Prior Authorization Review Panel
MCO Policy
Submission

A separate copy of this form must accompany each policy submitted for review.

Policies submitted without this form will not be considered for review.

Plan: Keystone First (KF), AmeriHealth Caritas Pennsylvania (ACP)	**Submission Date 9/25/2024**
Policy Number: 152.100	**Effective Date:9/17/11** **Revision Date:11/7/2024**
Policy Name: Review Process and Criteria for Dental Services Subject to Prior Authorization (Pre-service) or Retrospective Review	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Annual Review – No Revisions**
- ☒ **Revision of Currently "Passed" Policy**
- ☐ **Revision of a Previously "Failed" Policy**
- ☐ **Base Policy**
- ☐ **Attachment to Base Policy**
- ☐ **Attestation of unchanged policies**

Change to Dx code requirement
Addition of codes requiring authorization, documentation and criteria requirements
Change of criteria for scaling and root planning
Change to processing rules for direct restorations
Addition of code to benefit

Name of Authorized Individual (Please type or print): **Peter Charles Madden, Chief Dental Director**	**Signature of Authorized Individual:** 

Keystone First
AmeriHealth Caritas Pennsylvania

Supersedes:

Policy No: 152.100

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

Department: Clinical Services

Original Effective Date: November 17, 2011
Next Review Date: 3/23/25

Unit: Dental Department

Stakeholder(s):

Applicable Party(s):

Review Cycle: Annual

Line(s) of Business: 100/500/530/540/550

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) /AmeriHealth Caritas Pennsylvania (ACP) collectively 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 Attachments A.

A KF/ACP Associate may need to use and/or disclose a Member'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 a Member's written consent or Authorization prior to Using, Disclosing, or requesting PHI for purposes of TPO. Therefore, KF/ACP is not required to seek a Member's authorization to release their PHI for any one of the aforementioned purposes (See Policy #168.227, *General Policy – Use and Disclosure of Protected Health Information Without Member Consent/Authorization).*

KF/ACP 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 #168.217, *Minimum Necessary Standard).* KF/ACP 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.

KF/ACP sometimes contracts with other organizations or with individuals who are not members of KF/ACP's workforce to perform provider services. This includes Contractors and Consultants. Contractors and Consultants may require Access to PHI to perform their services for KF/ACP are termed Business Associates (See Policy #168.209, *Disclosure of Protected Health Information to Business Associates and other Contractors).*

KF/ACP 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 KF/ACP policies and procedures *(See Policy #168.213- Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*.

KF/ACP 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 #168.213- Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*.

KF/ACP 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.

KF/ACP Associates must follow Facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see Policy #168.212, *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.001 Glossary of Terms

See Policy # 168.235 HIPAA and ACFC Privacy Definitions

Medically Necessary — A service, item, procedure, or level of care compensable under the Medical Assistance (MA) program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- **Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.**
- **Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.**
- **Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.**

Determinations of medical necessity for covered care and services, whether made on a Prior Authorization, post-utilization, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member's family/caretaker, Dentist and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Provider. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

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 a Member prior to the provider's initiating provision of the requested service.

Retrospective Review: A review conducted by KF/ACP or its representative after the delivery of services to determine whether services were delivered as prescribed and consistent with KF's/ACP'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.

Procedure:

A) Dental Authorization Review Process

1. Requests for Prior or Retrospective Review are submitted electronically, by telephone, fax, or written request to the KF/ACP Utilization Management (UM) department or Delegate.

2. The UM/Delegate staff verifies Member eligibility and Health Care Provider participation with the Health Plan (KF/ACP) and if either Member eligibility or Provider participation with the Health Plan can't be verified, denial notification is made in accordance with Policy #UM017P, *Denial Notice Contents and Distribution*.
   .

3. UM/Delegate staff will review the request to determine if the item/services are covered under the Medical Assistance (MA) Program. If the item is not covered under the MA 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.017P, Denial Notice Contents and Distribution.

4. For Members under age twenty-one (21), all services are reviewed for Medical Necessity

5. For services covered under the MA Program and not subject to benefit limitation, the UM/Delegate staff reviews the information submitted in support of the request against the definition of Medically Necessary and applicable Dental Clinical Criteria (See Policy #UM.008P, Utilization Management Criteria). Additionally, requests for certain Dental services which are limited by procedure code, age, residence, and past dental history shall be reviewed against the Benefit Limit Exceptions as outlined in policy 152.101 Dental Benefit Limit Exceptions. Prior Authorization (Urgent and Non-Urgent), and Retrospective Review requests are reviewed in accordance with the timeframes outlined in Policy #UM.010P, Decision Response Time.

