Dental Provider Manual

UnitedHealthcare Community Plan of New York

Health and Recovery Plan (HARP)

Medicaid Managed Care (MMC)

Dual Complete NY-Y001 (HMO D-SNP) / Medicaid Advantage Plus (MAP)

Child Health Plus (CHP)

Essential Plan Programs (EPP)

Provider Services: 1-800-304-0634

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UnitedHealthcare® | Dental Benefit Providers®

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Section 1: Introduction — who we are

Welcome to UnitedHealthcare Community Plan

UnitedHealthcare welcomes you as a participating Dental Provider in providing dental services to our members.

We are committed to providing accessible, quality, comprehensive dental services in the most cost-effective and efficient manner possible. We realize that to do so, strong partnerships with our providers are critical, and we value you as an important part of our program.

We offer a portfolio of products including, but not limited to, Medicaid and Medicare Special Needs plans, as well as Commercial products such as Preferred Provider Organization (PPO) plans.

This Provider Manual (the "Manual") is designed as a comprehensive reference guide for the dental plans in your area, primarily UnitedHealthcare Community Plan Medicaid and Medicare plans. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, it will be uploaded on the portal at **UHCdental.com/medicaid** under state-specific provider resources. Additional NY Provider information can also be found at: **https://www.emedny.org/ProviderManuals/index.aspx.**

Our Commercial program plan requirements are contained in a separate Provider Manual. If you support one of our Commercial plans and need that Manual, please contact Provider Services at **1-800-822-5353**.

If you have any questions or concerns about the information contained within this Manual, please contact the UnitedHealthcare Community Plan Provider Services team at the telephone number listed on the cover of this document.

Unless otherwise specified herein, this Manual is effective the date found of the cover of this document for dental providers currently participating in the UnitedHealthcare Community Plan's network, and effective immediately for newly contracted dental providers.

Please note: "Member" is used in this Manual to refer to a person eligible and enrolled to receive coverage for covered services in connection with your agreement with us. "You" or "your" refers to any provider subject to this Manual. "Us", "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this Manual.

The codes and code ranges listed in this Manual were current at the time this Manual was published. Codes and coding requirements, as established by the organizations that create the codes, may periodically change. Please refer to the applicable coding guide for appropriate codes.

Thank you for your continued support as we serve the Medicaid and Medicare beneficiaries in your community.

Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions

- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit **UHCdental.com/medicaid** and go to Resources > Dental Provider Online Academy.

Required training

The New York State Department of Health (NYSDOH) requires all Medicaid health care professionals to take the "Think Cultural Health" training class and report completion of the training. All clinical and non-clinical staff involved in patient care or services must complete this training by December 31st annually.

Cultural competency is essential to delivering equitable, respectful, and effective care. This training will help ensure that all patients -- regardless of background, identity, or lived experience - feel safe and supported in our care.

To complete the training:

- Visit **uhcdental.com/provideracademy** > State-specific training page > New York
- Select the New York Specific Cultural Competency Training - Required Training*
- Start course to complete the attestation form and submit
- After submitting the completed Attestation, click the link found on the next page. You will be directed to the U.S. Department of Health and Human Services website to register and complete the training.

Section 2: Patient eligibility verification procedures

2.1 Member eligibility

Member eligibility or dental benefits may be verified online or via phone.

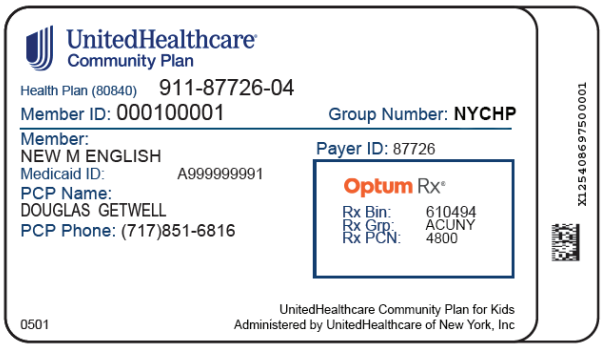
We receive daily updates on member eligibility and can provide the most up-to-date information available.

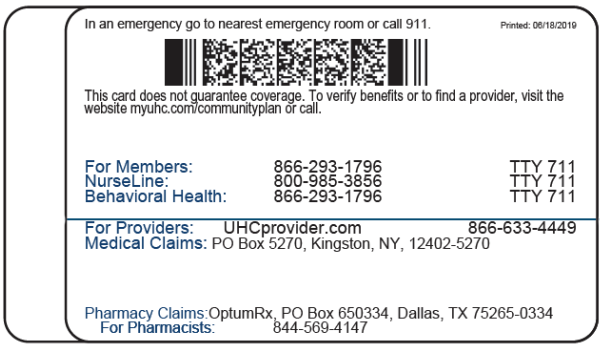
Important Note: Eligibility should be verified on the date of service. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. **Additional rules may apply to some benefit plans.**

2.2 Identification card

Members are issued an identification (ID) card by UnitedHealthcare Community Plan. There will not be separate dental cards for UnitedHealthcare Community Plan members. The ID cards are customized with the UnitedHealthcare Community Plan logo and include the toll-free customer service number for the health plan.

A member ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service. To verify a member's dental coverage, go to **UHCdental.com/medicaid** or contact the dental Provider Services line at the telephone number listed on the cover of this document. A sample ID card is provided below. The member's actual ID card may look slightly different.





2.3 Eligibility verification

Eligibility can be verified on our website at **UHCdental.com/medicaid** 24 hours a day, 7 days a week. In addition to current eligibility verification, our website offers other functionality for your convenience, such as claim status. Once you have registered on our provider website, you can verify your patients' eligibility online with just a few clicks.

The username and password that are established during the registration process will be used to access the website. One username and password are granted for each payee ID number.

UnitedHealthcare Community Plan also offers an Interactive Voice Response (IVR) system for eligibility verification; please see Appendix A of this manual to see details of the IVR system. The IVR is available 24 hours a day, 7 days a week.

2.4 Quick reference guide

UnitedHealthcare Community Plan is committed to providing your office accurate and timely information about our programs, products and policies.

Our **Provider Services Line** (noted on the cover of this manual) and Provider Services teams are available to assist you with any questions you may have. Our toll-free provider services number is available during normal business hours and is staffed with knowledgeable specialists. They are trained to handle specific dentist issues such as **eligibility, claims, benefits information and contractual questions.**

The following is a quick reference table to guide you to the best resource(s) available to meet your needs when questions arise:

You want to:	Provider Services Line– Dedicated Service Representatives Hours: 8 a.m.-6 p.m. (EST) Monday-Friday	Online UHCdental.com/ medicaid	Interactive Voice Response (IVR) System and Voicemail Hours: 24 hours a day, 7 days a week
Ask a Benefit/Plan Question (including prior authorization requirements)	✓	✓	
Ask a question about your contract	✓		
Changes to practice information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation)	✓	✓	
Inquire about a claim	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Request a copy of your contract	✓		
Request a Fee Schedule	✓	✓	
Request an EOB	✓	✓	
Request an office visit (e.g., staff training)	✓		
Request benefit information	✓	✓	
Request documents	✓	✓	
Request participation status change	✓		

2.5 Provider Portal/Dental Hub

The UnitedHealthcare Community Plan website at **UHCdental.com/medicaid** offers many time-saving features including **eligibility verification, benefits, claims submission and status, print remittance information, claim receipt acknowledgment and network specialist locations.** The portal is also a helpful content library for **standard forms, provider manuals, quick reference guides, training resources,** and more.

To use the website, go to **UHCdental.com/medicaid** and register or log-in for Dental Hub as a participating user. Online access requires only an internet browser, a valid user ID, and a password once registered. There is no need to download or purchase software.

To register on the site, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services.

2.6 Integrated Voice Response (IVR) system 1-800-304-0634

We have a toll-free Integrated Voice Response (IVR) system that enables you to access information 24 hours a day, 7 days a week, by responding to the system's voice prompts.

Through this system, network dental offices can obtain immediate **eligibility information**, validate **practitioner participation status** and perform member **claim history** search (by surfaced code and tooth number).

Section 3: Office administration

3.1 Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of services (QOS) concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all primary care provider office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance.
- Available handicapped parking and handicapped accessible facilities.
- Available adequate waiting room space and dental operatories for providing member care.
- Privacy in the operatory.
- Clearly marked exits.
- Accessible fire extinguishers.

3.2 Office conditions

Your dental office must meet applicable Occupational Safety & Health Administration (OSHA), CDC infection control guidelines and American Dental Association (ADA) standards.

An attestation is required for each dental office location that the physical office meets ADA standards or describes how accommodation for ADA standards is made, and that medical recordkeeping practices conform with our standards.

3.3 Sterilization and infection control fees

Dental office infection control programs must meet the minimum requirements based on the Centers for Disease Control & Prevention's (CDC) guiding principles of infection control. All instruments should be sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA and state guidelines.

Sterilization and infection control fees are to be included within office procedure charges and should not be billed to members or the plan as a separate fee.

3.4 Recall system

It is expected that offices will have an active and definable recall system to make sure that the practice maintains preventive services, including patient education and appropriate access. Examples of an active recall system include, but are not limited to: postcards, letters, phone calls, emails and advance appointment scheduling.

3.5 Transfer of dental records

Your office shall copy all requested member dental records to another participating dentist as designated by UnitedHealthcare Community Plan or as requested by the member. The member is responsible for the cost of copying the patient dental records if the member is transferring to another provider. If your office terminates from UnitedHealthcare Community Plan, dismisses the member from your practice or is terminated by UnitedHealthcare Community Plan, the cost of copying records shall be borne by your office. Your office shall cooperate with UnitedHealthcare Community Plan in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.

3.6 Office hours

Provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

3.7 Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

3.8 Provide access to your records

You shall provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for six years or longer if required by applicable statutes or regulations.

3.9 Inform members of advance directives

Members have the right to make their own health care decisions. This includes accepting or refusing treatment. They may execute an advance directive at any time. An advance directive is a document in which the member makes rules around their health care decisions if they later cannot make those decisions.

Several types of advance directives are available. You must comply with all applicable state law requirements about advance directives.

Members are not required to have an advance directive. You cannot provide care or otherwise discriminate against a member based on whether they have executed one. Document in a member's medical record whether they have executed or refused to have an advance directive.

If a member has one, keep a copy in their medical record. Or provide a copy to the member's PCP. Do not send a copy of a member's advance directive to UnitedHealthcare Community Plan.

If a member has a complaint about non-compliance with an advance directive requirement, they may file a complaint with the UnitedHealthcare Community Plan medical director, the physician reviewer, and/or the state survey and certification agency.

3.10 Participate in quality initiatives

You shall help our quality assessment and improvement activities. You shall also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for particular diseases and conditions. This is determined by United States government agencies and professional specialty societies.

3.11 New associates

As your practice expands and changes and new associates are added, you must contact us within 10 calendar days to request an application so that we may get them credentialed and set up as a participating provider.

It is important to remember that associates may not see members as a participating provider until they've been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact Provider Services at the telephone number listed on the cover of this document.

3.12 Change of address, phone number, email address, fax or tax identification number

When there are demographic changes within your office, you must notify us at least 10 calendar days prior to the effective date of the change. This supports accurate claims processing as well as helps to make sure that member directories are up-to-date.

Changes should be submitted to:

UnitedHealthcare – RMO
ATTN: 400-Provider Services
PO BOX 30567
SALT LAKE CITY, UT 84130

Fax: 1-855-363-9691
Email: dbpprvfx@uhc.com

Credentialing updates should be sent to:

2300 Clayton Road
Suite 1000
Concord, CA 94520

Requests must be made in writing with corresponding and/or backup documentation. For example, a tax identification number (TIN) change would require submission of a copy of the new W9, versus an office closing notice where we'd need the notice submitted in writing on office letterhead.

When changes need to be made to your practice, we will need an outline of the old information as well as the changes that are being requested. This should include the name(s), TIN(s) and/or Practitioner ID(s) for all associates to whom that the changes apply.

UnitedHealthcare reserves the right to conduct an onsite inspection of any new facilities and will do so based on state and plan requirements.

If you have any questions, don't hesitate to contact Provider Services at the telephone number listed on the cover of this document for guidance.

Section 4: Patient access

4.1 Appointment scheduling standards

We are committed to ensuring that providers are accessible and available to members for the full range of services specified in the UnitedHealthcare Community Plan provider agreement and this manual. Participating providers must meet or exceed the following state mandated or plan requirements:

- **Emergency Care or Urgent care appointments**: Immeditaely or within 24 hours
- **Routine care appointments**: Offered within 30 calendar days of the request

We may monitor compliance with these access and availability standards through a variety of methods including member feedback, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. If necessary, the findings may be presented to UnitedHealthcare Community Plan's Quality Committee for further discussion and development of a corrective action plan.

Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.

Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

4.2 Emergency coverage

All network dental providers must be available to members during normal business hours. Practitioners will provide members access to emergency care 24 hours a day, 7 days a week through their practice or through other resources (such as another practice or a local emergency care facility). The out-of-office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

UnitedHealthcare Community Plan conducts periodic surveys to make sure our network providers' emergency coverage practices meet these standards.

4.3 Specialist referral process

If a member needs specialty care, a general dentist may recommend a network specialty dentist, or the member can self-select a participating network specialist. Referrals must be made to qualified specialists who are participating within the provider network. No written referrals are needed for specialty dental care.

To obtain a list of participating dental network specialists, go to our website at **UHCdental.com/medicaid** or contact Provider Services at the telephone number listed on the cover of this manual.

4.4 Missed appointments

Enrolled Participating Providers are not allowed to charge Members for missed appointments.

If your office mails letters to Members who miss appointments, the following language may be helpful to include:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Contacting the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment may help to decrease the number of missed appointments.

The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a Provider from billing Medicaid and CHP Members for missed appointments. In addition, your missed appointment policy for UnitedHealthcare members cannot be stricter than that of your private or commercial patients.

4.5 Nondiscrimination

The Practice shall accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. The Practice shall not discriminate against any member on the basis of source of payment or in any manner in regards to access to, and the provision of, Covered Services. The Practice shall not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, ethnicity, religion, national origin, ancestry, disability, medical condition, claims experience, evidence of insurability, source of payment, marital status, age, sexual orientation or gender.

4.6 Dental requirements for youth and children in foster care

As of July 1, 2021, children and youth in direct placement foster care in New York state are mandatorily enrolled in Medicaid managed care (MMC) unless they are otherwise exempt or excluded from enrollment. This mandate also applies to children and youth in Voluntary Foster Care Agencies (VFCA). Children who enter foster care placement receive a dental screening during their initial medical assessment. It is required that foster care children up to age three have their mouths examined at such medical examination and where appropriate, referred for dental care. Foster care children over the age of three are required to see a dentist at minimum, once a year, and must be provided dental care when needed.

What this means for you

It is critical that these children receive expedited access to care. They may visit any dental practitioner in the MMC plan network. Please consider making an extra effort to accommodate these children into your dental practice by ensuring availability of appointments.

Section 5: Utilization Management program

5.1 Utilization Management

Through Utilization Management practices, UnitedHealthcare aims to provide members with cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including provider analytics, utilization review, prior authorization, claims data and audits, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns that demonstrate significant variation from norms.

By identifying and remediating providers who demonstrate unwarranted variation, we can reduce the overall impact of such variation on cost of care, and improve the quality of dental care delivered.

5.2 Community practice patterns

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The quantity and distribution of procedures performed in each category are compared with benchmarks such as similarly designed UnitedHealthcare plans and peers to determine if utilization for each category and overall are within expected levels.

Significant variation might suggest either overutilization or underutilization. Variables which might influence utilization, such as plan design and/or population demographics, are taken into account. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

5.3 Evaluation of utilization management data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having practice patterns demonstrating significant variation, his or her utilization may be reviewed further. For each specific dentist, a Peer Comparison Report may be generated and analysis may be performed that identifies all procedures performed on all patients for a specified time period. Potential causes of significant variation include upcoding, unbundling, miscoding, excessive treatment, under-treatment, duplicate billing, or duplicate payments. Providers demonstrating significant variation may be selected for counseling or other corrective actions.

5.4 Utilization Management analysis results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers.

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including:

- Provider Manual/Standards of Care
- Provider Training

- Continuing Education
- Provider News Bulletins

5.5 Utilization review

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

Utilization review may also occur prior to dental services being rendered. This is known as prior authorization, pre-authorization, or a request for a pre-treatment estimate. UnitedHealthcare does not require prior authorization or pre-treatment estimates (although we encourage these before costly procedures are undertaken).

Retrospective reviews and prior authorization reviews are performed by licensed dentists.

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the Dental Clinical Policy and Technology Committee, and state regulatory agencies where required.
- To determine whether an alternate benefit should be provided.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

5.6 Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

According to the American Dental Association (ADA), Evidence-Based Dentistry is defined as:

"An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences." Evidence-based dentistry is a methodology to help reduce variation and determine proven treatments and technologies. It can be used to support or refute treatment for the individual patient, practice, plan or population levels. At UnitedHealthcare Community Plan, it ensures that our clinical programs and policies are grounded in science. This can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses on identifying those with medical conditions thought to be impacted by dental health, early childhood caries programs, oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

Evidence is gathered from published studies, typically from peer reviewed journals. However, not all evidence is created equal, and in the absence of high-quality evidence, the "best available" evidence may be used. The hierarchy of evidence used at United Healthcare is as follows:

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies

- Case series
- Case studies

Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines) Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks
- Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare Community Plan, we use evidence as the foundation of our efforts, including:
- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare Community Plan dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes every other month and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 6: Quality management

6.1 Quality Improvement Program (QIP) description

UnitedHealthcare Community Plan has established and continues to maintain an ongoing program of quality management and quality improvement to facilitate, enhance and improve member care and services while meeting or exceeding customer needs, expectations, accreditation and regulatory standards.

The objective of the QIP is to make sure that quality of care is being assessed; that problems are being identified; and that follow up is completed where indicated. The QIP is directed by all state, federal and client requirements. The QIP addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to make sure they meet professionally recognized standards of care.

The QIP description is reviewed and updated annually:

- To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
- To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
- To evaluate the effectiveness of implemented changes to the QIP.
- To reduce or minimize opportunity for adverse impact to members.
- To improve efficiency, cost effectiveness, value and productivity in the delivery of oral health services.
- To promote effective communications, awareness and cooperation between members, participating providers and the Plan.
- To comply with all pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- To make sure that written policies and procedures are established and maintained by the Plan to make sure that quality dental care is provided to the members.

As a participating practitioner, any requests from the QIP or any of its committee members must be responded to as outlined in the request.

6.2 Credentialing

To become a participating provider in UnitedHealthcare's network, all applicants must be fully credentialed and approved by our Credentialing Committee. In addition, to remain a participating provider, all practitioners must go through periodic recredentialing approval (typically every 3 years unless otherwise mandated by the state in which you practice).

Depending on the state in which you practice, UnitedHealthcare will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. UnitedHealthcare will request a written explanation regarding any adverse incident and its resolution and will request corrective action be taken to prevent future occurrences.

Before an applicant dentist is accepted as a participating provider, the dentist's credentials are evaluated. Initial facility site visits are required for each location specified by the state requirements for some plans and/or markets. Offices must pass the facility review prior to activation. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process.

Dental Benefit Providers Credentialing Committee reviews adverse incidents based on the information provided by the applicant. Dental Benefit Providers will request a resolution of any discrepancy in credentialing forms submitted. Providers have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria is reviewed/ approved by the Credentialing Committee, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines.

Dental Benefit Providers contracts with an external Credentialing Verification Organization (CVO) to assist with collecting the data required for the recredentialing process. The CVO will occasionally contact our contracted providers to collect outstanding credentialing information.

It is important to note that the recredentialing process is a requirement for your continued participation with UnitedHealthcare Community Plan. Any failure to comply with the recredentialing process constitutes termination for cause under your provider agreement.

So that a thorough review can be completed at the time of recredentialing, in addition to the items verified during the initial credentialing process, Dental Benefit Providers may review provider performance measures such as, but not limited to:

- Utilization Reports
- Current Facility Review Scores
- Current Member Chart Review Score
- Grievance and Appeals Data

Recredentialing requests are sent months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, Dental Benefit Providers will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

A list of the documents required for Initial Credentialing and Recredentialing is as follows (unless otherwise specified by state law):

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits – limits $1/3m

- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)
- Disclosure of Ownership form (as required by the Federal Government), only if applicable

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- Current copy of their Controlled Dangerous Substance (CDS) certificate, if applicable
- Current copy of their Sedation and/or General Anesthesia certificates, if applicable
- Copy of their Sedation and/or General Anesthesia training certificate/diploma, if applicable
- Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits— limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

Any questions regarding your initial or recredentialing status can be directed to Provider Services.

6.3 Site visits

With appropriate notice, provider locations may receive an in-office site visit as part of our quality management oversight processes. All surveyed offices are expected to perform quality dental work and maintain appropriate dental records.

The site visit focuses primarily on: dental record keeping, patient accessibility, infection control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

UnitedHealthcare Dental, Dental Benefit Providers, reserves the right to conduct an on-site inspection prior to and any time during the effectuation of the contract of any Mobile Dental Facility or Portable Dental Operation bound by the "Mobile Dental Facilities Standard of Care Addendum."

6.4 Preventive health guideline

The UnitedHealthcare Community Plan approach to preventive health is a multi-focused strategy which includes several integrated areas. The following guidelines are for informational purposes for the dental provider, and will be referred to in a general way, in judging clinical appropriateness and competence.

UnitedHealthcare Community Plan's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to,

current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Endodontists, American Association of Oral and Maxillofacial Surgeons, and the American Association of Dental Consultants. Additional resources include publications such as the Journal of Evidence-Based Dental Practice, online resources obtained via the Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence Based Dentistry as well as respected public health benchmarks such as the Surgeon General's Report on Oral Health in America. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

Caries Management – Begins with a complete evaluation including an assessment for risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity – Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions – Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient and based on age, results of a clinical assessment and risk, including application of prophylaxis, fluoride application, placement of sealants and adjunctive therapies where appropriate.
- Consideration should be given to conservative nonsurgical approaches to early caries, such as Caries Management by Risk Assessment (CAMBRA), where the lesion is non-cavitating, slowing progressing or restricted to the enamel or just the dentin; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

Periodontal management – Screening, and as appropriate, complete evaluation for periodontal diseases should be performed on all adults, and children in late adolescence and younger, if that patient exhibits signs and symptoms or a history of periodontal disease.

