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: **ACPCHC, KFCHC**	**Submission Date: 9/30/2024**
Policy Number: DEN.003-PA	**Effective Date: 1/1/2018** **Revision Date: 9/30/2024**
Policy Name: Dental Authorization	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- **X** **Revised Policy***
- ☐ **Annual Review – No Revisions**
- ☐ **Statewide PDL**

***All revisions to the policy must be highlighted using track changes throughout the document.**

Changes:

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):	**Signature of Authorized Individual:**
Peter Charles Madden Corporate Director Dental Programs, Chief Dental Officer	

Keystone First Community HealthChoices (KFCHC)
AmeriHealth Caritas Pennsylvania Community HealthChoices (ACPCHC)
Policy and Procedure

Supersedes: **Policy No: DEN.003PA**

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

Department: Clinical Services **Original Effective Date: 1/1/2018**
Next Review Date: 5/1/2025

Unit: Dental Department

Stakeholder(s): Dental, Medical Management, Provider Network Management

Applicable Party(s): **Review Cycle: Annual**

Line(s) of Business: 7200

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 variation exists among practitioners in the utilization of selected services.

All dental services requiring authorization are reviewed utilizing the Department of Human Services' ("DHS") definition of Medically Necessary adopted by Keystone First Community HealthChoices (KFCHC), AmeriHealth Caritas Pennsylvania Community HealthChoices (ACPCHC) and referred to herein as "the Health Plan". Review of requests for authorization of dental services are performed by Dental Directors and Consulting Dentists (Dental Reviewer) with a designation of D.D.S. or D.M.D. who are licensed in the Commonwealth of Pennsylvania. Services and categories of dental services which require authorization either pre-service or retrospectively are listed in Attachment A.

An Associate may need to use and/or disclose a Participant'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 Participant'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 a Participant's authorization to release his/her PHI for any one of the aforementioned purposes (See Policy #168.277, *General Policy – Use and Disclosure of Protected Health Information Without Participant Consent/Authorization).*

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).* 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 Participants of the

Plan'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 #168.209, *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 CHC 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).*

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 #168.213, *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 10 years in accordance with Policy #591.001, *Records Retention Policy and Schedule,* unless otherwise required by Law or regulation.

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.A.001CHC and UM.A.001HC Glossary of Terms

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 the authorization review process which may include Non-Urgent Care and Urgent Care Prior (Pre-Service) Authorization, Concurrent or Retrospective Review and determination.

Medically Necessary: Compensable under the Medical Assistance Program and if it meets any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonable expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.
- Will provide the opportunity for the Participant receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

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 Plan's payment policies and procedures.

Procedure:

A) Dental Authorization Review Process

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

2. The UM/Delegate staff verifies Participant eligibility and Provider participation with the Health Plan and if either Participant 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 Community HealthChoices (CHC) program. If the item/service is not covered under CHC program, the request is forwarded to the Dental Reviewer for denial as a non-covered benefit. Denial notification is made in accordance with Policy #UM017P, *Denial Notice Contents and Distribution*.

4. For services covered under the CHC program, 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 #UM008P, *Utilization Management Criteria*). Prior Authorization (Urgent and Non-Urgent), and Retrospective Review requests are reviewed in accordance with the timeframes outlined in Policy #UM010CHC, *Utilization Management Decision Response Time*.

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 #UM010P, *Utilization Management Decision Response Time.* Lack of sufficient information is defined as but not limited to:

    a. Lack of medically necessary information.
    b. Lack of consultant findings.

7. If the information submitted meets the definition of Medically Necessary and the applicable Dental Clinical Criteria as stated in Policy #UM008CHC*, Utilization Management Criteria,* the request is approved. The UM staff notifies the Provider and Participant as outlined in Policy #UM010P, *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. For Medically Necessary case reviews, a Dental Reviewer may consult with a same specialty Dental Reviewer or the Plan's Dental Director (who in turn may consult with the 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 Participant are notified in accordance with Policy #UM010P, *Utilization Management Decision Response Time.*

11. If the Dental Reviewer determines that the item/service is not medically necessary, the denial is made in accordance with Policy #UM017P*, Denial Notice Contents and Distribution* and Policy #UM010P, *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 #UM105P, *Peer-to-Peer Discussion*).

