Narrative of medical necessity, x-rays or photos optional	T	0	18	1	1	Day per patient.
D7910	Suture of recent small wounds up to 5 cm	No					0	18	1	1	Per Day per patient
D7953	Bone replacement graft for ridge preservation – per site	Yes	0	18	Narrative of medical necessity, x-rays.	T	0	18	1	1	Per Lifetime per site
D7971	Excision of pericoronal gingiva	No					0	18	1	1	Per Day per patient
D7999	Unspecified oral surgery procedure, by report	Yes	0	18	Narrative of medical necessity and description of procedure; name, license number, and Tax ID of Assistant surgeon required if D7999 is submitted for this purpose		0	18	1	1	Day per patient
D8010	Limited orthodontic treatment of the primary dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.		0	18	1	1	Per Lifetime per patient. (A combined total of one D8010, D8020, D8030 or D8040 is eligible per lifetime per patient.)

D8020	Limited orthodontic treatment of the transitional dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.		0	18	1	1	Per Lifetime per patient. (A combined total of one D8010, D8020, D8030 or D8040 is eligible per lifetime per patient.)
D8030	Limited orthodontic treatment of the adolescent dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index		0	18	1	1	Per Lifetime per patient. (A combined total of one D8010, D8020, D8030 or D8040 is eligible per lifetime per patient.)
D8040	Limited orthodontic treatment of the adult dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.		0	18	1	1	Lifetime per patient. (A combined total of one D8010, D8020, D8030 or D8040 is eligible per lifetime per patient.)
D8070	Comprehensive orthodontic treatment of the transitional dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.		0	18	1	1	Per Lifetime per patient. (A combined total of one D8070, D8080 or D8090 is eligible per lifetime per patient.)

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D8080	Comprehensive orthodontic treatment of the adolescent dentition	YES	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.	N	0	18	1	1	Per Lifetime per patient (A combined total of one D8070, D8080 or D8090 is eligible per lifetime per patient.)
D8090	Comprehensive orthodontic treatment of the transitional dentition	Yes	0	18	Panoramic radiographic image and /or cephalometric radiographic image; plus 5-7 diagnostic quality photos; plus a completed Salzman Criteria Index Form.		0	18	1	1	Per Lifetime per patient. (A combined total of one D8070, D8080 or D8090 is eligible per lifetime per patient.)
D8660	Pre-orthodontic treatment examination to monitor growth and development	No				N	0	18	1	1	Per Year (per patient/per provider)
D8670	Periodic orthodontic treatment visit	Yes	0	18	For Continuation of care (COC), Completed COC form	N	0	18	7	1	Per Lifetime per patient
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Yes	0	18	Evidence of successful completion of comprehensive orthodontics	N	0	18	1	1	Per Lifetime per patient
D8695	Removal of fixed orthodontic appliances	No				N	0	18	1	1	Per Lifetime per patient (D8680 or D8695)
D8210	Removable appliance therapy	Yes	0	20	Panoramic/cephalometric x-ray, Narr of medical necessity.	N	0	18	1 per arch	1	\Per Lifetime per patient (either D8210 or D8220)
D8220	Fixed appliance therapy	Yes	0	20	Panoramic/cephalometric x-ray, Narr of medical necessity.	N	0	18	1 per arch	1	Per Lifetime per patient (either D8210 or D8220)
D9110	Palliative treatment of dental pain – per visit	No				N	0	18	1	1	Per Day per patient

D9222	Deep sedation/general anesthesia – first 15 minutes	Yes	0	18	Narrative of medical necessity	N	0	18	1	1	Per Day per patient
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	Yes	0	18	Narrative of medical necessity	N	0	18	7	1	Per Day per patient
D9224 (New)	Administration of general anesthesia with advanced airway – first 15 minutes	Yes	0	18	Narrative of medical necessity	N	0	18	1	1	Day per patient
D9225 (New)	Administration of general anesthesia with advanced airway – each susequent 15	Yes	0	18	Narrative of medical necessity	N	0	18	7	1	Day per patient
D9230	Inhalation of nitrous oxide / analgesia, anxiolysis	No				N	0	18	1	1	Per Day per patient
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	Yes	0	18	Narrative of medical necessity	N	0	18	1	1	Per Day per patient
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent15 minute increment	Yes	0	18	Narrative of medical necessity	N	0	18	7	1	Per Day per patient
D9246 (New)	Administration of moderate sedation – non-intravenous parenteral – first 15	Yes	0	18	Narrative of medical necessity	N	0	18	1	1	Day per patient
D9247 (New)	Administration of moderate sedation – non-intravenous parenteral – each	Yes	0	18	Narrative of medical necessity	N	0	18	7	1	Day per patient
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	No	0	18		N	0	18	1	1	Per Day per patient. Not payable if billed on the same date of service as D0120, D0140, D0145, D0150, D0160, or D0180.
D9610	Therapeutic psrenteral drug, single administration	Yes	0	18	Narrative of medical necessity		0	18	1	1	Per Day per patient
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report	Yes	0	18	Narrative of medical necessity	N	0	18 n	1	1	Per Day per patient
D9932	Cleaning and inspection of removable complete denture, maxillary	No					0	18	1	5	Years
D9933	Cleaning and inspection of removable complete denture, mandibular	No					0	18	1	5	Years
D9934	Cleaning and inspection of removable partial denture, maxillary	No					0	18	1	5	Years