- A periodontal evaluation should be conducted at the initial examination and periodically thereafter, as appropriate, based on American Academy of Periodontology guidelines.
- Periodontal evaluation and measures to maintain periodontal health after active periodontal treatment should be performed as appropriate.
- Special consideration should be given to those patients with periodontal disease, a previous history of periodontal disease and/or those at risk for future periodontal disease if they concurrently have systemic conditions reported to be linked to periodontal disease such as diabetes, cardiovascular disease and/or pregnancy complications.

Oral cancer screening should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk. Screening should be done at the initial evaluation and again at each recall. Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare Community Plan may perform clinical studies and conduct interventions in the following target areas:

- Access
- Preventive services, including topical fluoride and sealant application
- Procedure utilization patterns

Multiple channels of communication will be used to share information with providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of UnitedHealthcare Community Plan to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

6.5 Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community relationships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

Prevention: Prevent Opioid-Use Disorders before they occur through pharmacy management, provider practices, and education.

Treatment: Access and reduce barriers to evidence-based and integrated treatment.

Recovery: Support care management and referral to person-centered recovery resources.

Harm Reduction: Access to Naloxone and facilitating safe use, storage, and disposal of opioids.

Strategic community relationships and approaches: Tailor solutions to local needs.

Enhanced solutions for pregnant mom and child: Prevent neonatal abstinence syndrome and supporting moms in recovery.

Enhanced data infrastructure and analytics: Identify needs early and measure progress.

Increasing education & awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep Opioid Use Disorders (OUD) related trainings and resources available on our provider portal to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars

such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com** > Tools and resources > Resource library > Pharmacy resources > Drug lists and pharmacy > Opioid Programs and Resources - Community Plan (Medicaid).

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and member and care provider education is central to our strategy.

UnitedHealthcare Community Plan has implemented a 90 MED supply limit for the long-acting opioid class. The prior authorization criteria coincide with the CDC’s recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines for opioid prevention and overdose can be found at **Preventing Opioid Overdose | Overdose Prevention | CDC**.

Section 7: Fraud, waste, and abuse training

Providers are required to establish written policies for their employees, contractors or agents and to provide training to their staff on the following policies and procedures:

- Provide detailed information about the Federal False Claims Act,
- Cite administrative remedies for false claims and statements,
- Reference state laws pertaining to civil or criminal penalties for false claims and statements, and
- With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

The required training materials can be found at the website listed below. The website provides information on the following topics:

- FWA in the Medicare Program
- The major laws and regulations pertaining to FWA
- Potential consequences and penalties associated with violations
- Methods of preventing FWA
- How to report FWA
- How to correct FWA

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244

Section 8: Governance

8.1 Provider rights bulletin

If you elect to participate/continue to participate with the plan, please complete the application in its entirety; sign and date the Attestation Form and provide current copies of the requested documents. You also have the following rights:

To review your information

You may review any information the plan has utilized to evaluate your credentialing application, including information received from any outside source (e.g., malpractice insurance carriers; state license boards), with the exception of references or other peer-review protected information.

To correct erroneous information

If the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within 15 business days of receipt of the information. You will have an additional 15 business days to submit your reply in writing. Within two business days, the plan will send a written notification acknowledging receipt of the information.

To be informed of status of your application

You may submit your application status questions in writing or telephonically.

To appeal adverse committee decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 days of the date of receipt of the rejection/denial letter and is applicable to certain states.

UnitedHealthcare Dental
Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520
Phone: **1-855-918-2265**
Fax: **1-844-881-4963**

8.2 Quality of care issues

A provider who has demonstrated behavior inconsistent with the provision of quality of care is subject to review, corrective action, and/or termination. Questions of quality-of-care may arise for, but are not limited to, the following reasons:

- Chart audit reveals clear and convincing evidence of under- or over utilization, fraud, upcoding, overcharging, or other inappropriate billing practices.
- Multiple quality-of-care related complaints or complaints of an egregious nature for which investigation confirms quality concerns.
- Malpractice or disciplinary history that elicits risk management concerns.

Note: A provider cannot be prohibited from the following actions, nor may a provider be refused a contract solely for the following:

- Advocating on behalf of an enrollee
- Filing a complaint against the MCO
- Appealing a decision of the MCO
- Providing information or filing a report pursuant to PHL4406-c regarding prohibition of plans
- Requesting a hearing or review

We may not terminate a contract unless we provide the practitioner with a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below.

- Cases which meet disciplinary or malpractice criteria are initially reviewed by the Credentialing Committee. Other quality-of-care cases are reviewed by the Peer Review Committee.
- The Committees make every effort to obtain a provider narrative and appropriate documents prior to making any determination.
- The Committees may elect to accept, suspend, unpublish, place a provider on probation, require corrective action or terminate the provider.
- The provider will be allowed to continue to provide services to members for a period of up to sixty (60) days from the date of the provider's notice of termination.
- The Hearing Committee will immediately remove from our network any provider who is unable to provide health care services due to a final disciplinary action. In such cases, the provider must cease treating members upon receipt of this determination.

8.3 Peer to Peer Request prior to Appeal

The attending dentist may ask to speak on the telephone with a licensed dental consultant regarding an adverse determination, on a peer-to-peer basis. Call Provider Services to request a Peer to Peer discussion **1-800-304-0634**.

If additional information can be provided to the dental consultant, a reversal of the adverse determination can be considered.

If a peer-to-peer conversation does not result in redetermination the provider and member have the right to initiate an appeal.

8.4 Appeals process

You have the right to appeal any credentialing decision if your practice is in a state that allows for credentialing Appeals which is based on information received during the credentialing process. If you practice in a state that allows for Appeals, to initiate an appeal of a recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Committee Coordinator.

- Providers are notified in writing of their appeal rights within fifteen (15) calendar days of the Committee's determination. The letter will include the reason for denial/termination; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by UnitedHealthcare; notice of a thirty (30)-day time frame for the request; and, a time

limit for the hearing date, which must be held within thirty (30) days after the receipt of a request for a hearing.

- The Hearing will be scheduled within thirty (30) days of the request for a hearing.
- The Hearing Committee includes at least three members appointed by UnitedHealthcare, who are not in direct economic competition with the provider, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one person on the panel will be the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitute one-third or more of the total membership.
- The Hearing Committee may uphold, overturn, or modify the original determination. Modifications may include, but are not limited to, placing the provider on probation, requiring completion of specific continuing education courses, requiring site or chart audits, or other corrective actions.
- The decision of the Hearing Committee is sent to the provider by certified letter within thirty (30) calendar days.
- Decisions of terminations shall be effective not less than thirty (30) days after the receipt by the provider of the Hearing Panel's decision.
- In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination.

Note: A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or review.

8.5 Cultural competency

Cultural competence is of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent health care providers. Cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients' cultural parameters.

UnitedHealthcare Community Plan recognizes that the diversity of American society has long been reflected in our member population. UnitedHealthcare Community Plan acknowledges the impact of race and ethnicity and the need to address varying risk conditions and dental care disparities. Understanding diverse cultures, their values, traditions, history and institutions is integral to eliminating dental care disparities and providing high-quality care. A culturally proficient health care system can help improve dental outcomes, quality of care and contribute to the elimination of racial and ethnic health disparities.

UnitedHealthcare Community Plan is committed to providing a diverse provider network that supports the achievement of the best possible clinical outcomes through culturally proficient care for our members.

The website listed below contains valuable materials that will assist dental providers and their staff to become culturally competent.

https://www.uhcprovider.com/en/resource-library/patient-health-safety/cultural-competency.html

Please refer to the **Required Training** section on page 2 of the manual for important information about the New York State Department of Health (NYSDOH) mandated 'Think Cultural Health' training.

Section 9: Claim submission procedures

9.1 Claim submission options

9.1.a Paper claims

To receive payment for services, practices must submit claims via paper or electronically. When submitting a paper claim, dentists are required to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later). If an incorrect claim form is used, the claim cannot be processed and will be returned.

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached, when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Refer to the Exclusions, Limitations and Benefits section of this Manual to find the recommendations for dental services.

Refer to Section 9.2 for more information on claims submission best practices and required information. Appendix A will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

9.1.b Electronic claims

Electronic Claims Submission refers to the ability to submit claims electronically versus paper. This expedites the claim adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Payments, which is the ability to be paid electronically directly into your bank account).

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process. The UnitedHealthcare Community Plan website (**UHCdental.com/medicaid**) also offers the feature to directly submit your claims online through the provider portal / Dental Hub. Refer to Section 2.5 for more information on how to register as a participating user.

9.1.c Electronic payments

ePayment Center replaced the current electronic payment and statement process for UnitedHealthcare Dental Government Program Plans.

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7

- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

1. Visit **UHCdental.epayment.center/register**
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into **UHCdental.epayment.center**
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click "Submit"
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call **1-855-774-4392** or email **help@epayment.center**.

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

The Zelis Payments advantage:

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments
- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage) in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via **provider.zelispayments.com** and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at **1-877-828-8770**.

9.2 Claim submission requirements and best practices

9.2.a Dental claim form required information

The most current Dental ADA claim form (2019 or later) must be submitted for payment of services rendered.

One claim form should be used for each patient and the claim should reflect only 1 treating dentist for services rendered. The claims must also have all necessary fields populated as outlined in the following:

Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services.

Subscriber information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Subscriber ID number

Patient information

- Name (last, first and middle initial)
- Address (street, city, state, ZIP code)
- Date of birth
- Gender
- Patient ID number

Primary payer information

Record the name, address, city, state and ZIP code of the carrier.

Other coverage

If the patient has other insurance coverage, completing the "Other Coverage" section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the "other insurance" is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

Other insured's information (only if other coverage exists)

If the patient has other coverage, provide the following information:

- Name of subscriber/policy holder (last, first and middle initial)
- Date of birth
- Gender
- Subscriber ID number
- Relationship to the member

Billing dentist or dental entity

Indicate the provider or entity responsible for billing, including the following:

- Name
- Address (street, city, state, ZIP code)
- License number
- Social Security number (SSN) or tax identification number (TIN)
- Phone number
- National provider identifier (NPI)

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment:

- Certification – Signature of dentist and the date the form was signed
- Name (use name provided on the Practitioner Application)
- License number
- TIN (or SSN)
- Address (street, city, state, ZIP code)
- Phone number
- NPI
- Provider specialty code (Taxonomy code)

Record of services provided

Most claim forms have 10 fields for recording procedures. Each procedure must be listed separately and must include the following information, if applicable. If the number of procedures exceeds the number of available lines, the remaining procedures must be listed on a separate, fully completed claim form.

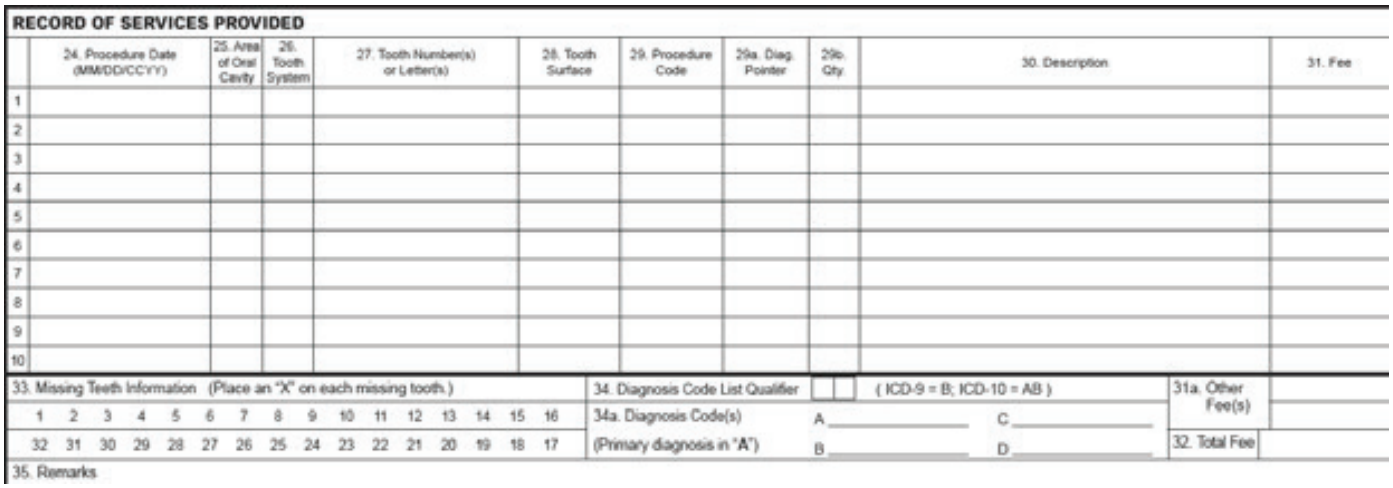
Missing teeth information

When submitting for periodontal or prosthodontal procedures, this area should be completed. An “X” can be placed on any missing tooth number or letter when missing.

Remarks section

Some procedures require a narrative. If space allows, you may record your narrative in this field. Otherwise, a narrative attached to the claim form, preferably on practice letterhead with all pertinent member information, is acceptable.

ICD-10 instructions



RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A B C D

31a. Other Fee(s)

32. Total Fee

35. Remarks

29a **Diagnosis Code Pointer:** Enter the letter(s) from Item 34 that identifies the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b **Quantity:** Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is "01".

34 **Diagnosis Code List Qualifier:** Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM **AB** = ICD-10-CM (as of Oct. 1, 2013)

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

34a **Diagnosis Code(s):** Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter "A."

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

By Report procedures

All "By Report" procedures require a narrative along with the submitted claim form. The narrative should explain the need for the procedure and any other pertinent information.

Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the catalog website at adacatalog.org.

Supernumerary teeth

UnitedHealthcare recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as. These procedure codes

must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of 7 years.

Insurance fraud

All insurance claims must reflect truthful and accurate information to avoid committing insurance fraud. Examples of fraud are falsification of records and using incorrect charges or codes. Falsification of records includes errors that have been corrected using "white-out," pre- or post-dating claim forms, and insurance billing before completion of service. Incorrect charges and codes include billing for services not performed, billing for more expensive services than performed, or adding unnecessary charges or services.

Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the practitioner certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the practitioner or an employee under the practitioner's direction. The practitioner certifies that the information contained on the claim is true and accurate.

Invalid or incomplete claims

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider. For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

9.2.b Coordination of Benefits (COB)

Our benefits contracts are subject to coordination of benefits (COB) rules. We coordinate benefits based on the member's benefit contract and applicable regulations.

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan as a secondary payer, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

9.2.c Timely submission (Timely filing)

All claims should be submitted within 120 calendar days from the date of service.

All adjustments or requests for reprocessing must be made within 365 days from date of service, or date of eligibility posting, only if the initial submission time period has been met. An adjustment can be requested in writing or telephonically.

Secondary claims must be received within 120 calendar days of the primary payer's determination (see section 9.2.b).

Refer to the Quick Reference Guide for address and phone number information.

9.3 Timely payment

- 90% of all clean claims will be paid or denied within 30 calendar days of receipt.
- 99% of all clean claims will be paid or denied within 45 calendar days of receipt.

Dual Complete NY-Y001 (HMO D-SNP) / Medicaid Advantage Plus (MAP) Timely payment

- 100% of all clean claims will be paid or denied within 30 calendar days of receipt
- 100% of all clean claims will be paid or denied within 45 calendar days of receipt

Quality Assurance (QA) audits are performed to ensure the accuracy and effectiveness of our claim adjudication procedures. Any identified discrepancies are resolved within established timelines. The QA process is based on an established methodology but as a general overview, on a daily basis various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated by newly hired claims processors, and high-dollar claims. In addition, management selects other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

9.4 Provider remittance advice

9.4.a Explanation of dental plan reimbursement (remittance advice)

The Provider Remittance Advice is a claim detail of each patient and each procedure considered for payment. Use these as a guide to reconcile member payments. As a best practice, it is recommended that remittance advice is kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER- Provider Name and ID number – Treating dentists name, Practitioner ID number (NPI National Provider Identifier, TIN Tax Identification Number)

PROVIDER LOCATION AND ID - Treating location as identified on submitted claim and location ID number

AMOUNT BILLED - Amount submitted by provider

AMOUNT PAYABLE - Amount payable after benefits have been applied

PATIENT PAY - Any amounts owed by the patient after benefits have been applied

OTHER INSURANCE - Amount payable by another carrier

PRIOR MONTH ADJUSTMENT - Adjustment amount(s) applied to prior overpayments

NET AMOUNT (Summary Page) - Total amount paid

PATIENT NAME

SUBSCRIBER/MEMBER NO - Identifying number on the subscriber's ID card

PATIENT DOB

PLAN - Health plan through which the member receives benefits (i.e., UnitedHealthcare Community Plan)

PRODUCT - Benefit plan that the member is under (i.e., Medicaid or Family Care)

ENCOUNTER NUMBER - Claim reference number

BENEFIT LEVEL - In or out-of-network coverage

LINE ITEM NUMBER - Reference number for item number within a claim

DOS - Dates of Service: Dates that services are rendered/performed

CDTCODE - Current Dental Terminology - Procedure code of service performed

TOOTH NO. - Tooth Number procedure code of service performed (if applicable)

SURFACE(S) - Tooth Surface of service performed (if applicable)

PLACE OF SERVICE - Treating location (office, hospital, other)

QTY OR NO. OF UNITS

PAYMENT PERCENTAGE - Reflects benefit coverage level in terms of percentage to be paid by plan

PAYABLE AMOUNT - Contracted amount

COPAY AMOUNT - Member responsibility

COINSURANCE AMOUNT - Member responsibility of total payment amount

DEDUCTIBLE AMOUNT - Member responsibility before benefits begin

PATIENT PAY - Amount to be paid by the member

OTHER INSURANCE AMOUNT - Amount paid by other carriers

NET AMOUNT (Services Detail) - Final amount to be paid

EXCEPTION CODES - Codes that explain how the claim was adjudicated

9.4.b Provider Remittance Advice sample (page 1)

UnitedHealthcare Dental - NY

Payee ID: 5555 Payee Name: Dental Office Name Remittance Date: 02/15/2024

UnitedHealthcare
A UnitedHealth Group Company

Please address questions to:

UnitedHealthcare Dental - NY
PO Box 1267

Milwaukee, WI 53201

Contact: UnitedHealthcare Dental - Provider Services
Phone: (800)304-0634
Fax:

DENTAL OFFICE NAME
STREET ADDRESS
CITY, STATE ZIP

Current Period:	**02/15/2024**
Payee ID:	5555
Phone:	(555)555-5555
Fax:	(555)555-5555
Tax ID:	555555555

Remittance Summary

Fee For Service:	**$2164.33**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2164.33**

I M P O R T A N T R E M I N D E R
Claims must be received within 120 days from date of service unless otherwise agreed. Appeals of denied or disputed claims must be received within 60 calendar days of receipt of the remittance advice. Late appeals will not be considered. All appeals must be sent in writing to the address below:
UnitedHealthcare
P O Box 31364
Salt Lake City, UT 84131

Reminder: Under state regulations, providers are prohibited from billing Medicaid recipients for covered services. Claims from providers received electronically (Payor I.D. Number GP133) are paid faster than paper. UnitedHealthcare Dental will accept electronic claims submitted directly or through a clearinghouse. Providers interested in submitting electronically can call 800 304-0634

Reimbursement requests for orthodontic treatment after member eligibility has termed should be forwarded to the State FFS program.

IMPORTANT NOTICE: In order to maintain HIPAA compliance, effective with claims received August 1, 2024, only ADA 2019 or later Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms dated prior to 2019, will not be accepted and will result in a rejection of the claim or pre-authorization request.

Additionally, when making a correction to a previously submitted claim, please send it clearly marked “Corrected Claims” on an ADA 2019 or later form to the Appeals mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.

To report potential billing irregularities, please call our Fraud Hotline at 1-888-233-4877.

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9.4.c Provider Remittance Advice sample (page 2)

UnitedHealthcare Dental – NY

Medicaid Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 02/15/2024

Fee For Service Summary

Dental Office Name
Street Address
City, State ZIP

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
Provider Name/ 55555	Dental Office Name / 55555	$4,785.00	$1,870.84	$0.00	$0.00	$0.00	$1,870.84
Provider Name / 55555	Dental Office Name / 55555	$1,110.00	$109.37	$0.00	$0.00	$0.00	$109.37
Provider Name / 55555	Dental Office Name / 55555	$450.00	$184.12	$0.00	$0.00	$0.00	$184.12
	Totals:	**$6,345.00**	**$2,164.33**	**$0.00**	**$0.00**	**$0.00**	**$2,164.33**

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9.4.d Provider Remittance Advice sample (page 3)

UnitedHealthcare Dental – NY

Payee ID: 55555 Payee Name: Dental Office Name Remittance Date: 02/15/24

Services Detail

FFS - Fee For Service	GBA - Global Budget Allocation
CAP - Capitation	CASE - Case Fee
ENC - Encounter Payment	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare New York
Product: UHC Dental - NY
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/27/24	D2740 4	11	1	$885.00	0	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	01/27/24	D2954 4	11	1	$225.00	1	$109.37	100.00 %	$109.37	$0.00	$0.00	$0.00	$0.00	$0.00	$109.37	FFS
					$1,110.00		**$109.37**		**$109.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$109.37**	

ITEM: 1 Exception Code: 1096 Service Authorization not Found.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare New York
Product: UHC Dental - NY
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/27/24	D2392 29 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
2	01/27/24	D7140 30	11	1	$160.00	1	$52.28	100.00 %	$52.28	$0.00	$0.00	$0.00	$0.00	$0.00	$52.28	FFS
					$295.00		**$124.12**		**$124.12**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$124.12**	

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare New York
Product: UHC Dental - NY
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/27/24	D0120 00	11	1	$50.00	1	$0.00	100.00 %	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS
2	01/27/24	D0220 00	11	1	$25.00	1	$9.58	100.00 %	$9.58	$0.00	$0.00	$0.00	$0.00	$0.00	$9.58	FFS
3	01/27/24	D0230 00	11	1	$20.00	1	$7.98	100.00 %	$7.98	$0.00	$0.00	$0.00	$0.00	$0.00	$7.98	FFS
4	01/27/24	D0274 00	11	1	$50.00	1	$21.63	100.00 %	$21.63	$0.00	$0.00	$0.00	$0.00	$0.00	$21.63	FFS
5	01/27/24	D2392 13 DO	11	1	$135.00	1	$71.84	100.00 %	$71.84	$0.00	$0.00	$0.00	$0.00	$0.00	$71.84	FFS
					$280.00		**$111.03**		**$111.03**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$111.03**	

ITEM: 1 Exception Code: 1039 This service is not covered under the plan.