6. The Health Plan provides continuing coverage of care for Members 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 706 HC . Continuity of Care - If a request is identified to meet continuity of care, the continuity of care process outlined in Policy UM 706 HC 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.

8. Health Care Providers are not required to submit the numerical diagnosis code to have the service considered for authorization. Codes requiring benefit limit exception (BLE) must be submitted on a separate authorization request containing only codes requiring BLE or codes may be denied.

9. 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.010P, *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

10. If the information submitted meets the definition of Medically Necessary as stated in Policy #UM.008P, *Utilization Management Criteria* and the appropriate Dental Clinical Criteria, as stated in Attachment "C , and is not subject to benefit limitations /exception review, the request is approved. The UM staff notifies the Health Care Provider and Member as outlined in Policy #UM.010P, *Utilization Management Decision Response Time* and enters the authorization information into the appropriate medical management information system.

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

12. For Medically Necessary case reviews, a Dental Reviewer may consult a same specialty Dental Reviewer or the 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.

13. If the Dental Reviewer determines that the service is Medically Necessary, the Health Care Provider and Member are notified in accordance with Policy # UM.010P, *Decision Response Time.*

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

15. At the time of the notification of the denial, the Health Care 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.105P, Peer- to-Peer Discussion).

16. Providers and Members who do not agree with the denial determination may appeal the determination in accordance with Policy # AP.102P, *Formal Provider Appeals Process for UM Denials* and Policy # AP.700P, *Medical Assistance Member Complaint, Grievance & DHS Fair Hearing.*
17. KF/ACP reimburses Health Care Providers for the cost of providing medical information, including copying, only when such payment is required by the Provider's participation agreement with KF/ACP.

18. 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 #168.213- 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:

152.101 – Dental Benefit Limit Exceptions
AP.102P - Formal Provider Appeals Process for UM Denials
AP.700P – Medical Assistance Member Complaint, Grievance and DHS Fair Hearing Policy and Procedures
151.5-Prior Authorization for Prescription Medications
UM.001 – Glossary of Terms
UM.003P – Non-Urgent and Urgent Care Prior (Pre-Services) Authorization Process
UM.010P – Utilization Management Decision Response Time
UM.008P – Utilization Management criteria
UM.017P – Utilization Management Denial Letter Content and Distribution
UM.105P – Peer to Peer Discussion
UM.200P – Retrospective Review Process
UM 706 HC – Continuity of Care
168.209-Disclosure of Protected Health Information to Business Associates and Other Contractors
168.212-Facsimile Machines and Transmission of PHI
168.217-Minimum Necessary Standard
168.235-HIPAA and ACFC Privacy Definitions
591.001 Records Retention Policy and Schedule

Source Documents and References:

1. Pennsylvania Medical Assistance Manual
2. Current HealthChoice Agreement

Attachments:

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

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

Attachment D: Procedure Codes and Eligibility Criteria

Approved By:

Date May 23, 2024

Peter Charles Madden, DDS
Chief Dental Director
AmeriHealth Caritas

Attachment A

Dental Services for which Prior Authorization or Retrospective Review are Required

The Codes and Descriptions listed in the following table

** NOTE: some of the services may also be subject to dental benefit limitations refer to: Policy 152.101 Dental Benefit Limit and Exceptions*

Code	Description
D2710	Crown-resin-based composite (indirect)
D2721	Crown-resin with predominantly base metal
D2740	Crown-porcelain / ceramic
D2751	Crown-porcelain fused to predominantly base metal
D2752	Crown-porcelain fused to noble metal
D2791	Crown-full cast predominantly base metal
D2952	Cast post and core in addition to crown
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)
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption - premolar
D3473	Surgical repair of root resorption - molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption -
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption -
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption -
D3921	Decoronation or submergence of an erupted tooth
D4210	Gingivectomy - gingivoplasty/4 or more teeth per quadrant
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
D7220	Removal of impacted tooth – soft tissue
D7230	Remove of impacted tooth - partially bony
D7240	Remove of impacted tooth – completely bony
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed tooth
D7280	Exposure of an unerupted tooth