13. Providers and Participants 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.700CHC, *Medical Assistance Participant Complaint, Grievance & DHS Fair Hearing.*

14. The Health Plan provides continuity of care for Participants who are engaged in an ongoing course of treatment with a non-participating Practitioner or Provider in accordance with continuity of care coverage guidelines outlined in Policy #UM706CHC, *Continuity of Care*.

15. 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 Plan.

16. Written or Faxed documentation received in connection with a request for Prior Authorization Pre-Service or Retrospective Review of Dental services is stored in the appropriate document imaging/storage application. All information with PHI is handled in accordance with Policy (See Policy #168.213, *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data).*

Related Procedures:

152.100 Review Process and Criteria for Dental Services Subject to Prior Authorization (free service) for Retrospective review
AP.102P-Formal Provider Appeals Process for Medically Necessary Denials
AP.700CHC-Medical Assistance Participant Complaint, Grievance and DHS Fair Hearing Policy and Procedures
UM.A.001CHC-Glossary of Terms
UM010CHC-Utilization Management Decision Response Time
UM008CHC-Utilization Management Criteria
UM017P-Utilization Management Denial Letter Content and Distribution
UM105P-Peer-to-Peer Discussion
UM706CHC-Continuity of Care
168.209-Disclosure of Protected Health Information to Business Associates and Other Contractors
168.212-Facsimile Machines and Transmission of PHI
168.213-Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data
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. Community HealthChoices Agreement

Attachments:
Attachment A: Dental Services Requiring Prior Authorization or Retrospective Review
Attachment B: Clinical Criteria for Prior and Retro Authorization of Treatment and Emergency Treatment
Attachment C: Procedure Codes and Eligibility Criteria

Approved By:

DATE: 5/1/2024

Peter Charles Madden, DDS
Corporate Director Dental Programs, Chief Dental Officer
AmeriHealth Caritas

Attachment A
Dental Services Requiring Prior Authorization or Retrospective Review

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 apico or repair of root resorption - anterior
D3502	Surgical exposure of root surface without apico or repair of root resorption - premolar
D3503	Surgical exposure of root surface without apico or repair of root resorption - molar
D3921	Decoronation or submergence of an erupted tooth
D4210	Gingivectomy or 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 – 1to3 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	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7270	Tooth reimplantation 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
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8670*	Periodic orthodontic treatment visit
D8680	Orthodontic retention
D8703	Replacement of lost or broken retainer - maxillary
D8704	Replacement of lost or broken retainer - mandibular
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; retrospective authorization not permitted.

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

The Dental Benefit Limitation Exception process does not apply to Community HealthChoices participants.

The Health Plan will accept requests for Community HealthChoices participants through the Program Exception Process (1150 Administrative Waiver Process) to exceed limits for items that are currently on the fee schedule if the limits are not based on statute or regulation and for items or services which are included in the participants benefit package but are not currently listed on the MA program fee schedule.

Crowns (D2710, D2721, D2740, D2751, D2752, D2791)
Required documentation – Periapical x-ray showing the root and crown of the natural tooth. Non-abutment teeth: Current periapical x-rays of the tooth/teeth to be crowned. Abutment teeth: Current periapical x-rays of the tooth/teeth and 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 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)
- And 1 of the criteria below must be met:
    - 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
    - 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
    - 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 x-ray 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 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 canal therapy (D3310, D3320, D3330)

Required documentation – pre-operative x-rays (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 furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- 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

Surgical Repair of Root Resorption (D3471, D3472, D3473)
Required documentation – pre-operative x-rays 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 x-rays 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 x-rays (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 x-rays, 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 scaling and root planing (D4341 and D4342)
Required documentation – periodontal charting and pre-op x-rays
Limited to no more than four different quadrant reimbursements within a 24-month period.