Patient Name: Last, First Name
Subscriber/Member: 555555555 / 00
DOB: 00/00/0000
Office Reference No: 555555555
Provider Name: Last, First Name
Provider NPI: 5555555555
Plan: UnitedHealthcare New York
Product: UHC Dental - NY
Encounter #: **55555555555555**
Referral #:
Referral Date:
Benefit Level: In Network

ITM	DOS	CODE	POS	BILLED QTY	BILLED AMOUNT	ALLOWED QTY	ALLOWED AMOUNT	PAY %	PAYABLE AMOUNT	COPAY AMOUNT	COINS AMOUNT	DEDUCT AMOUNT	PATIENT PAY	OTHER INSUR	NET AMOUNT	PAY CODE
1	01/27/24	D0150 00	11	1	$55.00	1	$39.66	100.00 %	$39.66	$0.00	$0.00	$0.00	$0.00	$0.00	$39.66	FFS
2	01/27/24	D0210 00	11	1	$125.00	1	$40.72	100.00 %	$40.72	$0.00	$0.00	$0.00	$0.00	$0.00	$40.72	FFS
3	01/27/24	D1120 00	11	1	$60.00	1	$21.95	100.00 %	$21.95	$0.00	$0.00	$0.00	$0.00	$0.00	$21.95	FFS
4	01/27/24	D1208 00	11	1	$25.00	1	$11.98	100.00 %	$11.98	$0.00	$0.00	$0.00	$0.00	$0.00	$11.98	FFS
					$265.00		**$114.31**		**$114.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$114.31**	

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9.5 Overpayment

If you find an overpaid claim, notify us of the overpayment immediately. Send us the overpayment within the time specified in your Agreement. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer us to recoup the funds from your next payment, call Provider Services.

If you prefer to mail a refund, send an Overpayment Return Check with the following information:

- Name and contact information for the person authorized to sign checks or approve financial decisions.
- Member identification number.
- Date of service.
- Original claim number (if known).
- Date of payment.
- Amount paid.
- Amount of overpayment.
- Overpayment reason.
- Check number
- Submit to:
  Overpayment
  P.O. Box 481
  Milwaukee, WI 53201

9.6 Tips for successful claims resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan. Secondary claims must be received within 120 calendar days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

9.7 Payment for non-covered services

When non-covered services are provided for Medicaid members, providers shall hold members and UnitedHealthcare Community Plan harmless, except as outlined below.

In instances when non-covered services are recommended by the provider or requested by the member, an Informed Consent Form or similar waiver must be signed by the member confirming:

- That the member was informed and given written acknowledgement regarding proposed treatment plan and associated costs in advance of rendering treatment;
- That those specific services are not covered under the member's plan and that the member is financially liable for such services rendered.
- That the member was advised that they have the right to request a determination from the insurance company prior to services being rendered.

Please note: It is recommended that benefits and eligibility be confirmed by the provider before treatment is rendered. Members are held harmless and cannot be billed for services that are covered under the plan.

9.8 Radiology requirements

Guidelines for providing radiographs are as follows:

- Send a copy or duplicate radiograph instead of the original.
- Radiograph must be diagnostic for the condition or site.
- Radiographs should be mounted and labeled with the practice name, patient name and exposure date (not the duplication date).
- When a radiograph does not demonstrate a clinical condition well, an intra-oral photo and/or narrative are suggested as additional diagnostic aides.

X-rays submitted with Authorizations or Claims will not be returned. This includes original film radiographs, duplicate films, paper copies of x-rays and photographs.

Electronic submission, rather than paper copies of digital x-rays is preferred. Film copies are only accepted if labeled, mounted and paper clipped to the authorization. Please do not utilize staples.

Orthodontic and other models are not accepted forms of supporting documentation and will not be reviewed. Orthodontic models will be returned to you along with a copy of the paperwork submitted.

Please note: Authorizations, including attachments, can be submitted online at no additional cost by visiting our website: **UHCdental.com/medicaid**.

9.9 Corrected claim submission guidelines

A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. As part of the process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

Examples of correction(s) for a prior paid claim are:

- Incorrect Provider NPI or location
- Payee Tax ID
- Incorrect Member
- Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

A corrected claim may be submitted using the methods below:

- Electronically through Clearing House

- Electronically through the Dental Hub if original claim was submitted on the Dental Hub. If original claim was not submitted on the Dental Hub, another method should be utilized.
- Paper to the mailing address below

  UnitedHealthcare Community Plan Corrected Claims
  P.O. Box 481
  Milwaukee, WI 53201

Electronic submission is the most efficient and preferred method. If providers do not have access to electronic submissions, and need to submit on paper, the following steps are required.

- Must be submitted to the Corrected Claims P.O. Box for proper processing and include the following:
  - Current version of the ADA form and all required information
  - The ADA form must be clearly noted "Corrected Claim"
  - In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.
    Note: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.

If a claim or service originally DENIED due to incorrect or missing information/authorization, or was not previously processed for payment, DO NOT submit a corrected claim. Denied services have no impact on member tooth history or service accumulators, and, as such, do not require reprocessing. Submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to the appeals language on the Provider Remittance Advice for guidance with the appeals process applicable to the state plan.

Appendices for the State of New York

Appendix A: Resources and services — how we help you

Addresses and phone numbers

A.1 HARP, MMC, CHP, EPP

Need	Address	Phone number	Payor ID	Submission guidelines	Form(s) required
Claim Submission	Claims: P.O. Box 2061 Milwaukee, WI 53201	**1-800-304-0634**	GP133	120 calendar days from the date of service.	ADA* Claim Form, 2019 version or later
Corrected Claims	Corrected Claims: P.O. Box 481 Milwaukee, WI 53201	**1-800-304-0634**	GP133	Within 60 calendar days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals	Claim Appeals: UnitedHealthcare P.O. Box 31364 Salt Lake City,UT 84131	**1-888-456-0218**	GP133	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Auth Requests	Pre-authorizations: P.O. Box 2067 Milwaukee, WI 53201	**1-800-304-0634**	GP133		ADA Claim Form - check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Auth	UnitedHealthcare Community Attn: Appeals and Grievances Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	**1-800-493-4647**	N/A	Within 60 calendar days from the date of the adverse benefit determination	

A.2 Dual Complete NY-Y001 (HMO D-SNP) / Medicaid Advantage Plus (MAP)

Need	Address	Phone number	Payor ID	Submission guidelines	Form(s) required
Claim Submission	Claims: P.O. Box 2061 Milwaukee, WI 53201	**1-800-304-0634**	GP133	120 calendar days from the date of service.	ADA* Claim Form, 2019 version or later
Corrected Claims	Corrected Claims: P.O. Box 481 Milwaukee, WI 53201	**1-800-304-0634**	GP133	Within 60 calendar days from receipt of payment	ADA Claim Form Reason for requesting adjustment or resubmission
Claim Appeals	Claim Appeals: UnitedHealthcare P.O. Box 1427 Milwaukee, WI 53201	**1-888-456-0218**	GP133	Within 60 days after the claim determination	Supporting documentation, including claim number is required for processing.
Prior Auth Requests	Pre-authorizations: P.O. Box 2067 Milwaukee, WI 53201	**1-800-304-0634**	GP133		ADA Claim Form - check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Member Benefit Appeal for Service Auth	UnitedHealthcare Community Attn: Complaint and Appeals Department P.O. Box 6103, MS CA124-0187 Cypress, CA 90630-0023 Email Expedited: medicare_urgent_dsnp@uhc.com	**1-866-547-0772 (TTY: 711)** **A&G Expedited Fax / Part C:** **1-866-373-1081-New A&G Standard Fax** **1-844-226-0356**	N/A	Within 60 calendar days from the date of the adverse benefit determination	

Appendix B: Member benefits/exclusions and limitations

For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**. We align benefit design to meet all regulatory requirements by your state's Medicaid and legislature included in your state's Medicaid Provider Billing Manual.

B.1 Exclusions & limitations

Please refer to the benefits grid for applicable exclusions and limitations and covered services. Standard ADA coding guidelines are applied to all claims.

Any service not listed as a covered service in the benefit grids (Appendix B.2) is excluded.

Please call Provider Services if you have any questions regarding frequency limitations.

General exclusions

1. Unnecessary dental services.
2. Any dental procedure performed solely for cosmetic/aesthetic reasons.
3. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
4. Any dental procedure not directly associated with dental disease.
5. Any procedure not performed in a dental setting that has not had prior authorization.
6. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
7. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
8. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
9. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates.
10. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
11. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

B.2 Benefit grid

The following Benefit Grid contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line. Failure to follow such requirements may result in delay or denial of payment for services rendered.

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0120	Periodic Oral Exam	1 per code every 6 Months	No	
D0140	Limited Oral Evaluation - Problem Focused	2 per code every 12 Months	No	
D0145	Oral Evaluation, Patient Under Three	1 per code every 6 Months	No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per code every Lifetime	No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	3 per code every 12 Months	No	
D0170	Re-Evaluation - Limited, Problem Focused		No	
D0180	Comprehensive periodontal evaluation	2 per code every 12 Months	No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	1 per code every 36 Months	No	
D0220	Intraoral - Periapical First Radiographic Image		No	
D0230	Intraoral - Periapical Each Additional Image	6 per code every 12 Months	No	
D0240	Intraoral - Occlusal Radiographic Image	1 per code every 36 Months	No	
D0250	Extraoral - 2D Projection Radiographic image	2 per code every 7 Days	No	
D0251	Extra-Oral Posterior Dental Radiographic Image	2 per code every 7 Days	No	
D0270	Bitewing - Single Radiographic Image	3 per code every 12 Months	No	
D0272	Bitewings - Two Radiographic Images	2 per code every 12 Months	No	
D0273	Bitewings - Three Radiographic Images	2 per code every 12 Months	No	
D0274	Bitewings - Four Radiographic Images	2 per code every 12 Months	No	
D0310	Sialography	2 per code every 7 Days	No	
D0320	Temporomandibular Joint Arthrogram, Including Injection	2 per code every Lifetime	No	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	2 per code every 12 Months	No	
D0330	Panoramic Radiographic Image	1 per code every 36 Months	No	
D0340	2D Cephalometric Radiographic Image	1 per code every 36 Months	No	
D0350	Oral/Facial Photographic Images	2 per code every 6 Months	No	
D0364	Cone Beam - Less Than One Whole Jaw		Yes	Panoramic, narrative of medical necessity
D0365	Cone Beam - One Full Dental Arch - Mandible		Yes	Panoramic, narrative of medical necessity
D0366	Cone Beam - One Full Dental Arch - Maxilla		Yes	Panoramic, narrative of medical necessity

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0367	Cone Beam - Both Jaws		Yes	Panoramic, narrative of medical necessity
D0368	Cone Beam o TMJ Series		Yes	Panoramic, narrative of medical necessity
D0470	Diagnostic Casts	1 per code every 12 Months	No	
D0474	Accession Of Tissue, Gross And Microscopic Examination		No	
D0485	Consultation, Including Preparation Of Slides From Biopsy Material		No	
D0502	Other Pathology Procedures, By Report		No	
D0999	Unspecified Diagnostic Procedures, By Report		Yes	Description of procedure and narrative of medical necessity
D1110	Prophylaxis - Adult	2 per code every 12 Months	No	
D1120	Prophylaxis - Child	2 per code every 12 Months	No	
D1206	Topical Application Of Fluoride Varnish	1 per code every 3 Months	No	
D1208	Topical Application of Fluoride	1 per code every 6 Months	No	
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease		No	
D1351	Sealant - Per Tooth	1 per code per tooth every 60 Months	No	
D1354	Interim Caries Arresting Medicament Application - per tooth	2 per code per tooth every Accum Year 5 per code every Day	No	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	1 per code per quadrant every 12 Months	No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1 per code per tooth every 12 Months	No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1 per code per tooth every 12 Months	No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	1 per code every 12 Years	No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	1 per code every 12 Years	No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	1 per code per quadrant every 12 Years	No	
D1575	Distal shoe space maintainer - fixed - per quadrant	1 per code per quadrant every 12 Years	No	
D2140	Amalgam - One Surface, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2330	Resin-Based Composite - One Surface, Anterior	1 per code per tooth every 2 Accum Years	No	
D2331	Resin-Based Composite - Two Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2332	Resin-Based Composite - Three Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2335	resin-based composite - four or more surfaces (anterior)	1 per code per tooth every 2 Accum Years	No	
D2390	Resin-Based Composite Crown, Anterior	1 per code per tooth every 2 Accum Years	No	
D2391	Resin-Based Composite - One Surface, Posterior	1 per code per tooth every 2 Accum Years	No	
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2710	Crown - Resin-Based Composite (Indirect)	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2720	Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2721	Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2722	Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2740	Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2750	Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2752	Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Pre-op Xrays, narr, specific tests if cracked tth synd, post RCT PA (if RCT)
D2780	Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2781	Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2782	Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2790	Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2791	Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2792	Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2794	crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D2920	Re-Cement or Re-Bond Crown	1 per code per tooth every 24 Months	No	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 60 Months	No	
D2931	prefabricated stainless steel crown - permanent tooth	1 per code per tooth every 60 Months	No	
D2932	Prefabricated Resin Crown	1 per code per tooth every 24 Months	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window	1 per code per tooth every 24 Months	No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 24 Months	No	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	2 per code per tooth every 12 Months	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2954	Prefabricated Post And Core In Addition To Crown	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D2955	Post Removal	1 per code per tooth every 5 Years	No	
D2980	Crown Repair	1 per code per tooth every 5 Years	Yes	Description of procedure and narrative of medical necessity
D2999	Unspecified Restorative Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	1 per code per tooth every Lifetime	No	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3351	Apexification / Recalcification - Initial Visit	1 per code per tooth every Lifetime	No	
D3352	Apexification / Recalcification - Interim	1 per code per tooth every Lifetime	No	
D3353	Apexification / Recalcification - Final Visit	1 per code per tooth every Lifetime	No	
D3410	Apicoectomy - Anterior	1 per code per tooth every Lifetime	No	
D3421	Apicoectomy - Premolar (First Root)	1 per code per tooth every Lifetime	No	
D3425	Apicoectomy - Molar (First Root)	1 per code per tooth every Lifetime	No	
D3426	Apicoectomy - Each Additional Root)	1 per code per tooth every Lifetime	No	
D3430	Retrograde Filling - Per Root	1 per code per tooth every Lifetime	No	
D3999	Unspecified Endodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4245	Apically Positioned Flap		Yes	Periodontal charting, pre-op x-rays and narrative of necessity