D7283	Placement of device to facilitate eruption of impacted tooth
D7320	Alveoloplasty without extractions
D7450	Removal of benign odontogenic cyst or tumor-diameter up to 1.25 cm.
D7451	Removal of benign odontogenic cyst or tumor-diameter greater than 1.25 cm.
D7460	Removal of benign nonodontogenic cyst or tumor-diameter up to 1.25 cm.
D7461	Removal of benign nonodontogenic cyst or tumor-diameter greater than 1.25 cm.
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
D7871	Non-arthroscopic lysis and lavage
D7962	Lingual frenectomy (frenulectomy)
D7970	Excision of hyperplastic tissue
D7999	Unspecified oral surgery procedure
D8080*	Comprehensive Orthodontic Treatment of the Adolescent Dentition
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention
D8703	Replacement of lost or broken retainer - maxillary
D8704	Replacement of lost or broken retainer - mandibular
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
D9239	Intravenous moderate sedation/analgesia – first 15 minutes
D9243	Intravenous moderate sedation/analgesia – each subsequent 15 minute increment
D9248	Non-intravenous conscious sedation
D9930	Treatment of complications (post surgical) – unusual circumstances, by report
D9947	Custom sleep apnea appliance fabrication and placement

* Prior authorization required, retro authorization not permitted.

ATTACHMENT C

Clinical Criteria for Prior and Retro Authorization of Treatment and Emergency Treatment

Adults age 21 and older have benefit limitations. See benefit grid on Attachment D for procedure codes and eligibility criteria.

Medical necessity reviews will be performed for Members under 21 years of age who require medically necessary dental services not listed as a covered service or beyond the fee schedule limits; the dentist should submit all necessary clinical documentation along with a narrative stating why the dentist feels the services are medically necessary.

Crowns (D2710, D2721, D2740, D2751, D2752, D2791)

Required documentation – Periapical x-ray showing the root and crown of the natural tooth. Current periapical radiographs of the tooth/teeth to be crowned and/or used as abutments for removable partial dentures along with a panorex or full mouth are needed for evaluation

All criteria below must be met:
Tooth to be crowned 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 / 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

Posts and cores (D2952, 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:
  - The tooth is filled within two millimeters of the radiographic apex
  - The root canal is not filled beyond the radiographic apex
  - The root canal filling is adequately condensed and/or filled
  - Healthy periapical tissue (healing PARL or no PARL)

Root canals (D3310, D3320, D3330)
Required documentation – pre-operative radiographs (excluding bitewings)

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

And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray

1. Evidence of apical pathology/fistula
2. Pain from percussion / temp

Surgical Repair of Root Resorption (D3471, D3472, D3473)
Required documentation – pre-operative radiographs of adjacent and opposing teeth

All criteria below must be met:

- Minimum 50% bone support
- History of RCT
- Apical pathology
- The patient must be free of active / advanced periodontal disease
- No periodontal furcation lesion and / or furcation involvement

Surgical exposure of root surface without apicoectomy (D3501, D3502, D3503) –

Required documentation – pre-operative radiographs of adjacent and opposing teeth

All criteria below must be met:

- History of pain or discomfort which could not be diagnosed from clinical evaluation or radiographic images
  - Minimum 50% bone support
  - The patient must be free of active / advanced periodontal disease
  - No periodontal furcation lesion and / or furcation involvement
    - Tooth must be crucial to arch/occlusion
  - Benefit limit exception necessary (if applicable)

Decoronation or submergence of an erupted tooth (D3921)

Required documentation – post operative radiographs (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es)
All criteria must be met:

- Clinically acceptable root canal therapy
- The patient must be free of active / advanced periodontal disease
- No periodontal furcation lesion and / or furcation involvement

Gingivectomy or Gingivoplasty (D4210)

Required documentation – pre-operative radiographs, perio 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 perio charting

Periodontal scaling and root planning (D4341, D4342)

Required documentation – periodontal charting and pre-op x-rays

All criteria below must be met:

Pockets depths 5 mm or greater on 4 or more teeth (for D4341); or on 1 to 3 teeth (for D4342) indicated on the periodontal charting and;

Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Involved teeth must not have poor prognosis, require or be planned for replacement by denture and/or extraction

Complete dentures (D5110, D5120)

Required documentation – Complete series of radiographic images (D0210) or panoramic radiographic image (D0330)
Criteria below must be met:

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

Immediate dentures (D5130, D5140)
Required documentation –
Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

Criteria below must be met:

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

Removable partial dentures (D5211, D5212, D5213, D5214) – prior authorization

Required documentation –Complete series of radiographic images (D0210) or panoramic radiographic image (D0330)
Criteria below must be met:

- *Remaining teeth have greater than 50% bone support and are restorable*

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)*

Impacted teeth (D7220, D7230, D7240)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity
Documentation describes pain, swelling, etc. around tooth
(symptomatic) Radiographs matches type of impaction code described
Documentation of clinical evidence indicating 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)

Oroantral fistula closure (D7260)

Documentation required – Narrative of medical necessity

All criteria below must be met:
Narrative must substantiate need due to extraction, oral infection or sinus infection

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 unerupted tooth(D7280)

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

Criteria below must be met:
Documentation supports impacted/unerupted tooth

Placement of device to facilitate eruption (D7283)

Documentation required – Narrative of medical necessity

All criteria below must be met:
Documentation describes condition preventing normal eruption
Documentation describes device type and need for placement of device

Alveoloplasty without extractions (D7320)

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

Criteria below must be met:

Documentation supports medical necessity for fabrication of a prosthesis

Excision of lesion / tumor (D7450, D7451, D7460, D7461)

Documentation required – Copy of pathology report

Criteria below must be met:

Copy of pathology report indicating lesion / tumor

Incision / drain abscess (D7510, D7511, D7520, D7521)

Documentation required – Narrative of medical necessity, radiographs or

photos optional All criteria below must be met:

For Intraoral incision:

Documentation describes non-vital tooth or foreign body

For extraoral incision

Documentation describes periapical or periodontal abscess

Non-arthroscopic lysis and lavage - (D7871)

Documentation required – Narrative of medical necessity, radiographs or photos optional

All criteria below must be met:

Documentation describes nature and etiology of TMJ dysfunction

Documentation describes treatment to manage the TMJ condition

Lingual frenectomy(D7962)

Documentation required – Narrative of medical necessity, radiographs or photos optional

Criteria below must be met:

Documentation describes tongue tied, diastema or tissue pull condition

Excision of hyperplastic tissue (D7970)

Documentation required – Pre-operative radiogrpahs, narrative of medical necessity, photos optional

Criteria below must be met:

Documentation describes medical necessity due to ill fitting denture

Unspecified oral surgery procedure (D7999)

Documentation required – Narrative of medical necessity, name, license number and tax ID of Asst surgeon

All criteria below must be met:

Documentation describes medical necessity need for Asst surgeon

Name / license number of Assistant surgeon is provided

General anesthesia / IV sedation (Dental Office Setting) -

(D9222, D9223, D9239, D9243)

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 that patient is less than 9 years old with extensive treatment

(described)

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/D9223, D9243 may be prior authorized as described above and may be retrospectively authorized (with anesthesia log required)

Non-intravenous conscious sedation (Dental Office Setting) -

(D9248)

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 that patient is less than 9 years old with extensive treatment

(described)

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.

Treatment of complications (post surgical) – (D9930)

Documentation required – Narrative of medical necessity

Documentation describes post surgical condition supporting medical necessity for procedure

Orthodontics

Fixed or removable appliance therapy (D8210, D8220)

Documentation required Panoramic and /or cephalometric radiograph, 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.

Comprehensive orthodontic services (D8080)

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

All the criteria below must be met:

- Salzmann Criteria Index Form score of 25+ or greater when the case is evaluated using the Salzmann Index
- A full permanent dentition is present, with no primary teeth present (except for primary teeth where there is no permanent succedaneous tooth)
- Dentition must be free of carious lesions.
- Patient must demonstrate the ability to maintain adequate oral hygiene.

Replacement of broken or lost retainer (D8703, D8704)

Documentation required:

narrative with orthodontic case completion date and justification /medical necessity of continued retention and history of broken/lost retainer

Periodic orthodontic treatment visit (D8670)

Documentation requirements – Completed AmeriHealth Caritas

PA or Keystone First Orthodontic Continuation of Care form.

Photos of current orthodontic status.

The criteria below must be met:

Ongoing active comprehensive orthodontic treatment.

Retention (D8680)

Documentation required – diagnostic quality photos **All criteria below must be met:**

- Photos demonstrate malocclusion was corrected through comprehensive orthodontic treatment.