D9935	Cleaning and inspection of removable partial denture, mandibular	No					0	18	1	5	Years
D9936 (New)	Cleaning and inspection of occlusal guard – per appliance	No					0	18	1	12	Months
D9943	Occlusal guard adjustment	No					0	18	1	24	Months
D9944	Occlusal guard - hard appliance, full arch	Yes	0	18	Pre-operative x-rays (excluding bitewings) and Narrative of medical necessity		13	18	1	12	Months per patient. Only for Members 13 and older.
D9945	Occlusal guard - soft appliance, full arch	Yes	0	18	Pre-operative x-rays (excluding bitewings) and Narrative of medical		13	18	1	12	Months per patient. Only for Members 13 and older.
D9946	Occlusal guard - hard appliance, partial arch	Yes	0	18	Pre-operative x-rays (excluding bitewings) and Narrative of medical necessity		13	18	1	12	Months per patient. Only for Members 13 and older.

N = no reporting requirements

T = tooth reporting requirement

Q = quadrant reporting requirement

Procedure Codes not listed in this benefit grid are not considered benefits

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
	Cleft Palate Services										
D0160	Detailed and Extensive Oral Evaluation, by report	NO			Complete initial examination at a Cleft Palate Clinic only involving all licensed staff	N	0	20	1	1	Day per provider (Complete initial examination at a Cleft Palate Clinic only) involving all licensed staff
D0170	Re-evaluation, LimitedProblem Focused (established patient; not postoperative visit)	NO			Cleft Palate Clinic	N	0	20	1	1	Day per patient

N = no reporting requirements

T = tooth reporting requirement

Q = quadrant reporting requirement

Services Not Covered

The following are not covered under the Dental Care benefits of this program:

- Claims involving covered services in which the dentist and the Enrollee select a more expensive course of treatment than is customarily provided by the dental profession and consistent with sound professional standards of dental practice for the dental condition concerned.
- Dentures and other prosthodontics, unless medically necessary, as a result of surgery for trauma or a disease process that renders the dental condition untreatable by a less intensive restorative procedure
- Duplicate, provisional and temporary devices, appliances, and services.
- Gold foil restorations.
- Restorations or prosthodontics using high noble or noble metals unless the use of such materials is determined to be medically necessary.
- Labial veneers.
- Laminates done for cosmetic purposes.
- Local anesthesia when billed for separately by a dentist.
- Oral surgery that is covered under the medical portion of the benefits.
- Plaque-control programs, oral hygiene instructions, and/or dietary instructions.
- Retainer replacement.
- Periodontics not otherwise listed.
- Orthodontics (braces) that do not meet the criteria required (braces are not covered for cosmetic purposes).
- Procedures to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for malalignment of teeth.

- Any treatment that is necessitated by lack of cooperation by the Enrollee or the eligible Enrollee's family with the dentist or noncompliance with professionally prescribed dental care.
- A contract between the Enrollee or Enrollee's family and dentist prior to the effective date of coverage.
- Services and treatment not prescribed by or under the direct supervision of a dentist, except where a dental hygienist is permitted to practice without supervision by a dentist.
- Services or treatment which are experimental or investigational.
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under provision of any law or regulation or any government unit. This exclusion applies whether or not the Enrollee claim the benefits or compensation.
- Services and treatment received from a dental or medical department maintained by on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
- Services and treatment performed prior to the Enrollee's effective date of coverage.
- Services and treatment incurred after termination date of the Enrollee's coverage unless otherwise indicated.
- Services and treatment which are not dentally necessary of which do not meet generally accepted standards of dental practice.
- Telephone consultations.
- Any charge for failure to keep a scheduled appointment.
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
- Services related to the diagnosis and/or treatment of Temporomandibular Joint Dysfunction (TMJ).
- Services or treatment provided as a result of intentionally self-inflicted injury or illness.
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging is an illegal occupation, or participating in a riot, rebellion, or insurrection.
- Office infection control charges.
- Charges for copies of Enrollee's records, charts, or x-rays, or any costs associated with forwarding/mailing copies of Enrollee's records, charts or x-rays.
- State or territorial taxes on dental services performed.
- Those submitted by a dentist, which is for the same services performed on the same date for the same Enrollee by another dentist.
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
- Those for which the Enrollee would have no obligation to pay in the absence of this or any similar coverage.
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
- Treatment or services for injuries resulting from war or an act of war, whether declared or undeclared, for from police or military service for any country or organization.
- Hospital costs or any additional fees that the dentist or hospital charges for treatment as the hospital (inpatient of outpatient).
- Charges by the provider for completing dental forms.
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it.
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
- Cone beam imaging and cone beam MRI procedures.
- Precision attachments, personalization, precious metal bases and other specialized techniques.
- Repair of damaged orthodontic appliances.
- Removable orthodontic retainer adjustment
- Replacement of lost or missing appliances.
- Fabrication of athletic mouthguards.
- Internal and/or external bleaching.

- Topical medicament center.
- Bone grafts when done in connection with extractions, apicoectomies, or non-covered/non-eligible implants.
- When two or more services are submitted and the services are considered part of the same service to one another, the plan will pay the most comprehensive service (the service that includes the other non-benefitted service) as determined by the plan.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service) the plan will pay for the service that represents the final treatment
- All out of network services covered are subject to the usual and customary maximum allowable fee charges as defined by the CHIP plan. The Enrollee is responsible for all remaining charges that e