All criteria below must be met:

- Pocket depths 5mm or greater on 4 or more teeth (D4341) or on 1 to 3 teeth (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 a poor prognosis, require or be planned for replacement by denture and/or extraction.

Complete dentures (D5110, D5120)
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

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

Partial dentures (D5211, D5212, D5213, D5214)
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
- In addition, 1 of the criteria below must be met
    a. Replacing one or more anterior teeth
    b. Replacing three or more posterior teeth (excluding 3rd molars)

Impacted teeth – (D7220, D7230, D7240)
Documentation required – pre-operative x-rays (excluding bitewings) and narrative of medical necessity

- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- X-rays 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 x-rays (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 x-rays 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 x-rays (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, x-rays 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, x-rays 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, x-rays 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 x-rays, 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 and description of procedure; name, license number and tax ID of Asst surgeon required if D7999 is used for this purpose

General anesthesia/IV sedation (Dental Office Setting - D9222, D9223, D9239, D9243)
Documentation required – Narrative of medical necessity, anesthesia log (retro auth)
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/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 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

Custom sleep apnea appliance fabrication and placement (D9947)
Documentation requirements:

- Lab Rx for custom appliance with Participant name
- Letter of Medical Necessity (LOMN) from physician containing clinical criteria listed below:

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

- diagnosis of obstructive sleep apnea (G47.33)
- face-to-face evaluation of Participant by physician
- patient attended a facility based polysomnogram or approved home sleep test
- 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)

Orthodontics

Comprehensive orthodontic services (D8080)
Documentation requirements – Panoramic and /or cephalometric radiograph, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form; documentation must support Salzmann Criteria Index Form score of 25 points or greater when the case is evaluated using the Salzmann Index to meet criteria for benefit.

- 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.

Fixed or removable appliance therapy (D8210, D8220)
Documentation required – Panorex and/or cephalometric x-rays, 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.

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.

Orthodontic Retention (D8680)
Documentation required – diagnostic quality photos.
All criteria below must be met:

Photos demonstrate malocclusion was corrected through comprehensive orthodontic treatment.

Replacement of lost or broken retainer – Maxillary/Mandibular (D8703/D8704)

Documentation requirements – narrative or evidence of previous lost or broken orthodontic retainer (D8680).

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

ATTACHMENT C

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 Require-ments**	**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
D0140	Limited oral evaluation-problem focused	No				N	0	999	1	1	Days per patient (audio or video teledentistry allowed; pt initiated by call in to office for POS 02)
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
D0150	Comprehensive oral evaluation – new or established patient	No				N	0	999	1	1	ONCE PER LIFETIME Per patient per dentist/dental group
D0160	Detailed and Extensive Oral Evaluation, by report	No			Detailed and extensive oral eval at a Cleft Palate Clinic Only	N	0	999	1	1	Day per provider (complete initial examination at a cleft palate clinic only)
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No			Re-eval – established cleft palate patient at a Cleft Palate Clinic only	N	0	999	1	1	Day per patient (cleft palate clinic only)
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
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
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	No				N	0	20	1	1	Day per patient
D1110	Prophylaxis-adult	No				N	12	999	1	180	Days per patient

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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)
D1310	Nutritional counseling for control of dental disease	No				N	0	999	1	180	Days per patient (teledentistry POS 02,10)
D1320	Tobacco counseling for the control and prevention of oral 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 system health effects associated with high-risk substance abuse	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient (teledentistry allowed POS 02,10)
D1321	Counseling for the control and prevention of adverse oral behavioral and system 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,1st and 2nd molars, and on 1st and 2nd molars where a buccal restoration might exist
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	10 teeth	1	Day per patient
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	4	1	Year per tooth per patient)
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	6	1	Lifetime per tooth per patient
D1510	Space maintainer – fixed, unilateral, per quad	No				Q	0	20	4	1	1 appliance per quad per Lifetime
D1516	Space maintainer – fixed, bilateral, max	No				T	0	20	1	1	1 appliance per arch per Lifetime
D1517	Space maintainer – fixed, bilateral, man	No				T	0	20	1	1	1 appliance per arch per Lifetime
D1551	Re-cement or re-bond bilateral space maintainer - max	No				N	0	20	1	1	Day appliance per patient
D1552	Re-cement or re-bond bilateral space maintainer - man	No				N	0	20	1	1	Day appliance per patient
D1553	Re-cement or re-bond unilateral space maintainer – per quad	No				N	0	20	4	1	Day appliance per patient
D1556	Removal of fixed unilateral space maintainer – per quad	No				N	0	20	4	1	Day appliance per patient
D1557	Removal of fixed bilateral space maintainer – max	No				N	0	20	1	1	Day appliance per patient
D1558	Removal of fixed bilateral space maintainer – man	No				N	0	20	1	1	Day appliance per patient