Custom sleep apnea appliance fabrication and placement (D9947)

Documentation requirements:

- **Lab Rx for custom appliance with member's name**
- **Letter of Medical Necessity from physician containing clinical criteria listed below**

Clinical Criteria:
LOMN from physician describing that all of the following took place within the past 12 months of request for authorization:

- diagnosis of obstructive sleep apnea (G47.33)
  and
- face-to-face evaluation of member by physician
  and
- patient attended a facility based polysomnogram or approved home sleep test
  and
- sleep study results demonstrated API Apnea-hypopnea Index or RDI Respiratory Disturbance Index of 5 or more events per hour
  - if between 5 and 14 events per hour, patient must have one or more of the following symptoms or findings:
    Hypertension (HTN)
    History of stroke
    Ischemic heart disease
    Excessive daytime sleepiness
    Impaired cognition

Mood disorder
Insomnia

Other clinical information (add comment)

and

- positive airway pressure history of contraindication – skin irritation, claustrophobia or noise generated by the machine

or

- positive airway pressure history of non-tolerance

or

- Other clinical information (add comment)

ATTACHMENT D

Procedure Codes and Eligibility Criteria

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**
D0120	Periodic oral evaluation-established patient	No				N	0	999	1	180	Days Per patient Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D0140	Limited oral evaluation-problem focused	No				N	0	999	1	1	Days Per patient (audio or video teledentistry allowed…pt initiatiated by call in to office for POS
D0150	Comprehensive oral evaluation- new or established patient	No				N	0	999	1	1	Lifetime Per patient per dentist/dental group
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No				N	0	2	1	180	Days 1 per patient
D0210	Intraoral – comprehensive series of radiographic images	No				N	0	999	1	5	Year per patient
D0220	Intraoral- periapical first radiographic image	No				N	0	999	1	1	Day per patient
D0230	Intraoral – periapical each additional radiographic image	No				N	0	999	10	1	Day per patient
D0240	Intraoral -occlusal radiographic image	No				N	0	999	2	1	Day per patient
D0250	Extra oral 2-D radiographic image created using a stationary radiation source, and detector	No				N	0	999	1	1	Day per patient
D0251	Extra oral posterior dental radiographic image	No				N	0	999	10	1	Day per patient
D0270	Bitewing - single radiographic image	No				N	0	999	1	1	Day per patient
D0272	Bitewings -two radiographic images	No				N	0	999	1	1	Day per patient
D0273	Bitewings - three radiographic images	No				N	0	999	1	1	Day per patient
D0274	Bitewings – four radiographic images	No				N	0	999	1	1	Day per patient
D0330	Panoramic radiographic image	No				N	0	999	1	5	Year per patient

D0340	2D cephalometric radiographic image – acquisition, measurement and analysisf	No				N	0	20	1	1	Day per patient
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	No				N	0	999	1	5	Years (Image series) per patient
D0373	Intraoral tomosynthesis - bitewing radiographic image	No				N	0	999	4	1	Day per patient
D0374	Intraoral tomosynthesis - periapical radiographic image	No				N	0	999	11	1	Day per patient
D0190	Screening of a patient	No				N	0	999	1	1	Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27
D0191	Assessment of a patient	No				N	0	999	1	1	Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27
D1110	Prophylaxis -adult	No				N	12	999	1	180	DAYS (per patient . Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

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D1120	Prophylaxis - child	No				N	0	11	1	180	DAYS per patient
D1206	Topical application of fluoride varnish	No				N	0	20	6	1	Year per patient (teledentistry POS 02,10)
D1208	Topical application of fluoride – excluding varnish	No				N	0	20	1	180	Days per patient
D1310	Nutritional counseling for control of dental disease	No				N	0	999	1	180	Days per patient (teledentistry P02, 10)
D1320	Tobacco counseling for the control and prevention of dental disease	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient (teledentistry allowed POS 02, 10)
D1320	Tobacco counseling for the control and prevention of oral disease	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient teledentistry allowed POS 02, 10)
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance abuse	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance abuse	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient
D1330	Oral hygiene instructions	No				N	0	999	1	180	Days per patient(teledentistry POS 02, 10)
D1351	Sealant - per tooth	No				T	0	20	1	1	Lifetime per patient Allowed on 1st and 2nd premolars.Allowed on 1st and second molars and on 1st and second molars where a buccal restoration might existtorations
D1354	Application of caries arresting medicament – per tooth	No				T	0	9990	10 teeth	1	Day per patient
D1354	Application of caries arresting medicament – per tooth	No				T	0	999	4	1	Year per tooth per patient
D1354	Application of caries arresting medicament – per tooth	No				T	0	999	6	1	Lifetime per tooth per patient