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D4249	Clinical Crown Lengthening - Hard Tissue	1 per code per tooth every Lifetime	Yes	treatment plan, Pre-op x-rays, perio charting, narrative, photos(optional)
D4266	Guided Tissue Generation, Natural Teeth - Resorbable Barrier, Per Site		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4267	Guided Tissue Regeneration, Natural Teeth - Nonresorbable Barrier, Per Site (Inc		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4285	Non-Autogenous Connective Tissue Graft, Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4910	Periodontal Maintenance	2 per code every 24 Months	Yes	Date of previous perio surgical or S&C service with claim
D4999	Unspecified Periodontal Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5110	Complete Denture - Maxillary	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5120	Complete Denture - Mandibular	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5211	Maxillary Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5212	Mandibular Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5225	maxillary partial denture - flexible base (including any retentive clasping mate	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5226	mandibular partial denture - flexible base (including any retentive clasping mat	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5410	Adjust Complete Denture - Maxillary	4 per code every 12 Months	No	
D5411	Adjust Complete Denture - Mandibular	4 per code every 12 Months	No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5421	Adjust Partial Denture - Maxillary	4 per code every 12 Months	No	
D5422	Adjust Partial Denture - Mandibular	4 per code every 12 Months	No	
D5511	Repair Broken Complete Denture Base - Mandibular	2 per code every 12 Months	No	
D5512	Repair Broken Complete Denture Base - Maxillary	2 per code every 12 Months	No	
D5520	Replace missing or broken teeth - complete denture (each tooth) - per tooth	1 per code per tooth every 12 Months	No	
D5611	Repair Resin Partial Denture Base - Mandibular	2 per code every 12 Months	No	
D5612	Repair Resin Partial Denture Base - Maxillary	2 per code every 12 Months	No	
D5621	Repair Cast Partial Framework - Mandibular	1 per code every 12 Months	No	
D5622	Repair Cast Partial Framework - Maxillary	1 per code every 12 Months	No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	1 per code per tooth every 6 Months	No	
D5640	Replace missing or broken teeth - partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5650	Add tooth to existing partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	1 per code per tooth every 12 Months	No	
D5710	Rebase Complete Maxillary Denture	1 per code every 60 Months	No	
D5711	Rebase Complete Mandibular Denture	1 per code every 60 Months	No	
D5720	Rebase Maxillary Partial Denture	1 per code every 60 Months	No	
D5721	Rebase Mandibular Partial Denture	1 per code every 60 Months	No	
D5730	reline complete maxillary denture (direct)	1 per code every 12 Months	No	
D5731	reline complete mandibular denture (direct)	1 per code every 12 Months	No	
D5740	reline maxillary partial denture (direct)	1 per code every 12 Months	No	
D5741	reline mandibular partial denture (direct)	1 per code every 12 Months	No	
D5750	reline complete maxillary denture (indirect)	1 per code every 24 Months	No	
D5751	reline complete mandibular denture (indirect)	1 per code every 24 Months	No	
D5760	reline maxillary partial denture (indirect)	1 per code every 24 Months	No	
D5761	reline mandibular partial denture (indirect)	1 per code every 24 Months	No	
D5820	interim partial denture (Including retentive clasping materials and teeth) - max	1 per code every 24 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5821	interim partial denture (Including retentive clasping materials and teeth) - man	1 per code every 12 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5850	Tissue Conditioning, Maxillary	1 per code every 60 Months	No	
D5851	Tissue Conditioning, Mandibular	1 per code every 60 Months	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5911	Facial Moulage (Sectional)	1 per code every 12 Months	No	
D5912	Facial Moulage (Complete)	1 per code every 12 Months	No	
D5913	Nasal Prosthesis	1 per code every 12 Months	No	
D5914	Auricular Prosthesis	1 per code every 12 Months	No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5915	Orbital Prosthesis	1 per code every 12 Months	No	
D5916	Ocular Prosthesis	1 per code every 12 Months	No	
D5919	Facial Prosthesis	6 per code every 2 Months	No	
D5922	Nasal Septal Prosthesis	1 per code every 12 Months	No	
D5923	Ocular Prosthesis, Interim	1 per code every 12 Months	No	
D5924	Cranial Prosthesis	1 per code every 12 Months	No	
D5925	Facial Augmentation Implant Prosthesis	1 per code every 12 Months	No	
D5926	Nasal Posthesis, Replacement	1 per code every 12 Months	No	
D5927	Auricular Prosthesis, Replacement	1 per code every 12 Months	No	
D5928	Orbital Prosthesis, Replacement	1 per code every 12 Months	No	
D5929	Facial Prosthesis, Replacement	1 per code every 12 Months	No	
D5931	Obturator Prosthesis, Surgical	1 per code every 12 Months	No	
D5932	Obturator Prosthesis, Definitive	1 per code every 12 Months	No	
D5933	Obturator Prosthesis, Modification	1 per code every 6 Months	No	
D5934	Mandibular Resection Prosthesis With Guide Flange	1 per code every 12 Months	No	
D5935	Mandibular Resection Prosthesis Without Guide Flange	1 per code every 12 Months	No	
D5936	Obturator Prosthesis, Interim	1 per code every 12 Months	No	
D5937	Trismus Appliance (Not For Tmd Treatment)	1 per code every 12 Months	No	
D5951	Feeding Aid	1 per code every 12 Months	No	
D5952	Speech Aid Prosthesis, Pediatric	1 per code every 12 Months	No	
D5953	Speech Aid Prosthesis, Adult	1 per code every 12 Months	No	
D5954	Palatal Augmentation Prosthesis	1 per code every 12 Months	No	
D5955	Palatal Lift Prosthesis, Definitive	1 per code every 12 Months	No	
D5958	Palatal Lift Prosthesis, Interim	1 per code every 12 Months	No	
D5959	Palatal Lift Prosthesis, Modification	1 per code every 12 Months	No	
D5960	Speech Aid Prosthesis, Modification	1 per code every 12 Months	No	
D5982	Surgical Stent	1 per code every 12 Months	No	
D5983	Radiation Carrier	1 per code every 12 Months	No	
D5984	Radiation Shield	1 per code every 12 Months	No	
D5985	Radiation Cone Locator	1 per code every 12 Months	No	
D5986	Fluoride Gel Carrier	2 per code every 12 Months	No	
D5987	Commissure Splint	1 per code every 12 Months	No	
D5988	Surgical Splint	1 per code every 12 Months	No	
D5999	Unspecified Maxillofacial Prosthesis, By Report		Yes	Description of procedure and narrative of medical necessity
D6010	Surgical Placement Of Implant Body: Endosteal Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6013	Surgical Placement Of Mini Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6055	Connecting Bar - Implant Supported Or Abutment Supported	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6056	Prefabricated Abutment - Includes Modification And Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6057	Custom Fabricated Abutment - Includes Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6058	Abutment Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6065	Implant Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6066	implant supported crown - porcelain fused to metal crown (titanium, titanium all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6067	implant supported metal crown - (titanium, titanium alloy, high noble metals all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6081	Scaling and debridement of a single implant in the presence of inflammation or m	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6090	Repair of implant/abutment supported prosthesis, by report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6091	Replacement Of Semi-Precision Or Precision Attachment	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6094	abutment supported crown - (titanium) and titanium alloys	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6096	Remove Broken Implant Retaining Screw	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6100	Surgical removal of implant body removal, by report		Yes	Narrative of medical necessity
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/Closure	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6104	Bone Graft At Time Of Implant Placement	1 per code per tooth every Lifetime	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6190	Radiographic/Surgical Implant Index, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6191	semi-precision abutment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6192	semi-precision attachment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6193	Replacement of an implant screw	1 per code every 12 Months	No	
D6199	Unspecified Implant Procedure, By Report		Yes	Narrative of medical necessity
D6210	Pontic - Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6211	Pontic - Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6212	Pontic - Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6214	pontic - titanium and titanium alloys	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6242	Pontic - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6243	Pontic - porcelain fused to Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6245	Pontic - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6250	Pontic - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6251	Pontic - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6252	Pontic - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6720	Retainer Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6721	Retainer Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6722	Retainer Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6740	Retainer Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6752	Retainer Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6753	Retainer Crown - Porcelain Fused To Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6780	Retainer Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	No	
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	No	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	1 per code per tooth every 5 Years	No	
D6784	Retainer Crown - 3/4 Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6790	Retainer Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6792	Retainer Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6794	retainer crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	1 per code per tooth every 5 Years	No	
D6980	Fixed Partial Denture Repair	1 per code per tooth every 5 Years	Yes	Narrative of medical necessity with pre authorization
D6999	Unspecified Fixed Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per code per tooth every Lifetime	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per code per tooth every Lifetime	No	
D7210	Extraction, Erupted Tooth	1 per code per tooth every Lifetime	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7230	Removal Of Impacted Tooth - Partially Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7240	Removal Of Impacted Tooth - Completely Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per code per tooth every Lifetime	No	
D7260	Oroantral Fistula Closure	1 per code every Lifetime	No	
D7261	Primary Closure Of Sinus Perforation	1 per code every Lifetime	No	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 per code per tooth every Lifetime	No	
D7272	Tooth Transplantation (Includes Reimplantation)	1 per code per tooth every Lifetime	No	
D7280	Exposure of an Unerupted Tooth	1 per code per tooth every Lifetime	No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	1 per code per tooth every Lifetime	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	1 per code every 12 Months	No	
D7286	Incisional Biopsy Of Oral Tissue - Soft	1 per code every 12 Months	No	
D7287	Exfoliative Cytological Sample Collection		No	
D7290	Surgical Repositioning Of Teeth	1 per code per tooth every Lifetime	No	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	2 per code per quadrant every 5 Years	No	
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	2 per code per quadrant every 5 Years	No	
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	
D7412	Excision Of Benign Lesion, Complicated		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	
D7415	Excision Of Malignant Lesion, Complicated		No	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 per code per arch every Lifetime	No	
D7472	Removal Of Torus Palatinus		No	
D7473	Removal Of Torus Mandibularis		No	
D7485	Reduction Of Osseous Tuberosity	1 per code every Lifetime	No	
D7490	Radical Resection Of Maxilla Or Mandible		No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	
D7530	Removal Of Foreign Body From Mucosa		No	
D7540	Removal Of Reaction Producing Foreign Bodies		No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone		No	
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		No	
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No	
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth		No	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		No	
D7710	Maxilla - Open Reduction		No	
D7720	Maxilla - Closed Reduction		No	
D7730	Mandible - Open Reduction		No	
D7740	Mandible - Closed Reduction		No	
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No	
D7771	Alveolus - Closed Reduction Stabilization Of Teeth		No	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No	
D7810	Open Reduction Of Dislocation		No	
D7820	Closed Reduction Of Dislocation		No	
D7830	Manipulation Under Anesthesia		No	
D7840	Condylectomy		No	
D7850	Surgical Discetomy, With/Without Implant	2 per code every Lifetime	No	
D7852	Disc Repair	2 per code every Lifetime	No	
D7854	Synovectomy	2 per code every Lifetime	No	
D7856	Myotomy	2 per code every Lifetime	No	
D7858	Joint Reconstruction	2 per code every Lifetime	No	
D7860	Arthrotomy	2 per code every Lifetime	No	
D7865	Arthroplasty	2 per code every Lifetime	No	
D7870	Arthrocentesis	1 per code every 6 Months	No	
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy	2 per code every Lifetime	No	
D7873	Arthroscopy - Lavage And Lysis Of Adhesions	2 per code every Lifetime	No	
D7874	Arthroscopy - Disc Repositioning And Stabilization	2 per code every Lifetime	No	
D7875	Arthroscopy - Synovectomy	2 per code every Lifetime	No	
D7876	Arthroscopy - Discectomy	2 per code every Lifetime	No	
D7877	Arthroscopy - Debridement	2 per code every Lifetime	No	
D7880	Occlusal Orthotic Device, By Report	1 per code every 12 Months	No	
D7899	Unspecified Tmd Therapy, By Report		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7911	Complicated Suture - Up To 5 Cm		No	
D7912	Complicated Suture - Greater Than 5 Cm		No	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		No	
D7940	Osteoplasty - For Orthognathic Deformities		No	
D7941	Osteotomy - Mandibular Rami		No	
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft		No	
D7944	Osteotomy - Segmented Or Subapical		No	
D7945	Osteotomy - Body Of Mandible		No	
D7946	Lefort I - (Maxilla - Total)		No	
D7947	Lefort I - (Maxilla - Segmented)		No	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft		No	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft		No	
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla		No	
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach		Yes	Pre-op x-rays and narrative of medical necessity
D7952	Sinus Augmentation Via A Vertical Approach		No	
D7953	Bone Replacement Graft For Ridge Preservation - Per Site		Yes	Pre-op x-rays and narrative of medical necessity
D7961	buccal / labial frenectomy (frenulectomy)	3 per code per arch every Lifetime	No	
D7962	lingual frenectomy (frenulectomy)	3 per code every Lifetime	No	
D7970	Excision Of Hyperplastic Tissue - Per Arch	2 per code per arch every Lifetime	No	
D7971	Excision Of Pericoronal Gingiva	1 per code per tooth every 2 Years	Yes	Periapical & Narrative
D7972	Surgical Reduction Of Fibrous Tuberosity	1 per code every 2 Years	No	
D7979	Non-Surgical Sialolithotomy		No	
D7980	Surgical Sialolithotomy		No	
D7981	Excision Of Salivary Gland, By Report		No	
D7982	Sialodochoplasty		No	
D7983	Closure Of Salivary Fistula		No	
D7990	Emergency Tracheotomy		No	
D7991	Coronoidectomy	1 per code every Lifetime	No	
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)		No	
D7998	Intraoral Placement Of A Fixation Device		No	
D7999	Unspecified Oral Surgery Procedure, By Report		No	
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8210	Removable Appliance Therapy	2 per code every Year	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8220	Fixed Appliance Therapy	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	3 per code every Year	No	
D8670	Periodic Orthodontic Treatment Visit	24 per code every Lifetime	Yes	Approved ortho banding or approved D8999/COC code is present on the same auth
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)		Yes	Diagnostic quality photos
D8695	Removal Of Fixed Orthodontic Appliances	1 per code every Lifetime	Yes	Copy of original approval, banding date, payment history
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	1 per code every Lifetime	No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	1 per code every Lifetime	No	
D8999	Unspecified Orthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	2 per code every 12 Months	No	
D9120	Fixed Partial Denture Sectioning		No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	1 per code every Day	Yes	Narrative of medical necessity with claim
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9248	Non-Intravenous Conscious Sedation	1 per code every Day	Yes	Narrative of medical necessity with claim
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	1 per code every 6 Months	No	

MAP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D9410	House/Extended Care Facility Call	1 per code every Day	No	
D9420	Hospital Or Ambulatory Surgical Center Call	3 per code every 7 Days	No	
D9430	Office Visit For Observation (During Regularly Scheduled Hours)	4 per code every 12 Months	No	
D9440	Office Visit - After Regularly Scheduled Hours	1 per code every Day	No	
D9610	Therapeutic Parenteral Drug, Single Administration		No	
D9944	Occlusal Guard-hard appliance, full arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9945	Occlusal Guard-soft appliance, full arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9946	Occlusal Guard-hard appliance, partial arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9990	Translation Services	2 per code every Day	No	
D9991	Dental Case Management - addressing appointment compliance barriers		No	
D9995	Teledentistry - Synchronous; Real-Time Encounter	1 per code every Day	No	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	1 per code every Day	No	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	Desc of procedure/ narr of med nec/ name of hospital/OR facility(if necessary)
Q3014	Telehealth facility fee		No	
T1015	FQHC Encounter Payment-ADA			

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0120	Periodic Oral Exam	1 per code every 6 Months	No	
D0140	Limited Oral Evaluation - Problem Focused	2 per code every 12 Months	No	
D0145	Oral Evaluation, Patient Under Three	1 per code every 6 Months	No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per code every Lifetime	No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	3 per code every 12 Months	No	
D0170	Re-Evaluation - Limited, Problem Focused		No	
D0180	Comprehensive periodontal evaluation	2 per code every 12 Months	No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	1 per code every 36 Months	No	
D0220	Intraoral - Periapical First Radiographic Image	1 per code every Day	No	
D0230	Intraoral - Periapical Each Additional Image	6 per code every 12 Months	No	
D0240	Intraoral - Occlusal Radiographic Image	1 per code every 36 Months	No	
D0250	Extraoral - 2D Projection Radiographic image	2 per code every 7 Days	No	
D0251	Extra-Oral Posterior Dental Radiographic Image	2 per code every 7 Days	No	
D0270	Bitewing - Single Radiographic Image	3 per code every 12 Months	No	
D0272	Bitewings - Two Radiographic Images	2 per code every 12 Months	No	
D0273	Bitewings - Three Radiographic Images	2 per code every 12 Months	No	
D0274	Bitewings - Four Radiographic Images	2 per code every 12 Months	No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0310	Sialography	2 per code every 7 Days	No	
D0320	Temporomandibular Joint Arthrogram, Including Injection	2 per code every Lifetime	No	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	2 per code every 12 Months	No	
D0330	Panoramic Radiographic Image	1 per code every 36 Months	No	
D0340	2D Cephalometric Radiographic Image	1 per code every 36 Months	No	
D0350	Oral/Facial Photographic Images	2 per code every 6 Months	No	
D0364	Cone Beam - Less Than One Whole Jaw		Yes	Panoramic, narrative of medical necessity
D0365	Cone Beam - One Full Dental Arch - Mandible		Yes	Panoramic, narrative of medical necessity
D0366	Cone Beam - One Full Dental Arch - Maxilla		Yes	Panoramic, narrative of medical necessity
D0367	Cone Beam - Both Jaws		Yes	Panoramic, narrative of medical necessity
D0368	Cone Beam o TMJ Series		Yes	Panoramic, narrative of medical necessity
D0470	Diagnostic Casts	1 per code every 12 Months	No	
D0474	Accession Of Tissue, Gross And Microscopic Examination		No	
D0485	Consultation, Including Preparation Of Slides From Biopsy Material		No	
D0502	Other Pathology Procedures, By Report		No	
D0999	Unspecified Diagnostic Procedures, By Report			
D1110	Prophylaxis - Adult	2 per code every 12 Months	No	
D1120	Prophylaxis - Child	2 per code every 12 Months	No	
D1206	Topical Application Of Fluoride Varnish	1 per code every 3 Months	No	
D1208	Topical Application of Fluoride	1 per code every 6 Months	No	
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease		No	
D1351	Sealant - Per Tooth	1 per code per tooth every 60 Months	No	
D1354	Interim Caries Arresting Medicament Application - per tooth	2 per code per tooth every Accum Year	No	
		5 per code every Day		
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	1 per code per quadrant every 12 Months	No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1 per code per tooth every 12 Months	No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1 per code per tooth every 12 Months	No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	1 per code every 12 Years	No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	1 per code every 12 Years	No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	1 per code per quadrant every 12 Years	No	
D1575	Distal shoe space maintainer - fixed - per quadrant	1 per code per quadrant every 12 Years	No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2140	Amalgam - One Surface, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2330	Resin-Based Composite - One Surface, Anterior	1 per code per tooth every 2 Accum Years	No	
D2331	Resin-Based Composite - Two Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2332	Resin-Based Composite - Three Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2335	resin-based composite – four or more surfaces (anterior)	1 per code per tooth every 2 Accum Years	No	
D2390	Resin-Based Composite Crown, Anterior	1 per code per tooth every 2 Accum Years	No	
D2391	Resin-Based Composite - One Surface, Posterior	1 per code per tooth every 2 Accum Years	No	
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2710	Crown - Resin-Based Composite (Indirect)	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2720	Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2721	Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2722	Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2740	Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2750	Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2752	Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Pre-op Xrays, narr, specific tests if cracked tth synd, post RCT PA (if RCT)
D2780	Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2781	Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2782	Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2790	Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2791	Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2792	Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2794	crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D2920	Re-Cement or Re-Bond Crown	1 per code per tooth every 24 Months	No	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 60 Months	No	
D2931	prefabricated stainless steel crown - permanent tooth	1 per code per tooth every 60 Months	No	
D2932	Prefabricated Resin Crown	1 per code per tooth every 24 Months	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window	1 per code per tooth every 24 Months	No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 24 Months	No	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	2 per code per tooth every 12 Months	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D2954	Prefabricated Post And Core In Addition To Crown	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D2955	Post Removal	1 per code per tooth every 5 Years	No	
D2980	Crown Repair	1 per code per tooth every 5 Years	Yes	Description of procedure and narrative of medical necessity
D2999	Unspecified Restorative Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	1 per code per tooth every Lifetime	No	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3351	Apexification / Recalcification - Initial Visit	1 per code per tooth every Lifetime	No	
D3352	Apexification / Recalcification - Interim	1 per code per tooth every Lifetime	No	
D3353	Apexification / Recalcification - Final Visit	1 per code per tooth every Lifetime	No	
D3410	Apicoectomy - Anterior	1 per code per tooth every Lifetime	No	
D3421	Apicoectomy - Premolar (First Root)	1 per code per tooth every Lifetime	No	
D3425	Apicoectomy - Molar (First Root)	1 per code per tooth every Lifetime	No	
D3426	Apicoectomy - Each Additional Root)	1 per code per tooth every Lifetime	No	
D3430	Retrograde Filling - Per Root	1 per code per tooth every Lifetime	No	
D3999	Unspecified Endodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4245	Apically Positioned Flap		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4249	Clinical Crown Lengthening - Hard Tissue	1 per code per tooth every Lifetime	Yes	treatment plan, Pre-op x-rays, perio charting, narrative, photos(optional)
D4266	Guided Tissue Generation, Natural Teeth - Resorbable Barrier, Per Site		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4267	Guided Tissue Regeneration, Natural Teeth - Nonresorbable Barrier, Per Site (Inc		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position		Yes	Periodontal charting, pre-op x-rays and narrative of necessity

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4285	Non-Autogenous Connective Tissue Graft, Each Additional		Yes	Periodontal charting, pre-op x-rays and narrative of necessity
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4910	Periodontal Maintenance	2 per code every 24 Months	Yes	Date of previous perio surgical or S&C service with claim
D4999	Unspecified Periodontal Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5110	Complete Denture - Maxillary	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5120	Complete Denture - Mandibular	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5211	Maxillary Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5212	Mandibular Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5225	maxillary partial denture - flexible base (including any retentive clasping mate	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5226	mandibular partial denture - flexible base (including any retentive clasping mat	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5410	Adjust Complete Denture - Maxillary	4 per code every 12 Months	No	
D5411	Adjust Complete Denture - Mandibular	4 per code every 12 Months	No	
D5421	Adjust Partial Denture - Maxillary	4 per code every 12 Months	No	
D5422	Adjust Partial Denture - Mandibular	4 per code every 12 Months	No	
D5511	Repair Broken Complete Denture Base - Mandibular	2 per code every 12 Months	No	
D5512	Repair Broken Complete Denture Base - Maxillary	2 per code every 12 Months	No	
D5520	Replace missing or broken teeth - complete denture (each tooth) - per tooth	1 per code per tooth every 12 Months	No	
D5611	Repair Resin Partial Denture Base - Mandibular	2 per code every 12 Months	No	
D5612	Repair Resin Partial Denture Base - Maxillary	2 per code every 12 Months	No	
D5621	Repair Cast Partial Framework - Mandibular	1 per code every 12 Months	No	
D5622	Repair Cast Partial Framework - Maxillary	1 per code every 12 Months	No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	1 per code per tooth every 6 Months	No	
D5640	Replace missing or broken teeth - partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5650	Add tooth to existing partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	1 per code per tooth every 12 Months	No	
D5710	Rebase Complete Maxillary Denture	1 per code every 60 Months	No	
D5711	Rebase Complete Mandibular Denture	1 per code every 60 Months	No	
D5720	Rebase Maxillary Partial Denture	1 per code every 60 Months	No	
D5721	Rebase Mandibular Partial Denture	1 per code every 60 Months	No	
D5730	reline complete maxillary denture (direct)	1 per code every 12 Months	No	
D5731	reline complete mandibular denture (direct)	1 per code every 12 Months	No	
D5740	reline maxillary partial denture (direct)	1 per code every 12 Months	No	
D5741	reline mandibular partial denture (direct)	1 per code every 12 Months	No	
D5750	reline complete maxillary denture (indirect)	1 per code every 24 Months	No	
D5751	reline complete mandibular denture (indirect)	1 per code every 24 Months	No	
D5760	reline maxillary partial denture (indirect)	1 per code every 24 Months	No	
D5761	reline mandibular partial denture (indirect)	1 per code every 24 Months	No	
D5820	interim partial denture (Including retentive clasping materials and teeth) - max	1 per code every 24 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5821	interim partial denture (Including retentive clasping materials and teeth) - man	1 per code every 12 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5850	Tissue Conditioning, Maxillary	1 per code every 60 Months	No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5851	Tissue Conditioning, Mandibular	1 per code every 60 Months	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5911	Facial Moulage (Sectional)	1 per code every 12 Months	No	
D5912	Facial Moulage (Complete)	1 per code every 12 Months	No	
D5913	Nasal Prosthesis	1 per code every 12 Months	No	
D5914	Auricular Prosthesis	1 per code every 12 Months	No	
D5915	Orbital Prosthesis	1 per code every 12 Months	No	
D5916	Ocular Prosthesis	1 per code every 12 Months	No	
D5919	Facial Prosthesis	6 per code every 2 Months	No	
D5922	Nasal Septal Prosthesis	1 per code every 12 Months	No	
D5923	Ocular Prosthesis, Interim	1 per code every 12 Months	No	
D5924	Cranial Prosthesis	1 per code every 12 Months	No	
D5925	Facial Augmentation Implant Prosthesis	1 per code every 12 Months	No	
D5926	Nasal Posthesis, Replacement	1 per code every 12 Months	No	
D5927	Auricular Prosthesis, Replacement	1 per code every 12 Months	No	
D5928	Orbital Prosthesis, Replacement	1 per code every 12 Months	No	
D5929	Facial Prosthesis, Replacement	1 per code every 12 Months	No	
D5931	Obturator Prosthesis, Surgical	1 per code every 12 Months	No	
D5932	Obturator Prosthesis, Definitive	1 per code every 12 Months	No	
D5933	Obturator Prosthesis, Modification	1 per code every 6 Months	No	
D5934	Mandibular Resection Prosthesis With Guide Flange	1 per code every 12 Months	No	
D5935	Mandibular Resection Prosthesis Without Guide Flange	1 per code every 12 Months	No	
D5936	Obturator Prosthesis, Interim	1 per code every 12 Months	No	
D5937	Trismus Appliance (Not For Tmd Treatment)	1 per code every 12 Months	No	
D5951	Feeding Aid	1 per code every 12 Months	No	
D5952	Speech Aid Prosthesis, Pediatric	1 per code every 12 Months	No	
D5953	Speech Aid Prosthesis, Adult	1 per code every 12 Months	No	
D5954	Palatal Augmentation Prosthesis	1 per code every 12 Months	No	
D5955	Palatal Lift Prosthesis, Definitive	1 per code every 12 Months	No	
D5958	Palatal Lift Prosthesis, Interim	1 per code every 12 Months	No	
D5959	Palatal Lift Prosthesis, Modification	1 per code every 12 Months	No	
D5960	Speech Aid Prosthesis, Modification	1 per code every 12 Months	No	
D5982	Surgical Stent	1 per code every 12 Months	No	
D5983	Radiation Carrier	1 per code every 12 Months	No	
D5984	Radiation Shield	1 per code every 12 Months	No	
D5985	Radiation Cone Locator	1 per code every 12 Months	No	
D5986	Fluoride Gel Carrier	2 per code every 12 Months	No	
D5987	Commissure Splint	1 per code every 12 Months	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D5988	Surgical Splint	1 per code every 12 Months	No	
D5999	Unspecified Maxillofacial Prosthesis, By Report		Yes	Description of procedure and narrative of medical necessity
D6010	Surgical Placement Of Implant Body: Endosteal Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6013	Surgical Placement Of Mini Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6055	Connecting Bar - Implant Supported Or Abutment Supported	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6056	Prefabricated Abutment - Includes Modification And Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6057	Custom Fabricated Abutment - Includes Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6058	Abutment Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6065	Implant Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6066	implant supported crown - porcelain fused to metal crown (titanium, titanium all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6067	implant supported metal crown - (titanium, titanium alloy, high noble metals all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6081	Scaling and debridement of a single implant in the presence of inflammation or m	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6090	Repair of implant/abutment supported prosthesis, by report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6091	Replacement Of Semi-Precision Or Precision Attachment	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6094	abutment supported crown - (titanium) and titanium alloys	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6096	Remove Broken Implant Retaining Screw	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6100	Surgical removal of implant body removal, by report		Yes	Narrative of medical necessity
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/Closure	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6104	Bone Graft At Time Of Implant Placement	1 per code per tooth every Lifetime	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	1 per code every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6190	Radiographic/Surgical Implant Index, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6191	semi-precision abutment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6192	semi-precision attachment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6193	Replacement of an implant screw	1 per code every 12 Months	No	
D6199	Unspecified Implant Procedure, By Report		Yes	Narrative of medical necessity
D6210	Pontic - Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6211	Pontic - Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6212	Pontic - Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6214	pontic - titanium and titanium alloys	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6242	Pontic - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6243	Pontic - porcelain fused to Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/ Charting of missing teeth