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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.
D2160	Amalgam - three surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2161	Amalgam - four surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2330	Resin-based composite -1 surface, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2331	Resin-based composite – 2 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 - 3 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 - 4+ 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 composite 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 - 1 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 - 2 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 - 3 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 - 4+ surf, 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
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
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
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
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.
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
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restoration	No				T	0	999	1	1	Day per tooth per patient
D2915	Recement or rebond indirectly fabricated or prefabricated post and core	No				T	0	999	1	1	Day per tooth per patient
D2920	Recement or rebond crown	No				T	0	999	1	1	Day per tooth per patient

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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
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
D2954	Prefabricated post and core in addition to crown	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
D2980	Crown repair necessitated by restorative material failure	No				T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No			N	T	0	999	1	1	LIFETIME/PER TOOTH/PER PATIENT. NOT ALLOWED IF TOOTH WAS PREVIOUSLY
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No	0	20		T	0	20	6	1	PER DAY/PER TOOTH/PER PATIENT
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	No	0	20		T	0	20	1	1	PER DAY/PER TOOTH/PER PATIENT
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	No	0	20		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 of medical necessity	T	0	999	1	1	LIFETIME PER TOOTH
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings). Narrative of medical necessity	T	0	999	1	1	LIFETIME PER TOOTH
D3330	Endodontic therapy, Molar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), narrative of medical necessity	T	0	999	1	1	LIFETIME PER TOOTH
D3410	Apicoectomy - anterior	No				T	0	999	2 teeth	1	Day PER TOOTH per patient
D3421	Apicoectomy - premolar (first root)	No				T	0	999	2 teeth	1	Day PER TOOTH per patient
D3425	Apicoectomy - molar (first root)	No				T	0	999	2 teeth	1	Day PER TOOTH per patient
D3426	Apicoectomy each additional root	No				T	0	999	2 teeth	1	Day PER TOOTH per patient

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D3471	Surgical repair of root resorption - anterior	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	LIFETIME PER TOOTH
D3473	Surgical repair of root resorption - molar	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	LIFETIME PER TOOTH
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 necessity	T	0	999	1	1	LIFETIME PER TOOTH
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 necessity	T	0	999	1	1	LIFETIME PER TOOTH
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 necessity	T	0	999	1	1	LIFETIME PER TOOTH
D3921	Decoronation or submergence of an erupted tooth	Yes	0	999	Post operative x-rays (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es)	T	0	999	1	1	Lifetime per tooth
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 (optional)	Q	0	999	4 (different quadrants)	24	Months per patient
D4341	Periodontal scaling & 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
D4341	Periodontal scaling & 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 inclusive of D4342	24	Months per patient
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	4(different quadrants)	1	Day per patient
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative o medical necessity	Q	0	999	4 (different quadrants)	24	Months per patient
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
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 past 12 months .
D4910	Periodontal maintenance	No				N	0	999		90	Days per patient

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D5110	Complete denture - maxillary	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity)	N	0	999	1	5	Years 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) every 5 years
D5120	Complete denture - mandibular	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	0	999	1	5	Years 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) every 5 years
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) every 5 years
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) every 5 years
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	5	Years 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) every 5 years
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	5	Years 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) every 5 years
D5213	Maxillary partial denture - cast metal framework with resin denture 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	5	Years 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) every 5 years