D1510	Space maintainer - fi unilateral per quadrar	No				Q	0	20	4	1	1 appliance Per quaqdrant 4 per lifetime per patient
D1516	Space maintainer – fixed - bilateral, maxillary	No				T	0	20	1	1	1 appliance Per arch per lifetime per patient
D1517	Space maintainer – fixed - bilateral, mandibular	No				T	0	20	1	1	1 appliance Per arch per lifetime per patient
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No				N	0	20	1	1	Day appliance per patient
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No				N	0	20	1	1	Day appliance per patient
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No				N	0	20	4	1	Day appliances per patient
D1556	Removal of fixed unilateral space maintainer – per quadrant	No				N	0	20	4	1	Day appliances per patient
D1557	Removal of fixed bilateral space maintainer – maxillary	No				N	0	20	1	1	Day appliance per patient
D1558	Removal of fixed bilateral space maintainer – mandibular	No				N	0	20	1	1	Day appliance per patient
D2140	Amalgam - one surface, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2150	Amalgam – two surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2160	Amalgam – three surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if
D2161	Amalgam – four or more surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days
D2330	Resin-based composite - one surface, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days
D2331	Resin-based composite - two surfaces, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2332	Resin-based composite three surfaces, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2335	Resin- based composite four or surfaces or involving incisal angle (anterior)	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2390	Resin-based composit crown - anterior	No				T	0	20	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.

D2391	Resin - based Composite - one surface, posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2392	Resin - based Composite - two surfaces, posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2393	Resin - based Composite - three surfaces, posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2394	Resin - based composite-four or more surfaces, posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2710	Crown - resin - based composite (indirect)	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	3	Year per patient Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2721	Crown - resin with predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

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D2740	Crown-porcelain/ceramic	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2751	Crown-porcelain fused to predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2752	Crown-porcelain fused to noble metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2791	Crown - full cast predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No				T	0	999	1	1	Day per tooth per patient
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No				T	0	999	1	1	Day per tooth per patient
D2920	Re-cement or re-bond crown	No				T	0	999	1	1	Day per tooth per patient
D2930	Prefabricated stainless steel crown - primary tooth	No				T	0	20	1	1	Day per tooth per patient
D2931	Prefabricated stainless steel crown - permanent tooth	No				T	0	20	1	1	Day per tooth per patient
D2932	Prefabricated resin crown	No				T	0	20	1	1	Day per tooth per patient
D2933	Prefabricated stainless steel crown with resin window	No				T	0	20	1	1	Day per tooth per patient

D2934	Prefabricated esthetic coated stainless steel crown- primary tooth	No				T	0	20	1	1	Day per tooth per patient
D2952	Post and core in addition to crown, indirectly fabricated	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

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D2954	Prefabricated post and core in addition to crown	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2980	Crown repair necessitated by restorative material failure	No			Narrative of medical necessity	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT
D2991	Application of hydroxyappetite regeneration medicament – per tooth	No			N	T	0	999	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	20	6	1	PER DAY/PER TOOTH/PER PATIENT
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	No				T	0	20	1	1	PER DAY/PER TOOTH/PER PATIENT
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	No				T	0	20	1	1	PER DAY/PER TOOTH/PER PATIENT
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), Narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings). Narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3330	Endodontic therapy, molar tooth (excluding final restoration))	Yes	0	999	Pre-operative x-rays (excluding bitewings), narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

D3410	Apicoectomy - anterior	No				T	0	999	2 teeth	1	Day PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

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D3421	Apicoectomy - premolar – (first root)	No				T	0	999	2 teeth	1	Day PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3425	Apicoectomy - molar – first root	No				T	0	999	2 teeth	1	Day PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3426	Apicoectomy-(each additional root)	No				T	0	999	2 teeth	1	Day PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3471	Surgical repair of root resorption - anterior	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3472	Surgical repair of root resorption - premolar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3473	Surgical repair of root resorption - molar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3921	Decoronation or submergence of an erupted tooth	Yes	0	999	Post operative x-rays (excluding bitewings), narrative of medical	T	0	999	1	1	Lifetime per tooth PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	999	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo	Q	0	999	4 (different quadrants)	24	MONTHS PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	2 different quadrants	1	day PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	999	4 different quadrants	24	MONTHS PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4342	Periodontal scaling and root planning - one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical	Q	0	999	4 (different quadrants)	1	Day PER PATIENT PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4342	Periodontal scaling and root planning - one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative o medical	Q	0	999	4 (different quadra	24	Months PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	No				N	0	999	1	1	year PER PATIENT No history of prophylaxis or periodontal treatment in past12 months. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF.
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	No				N	0	999	1	180	Days per patient