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6245	Pontic - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6250	Pontic - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6251	Pontic - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6252	Pontic - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6720	Retainer Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6721	Retainer Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6722	Retainer Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6740	Retainer Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6752	Retainer Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6753	Retainer Crown - Porcelain Fused To Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/ Charting of missing teeth
D6780	Retainer Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	No	
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	No	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	1 per code per tooth every 5 Years	No	
D6784	Retainer Crown - 3/4 Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/ Charting of missing teeth
D6790	Retainer Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6792	Retainer Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6794	retainer crown – titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	1 per code per tooth every 5 Years	No	
D6980	Fixed Partial Denture Repair	1 per code per tooth every 5 Years	Yes	Narrative of medical necessity with pre authorization

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6999	Unspecified Fixed Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per code per tooth every Lifetime	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per code per tooth every Lifetime	No	
D7210	Extraction, Erupted Tooth	1 per code per tooth every Lifetime	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7230	Removal Of Impacted Tooth - Partially Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7240	Removal Of Impacted Tooth - Completely Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per code per tooth every Lifetime	No	
D7260	Oroantral Fistula Closure	1 per code every Lifetime	No	
D7261	Primary Closure Of Sinus Perforation	1 per code every Lifetime	No	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 per code per tooth every Lifetime	No	
D7272	Tooth Transplantation (Includes Reimplantation)	1 per code per tooth every Lifetime	No	
D7280	Exposure of an Unerupted Tooth	1 per code per tooth every Lifetime	No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	1 per code per tooth every Lifetime	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	1 per code every 12 Months	No	
D7286	Incisional Biopsy Of Oral Tissue - Soft	1 per code every 12 Months	No	
D7287	Exfoliative Cytological Sample Collection		No	
D7290	Surgical Repositioning Of Teeth	1 per code per tooth every Lifetime	No	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	2 per code per quadrant every 5 Years	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	2 per code per quadrant every 5 Years	No	
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	
D7412	Excision Of Benign Lesion, Complicated		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	
D7415	Excision Of Malignant Lesion, Complicated		No	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 per code per arch every Lifetime	No	
D7472	Removal Of Torus Palatinus		No	
D7473	Removal Of Torus Mandibularis		No	
D7485	Reduction Of Osseous Tuberosity	1 per code every Lifetime	No	
D7490	Radical Resection Of Maxilla Or Mandible		No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	
D7530	Removal Of Foreign Body From Mucosa		No	
D7540	Removal Of Reaction Producing Foreign Bodies		No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone		No	
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		No	
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No	
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth		No	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7710	Maxilla - Open Reduction		No	
D7720	Maxilla - Closed Reduction		No	
D7730	Mandible - Open Reduction		No	
D7740	Mandible - Closed Reduction		No	
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No	
D7771	Alveolus - Closed Reduction Stabilization Of Teeth		No	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No	
D7810	Open Reduction Of Dislocation		No	
D7820	Closed Reduction Of Dislocation		No	
D7830	Manipulation Under Anesthesia		No	
D7840	Condylectomy		No	
D7850	Surgical Discetomy, With/Without Implant	2 per code every Lifetime	No	
D7852	Disc Repair	2 per code every Lifetime	No	
D7854	Synovectomy	2 per code every Lifetime	No	
D7856	Myotomy	2 per code every Lifetime	No	
D7858	Joint Reconstruction	2 per code every Lifetime	No	
D7860	Arthrotomy	2 per code every Lifetime	No	
D7865	Arthroplasty	2 per code every Lifetime	No	
D7870	Arthrocentesis	1 per code every 6 Months	No	
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy	2 per code every Lifetime	No	
D7873	Arthroscopy - Lavage And Lysis Of Adhesions	2 per code every Lifetime	No	
D7874	Arthroscopy - Disc Repositioning And Stabilization	2 per code every Lifetime	No	
D7875	Arthroscopy - Synovectomy	2 per code every Lifetime	No	
D7876	Arthroscopy - Discectomy	2 per code every Lifetime	No	
D7877	Arthroscopy - Debridement	2 per code every Lifetime	No	
D7880	Occlusal Orthotic Device, By Report	1 per code every 12 Months	No	
D7899	Unspecified Tmd Therapy, By Report		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	
D7911	Complicated Suture - Up To 5 Cm		No	
D7912	Complicated Suture - Greater Than 5 Cm		No	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		No	
D7940	Osteoplasty - For Orthognathic Deformities		No	
D7941	Osteotomy - Mandibular Rami		No	
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft		No	
D7944	Osteotomy - Segmented Or Subapical		No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7945	Osteotomy - Body Of Mandible		No	
D7946	Lefort I - (Maxilla - Total)		No	
D7947	Lefort I - (Maxilla - Segmented)		No	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft		No	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft		No	
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla		No	
D7951	Sinus Augmentation With Bone Or Bone Substitutes Via A Lateral Open Approach		Yes	Pre-op x-rays and narrative of medical necessity
D7952	Sinus Augmentation Via A Vertical Approach		No	
D7953	Bone Replacement Graft For Ridge Preservation - Per Site		Yes	Pre-op x-rays and narrative of medical necessity
D7961	buccal / labial frenectomy (frenulectomy)	3 per code per arch every Lifetime	No	
D7962	lingual frenectomy (frenulectomy)	3 per code every Lifetime	No	
D7970	Excision Of Hyperplastic Tissue - Per Arch	2 per code per arch every Lifetime	No	
D7971	Excision Of Pericoronal Gingiva	1 per code per tooth every 2 Years	Yes	Periapical & Narrative
D7972	Surgical Reduction Of Fibrous Tuberosity	1 per code every 2 Years	No	
D7979	Non-Surgical Sialolithotomy		No	
D7980	Surgical Sialolithotomy		No	
D7981	Excision Of Salivary Gland, By Report		No	
D7982	Sialodochoplasty		No	
D7983	Closure Of Salivary Fistula		No	
D7990	Emergency Tracheotomy		No	
D7991	Coronoidectomy	1 per code every Lifetime	No	
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)		No	
D7998	Intraoral Placement Of A Fixation Device		No	
D7999	Unspecified Oral Surgery Procedure, By Report		No	
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8210	Removable Appliance Therapy	2 per code every Year	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8220	Fixed Appliance Therapy	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	3 per code every Year	No	
D8670	Periodic Orthodontic Treatment Visit	24 per code every Lifetime	Yes	Approved ortho banding or approved D8999/COC code is present on the same auth
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)		Yes	Diagnostic quality photos
D8695	Removal Of Fixed Orthodontic Appliances	1 per code every Lifetime	Yes	Copy of original approval, banding date, payment history
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	1 per code every Lifetime	No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	1 per code every Lifetime	No	
D8999	Unspecified Orthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	2 per code every 12 Months	No	
D9120	Fixed Partial Denture Sectioning		No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	1 per code every Day	Yes	Narrative of medical necessity with claim
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9248	Non-Intravenous Conscious Sedation	1 per code every Day	Yes	Narrative of medical necessity with claim
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	1 per code every 6 Months	No	
D9311	Consultation with a medical health care professional	1 per code every 7 Days	No	
D9410	House/Extended Care Facility Call	1 per code every Day	No	
D9420	Hospital Or Ambulatory Surgical Center Call	3 per code every 7 Days	No	
D9430	Office Visit For Observation (During Regularly Scheduled Hours)	4 per code every 12 Months	No	
D9440	Office Visit - After Regularly Scheduled Hours	1 per code every Day	No	
D9610	Therapeutic Parenteral Drug, Single Administration		No	

HARP and MMC benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D9944	Occlusal Guard-hard appliance, full arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9945	Occlusal Guard-soft appliance, full arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9946	Occlusal Guard-hard appliance, partial arch	1 per code every 12 Months	Yes	Narrative of medical necessity
D9990	Translation Services	2 per code every Day	No	
D9991	Dental Case Management - addressing appointment compliance barriers		No	
D9995	Teledentistry - Synchronous; Real-Time Encounter	1 per code every Day	No	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	1 per code every Day	No	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	Desc of procedure/ narr of med nec/ name of hospital/ OR facility(if necessary)
Q3014	Telehealth facility fee		No	
T1015	FQHC Encounter Payment-ADA			

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0120	Periodic Oral Exam	1 per code every 6 Months	No	
D0140	Limited Oral Evaluation - Problem Focused		No	
D0145	Oral Evaluation, Patient Under Three		No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per code every 12 Months	No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	2 per code every 12 Months	No	
D0170	Re-Evaluation - Limited, Problem Focused		No	
D0180	Comprehensive periodontal evaluation	2 per code every 12 Months	No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	1 per code every 36 Months	No	
D0220	Intraoral - Periapical First Radiographic Image		No	
D0230	Intraoral - Periapical Each Additional Image		No	
D0240	Intraoral - Occlusal Radiographic Image	2 per code every 36 Months	No	
D0250	Extraoral - 2D Projection Radiographic image		No	
D0251	Extra-Oral Posterior Dental Radiographic Image	2 per code every 12 Months	No	
D0270	Bitewing - Single Radiographic Image	2 per code every 12 Months	No	
D0272	Bitewings - Two Radiographic Images	2 per code every 12 Months	No	
D0273	Bitewings - Three Radiographic Images	2 per code every 12 Months	No	
D0274	Bitewings - Four Radiographic Images	2 per code every 12 Months	No	
D0310	Sialography		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0320	Temporomandibular Joint Arthrogram, Including Injection		No	
D0321	Other Temporomandibular Joint Radiographic Images, By Report		No	
D0330	Panoramic Radiographic Image	1 per code every 36 Months	No	
D0340	2D Cephalometric Radiographic Image	1 per code every 12 Months	No	
D0350	Oral/Facial Photographic Images	1 per code every 12 Months	No	
D0364	Cone Beam - Less Than One Whole Jaw		Yes	Panoramic, narrative of medical necessity
D0365	Cone Beam - One Full Dental Arch - Mandible		Yes	Panoramic, narrative of medical necessity
D0366	Cone Beam - One Full Dental Arch - Maxilla		Yes	Panoramic, narrative of medical necessity
D0367	Cone Beam - Both Jaws	1 per code every 5 Years	Yes	Panoramic, narrative of medical necessity
D0368	Cone Beam o TMJ Series		Yes	Panoramic, narrative of medical necessity
D0470	Diagnostic Casts	1 per code every 24 Months	No	
D0474	Accession Of Tissue, Gross And Microscopic Examination		No	
D0502	Other Pathology Procedures, By Report	2 per code every 12 Months	No	
D0999	Unspecified Diagnostic Procedures, By Report			
D1110	Prophylaxis - Adult	2 per code every 12 Months	No	
D1120	Prophylaxis - Child	2 per code every 12 Months	No	
D1206	Topical Application Of Fluoride Varnish	4 per code every 12 Months	No	
		2 per code every 12 Months		
D1208	Topical Application of Fluoride	4 per code every 12 Months	No	
		2 per code every 12 Months		
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	2 per code every 12 Months	No	
D1351	Sealant - Per Tooth	1 per code per tooth every 36 Months	No	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant		No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary		No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular		No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	1 per code every Accum Year	No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	1 per code every Accum Year	No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	1 per code per quadrant every Accum Year	No	
D1575	Distal shoe space maintainer - fixed - per quadrant	1 per code per quadrant every Accum Year	No	
D2140	Amalgam - One Surface, Primary Or Permanent		No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent		No	
D2160	Amalgam - Three Surfaces, Primary Or Permanent		No	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2330	Resin-Based Composite - One Surface, Anterior		No	
D2331	Resin-Based Composite - Two Surfaces, Anterior		No	
D2332	Resin-Based Composite - Three Surfaces, Anterior		No	
D2335	resin-based composite - four or more surfaces (anterior)		No	
D2390	Resin-Based Composite Crown, Anterior		No	
D2391	Resin-Based Composite - One Surface, Posterior		No	
D2392	Resin-Based Composite - Two Surfaces, Posterior		No	
D2393	Resin-Based Composite - Three Surfaces, Posterior		No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior		No	
D2710	Crown - Resin-Based Composite (Indirect)	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2720	Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2721	Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2722	Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2740	Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2750	Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2752	Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Pre-op Xrays, narr, specific tests if cracked tth synd, post RCT PA (if RCT)
D2780	Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2781	Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2782	Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2790	Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2791	Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2792	Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D2794	crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D2920	Re-Cement or Re-Bond Crown		No	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth		No	
D2931	prefabricated stainless steel crown - permanent tooth		No	
D2932	Prefabricated Resin Crown	1 per code per tooth every 24 Months	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window		No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 5 Years	No	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	1 per code per tooth every 12 Months	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D2954	Prefabricated Post And Core In Addition To Crown	1 per code per tooth every 5 Years	Yes	Pre-op x-rays of adjacent teeth and opposing teeth
D2955	Post Removal		No	
D2980	Crown Repair		Yes	Description of procedure and narrative of medical necessity

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2999	Unspecified Restorative Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	1 per code per tooth every Lifetime	No	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	1 per code per tooth every Lifetime	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3351	Apexification / Recalcification - Initial Visit	1 per code per tooth every Lifetime	No	
D3352	Apexification / Recalcification - Interim	1 per code per tooth every Lifetime	No	
D3353	Apexification / Recalcification - Final Visit	1 per code per tooth every Lifetime	No	
D3410	Apicoectomy - Anterior	1 per code per tooth every Lifetime	No	
D3421	Apicoectomy - Premolar (First Root)	1 per code per tooth every Lifetime	No	
D3425	Apicoectomy - Molar (First Root)	1 per code per tooth every Lifetime	No	
D3426	Apicoectomy - Each Additional Root)	1 per code per tooth every Lifetime	No	
D3430	Retrograde Filling - Per Root	3 per code per tooth every Lifetime	No	
D3999	Unspecified Endodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	1 per code per quadrant every 24 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	1 per code per quadrant every 24 Months	Yes	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	Periodontal charting and pre-op x-rays
D4910	Periodontal Maintenance	2 per code every 12 Months	Yes	Date of previous perio surgical or S&C service with claim
D4999	Unspecified Periodontal Procedure, By Report		Yes	Description of procedure and narrative of medical necessity

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5110	Complete Denture - Maxillary	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5120	Complete Denture - Mandibular	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5211	Maxillary Partial Denture - Resin Base	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5212	Mandibular Partial Denture - Resin Base	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5225	maxillary partial denture - flexible base (including any retentive clasping mate	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5226	mandibular partial denture - flexible base (including any retentive clasping mat	1 per code every 48 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form), FMX or panoramic x-rays
D5410	Adjust Complete Denture - Maxillary	1 per code every 6 Months	No	
D5411	Adjust Complete Denture - Mandibular	1 per code every 6 Months	No	
D5421	Adjust Partial Denture - Maxillary	1 per code every 6 Months	No	
D5422	Adjust Partial Denture - Mandibular	1 per code every 6 Months	No	
D5511	Repair Broken Complete Denture Base - Mandibular		No	
D5512	Repair Broken Complete Denture Base - Maxillary		No	
D5520	Replace missing or broken teeth – complete denture (each tooth) – per tooth		No	
D5611	Repair Resin Partial Denture Base - Mandibular		No	
D5612	Repair Resin Partial Denture Base - Maxillary		No	
D5621	Repair Cast Partial Framework - Mandibular		No	
D5622	Repair Cast Partial Framework - Maxillary		No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	1 per code per tooth every 6 Months	No	
D5640	Replace missing or broken teeth – partial denture – per tooth	1 per code per tooth every 6 Months	No	
D5650	Add tooth to existing partial denture – per tooth		No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth		No	
D5710	Rebase Complete Maxillary Denture	1 per code every 12 Months	No	
D5711	Rebase Complete Mandibular Denture	1 per code every 12 Months	No	
D5720	Rebase Maxillary Partial Denture	1 per code every 12 Months	No	
D5721	Rebase Mandibular Partial Denture	1 per code every 12 Months	No	
D5730	reline complete maxillary denture (direct)	1 per code every 12 Months	No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5731	reline complete mandibular denture (direct)	1 per code every 12 Months	No	
D5740	reline maxillary partial denture (direct)	1 per code every 12 Months	No	
D5741	reline mandibular partial denture (direct)	1 per code every 12 Months	No	
D5750	reline complete maxillary denture (indirect)	1 per code every 12 Months	No	
D5751	reline complete mandibular denture (indirect)	1 per code every 12 Months	No	
D5760	reline maxillary partial denture (indirect)	1 per code every 12 Months	No	
D5761	reline mandibular partial denture (indirect)	1 per code every 12 Months	No	
D5820	interim partial denture (Including retentive clasping materials and teeth) - max	1 per code every 12 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5821	interim partial denture (Including retentive clasping materials and teeth) - man	1 per code every 12 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5850	Tissue Conditioning, Maxillary	1 per code every 12 Months	No	
D5851	Tissue Conditioning, Mandibular	1 per code every 12 Months	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5911	Facial Moulage (Sectional)		No	
D5912	Facial Moulage (Complete)		No	
D5913	Nasal Prosthesis		No	
D5914	Auricular Prosthesis		No	
D5915	Orbital Prosthesis		No	
D5916	Ocular Prosthesis		No	
D5919	Facial Prosthesis		No	
D5922	Nasal Septal Prosthesis		No	
D5923	Ocular Prosthesis, Interim		No	
D5924	Cranial Prosthesis		No	
D5925	Facial Augmentation Implant Prosthesis		No	
D5926	Nasal Posthesis, Replacement		No	
D5927	Auricular Prosthesis, Replacement		No	
D5928	Orbital Prosthesis, Replacement		No	
D5929	Facial Prosthesis, Replacement		No	
D5931	Obturator Prosthesis, Surgical		No	
D5932	Obturator Prosthesis, Definitive		No	
D5933	Obturator Prosthesis, Modification		No	
D5934	Mandibular Resection Prosthesis With Guide Flange		No	
D5935	Mandibular Resection Prosthesis Without Guide Flange		No	
D5936	Obturator Prosthesis, Interim		No	
D5937	Trismus Appliance (Not For Tmd Treatment)		No	
D5951	Feeding Aid		No	
D5952	Speech Aid Prosthesis, Pediatric		No	
D5953	Speech Aid Prosthesis, Adult		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5954	Palatal Augmentation Prosthesis		No	
D5955	Palatal Lift Prosthesis, Definitive		No	
D5958	Palatal Lift Prosthesis, Interim		No	
D5959	Palatal Lift Prosthesis, Modification		No	
D5960	Speech Aid Prosthesis, Modification		No	
D5982	Surgical Stent		No	
D5983	Radiation Carrier		No	
D5984	Radiation Shield		No	
D5985	Radiation Cone Locator		No	
D5986	Fluoride Gel Carrier		No	
D5987	Commissure Splint		No	
D5988	Surgical Splint		No	
D5999	Unspecified Maxillofacial Prosthesis, By Report		Yes	Description of procedure and narrative of medical necessity
D6210	Pontic - Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6211	Pontic - Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6212	Pontic - Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6214	pontic - titanium and titanium alloys	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6242	Pontic - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6243	Pontic - porcelain fused to Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6245	Pontic - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6250	Pontic - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6251	Pontic - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6252	Pontic - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6720	Retainer Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6721	Retainer Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6722	Retainer Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6740	Retainer Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6752	Retainer Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6753	Retainer Crown - Porcelain Fused To Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6780	Retainer Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	No	
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	No	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	1 per code per tooth every 5 Years	No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6784	Retainer Crown - 3/4 Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6790	Retainer Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6792	Retainer Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6794	retainer crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture		No	
D6980	Fixed Partial Denture Repair		Yes	Narrative of medical necessity with pre authorization
D6999	Unspecified Fixed Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per code per tooth every Lifetime	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per code per tooth every Lifetime	No	
D7210	Extraction, Erupted Tooth	1 per code per tooth every Lifetime	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7230	Removal Of Impacted Tooth - Partially Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7240	Removal Of Impacted Tooth - Completely Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per code per tooth every Lifetime	No	
D7260	Oroantral Fistula Closure		No	
D7261	Primary Closure Of Sinus Perforation		No	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth		No	
D7272	Tooth Transplantation (Includes Reimplantation)		No	
D7280	Exposure of an Unerupted Tooth	1 per code per tooth every Lifetime	No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	1 per code per tooth every Lifetime	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)		No	
D7286	Incisional Biopsy Of Oral Tissue - Soft		No	
D7287	Exfoliative Cytological Sample Collection		No	
D7290	Surgical Repositioning Of Teeth		No	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth		No	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth		No	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth		No	
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)		No	
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)		No	
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	
D7412	Excision Of Benign Lesion, Complicated		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	
D7415	Excision Of Malignant Lesion, Complicated		No	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)		No	
D7472	Removal Of Torus Palatinus		No	
D7473	Removal Of Torus Mandibularis		No	
D7485	Reduction Of Osseous Tuberosity		No	
D7490	Radical Resection Of Maxilla Or Mandible		No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	
D7530	Removal Of Foreign Body From Mucosa		No	
D7540	Removal Of Reaction Producing Foreign Bodies		No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone		No	
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No	
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth		No	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		No	
D7710	Maxilla - Open Reduction		No	
D7720	Maxilla - Closed Reduction		No	
D7730	Mandible - Open Reduction		No	
D7740	Mandible - Closed Reduction		No	
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No	
D7771	Alveolus - Closed Reduction Stabilization Of Teeth		No	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No	
D7810	Open Reduction Of Dislocation		No	
D7820	Closed Reduction Of Dislocation		No	
D7830	Manipulation Under Anesthesia		No	
D7840	Condylectomy		No	
D7850	Surgical Discetomy, With/Without Implant		No	
D7852	Disc Repair		No	
D7854	Synovectomy		No	
D7856	Myotomy		No	
D7858	Joint Reconstruction		No	
D7860	Arthrotomy		No	
D7865	Arthroplasty		No	
D7870	Arthrocentesis		No	
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy		No	
D7873	Arthroscopy - Lavage And Lysis Of Adhesions		No	
D7874	Arthroscopy - Disc Repositioning And Stabilization		No	
D7875	Arthroscopy - Synovectomy		No	
D7876	Arthroscopy - Discectomy		No	
D7877	Arthroscopy - Debridement		No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7880	Occlusal Orthotic Device, By Report		No	
D7899	Unspecified Tmd Therapy, By Report		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	
D7911	Complicated Suture - Up To 5 Cm		No	
D7912	Complicated Suture - Greater Than 5 Cm		No	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		No	
D7940	Osteoplasty - For Orthognathic Deformities		No	
D7941	Osteotomy - Mandibular Rami		No	
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft		No	
D7944	Osteotomy - Segmented Or Subapical		No	
D7945	Osteotomy - Body Of Mandible		No	
D7946	Lefort I - (Maxilla - Total)		No	
D7947	Lefort I - (Maxilla - Segmented)		No	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft		No	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft		No	
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla		No	
D7952	Sinus Augmentation Via A Vertical Approach		No	
D7961	buccal / labial frenectomy (frenulectomy)		No	
D7962	lingual frenectomy (frenulectomy)		No	
D7970	Excision Of Hyperplastic Tissue - Per Arch		No	
D7971	Excision Of Pericoronal Gingiva		Yes	Periapical & Narrative
D7972	Surgical Reduction Of Fibrous Tuberosity		No	
D7979	Non-Surgical Sialolithotomy		No	
D7980	Surgical Sialolithotomy		No	
D7981	Excision Of Salivary Gland, By Report		No	
D7982	Sialodochoplasty		No	
D7983	Closure Of Salivary Fistula		No	
D7990	Emergency Tracheotomy		No	
D7991	Coronoidectomy		No	
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)		No	
D7998	Intraoral Placement Of A Fixation Device		No	
D7999	Unspecified Oral Surgery Procedure, By Report		No	
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8210	Removable Appliance Therapy	2 per code every Year	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8220	Fixed Appliance Therapy	1 per code every Lifetime	Yes	PAN,ceph, diag. quality photos, nar of med nec, tx plan,plan specific ortho form
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	3 per code every Year	No	
D8670	Periodic Orthodontic Treatment Visit	24 per code every Lifetime	Yes	Approved ortho banding or approved D8999/COC code is present on the same auth
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	1 per code every Lifetime	Yes	Diagnostic quality photos
D8695	Removal Of Fixed Orthodontic Appliances	1 per code every Lifetime	Yes	Copy of original approval, banding date, payment history
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	1 per code every Lifetime	No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	1 per code every Lifetime	No	
D8999	Unspecified Orthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit		No	
D9120	Fixed Partial Denture Sectioning	1 per code per tooth every Lifetime	No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes		Yes	Treatment plan and narrative of medical necessity
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment		Yes	Treatment plan and narrative of medical necessity
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	1 per code every Day	Yes	Narrative of medical necessity with claim
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes		Yes	Treatment plan and narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute		Yes	Treatment plan and narrative of medical necessity
D9248	Non-Intravenous Conscious Sedation	1 per code every Day	Yes	Narrative of medical necessity with claim
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	1 per code every 6 Months	No	