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D5214	Mandibular partial denture - cast metal framework with resin denture 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	5	Years 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) every 5 years
D5410	Adjust complete denture - maxillary	No				N	0	999	1	1	Day per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE through180 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 through180 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 through180 days post insertion
D5422	Adjust partial denture - mandibular	No				N	0	999	1	1	Day per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5511	Repair complete broken denture base mandibular	No				N	6	999	1	1	Day per patient
D5512	Repair complete broken denture base maxillary	No				N	6	999	1	1	Day per patient
D5520	Replace teeth-dent/per	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
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 TOOTH	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 through180 days post insertion

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D5731	Reline complete mandibular denture (direct)	No				N	0	999	1(per arch)	2	Year -RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5740	Reline maxillary partial Denture (direct)	No				N	0	999	1(per arch)	2	Year - RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5741	Reline mandibular partial denture (direct)	No				N	0	999	1(per arch)	2	Year - RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5750	Reline complete maxillary denture (indirect)	No				N	0	999	1(per arch)	2	Year - RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5751	Reline complete Mandibular denture (indirect)	No				N	0	999	1(per arch)	2	Year -RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5760	Reline maxillary partial denture (indirect)	No				N	0	999	1(per arch)	2	Year - RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D5761	Reline mandibular partial denture (indirect)	No				N	0	999	1(per arch)	2	Year -RELINES ARE INCLUDED IN THE FEE FOR THE DENTURE through180 days post insertion
D6930	Recement or rebond 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 of impacted tooth – soft tissue	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	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) and narrative of medical necessity	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) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient

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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 reimplantation 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-rays	T	0	23	1 per tooth	1	Lifetime per patient
D7283	Placement of device to facilitate eruption of impacted tooth	Yes	0	23	x-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 – 4 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 – 4 or more teeth or tooth spaces per quadrant	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	Q	0	999	1 per quadrant	1	Day per patient
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7451	Removal of benign 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
D7460	Removal of benign non-odontogenic cyst or tumor-lesion diameter up to 1.25cm	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	1	1	Day per patient
D7510	Incision and drainage of abscess intraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7511	Incision and drainage of abscess- intraoral – complicated (includes drainage of multiple fascial	Yes	0	999	Narrative of medical necessity, xrays or photos optional	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 or photos optional	N	0	999	2	1	Day per patient
D7521	Incision and drainage of abscess- extraoral – complicated (includes drainage of multiple fascial	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Require-ments**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D7871	Non-arthroscopic lysis and lavage	Yes	0	999	Narrative of medical necessity, x-rays or photos optional	N	0	999	1	1	Day per patient
D7961	Buccal/ labial frenectomy (frenulectomy)	No				N	0	999	2	1	Lifetime per patient
D7962	Lingual Frenectomy (frenulectomy)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	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, photos optional	N	0	999	1 per arch	1	Day per patient
D7999	Unspecified oral surgery procedure, by report	Yes	0	999	Narrative of medical necessity, name, license number and tax ID of Asst surgeon	N	0	999	1	1	Day per patient
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	Yes	0	20	Panorex and/or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form	N	0	20	1	1	Lifetime per patient
D8210	Removable appliance therapy	Yes	0	20	Panoramic/cephalo -metric x-ray, Narrative of medical necessity	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D8220	Fixed appliance therapy	Yes	0	20	Panoramic/cephalo - metric x-ray, Narrative of medical necessity	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
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 Continuation of care (COC), Completed 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 completion of comprehensive orthodontics	N	0	22	1	1	Day per patient
D8703	Replacement of lost or broken retainer - maxillary	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Lifetime per patient
D8704	Replacement of lost or broken retainer -mandibular	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Lifetime per patient
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 subsequent 15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Require-ments**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
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 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	14	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 containing Participant name, Physician letter of medical necessity containing clinical criteria	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 least180 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

Services not appearing in the benefit grid are not benefits of the plan.

N = no reporting requirements
T = tooth reporting requirement
Q = quadrant reporting requirement