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D4910	Periodontal maintenance	No				N	0	999	1	90	days per patient with past history of therapeutic periodontal treatment or periodontal maintenance
D5110***	Complete denture - maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity),	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5120***	Complete denture - mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5130	Immediate denture - maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5140	Immediate denture - mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or*
D5211***	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5212***	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

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D5213***	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5214***	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5410	Adjust complete denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5411	Adjust complete denture – mandibular	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5421	Adjust partial denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5422	Adjust partial denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5511	Repair broken complete denture base, mandibular	No				N	6	999	1	1	DAY per patient
D5512	Repair broken complete denture base, maxillary	No				N	6	999	1	1	DAY per patient
D5520	Replace missing or broken teeth – complete denture (each tooth)	No				T	0	999	3	1	DAY per patient
D5611	Repair resin partial denture base, mandibular	No				N	0	999	1	1	DAY per patient

D5612	Repair resin partial denture base, maxillary	No				N	0	999	1	1	DAY per patient
D5621	Repair cast partial framework, mandibular	No				N	0	999	1	1	DAY per patient
D5622	Repair cast partial framework, maxillary	No				N	0	999	1	1	DAY per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	999	1 clasp per tooth	1	DAY per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	999	4 clasps	1	Year per patient

		Authorization Requirements				Benefit Details					
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D5640	Replace broken teeth - per tooth	No				T	0	999	3 teeth	1	Day per patient
D5650	Add tooth to existing partial denture	No				T	0	999	2 teeth	1	Day per patient
D5660	Add clasp to existing partial denture - per tooth	No				T	0	999	1 PER TOTH	1	Lifetime per patient
D5730	Reline complete maxillary denture (direct)	No				N	0	999	1	2	Year Relines are included in the fee for the denture through 180 days post placementDAY (RELINES ARE INCLUDED IN THE FEE FOR THE
D5731	Reline complete mandibular denture (direct)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5740	Reline maxillary partial denture (direct)	NO				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5741	Reline mandibular partial denture (direct)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5750	Reline complete maxillary denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5751	Reline complete mandibular denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5760	Reline maxillary partial denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5761	Reline mandibular partial denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement

		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	999	1	1	Day per patient
D6980	Fixed partial denture repair necessitated by restorative material failure	No				N	0	999	1	1	Day per patient
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No				T	0	999	1 per tooth	1	Lifetime per patient
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No				T	0	999	1 per tooth	1	Lifetime per patient
D7220	Removal impacted tooth-soft tissue	Yes	0	999	Pre-operative x-rays (excluding bitewings	T	0	999	1 per tooth	1	Lifetime per patient
D7230	Removal of impacted tooth- partially bony	Yes	0	999	Pre-operative x-rays (excluding bitewings	T	0	999	1 per tooth	1	Lifetime per patient
D7240	Removal of impacted tooth – completely bony	Yes	0	999	Pre-operative x-rays (excluding bitewings	T	0	999	1 per tooth	1	Lifetime per patient
D7250	Removal of residual tooth roots (cutting procedure)	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7260	Oroantral fistula closure	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Yes	0	20	Narrative of medical necessity	T	0	20	1 per tooth	1	Day per patient
D7280	Exposure of unerupted tooth	Yes	0	23	Pre-operative x-	T	0	23	1 per tooth	1	Lifetime per patient
D7283	Placement of device to facilitate eruption of impacted tooth	Yes	0	23	rays (excluding bitewings)	T	0	23	1 per tooth	1	Day per patient
D7288	Brush biopsy - transepithelial sample collection	No				N	0	999	2	1	Day per patient