CHP benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D9410	House/Extended Care Facility Call		No	
D9420	Hospital Or Ambulatory Surgical Center Call		No	
D9430	Office Visit For Observation (During Regularly Scheduled Hours)		No	
D9440	Office Visit - After Regularly Scheduled Hours		No	
D9610	Therapeutic Parenteral Drug, Single Administration		No	
D9941	Fabrication Of Athletic Mouthguard		No	
D9942	Repair And/Or Reline Occlusal Guard		No	
D9944	Occlusal Guard-hard appliance, full arch		Yes	Narrative of medical necessity
D9945	Occlusal Guard-soft appliance, full arch		Yes	Narrative of medical necessity
D9946	Occlusal Guard-hard appliance, partial arch		Yes	Narrative of medical necessity
D9990	Translation Services	2 per code every Day	No	
D9995	Teledentistry - Synchronous; Real-Time Encounter	1 per code every Day	No	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	1 per code every Day	No	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	Desc of procedure/ narr of med nec/ name of hospital/OR facility(if necessary)
Q3014	Telehealth facility fee		No	
T1015	FQHC Encounter Payment-ADA			

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0120	Periodic Oral Exam	1 per code every 6 Months	No	
D0140	Limited Oral Evaluation - Problem Focused	2 per code every 12 Months	No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per code every Lifetime	No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	3 per code every 12 Months	No	
D0170	Re-Evaluation - Limited, Problem Focused		No	
D0180	Comprehensive periodontal evaluation	2 per code every 12 Months	No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	1 per code every 36 Months	No	
D0220	Intraoral - Periapical First Radiographic Image	1 per code every Day	No	
D0230	Intraoral - Periapical Each Additional Image	5 per code every 12 Months	No	
D0240	Intraoral - Occlusal Radiographic Image	1 per code every 36 Months	No	
D0250	Extraoral - 2D Projection Radiographic image	2 per code every 7 Days	No	
D0251	Extra-Oral Posterior Dental Radiographic Image	2 per code every 7 Days	No	
D0270	Bitewing - Single Radiographic Image	3 per code every 12 Months	No	
D0272	Bitewings - Two Radiographic Images	2 per code every 12 Months	No	
D0273	Bitewings - Three Radiographic Images	2 per code every 12 Months	No	

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0274	Bitewings - Four Radiographic Images	2 per code every 12 Months	No	
D0310	Sialography	2 per code every 7 Days	No	
D0320	Temporomandibular Joint Arthrogram, Including Injection	2 per code every Lifetime	No	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	2 per code every 12 Months	No	
D0330	Panoramic Radiographic Image	1 per code every 12 Months	No	
D0340	2D Cephalometric Radiographic Image	1 per code every 36 Months	No	
D0350	Oral/Facial Photographic Images	2 per code every 6 Months	No	
D0364	Cone Beam - Less Than One Whole Jaw		Yes	Panoramic, narrative of medical necessity
D0365	Cone Beam - One Full Dental Arch - Mandible		Yes	Panoramic, narrative of medical necessity
D0366	Cone Beam - One Full Dental Arch - Maxilla		Yes	Panoramic, narrative of medical necessity
D0367	Cone Beam - Both Jaws		Yes	Panoramic, narrative of medical necessity
D0368	Cone Beam o TMJ Series		Yes	Panoramic, narrative of medical necessity
D0470	Diagnostic Casts	1 per code every 12 Months	No	
D0474	Accession Of Tissue, Gross And Microscopic Examination		No	
D0502	Other Pathology Procedures, By Report		No	
D0999	Unspecified Diagnostic Procedures, By Report		No	
D1110	Prophylaxis - Adult	1 per code every 6 Months	No	
D1206	Topical Application Of Fluoride Varnish	1 per code every 3 Months	No	
D1208	Topical Application of Fluoride	1 per code every 6 Months	No	
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease		No	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	1 per code per quadrant every 12 Months	No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1 per code per tooth every 12 Months	No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1 per code per tooth every 12 Months	No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	1 per code every Accum Year	No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	1 per code every Accum Year	No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	1 per code per quadrant every Accum Year	No	
D1575	Distal shoe space maintainer - fixed - per quadrant	1 per code per quadrant every Accum Year	No	
D2140	Amalgam - One Surface, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2330	Resin-Based Composite - One Surface, Anterior	1 per code per tooth every 2 Accum Years	No	
D2331	Resin-Based Composite - Two Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2332	Resin-Based Composite - Three Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2335	resin-based composite - four or more surfaces (anterior)	1 per code per tooth every 2 Accum Years	No	
D2390	Resin-Based Composite Crown, Anterior	1 per code per tooth every 2 Accum Years	No	
D2391	Resin-Based Composite - One Surface, Posterior	1 per code per tooth every 2 Accum Years	No	
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2710	Crown - Resin-Based Composite (Indirect)	1 per code per tooth every 5 Years	Yes	PA x-ray of tooth and Narrative of necessity
D2720	Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2721	Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2722	Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2740	Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2750	Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2752	Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Pre-op Xrays, narr, specific tests if cracked tth synd, post RCT PA (if RCT)
D2780	Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2781	Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2782	Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2790	Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2791	Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2792	Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2794	crown - titanium and titanium alloys		Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2920	Re-Cement or Re-Bond Crown	1 per code per tooth every 24 Months	No	
D2931	prefabricated stainless steel crown - permanent tooth	1 per code per tooth every 60 Months	No	
D2932	Prefabricated Resin Crown	1 per code per tooth every 24 Months	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window	1 per code per tooth every 24 Months	No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 24 Months	No	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	2 per code per tooth every 12 Months	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per code per tooth every 5 Years	Yes	pre-op x-rays; post op x-rays of root canal
D2954	Prefabricated Post And Core In Addition To Crown	1 per code per tooth every 5 Years	Yes	pre-op x-rays; post op x-rays of root canal
D2955	Post Removal	1 per code per tooth every 5 Years	No	
D2980	Crown Repair	1 per code per tooth every 5 Years	No	
D2999	Unspecified Restorative Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	1 per code per tooth every Lifetime	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	Pre and post-op periapical images
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	Pre and post-op periapical images
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3351	Apexification / Recalcification - Initial Visit	1 per code per tooth every Lifetime	No	
D3352	Apexification / Recalcification - Interim	1 per code per tooth every Lifetime	No	
D3353	Apexification / Recalcification - Final Visit	1 per code per tooth every Lifetime	No	
D3410	Apicoectomy - Anterior	1 per code per tooth every Lifetime	No	
D3421	Apicoectomy - Premolar (First Root)	1 per code per tooth every Lifetime	No	
D3425	Apicoectomy - Molar (First Root)	1 per code per tooth every Lifetime	No	

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D3426	Apicoectomy - Each Additional Root)	1 per code per tooth every Lifetime	No	
D3430	Retrograde Filling - Per Root	1 per code per tooth every Lifetime	No	
D3999	Unspecified Endodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Periodontal charting, bitewings and photos (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Periodontal charting, bitewings and photos (optional)
D4249	Clinical Crown Lengthening - Hard Tissue		Yes	Periapical or BWX
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	FMX or Pan w/ bitewing x-rays
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	FMX or Pan w/ bitewing x-rays
D4910	Periodontal Maintenance	1 per code every 6 Months	Yes	perio chart, FMX or PAN w/ BWX and date of scaling and root planing
D4999	Unspecified Periodontal Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5110	Complete Denture - Maxillary	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5120	Complete Denture - Mandibular	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5211	Maxillary Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5212	Mandibular Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5225	maxillary partial denture - flexible base (including any retentive clasping mate	1 per code every 96 Months	No	
D5226	mandibular partial denture - flexible base (including any retentive clasping mat	1 per code every 96 Months	No	
D5410	Adjust Complete Denture - Maxillary	4 per code every 12 Months	No	
D5411	Adjust Complete Denture - Mandibular	4 per code every 12 Months	No	
D5421	Adjust Partial Denture - Maxillary	4 per code every 12 Months	No	
D5422	Adjust Partial Denture - Mandibular	4 per code every 12 Months	No	
D5511	Repair Broken Complete Denture Base - Mandibular	2 per code every 12 Months	No	
D5512	Repair Broken Complete Denture Base - Maxillary	2 per code every 12 Months	No	
D5520	Replace missing or broken teeth - complete denture (each tooth) - per tooth	1 per code per tooth every 12 Months	No	
D5611	Repair Resin Partial Denture Base - Mandibular	2 per code every 12 Months	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D5612	Repair Resin Partial Denture Base - Maxillary	2 per code every 12 Months	No	
D5621	Repair Cast Partial Framework - Mandibular	1 per code every 12 Months	No	
D5622	Repair Cast Partial Framework - Maxillary	1 per code every 12 Months	No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	2 per code per tooth every 12 Months	No	
D5640	Replace missing or broken teeth - partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5650	Add tooth to existing partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	1 per code per tooth every 12 Months	No	
D5710	Rebase Complete Maxillary Denture	1 per code every 60 Months	No	
D5711	Rebase Complete Mandibular Denture	1 per code every 60 Months	No	
D5720	Rebase Maxillary Partial Denture	1 per code every 60 Months	No	
D5721	Rebase Mandibular Partial Denture	1 per code every 60 Months	No	
D5730	reline complete maxillary denture (direct)	1 per code every 12 Months	No	
D5731	reline complete mandibular denture (direct)	1 per code every 12 Months	No	
D5740	reline maxillary partial denture (direct)	1 per code every 12 Months	No	
D5741	reline mandibular partial denture (direct)	1 per code every 12 Months	No	
D5750	reline complete maxillary denture (indirect)	1 per code every 24 Months	No	
D5751	reline complete mandibular denture (indirect)	1 per code every 24 Months	No	
D5760	reline maxillary partial denture (indirect)	1 per code every 24 Months	No	
D5761	reline mandibular partial denture (indirect)	1 per code every 24 Months	No	
D5810	Interim Complete Denture (Maxillary)		No	
D5820	interim partial denture (Including retentive clasping materials and teeth) - max	1 per code every 12 Months	No	
D5821	interim partial denture (Including retentive clasping materials and teeth) - man	1 per code every 12 Months	No	
D5850	Tissue Conditioning, Maxillary	1 per code every 60 Months	No	
D5851	Tissue Conditioning, Mandibular	1 per code every 60 Months	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5911	Facial Moulage (Sectional)	1 per code every 12 Months	No	
D5912	Facial Moulage (Complete)	1 per code every 12 Months	No	
D5913	Nasal Prosthesis	1 per code every 12 Months	No	
D5914	Auricular Prosthesis	1 per code every 12 Months	No	
D5915	Orbital Prosthesis	1 per code every 12 Months	No	
D5916	Ocular Prosthesis	1 per code every 12 Months	No	
D5919	Facial Prosthesis	6 per code every 2 Months	No	
D5922	Nasal Septal Prosthesis	1 per code every 12 Months	No	
D5923	Ocular Prosthesis, Interim	1 per code every 12 Months	No	
D5924	Cranial Prosthesis	1 per code every 12 Months	No	
D5925	Facial Augmentation Implant Prosthesis	1 per code every 12 Months	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D5926	Nasal Posthesis, Replacement	1 per code every 12 Months	No	
D5927	Auricular Prosthesis, Replacement	1 per code every 12 Months	No	
D5928	Orbital Prosthesis, Replacement	1 per code every 12 Months	No	
D5929	Facial Prosthesis, Replacement	1 per code every 12 Months	No	
D5931	Obturator Prosthesis, Surgical	1 per code every 12 Months	No	
D5932	Obturator Prosthesis, Definitive	1 per code every 12 Months	No	
D5933	Obturator Prosthesis, Modification	1 per code every 6 Months	No	
D5934	Mandibular Resection Prosthesis With Guide Flange	1 per code every 12 Months	No	
D5935	Mandibular Resection Prosthesis Without Guide Flange	1 per code every 12 Months	No	
D5936	Obturator Prosthesis, Interim	1 per code every 12 Months	No	
D5937	Trismus Appliance (Not For Tmd Treatment)	1 per code every 12 Months	No	
D5951	Feeding Aid	1 per code every 12 Months	No	
D5952	Speech Aid Prosthesis, Pediatric	1 per code every 12 Months	No	
D5953	Speech Aid Prosthesis, Adult	1 per code every 12 Months	No	
D5954	Palatal Augmentation Prosthesis	1 per code every 12 Months	No	
D5955	Palatal Lift Prosthesis, Definitive	1 per code every 12 Months	No	
D5958	Palatal Lift Prosthesis, Interim	1 per code every 12 Months	No	
D5959	Palatal Lift Prosthesis, Modification	1 per code every 12 Months	No	
D5960	Speech Aid Prosthesis, Modification	1 per code every 12 Months	No	
D5982	Surgical Stent	1 per code every 12 Months	No	
D5983	Radiation Carrier	1 per code every 12 Months	No	
D5984	Radiation Shield	1 per code every 12 Months	No	
D5985	Radiation Cone Locator	1 per code every 12 Months	No	
D5986	Fluoride Gel Carrier	2 per code every 12 Months	No	
D5987	Commissure Splint	1 per code every 12 Months	No	
D5988	Surgical Splint	1 per code every 12 Months	No	
D5999	Unspecified Maxillofacial Prosthesis, By Report		Yes	Description of procedure and narrative of medical necessity
D6010	Surgical Placement Of Implant Body: Endosteal Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6013	Surgical Placement Of Mini Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6055	Connecting Bar - Implant Supported Or Abutment Supported	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6056	Prefabricated Abutment - Includes Modification And Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6057	Custom Fabricated Abutment - Includes Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6058	Abutment Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6065	Implant Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6066	implant supported crown - porcelain fused to metal crown (titanium, titanium all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6067	implant supported metal crown - (titanium, titanium alloy, high noble metals all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6081	Scaling and debridement of a single implant in the presence of inflammation or m	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6090	Repair of implant/abutment supported prosthesis, by report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6091	Replacement Of Semi-Precision Or Precision Attachment	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6094	abutment supported crown - (titanium) and titanium alloys	1 per code per tooth every 8 Years	Yes	Narrative of medical necessity
D6096	Remove Broken Implant Retaining Screw	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6100	Surgical removal of implant body removal, by report	1 per code per tooth every Lifetime	Yes	Narrative of medical necessity
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/Closure	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6104	Bone Graft At Time Of Implant Placement	1 per code per tooth every Lifetime	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6190	Radiographic/Surgical Implant Index, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6191	semi-precision abutment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6192	semi-precision attachment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D6193	Replacement of an implant screw	1 per code every 12 Months	No	
D6199	Unspecified Implant Procedure, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6210	Pontic - Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6211	Pontic - Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6212	Pontic - Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6214	pontic – titanium and titanium alloys	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6242	Pontic - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6243	Pontic - porcelain fused to Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6245	Pontic - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6250	Pontic - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6251	Pontic - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6252	Pontic - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6720	Retainer Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6721	Retainer Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6722	Retainer Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6740	Retainer Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6752	Retainer Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6753	Retainer Crown - Porcelain Fused To Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6780	Retainer Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	No	
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	No	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	1 per code per tooth every 5 Years	No	
D6784	Retainer Crown - 3/4 Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D6790	Retainer Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6792	Retainer Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6794	retainer crown - titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	1 per code per tooth every 2 Years	No	
D6980	Fixed Partial Denture Repair	1 per code per tooth every 5 Years	Yes	Description of procedure and narrative of medical necessity
D6999	Unspecified Fixed Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per code per tooth every Lifetime	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per code per tooth every Lifetime	No	
D7210	Extraction, Erupted Tooth	1 per code per tooth every Lifetime	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7230	Removal Of Impacted Tooth - Partially Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7240	Removal Of Impacted Tooth - Completely Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per code per tooth every Lifetime	No	
D7260	Oroantral Fistula Closure	1 per code every Lifetime	No	
D7261	Primary Closure Of Sinus Perforation	1 per code every Lifetime	No	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 per code per tooth every Lifetime	No	
D7272	Tooth Transplantation (Includes Reimplantation)	1 per code per tooth every Lifetime	No	
D7280	Exposure of an Unerupted Tooth	1 per code per tooth every Lifetime	No	
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption		No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	1 per code per tooth every Lifetime	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	1 per code every 12 Months	No	
D7286	Incisional Biopsy Of Oral Tissue - Soft	1 per code every 12 Months	No	
D7287	Exfoliative Cytological Sample Collection		No	
D7290	Surgical Repositioning Of Teeth	1 per code per tooth every Lifetime	No	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	2 per code per quadrant every 5 Years	No	
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	2 per code per quadrant every 5 Years	No	
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	
D7412	Excision Of Benign Lesion, Complicated		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	
D7415	Excision Of Malignant Lesion, Complicated		No	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 per code per arch every Lifetime	No	
D7472	Removal Of Torus Palatinus		No	
D7473	Removal Of Torus Mandibularis		No	
D7485	Reduction Of Osseous Tuberosity	1 per code every Lifetime	No	
D7490	Radical Resection Of Maxilla Or Mandible		No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	
D7530	Removal Of Foreign Body From Mucosa		No	
D7540	Removal Of Reaction Producing Foreign Bodies		No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone		No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		No	
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No	
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth		No	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		No	
D7710	Maxilla - Open Reduction		No	
D7720	Maxilla - Closed Reduction		No	
D7730	Mandible - Open Reduction		No	
D7740	Mandible - Closed Reduction		No	
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No	
D7771	Alveolus - Closed Reduction Stabilization Of Teeth		No	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No	
D7810	Open Reduction Of Dislocation		No	
D7820	Closed Reduction Of Dislocation		No	
D7830	Manipulation Under Anesthesia		No	
D7840	Condylectomy		No	
D7850	Surgical Discetomy, With/Without Implant	2 per code every Lifetime	No	
D7852	Disc Repair	2 per code every Lifetime	No	
D7854	Synovectomy	2 per code every Lifetime	No	
D7856	Myotomy	2 per code every Lifetime	No	
D7858	Joint Reconstruction	2 per code every Lifetime	No	
D7860	Arthrotomy	2 per code every Lifetime	No	
D7865	Arthroplasty	2 per code every Lifetime	No	
D7870	Arthrocentesis	1 per code every 6 Months	No	
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy	2 per code every Lifetime	No	
D7873	Arthroscopy - Lavage And Lysis Of Adhesions	2 per code every Lifetime	No	
D7874	Arthroscopy - Disc Repositioning And Stabilization	2 per code every Lifetime	No	
D7875	Arthroscopy - Synovectomy	2 per code every Lifetime	No	
D7876	Arthroscopy - Discectomy	2 per code every Lifetime	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D7877	Arthroscopy - Debridement	2 per code every Lifetime	No	
D7880	Occlusal Orthotic Device, By Report	1 per code every 12 Months	No	
D7899	Unspecified Tmd Therapy, By Report		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	
D7911	Complicated Suture - Up To 5 Cm		No	
D7912	Complicated Suture - Greater Than 5 Cm		No	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		No	
D7940	Osteoplasty - For Orthognathic Deformities		No	
D7941	Osteotomy - Mandibular Rami		No	
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft		No	
D7944	Osteotomy - Segmented Or Subapical		No	
D7945	Osteotomy - Body Of Mandible		No	
D7946	Lefort I - (Maxilla - Total)		No	
D7947	Lefort I - (Maxilla - Segmented)		No	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft		No	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft		No	
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla		No	
D7952	Sinus Augmentation Via A Vertical Approach		No	
D7961	buccal / labial frenectomy (frenulectomy)	3 per code per arch every Lifetime	No	
D7962	lingual frenectomy (frenulectomy)	3 per code every Lifetime	No	
D7970	Excision Of Hyperplastic Tissue - Per Arch	2 per code per arch every Lifetime	No	
D7971	Excision Of Pericoronal Gingiva	1 per code per tooth every 2 Years	No	
D7972	Surgical Reduction Of Fibrous Tuberosity	2 per code every Lifetime	No	
D7979	Non-Surgical Sialolithotomy		No	
D7980	Surgical Sialolithotomy		No	
D7981	Excision Of Salivary Gland, By Report		No	
D7982	Sialodochoplasty		No	
D7983	Closure Of Salivary Fistula		No	
D7990	Emergency Tracheotomy		No	
D7991	Coronoidectomy	1 per code every Lifetime	No	
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)		No	
D7998	Intraoral Placement Of A Fixation Device		No	
D7999	Unspecified Oral Surgery Procedure, By Report		No	
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 per code every 12 Months	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8210	Removable Appliance Therapy	2 per code every Accum Year	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8220	Fixed Appliance Therapy	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	3 per code every Year	No	
D8670	Periodic Orthodontic Treatment Visit	24 per code every Lifetime	Yes	Approved ortho banding or approved D8999/COC code is present on the same auth
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8695	Removal Of Fixed Orthodontic Appliances	1 per code every Lifetime	Yes	Copy of original approval, banding date, payment history
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	1 per code every Lifetime	No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	1 per code every Lifetime	No	
D8999	Unspecified Orthodontic Procedure, By Report		No	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	2 per code every 12 Months	No	
D9120	Fixed Partial Denture Sectioning		No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	1 per code every Day	No	
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9248	Non-Intravenous Conscious Sedation	1 per code every Day	No	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	1 per code every 6 Months	No	
D9410	House/Extended Care Facility Call	1 per code every Day	No	
D9420	Hospital Or Ambulatory Surgical Center Call	3 per code every 7 Days	No	
D9430	Office Visit For Observation (During Regularly Scheduled Hours)	4 per code every 12 Months	No	
D9440	Office Visit - After Regularly Scheduled Hours	1 per code every Day	No	
D9610	Therapeutic Parenteral Drug, Single Administration		No	
D9944	Occlusal Guard-hard appliance, full arch	1 per code every 12 Months	No	

EPP 1, 2 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D9945	Occlusal Guard-soft appliance, full arch	1 per code every 12 Months	No	
D9946	Occlusal Guard-hard appliance, partial arch	1 per code every 12 Months	No	
D9990	Translation Services	2 per code every Day	No	
D9995	Teledentistry - Synchronous; Real-Time Encounter	1 per code every Day	No	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	1 per code every Day	No	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
Q3014	Telehealth facility fee		No	
T1015	FQHC Encounter Payment-ADA			

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0120	Periodic Oral Exam	1 per code every 6 Months	No	
D0140	Limited Oral Evaluation - Problem Focused	2 per code every 12 Months	No	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	1 per code every Lifetime	No	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	3 per code every 12 Months	No	
D0170	Re-Evaluation - Limited, Problem Focused		No	
D0180	Comprehensive periodontal evaluation	2 per code every 12 Months	No	
D0210	Intraoral - Comprehensive Series of Radiographic Images	1 per code every 36 Months	No	
D0220	Intraoral - Periapical First Radiographic Image	1 per code every Day	No	
D0230	Intraoral - Periapical Each Additional Image	5 per code every 12 Months	No	
D0240	Intraoral - Occlusal Radiographic Image	1 per code every 36 Months	No	
D0250	Extraoral - 2D Projection Radiographic image	2 per code every 7 Days	No	
D0251	Extra-Oral Posterior Dental Radiographic Image	2 per code every 7 Days	No	
D0270	Bitewing - Single Radiographic Image	3 per code every 12 Months	No	
D0272	Bitewings - Two Radiographic Images	2 per code every 12 Months	No	
D0273	Bitewings - Three Radiographic Images	2 per code every 12 Months	No	
D0274	Bitewings - Four Radiographic Images	2 per code every 12 Months	No	
D0310	Sialography	2 per code every 7 Days	No	
D0320	Temporomandibular Joint Arthrogram, Including Injection	2 per code every Lifetime	No	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	2 per code every 12 Months	No	
D0330	Panoramic Radiographic Image	1 per code every 12 Months	No	
D0340	2D Cephalometric Radiographic Image	1 per code every 36 Months	No	
D0350	Oral/Facial Photographic Images	2 per code every 6 Months	No	
D0364	Cone Beam - Less Than One Whole Jaw		Yes	Panoramic, narrative of medical necessity

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D0365	Cone Beam - One Full Dental Arch - Mandible		Yes	Panoramic, narrative of medical necessity
D0366	Cone Beam - One Full Dental Arch - Maxilla		Yes	Panoramic, narrative of medical necessity
D0367	Cone Beam - Both Jaws		Yes	Panoramic, narrative of medical necessity
D0368	Cone Beam o TMJ Series		Yes	Panoramic, narrative of medical necessity
D0470	Diagnostic Casts	1 per code every 12 Months	No	
D0474	Accession Of Tissue, Gross And Microscopic Examination		No	
D0502	Other Pathology Procedures, By Report		No	
D0999	Unspecified Diagnostic Procedures, By Report		No	
D1110	Prophylaxis - Adult	1 per code every 6 Months	No	
D1206	Topical Application Of Fluoride Varnish	1 per code every 3 Months	No	
D1208	Topical Application of Fluoride	1 per code every 6 Months	No	
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease		No	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	1 per code per quadrant every 12 Months	No	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1 per code per tooth every 12 Months	No	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1 per code per tooth every 12 Months	No	
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	1 per code every Accum Year	No	
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	1 per code every Accum Year	No	
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	1 per code per quadrant every Accum Year	No	
D1575	Distal shoe space maintainer - fixed - per quadrant	1 per code per quadrant every Accum Year	No	
D2140	Amalgam - One Surface, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 per code per tooth every 2 Accum Years	No	
D2330	Resin-Based Composite - One Surface, Anterior	1 per code per tooth every 2 Accum Years	No	
D2331	Resin-Based Composite - Two Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2332	Resin-Based Composite - Three Surfaces, Anterior	1 per code per tooth every 2 Accum Years	No	
D2335	resin-based composite – four or more surfaces (anterior)	1 per code per tooth every 2 Accum Years	No	
D2390	Resin-Based Composite Crown, Anterior	1 per code per tooth every 2 Accum Years	No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2391	Resin-Based Composite - One Surface, Posterior	1 per code per tooth every 2 Accum Years	No	
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 per code per tooth every 2 Accum Years	No	
D2710	Crown - Resin-Based Composite (Indirect)	1 per code per tooth every 5 Years	Yes	PA x-ray of tooth and Narrative of necessity
D2720	Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2721	Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2722	Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2740	Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2750	Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2752	Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Pre-op Xrays, narr, specific tests if cracked tth synd, post RCT PA (if RCT)
D2780	Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2781	Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2782	Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2790	Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2791	Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2792	Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2794	crown - titanium and titanium alloys		Yes	Pre-op x-rays, narr. of med nec., post RCT PA (if RCT tx)
D2920	Re-Cement or Re-Bond Crown	1 per code per tooth every 24 Months	No	
D2931	prefabricated stainless steel crown - permanent tooth	1 per code per tooth every 60 Months	No	
D2932	Prefabricated Resin Crown	1 per code per tooth every 24 Months	No	
D2933	Prefabricated Stainless Steel Crown With Resin Window	1 per code per tooth every 24 Months	No	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	1 per code per tooth every 24 Months	No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D2951	Pin Retention - Per Tooth, In Addition To Restoration	2 per code per tooth every 12 Months	No	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	1 per code per tooth every 5 Years	Yes	pre-op x-rays; post op x-rays of root canal
D2954	Prefabricated Post And Core In Addition To Crown	1 per code per tooth every 5 Years	Yes	pre-op x-rays; post op x-rays of root canal
D2955	Post Removal	1 per code per tooth every 5 Years	No	
D2980	Crown Repair	1 per code per tooth every 5 Years	No	
D2999	Unspecified Restorative Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D3220	Therapeutic Pulpotomy	1 per code per tooth every Lifetime	No	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	FMX or panoramic, fill x-ray with claim
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	Pre and post-op periapical images
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	1 per code per tooth every Lifetime	Yes	Pre and post-op periapical images
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3348	Retreatment Of Previous Root Canal Therapy - Molar	1 per code per tooth every Lifetime	Yes	Pre and post op periapicals and Narrative of Medical Necessity
D3351	Apexification / Recalcification - Initial Visit	1 per code per tooth every Lifetime	No	
D3352	Apexification / Recalcification - Interim	1 per code per tooth every Lifetime	No	
D3353	Apexification / Recalcification - Final Visit	1 per code per tooth every Lifetime	No	
D3410	Apicoectomy - Anterior	1 per code per tooth every Lifetime	No	
D3421	Apicoectomy - Premolar (First Root)	1 per code per tooth every Lifetime	No	
D3425	Apicoectomy - Molar (First Root)	1 per code per tooth every Lifetime	No	
D3426	Apicoectomy - Each Additional Root)	1 per code per tooth every Lifetime	No	
D3430	Retrograde Filling - Per Root	1 per code per tooth every Lifetime	No	
D3999	Unspecified Endodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Periodontal charting, bitewings and photos (optional)
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	1 per code per quadrant every 12 Months	Yes	Periodontal charting, bitewings and photos (optional)
D4249	Clinical Crown Lengthening - Hard Tissue		Yes	Periapical or BWX
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	FMX or Pan w/ bitewing x-rays

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	1 per code per quadrant every 24 Months	Yes	FMX or Pan w/ bitewing x-rays
D4910	Periodontal Maintenance	1 per code every 6 Months	Yes	perio chart, FMX or PAN w/ BWX and date of scaling and root planing
D4999	Unspecified Periodontal Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5110	Complete Denture - Maxillary	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5120	Complete Denture - Mandibular	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5211	Maxillary Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5212	Mandibular Partial Denture - Resin Base	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5213	maxillary partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5214	mandibular partial denture - cast metal framework with resin denture bases	1 per code every 96 Months	Yes	FMS or PAN(if replacement:Justification of Need for Replacement Prosthesis Form)
D5225	maxillary partial denture - flexible base (including any retentive clasping mate	1 per code every 96 Months	No	
D5226	mandibular partial denture - flexible base (including any retentive clasping mat	1 per code every 96 Months	No	
D5410	Adjust Complete Denture - Maxillary	4 per code every 12 Months	No	
D5411	Adjust Complete Denture - Mandibular	4 per code every 12 Months	No	
D5421	Adjust Partial Denture - Maxillary	4 per code every 12 Months	No	
D5422	Adjust Partial Denture - Mandibular	4 per code every 12 Months	No	
D5511	Repair Broken Complete Denture Base - Mandibular	2 per code every 12 Months	No	
D5512	Repair Broken Complete Denture Base - Maxillary	2 per code every 12 Months	No	
D5520	Replace missing or broken teeth - complete denture (each tooth) - per tooth	1 per code per tooth every 12 Months	No	
D5611	Repair Resin Partial Denture Base - Mandibular	2 per code every 12 Months	No	
D5612	Repair Resin Partial Denture Base - Maxillary	2 per code every 12 Months	No	
D5621	Repair Cast Partial Framework - Mandibular	1 per code every 12 Months	No	
D5622	Repair Cast Partial Framework - Maxillary	1 per code every 12 Months	No	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	2 per code per tooth every 12 Months	No	
D5640	Replace missing or broken teeth - partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5650	Add tooth to existing partial denture - per tooth	1 per code per tooth every 12 Months	No	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	1 per code per tooth every 12 Months	No	
D5710	Rebase Complete Maxillary Denture	1 per code every 60 Months	No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D5711	Rebase Complete Mandibular Denture	1 per code every 60 Months	No	
D5720	Rebase Maxillary Partial Denture	1 per code every 60 Months	No	
D5721	Rebase Mandibular Partial Denture	1 per code every 60 Months	No	
D5730	reline complete maxillary denture (direct)	1 per code every 12 Months	No	
D5731	reline complete mandibular denture (direct)	1 per code every 12 Months	No	
D5740	reline maxillary partial denture (direct)	1 per code every 12 Months	No	
D5741	reline mandibular partial denture (direct)	1 per code every 12 Months	No	
D5750	reline complete maxillary denture (indirect)	1 per code every 24 Months	No	
D5751	reline complete mandibular denture (indirect)	1 per code every 24 Months	No	
D5760	reline maxillary partial denture (indirect)	1 per code every 24 Months	No	
D5761	reline mandibular partial denture (indirect)	1 per code every 24 Months	No	
D5810	Interim Complete Denture (Maxillary)		No	
D5820	interim partial denture (Including retentive clasping materials and teeth) - max	1 per code every 12 Months	No	
D5821	interim partial denture (Including retentive clasping materials and teeth) - man	1 per code every 12 Months	No	
D5850	Tissue Conditioning, Maxillary	1 per code every 60 Months	No	
D5851	Tissue Conditioning, Mandibular	1 per code every 60 Months	No	
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
D5911	Facial Moulage (Sectional)	1 per code every 12 Months	No	
D5912	Facial Moulage (Complete)	1 per code every 12 Months	No	
D5913	Nasal Prosthesis	1 per code every 12 Months	No	
D5914	Auricular Prosthesis	1 per code every 12 Months	No	
D5915	Orbital Prosthesis	1 per code every 12 Months	No	
D5916	Ocular Prosthesis	1 per code every 12 Months	No	
D5919	Facial Prosthesis	6 per code every 2 Months	No	
D5922	Nasal Septal Prosthesis	1 per code every 12 Months	No	
D5923	Ocular Prosthesis, Interim	1 per code every 12 Months	No	
D5924	Cranial Prosthesis	1 per code every 12 Months	No	
D5925	Facial Augmentation Implant Prosthesis	1 per code every 12 Months	No	
D5926	Nasal Posthesis, Replacement	1 per code every 12 Months	No	
D5927	Auricular Prosthesis, Replacement	1 per code every 12 Months	No	
D5928	Orbital Prosthesis, Replacement	1 per code every 12 Months	No	
D5929	Facial Prosthesis, Replacement	1 per code every 12 Months	No	
D5931	Obturator Prosthesis, Surgical	1 per code every 12 Months	No	
D5932	Obturator Prosthesis, Definitive	1 per code every 12 Months	No	
D5933	Obturator Prosthesis, Modification	1 per code every 6 Months	No	
D5934	Mandibular Resection Prosthesis With Guide Flange	1 per code every 12 Months	No	
D5935	Mandibular Resection Prosthesis Without Guide Flange	1 per code every 12 Months	No	
D5936	Obturator Prosthesis, Interim	1 per code every 12 Months	No	

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D5937	Trismus Appliance (Not For Tmd Treatment)	1 per code every 12 Months	No	
D5951	Feeding Aid	1 per code every 12 Months	No	
D5952	Speech Aid Prosthesis, Pediatric	1 per code every 12 Months	No	
D5953	Speech Aid Prosthesis, Adult	1 per code every 12 Months	No	
D5954	Palatal Augmentation Prosthesis	1 per code every 12 Months	No	
D5955	Palatal Lift Prosthesis, Definitive	1 per code every 12 Months	No	
D5958	Palatal Lift Prosthesis, Interim	1 per code every 12 Months	No	
D5959	Palatal Lift Prosthesis, Modification	1 per code every 12 Months	No	
D5960	Speech Aid Prosthesis, Modification	1 per code every 12 Months	No	
D5982	Surgical Stent	1 per code every 12 Months	No	
D5983	Radiation Carrier	1 per code every 12 Months	No	
D5984	Radiation Shield	1 per code every 12 Months	No	
D5985	Radiation Cone Locator	1 per code every 12 Months	No	
D5986	Fluoride Gel Carrier	2 per code every 12 Months	No	
D5987	Commissure Splint	1 per code every 12 Months	No	
D5988	Surgical Splint	1 per code every 12 Months	No	
D5999	Unspecified Maxillofacial Prosthesis, By Report		Yes	Description of procedure and narrative of medical necessity
D6010	Surgical Placement Of Implant Body: Endosteal Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6013	Surgical Placement Of Mini Implant	1 per code per tooth every Lifetime	Yes	FMS or PAN, PA of site and Eval. of the Dental Implant Patient Form
D6055	Connecting Bar - Implant Supported Or Abutment Supported	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6056	Prefabricated Abutment - Includes Modification And Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6057	Custom Fabricated Abutment - Includes Placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6058	Abutment Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6065	Implant Supported Porcelain/Ceramic Crown	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6066	implant supported crown - porcelain fused to metal crown (titanium, titanium all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo

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Code	Description of service	Frequency limits	Prior auth required	Required documents
D6067	implant supported metal crown - (titanium, titanium alloy, high noble metals all	1 per code per tooth every 8 Years	Yes	Post-op Implant Periapical and Intraoral Photo
D6081	Scaling and debridement of a single implant in the presence of inflammation or m	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6090	Repair of implant/abutment supported prosthesis, by report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6091	Replacement Of Semi-Precision Or Precision Attachment	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6092	Re-Cement Or Re-Bond Implant/Abutment Supported Crown	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6093	Re-Cement Or Re-Bond Implant/Abutment Supported Fixed Partial Denture	1 per code per tooth every 24 Months	Yes	Narrative of medical necessity
D6094	abutment supported crown - (titanium) and titanium alloys	1 per code per tooth every 8 Years	Yes	Narrative of medical necessity
D6096	Remove Broken Implant Retaining Screw	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6100	Surgical removal of implant body removal, by report	1 per code per tooth every Lifetime	Yes	Narrative of medical necessity
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/Closure	1 per code per tooth every 24 Months	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6104	Bone Graft At Time Of Implant Placement	1 per code per tooth every Lifetime	Yes	Periapical, narrative of medical necessity, and intraoral photo
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	1 per code every 8 Months	Yes	Post-op Implant Periapical and Intraoral Photo
D6190	Radiographic/Surgical Implant Index, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6191	semi-precision abutment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6192	semi-precision attachment - placement	1 per code per tooth every 8 Years	Yes	Implant Periapical and FMX or pano
D6193	Replacement of an implant screw	1 per code every 12 Months	No	
D6199	Unspecified Implant Procedure, By Report	1 per code per tooth every 12 Months	Yes	Narrative of medical necessity
D6210	Pontic - Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6211	Pontic - Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6212	Pontic - Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6214	pontic - titanium and titanium alloys	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6240	Pontic - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6242	Pontic - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6243	Pontic - porcelain fused to Titanium And Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6245	Pontic - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6250	Pontic - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6251	Pontic - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6252	Pontic - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6720	Retainer Crown - Resin With High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6721	Retainer Crown - Resin With Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6722	Retainer Crown - Resin With Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6740	Retainer Crown - Porcelain/Ceramic	1 per code per tooth every 5 Years	Yes	FMX or panoramic x-rays
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6752	Retainer Crown - Porcelain Fused To Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6753	Retainer Crown - Porcelain Fused To Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6780	Retainer Crown - 3/4 Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	1 per code per tooth every 5 Years	No	
D6782	Retainer Crown - 3/4 Cast Noble Metal	1 per code per tooth every 5 Years	No	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	1 per code per tooth every 5 Years	No	
D6784	Retainer Crown - 3/4 Titanium and Titanium Alloys	1 per code per tooth every 5 Years	Yes	Full arch radiographs w/Charting of missing teeth
D6790	Retainer Crown - Full Cast High Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6791	Retainer Crown - Full Cast Predominantly Base Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6792	Retainer Crown - Full Cast Noble Metal	1 per code per tooth every 5 Years	Yes	FMX or Pan w/ bitewings and Physician letter describing medical condition
D6794	retainer crown – titanium and titanium alloys	1 per code per tooth every 5 Years	No	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	1 per code per tooth every 2 Years	No	
D6980	Fixed Partial Denture Repair	1 per code per tooth every 5 Years	Yes	Description of procedure and narrative of medical necessity
D6999	Unspecified Fixed Prosthodontic Procedure, By Report		Yes	Description of procedure and narrative of medical necessity