D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	No				Q	0	999	1 per quadrant	1	Day per patient
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	0	999	Pre-operative x-rays (excluding bitewings	Q	0	999	1 per quadrant	1	Day per patient
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to1.25 cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day 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**
D7451	Removal of benign odontogenic cyst or tumor- - lesion diameter greater than 1.25 cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7460	Removal of benign non-odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7461	Removal of benign non-odontogenic cyst or tumor-lesion diameter greater than 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7471	Removal of lateral exostosis – maxilla or mandible-	No				N	0	999	2	1	Day per patient
D7472	Removal of torus palatinus	No				N	0	999	2	1	Day per patient
D7473	Removal of torus mandibularis	No				N	0	999	2	1	Day per patient
D7485	Reduction of osseous tuberosity	No				N	0	999	2	1	Day per patient
D7509	Marsupialization of odontogenic cyst	No				N	0	999	2	1	Day per patient
D7510	Incision and drainage of abscess - intraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7511	Incision and drainage of abscess- intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7520	Incision and drainage of abscess - extraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7521	Incision and drainage of abscess – extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7871	Non-arthroscopic lysis and lavage	Yes	0	999	Narrative of medical	N	0	999	1	1	Day per patient
D7961	Buccal/ labial frenectomy (frenulectomy)	No			Narrative of medical necessit	N	0	999	2	1	Lifetime per patient
D7962	Lingual Frenectomy (frenulectomy)	Yes	0	999	Narrative of medical necessit	N	0	999	1	1	Lifetime per patient

D7970	Excision of hyperplastic tissue - per arch	Yes	0	999	Pre-operative x-rays, narrative of medical necessity	N	0	999	1 per arch	1	Day per patient
D7999	Unspecified oral surgery procedure, by repoirt	Yes	0	999	Narrative of medical necessity, name, license	N	0	999	1	1	Day per patient

		Authorization Requirements				Benefit Details					
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D8080	Comprehensive orthodontic treatment of the adolescent dentition	YES	0	20	Panorex and /or cephalom etric x-	N	0	20	1	1	Lifetime per patient
D8660	Pre-orthodontic treatment examination to monitor growth and development	No				N	0	20	1	1	Year(per patient/per provider)
D8670	Periodic orthodontic treatment visit	Yes	0	22	For Continuat on of care (COC), Complete d COC form	N	0	22	7	1	Lifetime per patient
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Yes	0	22	evidence of successful completio n of comprehe	N	0	22	1	1	Lifetime per patient
D8695	Removal of fixed orthodontic appliances	No				N	0	999	1	1	Lifetime per patient D8680 or D8695)
D8703	Replacement of lost or broken retainer - maxillary	Yes	0	22	Evidence of previous lost/brok	N	0	22	1	1	Lifetime per patient
D8704	Replacement of lost or broken retainer - mandibular	Yes	0	22	Evidence of previous lost/brok	N	0	22	1	1	Lifetime per patient
D8210	Removable appliance therapy	Yes	0	20	Panoram ic/cephal ometric x-ray,	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D8220	Fixed appliance therapy	Yes	0	20	Panoram ic/cephal ometric x-ray,	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D9110	Palliative treatment of dental pain – per visit	No				N	0	999	1	1	Day per patient
D9222	Deep sedation/general anesthesia – first 15 minutes	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9230	Inhalation of nitrous oxide / analgesia, anxiolysis	No				N	0	20	1	1	Day per patient
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient

D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9248	Non-intravenous conscious sedation	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9920	Behavior management fee (a vist fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	1	1	Day per patient
D9920	Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	4	1	Calendar Year per patient
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9947	Custom sleep apnea appliance fabrication and placement	Yes	0	999	Lab Rx cont aini	N	0	999	1	1	Lifetime per patient
D9948	Adjustment of custom sleep apnea appliance	No				N	0	999	1	1	Day per patient at least 180 days post placement
D9949	Repair of custom sleep apnea appliance	No				N	0	999	1	1	Day per patient at least 180 days post placement
D9953	Reline custom sleep apnea appliance (indirect)	No				N	0	999	1	2	Year per patient at least 180 days post placement
D9995	Teledentistry – synchronous; real time encounter	No				N	0	999	1	1	Day per patient
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	No				N	0	999	1	1	Day per patient

		Authorization Requirements				Benefit Details					
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	Cleft Palate Services										
D0160	Detailed and Extensive Oral Evaluation, by report	NO			Complete initial examination at a Cleft	N	0	20	1	1	Day per provider (Complete initial examination at a Cleft Palate Clinic only)
D0170	Re-evaluation, Limited Problem Focused (established patient; not postoperative visit)	NO			Cleft Palate Clinic	N	0	20	1	1	Day per patient

***BLE only required for replacement denture

N = no reporting requirements

T = tooth reporting requirement

Q = quadrant reporting requirement

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