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7111	Extraction, Coronal Remnants - PrimaryTooth	1 per code per tooth every Lifetime	No	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 per code per tooth every Lifetime	No	
D7210	Extraction, Erupted Tooth	1 per code per tooth every Lifetime	No	
D7220	Removal Of Impacted Tooth - Soft Tissue	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7230	Removal Of Impacted Tooth - Partially Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7240	Removal Of Impacted Tooth - Completely Bony	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1 per code per tooth every Lifetime	Yes	Pre-op x-rays (excluding BWX)
D7250	Removal Of Residual Tooth (Cutting Procedure)	1 per code per tooth every Lifetime	No	
D7260	Oroantral Fistula Closure	1 per code every Lifetime	No	
D7261	Primary Closure Of Sinus Perforation	1 per code every Lifetime	No	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 per code per tooth every Lifetime	No	
D7272	Tooth Transplantation (Includes Reimplantation)	1 per code per tooth every Lifetime	No	
D7280	Exposure of an Unerupted Tooth	1 per code per tooth every Lifetime	No	
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption		No	
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	1 per code per tooth every Lifetime	No	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	1 per code every 12 Months	No	
D7286	Incisional Biopsy Of Oral Tissue - Soft	1 per code every 12 Months	No	
D7287	Exfoliative Cytological Sample Collection		No	
D7290	Surgical Repositioning Of Teeth	1 per code per tooth every Lifetime	No	
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant		No	
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant		No	
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	1 per code per quadrant every Lifetime	No	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	1 per code per quadrant every Lifetime	No	
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	2 per code per quadrant every 5 Years	No	
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	2 per code per quadrant every 5 Years	No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	
D7412	Excision Of Benign Lesion, Complicated		No	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	
D7415	Excision Of Malignant Lesion, Complicated		No	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	
D7465	Destruction Of Lesion(S) By Physical Or Chemical Method, By Report		No	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 per code per arch every Lifetime	No	
D7472	Removal Of Torus Palatinus		No	
D7473	Removal Of Torus Mandibularis		No	
D7485	Reduction Of Osseous Tuberosity	1 per code every Lifetime	No	
D7490	Radical Resection Of Maxilla Or Mandible		No	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	
D7530	Removal Of Foreign Body From Mucosa		No	
D7540	Removal Of Reaction Producing Foreign Bodies		No	
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone		No	
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		No	
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No	
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth		No	
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		No	
D7710	Maxilla - Open Reduction		No	
D7720	Maxilla - Closed Reduction		No	
D7730	Mandible - Open Reduction		No	
D7740	Mandible - Closed Reduction		No	
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No	
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No	
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No	
D7771	Alveolus - Closed Reduction Stabilization Of Teeth		No	
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No	
D7810	Open Reduction Of Dislocation		No	
D7820	Closed Reduction Of Dislocation		No	
D7830	Manipulation Under Anesthesia		No	
D7840	Condylectomy		No	
D7850	Surgical Discetomy, With/Without Implant	2 per code every Lifetime	No	
D7852	Disc Repair	2 per code every Lifetime	No	
D7854	Synovectomy	2 per code every Lifetime	No	
D7856	Myotomy	2 per code every Lifetime	No	
D7858	Joint Reconstruction	2 per code every Lifetime	No	
D7860	Arthrotomy	2 per code every Lifetime	No	
D7865	Arthroplasty	2 per code every Lifetime	No	
D7870	Arthrocentesis	1 per code every 6 Months	No	
D7872	Arthroscopy - Diagnosis, With Or Without Biopsy	2 per code every Lifetime	No	
D7873	Arthroscopy - Lavage And Lysis Of Adhesions	2 per code every Lifetime	No	
D7874	Arthroscopy - Disc Repositioning And Stabilization	2 per code every Lifetime	No	
D7875	Arthroscopy - Synovectomy	2 per code every Lifetime	No	
D7876	Arthroscopy - Discectomy	2 per code every Lifetime	No	
D7877	Arthroscopy - Debridement	2 per code every Lifetime	No	
D7880	Occlusal Orthotic Device, By Report	1 per code every 12 Months	No	
D7899	Unspecified Tmd Therapy, By Report		Yes	Description of procedure and narrative of medical necessity
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	
D7911	Complicated Suture - Up To 5 Cm		No	
D7912	Complicated Suture - Greater Than 5 Cm		No	
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		No	
D7940	Osteoplasty - For Orthognathic Deformities		No	
D7941	Osteotomy - Mandibular Rami		No	

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D7943	Osteotomy - Mandibular Rami With Bone Graft: Includes Obtaining The Graft		No	
D7944	Osteotomy - Segmented Or Subapical		No	
D7945	Osteotomy - Body Of Mandible		No	
D7946	Lefort I - (Maxilla - Total)		No	
D7947	Lefort I - (Maxilla - Segmented)		No	
D7948	Lefort Ii Or Lefort Iii (Osteoplasty Of Facial Bones) - Without Bone Graft		No	
D7949	Lefort Ii Or Lefort Iii - With Bone Graft		No	
D7950	Osseous, Osteoperiosteal, Or Cartilage Graft Of The Mandible Or Maxilla		No	
D7952	Sinus Augmentation Via A Vertical Approach		No	
D7961	buccal / labial frenectomy (frenulectomy)	3 per code per arch every Lifetime	No	
D7962	lingual frenectomy (frenulectomy)	3 per code every Lifetime	No	
D7970	Excision Of Hyperplastic Tissue - Per Arch	2 per code per arch every Lifetime	No	
D7971	Excision Of Pericoronal Gingiva	1 per code per tooth every 2 Years	No	
D7972	Surgical Reduction Of Fibrous Tuberosity	2 per code every Lifetime	No	
D7979	Non-Surgical Sialolithotomy		No	
D7980	Surgical Sialolithotomy		No	
D7981	Excision Of Salivary Gland, By Report		No	
D7982	Sialodochoplasty		No	
D7983	Closure Of Salivary Fistula		No	
D7990	Emergency Tracheotomy		No	
D7991	Coronoidectomy	1 per code every Lifetime	No	
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)		No	
D7998	Intraoral Placement Of A Fixation Device		No	
D7999	Unspecified Oral Surgery Procedure, By Report		No	
D8010	Limited Orthodontic Treatment Of The Primary Dentition	1 per code every 12 Months	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8040	Limited Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8210	Removable Appliance Therapy	2 per code every Accum Year	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8220	Fixed Appliance Therapy	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form

EPP 3, 4 benefit grid

Code	Description of service	Frequency limits	Prior auth required	Required documents
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	3 per code every Year	No	
D8670	Periodic Orthodontic Treatment Visit	24 per code every Lifetime	Yes	Approved ortho banding or approved D8999/COC code is present on the same auth
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	1 per code every Lifetime	Yes	PAN, CEPH, 5-7 Intraoral Photos and Standard NY EHB ortho form
D8695	Removal Of Fixed Orthodontic Appliances	1 per code every Lifetime	Yes	Copy of original approval, banding date, payment history
D8703	Replacement Of Lost Or Broken Rertainer - Maxillary	1 per code every Lifetime	No	
D8704	Replacement Of Lost Or Broken Rertainer - Mandibular	1 per code every Lifetime	No	
D8999	Unspecified Orthodontic Procedure, By Report		No	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	2 per code every 12 Months	No	
D9120	Fixed Partial Denture Sectioning		No	
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	1 per code every Day	No	
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	2 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	3 per code every 7 Days	Yes	Treatment plan and narrative of medical necessity
D9248	Non-Intravenous Conscious Sedation	1 per code every Day	No	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	1 per code every 6 Months	No	
D9410	House/Extended Care Facility Call	1 per code every Day	No	
D9420	Hospital Or Ambulatory Surgical Center Call	3 per code every 7 Days	No	
D9430	Office Visit For Observation (During Regularly Scheduled Hours)	4 per code every 12 Months	No	
D9440	Office Visit - After Regularly Scheduled Hours	1 per code every Day	No	
D9610	Therapeutic Parenteral Drug, Single Administration		No	
D9944	Occlusal Guard-hard appliance, full arch	1 per code every 12 Months	No	
D9945	Occlusal Guard-soft appliance, full arch	1 per code every 12 Months	No	
D9946	Occlusal Guard-hard appliance, partial arch	1 per code every 12 Months	No	
D9990	Translation Services	2 per code every Day	No	
D9995	Teledentistry - Synchronous; Real-Time Encounter	1 per code every Day	No	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	1 per code every Day	No	
D9999	Unspecified Adjunctive Procedure, By Report		Yes	Description of procedure and narrative of medical necessity
Q3014	Telehealth facility fee		No	
T1015	FQHC Encounter Payment-ADA			

Appendix C: Authorization for treatment

C.1 Dental treatment requiring authorization

To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services.

These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid within this manual.

Prior authorization means the practitioner must submit those procedures for approval with clinical documentation supporting necessity before initiating treatment. For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line.

All providers must comply with the Utilization Management program requirements. Failure to follow such requirements may result in delay or denial of payment for services rendered.

Prosthodontics

When submitting for Prosthodontics (Removable) CDT codes D5000-D5899, providers are REQUIRED to:

- submit a **Justification of Need for Replacement Prosthesis Form** with ALL prior approval requests for replacement denture(s) only if replacement occurs within 8 year frequency limit.
- complete the entirety of the **Justification of Need for Replacement Prosthesis Form** prior to submitting it to UnitedHealthcare Dental.
- Identify if initial or replacement removable prosthesis. Providers must identify if it is a second replacement within the frequency limit per the new form.

Implants

When submitting Implant Services D6000-D6199 CDT codes, providers are REQUIRED to:

- submit an **Evaluation of the Dental Implant Patient Form** with ALL prior approval requests for all dental implants.
- complete the entirety of the Evaluation of the Dental Implant Patient Form prior to submitting it to UnitedHealthcare Dental.

Samples of the **Need for Replacement Prosthesis Form** and **Evaluation of the Dental Implant Patient Form** can be found in Sections C.1.a and C.1.b of this manual. The forms can also be found on **UHCdental.com/medicaid** under State specific alerts and resources.

Orthodontia

With the exception of D8210, D8220 and D8999, Orthodontic care is reimbursable only when provided by a board certified or board eligible orthodontist or an Article 28 facility which have met the qualifications of the NY DOH and are enrolled with the appropriate specialty code.

Prior approval is required prior to rendering orthodontic treatment and active therapy begun (appliances placed and activated) prior to the member's 21st birthday.

Eligibility is limited to members who:

- are under 21 years of age
- meet financial standards for Medicaid eligibility
- exhibit a **severe physically handicapping malocclusion**

Orthodontic care for severe physically handicapping malocclusions is a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service.

The following orthodontic procedures codes require prior approval: **D8010*, D8020*, D8030, D8040, D8070, D8080, D8090, D8670*,** and **D8680**

The following documentation must be submitted along with the prior approval request:

- Pages 1 and 2 of the completed and signed "Handicapping Labio-Lingual (HLD) Index Report". The NY State HLD Index Report* is available at: **https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_NY.pdf**.
- A panoramic and/or mounted full mouth series of intra-oral radiographic images;
- A cephalometric radiographic image with teeth in centric occlusion and cephalometric analysis/tracing;
- Photographs of frontal and profile views;
- Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view;
- Maxillary and mandibular occlusal photographs;
- Photos of articulated models can be submitted optionally (Do NOT send stone casts).
- Subjective statements submitted by the provider or others

*For CHP eligible members, the UnitedHealthcare Dental HLD form is available for download from the Provider Portal/Dental Hub at **UHCdental.com/medicaid**.

*The member must have been seen and actively treated at least once during the quarter. Cannot be used for "observation". This code requires prior approval and can be billed to a maximum of twenty four (24) payments after the date of service on which orthodontic appliances have been placed and active treatment begun.

*A HLD index report is not required for procedure codes D8010 and D8020 as they are primarily intended and utilized for interceptive orthodontic treatment.

UnitedHealthcare of NY Ortho Continuation of Care (COC):

Prior to submission of CDT code D8670, if a patient was banded under another Medicaid Program within the state of New York and has switched to UnitedHealthcare Medicaid Dental MMC, HARP or EPP Plans, provider must mail COC request to:

UnitedHealthcare Appeals
P.O. Box 1267
Milwaukee, WI 53201

Mailing submission requirements:

- Copy of the original approval from prior Medicaid vendor
- Copy of EOB/remit showing paid banding (D8080)
- Payment history from prior vendor(s)

ADA Form is NOT REQUIRED per the state but is preferred.

If the member was banded under another Medicaid Program (within NY) and has now switched to UHC, they must submit COC to UnitedHealthcare Dental Appeals (PO Box 1267 Milwaukee, WI 53201) before submitting claims for D8670*.

Submission requirements:

- Copy of the original approval from prior Medicaid vendor
- Copy of EOB/remit showing paid banding (D8080)
- Payment history from prior vendor(s)
- ADA Form is NOT REQUIRED per the state but is preferred
  - Cases banded longer than 36 months will NOT be approved.
- If the member was banded under another Medicaid program or UHC (within NY) and is transferring providers, they can follow the above steps for continuation of care submission; however, they MUST submit the entire prior payment history from the original treating provider. These are processed in the member's call record if they have been processed.
- If the member was previously paying out of pocket or was commercially covered requests for continuation of care will be denied. The provider must submit all of the original records and a request to the auth department for brand new D8080. The case must be reviewed as if the treatment had never begun to determine if it would meet the state's Medicaid guidelines for D8080 approval.

C.1.a Justification of Need for Replacement Prosthesis Form

United Healthcare | Dental Benefit Providers

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Justification of Need for Replacement Prosthesis Form

NEW YORK STATE DEPARTMENT OF HEALTH - Bureau of Dental Review

Provider Name:_____ NPI:_____

Member Name:_____CIN:_____ Age:_____

ADDRESS BOTH ARCHES - COMPLETE EACH APPROPRIATE SECTION

---

1. Reason for replacement of existing maxillary appliance: ___worn/broken teeth ___loose __broken base/framework, __extraction of additional teeth ___lost ___stolen __other

2. Reason for replacement of existing mandibular appliance: ___worn/broken teeth __loose__broken base/framework, __extraction of additional teeth ___lost ___stolen __other

_____

3. If lost, provide explanation of circumstances:

_____.

4. If stolen, provide copy of police report (if available) or a statement containing a detailed explanation of circumstances of the theft. Please indicate which document you are submitting with this form below:

_____ Police Report

_____Statement of circumstances

5. Required field for Partial Dentures:

Maxillary Arch: teeth being replaced:_____, teeth being clasped:_____.

Mandibular Arch: teeth being replaced:_____, teeth being clasped:_____.

6. Has the member requested replacement dentures previously? ___Yes ___No

6a. If yes, is this request being made within eight (8) years of the member's prior request for replacement dentures? __ Yes ___No

6b. If yes, provide an explanation of the preventative measures instituted by the member/caretaker to alleviate this member's need for further replacements:

_____

_____

7. Additional comments pertaining to treatment plan:_____

_____

Provider signature:_____ Date:_____

C.1.b Evaluation of the Dental Implant Patient

United Healthcare | Dental Benefit Providers

Note: This form should accompany your prior authorization request. It should be attached to the prior authorization through the web portal. Please be sure that the personal health information (PHI) contained on this form pertains to our member and our member's information is not shared with another party or insurance carrier.

Evaluation of the Dental Implant Patient Form

NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Dental review

Dentist Name:_____ NPI:_____

Member Name:_____ CIN:_____ Age:_____

Medical History:_____

_____

_____.

Current Medications:_____

_____

_____.

Allergies to Medications:_____.

List any significant medical conditions that the member is currently being treated for: _____

_____.

Identify the physician(s) currently treating the member for any of the above-listed medical condition(s):

_____.

Detail the member's medical necessity for dental implants: _____

_____.

Detail why other covered functional alternatives for prosthetic replacement will not correct the member's dental condition:

_____

_____.

The above patient is an acceptable candidate for dental implant surgery: _____Yes _____No

_____

Dentist signature:_____ **Date:**_____

C.2 Prior Authorization Clinical Criteria for HARP, MMC, MAP, CHP, and EPP

The most recent and up to date clinical criteria for HARP, MMC, MAP, CHP and EPP can be found on the **New York State Medicaid Program Dental Policy and Procedure Code Manual**.

C.3 Member complaints and appeals

Action Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration.

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 work days from the date of our letter/notice to you to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services at **1-800-493-4647** if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing. You must sign the written action appeal that you send to us. You or your designee must sign the written action appeal.

If you need our help because of a hearing or vision impairment, or if you need translation services, or help filling out the forms we can help you.

Please send all written appeals to:

Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

Your action appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your action appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; or
- If your request was denied when you asked for home health care after you were in the hospital; or

- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal.

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- You can also provide information to be used in making the decision in person or in writing. Call UnitedHealthcare Community Plan at 1-800-493-4647 if you are not sure what information to give us.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained, or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Time frames for action appeals:

- **Standard action appeals:** If we have all the information we need, we will tell you our decision in 30 days from your action appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.
- **Fast track action appeals:** If we have all the information we need, fast track action appeal decisions will be made in 2 working days from your action appeal.
  - We will tell you in 3 working days after giving us your action appeal, if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.

We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling toll-free 1-800-493-4647 or writing. Please send written requests to:

UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can file this complaint with the health plan by calling Member Services at **1-800-493-4647** (if you have trouble hearing, call the TDD Relay Service at 711) or with the New York State Department of Health by calling **1-800-206-8125**.

If your original denial was because we said:

- The service was not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network; or
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs; or
- We do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to continue while appealing a decision about your care.

In some cases you may be able to continue the services while you wait for your action appeal to be decided.

You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your fair hearing results in another denial, you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

External appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary; or
- The service was experimental or investigational; or
- The out-of-network service was not different from a service that is available in our network; or
- The out-of-network service was available from a plan provider who has the training and experience to meet your needs.

You can ask New York State for an independent external appeal. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- You must file an action appeal with the plan and get the plan's final adverse determination; or

- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; or
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal; or
- You can prove the plan did not follow the rules correctly when processing your action appeal.

You have 4 months after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 4 months of when you made that agreement.

If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at **1-800-493-4647** if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882.
- Go to the Department of Financial Services' website at dfs.ny.gov.
- Contact the health plan at 1-800-493-4647.

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, the plan will continue to pay for your stay if:

- You ask for a fast track Internal Appeal within 24 hours, AND
- You ask for a fast track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Internal Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Fair hearings

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving UnitedHealthcare Community Plan.
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy about a decision we made to deny payment for care you received. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with UnitedHealthcare Community Plan. If UnitedHealthcare Community Plan agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are going to be reduced, stopped, or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. You must ask for a fair hearing within 10 days from the date of the notice that says your care will change or by the time the action takes effect. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can use one of the following ways to request a Fair Hearing:

1. By phone: toll-free 1-800-342-3334
2. By fax: 518-473-6735
3. Online: www.otda.state.ny.us/oah/forms.asp
4. By mail: NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings, Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023

When you ask for a fair hearing about a decision UnitedHealthcare Community Plan made, we must send you a copy of the evidence packet. This is information we used to make our decision about your care. The

plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-493-4647 to ask for it.

The health plan is required to protect minor confidentiality (age 0 – 17) and therefore, will not be sending notices to members of claim payment denials.

Starting July 1, 2016, the Health Plan must further ensure the risk for accidental release of confidential health information is reduced for all minor members (0 – 17 years of age). To do so, the Health Plan will not be sending notices to members about claim payment denials including dental and behavioral health claims.

If you receive a bill for health care services, you may contact Member Services at 1-800-493-4647, TTY 711 for assistance and confirm your right to a State fair hearing if you disagree with the determination to deny payment for a health care service. UnitedHealthcare Community Plan will continue to ensure prompt response to your or your designee's request to see your case file (a case file contains information related to a specific service request and information reviewed by UnitedHealthcare Community Plan in the process of reaching a coverage determination). UnitedHealthcare Community Plan will adhere to confidentiality requirements and, where required by law or regulation, obtain appropriate authorization prior to release of protected health information that may be included in your case file.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint process

Complaints.

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

NYS Department of Health Division of Managed Care
Bureau of Consumer Services
ESP Corning Tower, Room 2019
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to file a complaint with our plan.

To file by phone, call Member Services toll-free at 1-800-493-4647, Monday – Friday 8:00 a.m. to 6:00 p.m. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

What happens next.

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint.
- How to contact this person.
- If we need more information.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

After we review your complaint.

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.

When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint, but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.

- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

Complaint appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a complaint appeal with the plan.

How to make a complaint appeal.

- If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our

summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us. Please send all written correspondence to:

Member Complaints, Grievances and Appeals
UnitedHealthcare Community Plan of New York
P.O. Box 31364
Salt Lake City, UT 84131-0364

What happens after we get your complaint appeal.

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact someone at UnitedHealthcare about your complaint appeal.
- If we need more information.

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need, you will know our decision in 30 work days. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

C.4 Provider disputes:

An In Network Provider Contractual dispute is a dispute regarding the rate or amount paid on a claim. Members are not financially responsible or impacted by the outcome of a dispute. If there is any member liability outside of normal cost share, please refer to section 4.3 Member Appeals.

A reprocessing or adjustment request is a request to reprocess a claim. Examples include submitting a corrected billing, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status. Reprocessing requests and Contractual disputes may be initiated verbally or in writing to the number and address below:

1-800-304-0634

NY Adjustment Unit
P O Box 1267
Milwaukee, WI 53201

Corrected claims should be submitted to:

PO Box 541
Milwaukee, WI 53201

When a claim is reprocessed as a result of a reprocessing or adjustment request or dispute, providers will receive a new remittance advice within 30 days of receipt of the reprocessing/adjustment request or dispute. If the reprocessing or adjustment request or dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 days of receipt of the reprocessing or adjustment request or dispute.

C.5 Credentialing and recredentialing appeals

You may request an appeal in writing to Dental Benefit Providers' Peer Review Committee for reconsideration within 7 calendar days from the date of the letter. Dental Benefit Providers will not accept provider appeals after the 30-calendar day period. Your appeal should include any supporting information that will help the Peer Review Committee consider your request. We will send you an acknowledgement letter within 30 days of receipt. If no appeal request is received by the filing deadline, the Credentialing Committee's action is final.

Appendix D: Member rights and responsibilities

For the most updated information regarding Member Rights and Responsibilities, please review the Member Handbook.

D.1 Member rights

Members of UnitedHealthcare Community Plan of New York have a right to:

- Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination.
- A reasonable opportunity to choose a PCP and to change to another provider in a reasonable manner.
- Consent for or refusal of treatment and active participation in decision choices.
- Ask questions and receive complete information relating to your medical condition and treatment options, including specialty care.
- Voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a State Fair Hearing from UnitedHealthcare Community Plan of New York and/or the Department.
- Timely access to care that does not have any communication or physical access barriers.
- Prepare Advance Medical Directives.
- Assistance with requesting and receiving a copy of your medical records.
- Timely referral and access to medically indicated specialty care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be furnished health care services in accordance with federal and state regulations.

D.2 Member responsibilities

Members of UnitedHealthcare Community Plan of New York agree to:

- Work with their PCP to protect and improve their health.
- Find out how their health plan coverage works.
- Listen to their PCP's advice and ask questions when in doubt.
- Call or go back to their PCP if they do not get better or ask to see another provider.
- Treat health care staff with the respect they expect themselves.
- Tell us if they have problems with any health care staff by calling Member Services at 1-800-493-4647
- Keep their appointments, calling as soon as they can if they must cancel.
- Use the emergency department only for real emergencies.
- Call their PCP when you need medical care, even if it is after-hours.

Dental Benefit Providers®

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

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