CHAPTER 505–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL, ORTHODONTIC, AND ORAL HEALTH SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Added Fluoride Varnish Policy	Appendix C	January 16, 2012	January 16, 2012
Corrected verbiage in Appendix A Special Instructions	Appendix A	May 25, 2011	November 1, 2010
Added verbiage to Retrospective Review	505.8 Prior Authorization	May 25, 2011	November 1, 2010
Added verbiage for Orthodontics	505.4 Covered Services	May 25, 2011	November 1, 2010
Entire Chapter	Entire Chapter	September 1, 2010	November 1, 2010

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CHAPTER 505– COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR DENTAL, ORTHODONTIC, AND ORAL HEALTH SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in this chapter must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical, dental, and mental services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

General dentists and specialty dentists may provide a variety of covered dental services in accordance with his/her licensure and in accordance with the West Virginia State Code Chapter 30, Article 4 and 4A. Coverage decisions are based upon the member's age, medical necessity, and the member's need and may be provided in a practitioner's office, ambulatory surgical center, and outpatient or inpatient hospital. If a Current Dental Terminology (CDT) code requires prior authorization, the service requires prior authorization regardless of place of service. All inpatient hospitalizations require prior authorization (PA) by BMS' Utilization Management Contractor (UMC). Inpatient hospitalization shall not be reimbursed when the service could be provided in an outpatient setting. Requests for prior authorization do not guarantee approval or payment.

Medical doctors who possess a medical or osteopathic license in addition to a dental license will be assigned both a medical and dental provider number for billing services. Current Procedural Terminology (CPT) codes must be billed on a CMS 1500 claim or an 837P electronic claim format with the medical provider number. Current Dental Terminology (CDT) codes must be billed on an ADA claim or an 837D electronic format with the dental provider number. If both CPT and CDT codes exist for the services, CPT codes must be utilized for the service.

Enrolled children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Covered dental services for enrolled adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Refer to Appendix C for Infant and Child Oral Health Fluoride Varnish Policy.

The fact that a practitioner prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is

eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are provided.

This chapter describes West Virginia Medicaid's coverage policies for general dentistry, orthodontia, and oral surgery.

505.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Definitions and Acronyms.* In addition, the following definitions for general dentistry, specialty dentistry and other oral health services as described in this chapter, include but are not limited to the following:

Abscess – An acute or chronic localized inflammation, probably with a collection of pus, associated with tissue destruction and frequently, swelling; usually secondary to infection.

Benefit Package or Plan – The group of services which make up a plan or set of benefits covered by Medicaid.

Bicuspid – A premolar tooth; a tooth with two cusps.

Bitewing radiograph – An interproximal radiographic view of the coronal portion of the tooth/teeth.

Complete series – An entire set of intra-oral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.

Comprehensive Orthodontic Treatment – A phrase indicating multiple phases of treatment provided at different stages of dentofacial development.

Crown –

- An abutment (artificial crown serving for the retention or support of a dental prosthesis);
- Anatomical (that portion of tooth normally covered by, and including, enamel);
- Artificial (restoration covering or replacing the major part, or the whole of the clinical crown of a tooth); and,
- Clinical (that portion of a tooth not covered by tissues).

Current Dental Terminology (CDT) – A listing of procedure codes and descriptive terms published by the American Dental Association (ADA) for reporting dental services and procedures.

Current Procedural Terminology (CPT) – A listing of descriptive terms and identifying codes developed by the American Medical Association (AMA) for reporting practitioner services and procedures to medical plans and Medicare.

Cuspid – A single cusped tooth located between the incisors and bicuspids.

Dentition – The teeth in the dental arch:

- Adolescent (refers to the stage of permanent dentition prior to cessation of growth)
- Deciduous (refers to the deciduous or primary teeth in the dental arch)
- Permanent (adult, refers to the permanent teeth in the dental arch)
- Transitional (refers to a mixed dentition; begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous teeth).

Dental Assistant – An individual qualified by education, training, and experience who aids or assists a dentist in the delivery of patient care in accordance with delegated procedures or who may perform intra-oral tasks in the dental office. No occupational title other than dental assistant shall be used to describe this individual.

Dental Auxiliary Personnel – Dental hygienists and dental assistants who assist the dentist in the provision of oral health care services to patients.

Dental Hygienist – A person licensed by the West Virginia Board of Dental Examiners who provides preventive oral health care services to patients in the dental office and in a public health setting. No occupational title other than dental hygienist may be used to describe this individual. State dental regulations determine the dental hygienist duties.

Dentures – An artificial substitute for some or all of the natural teeth and adjacent tissues.

- Complete – a prosthetic for the edentulous maxillary or mandibular arch, replacing the full dentition.
- Fixed partial – a prosthetic replacement of one or more missing teeth cemented or otherwise attached to the abutment teeth.
- Removable partial – a removable prosthetic device that replaces missing teeth.

Direct Supervision – Supervision of dental auxiliary personnel provided by a licensed dentist who is physically present in the dental office or treatment facility when procedures are being performed.

Emergent Oral Health Procedures – Covered services provided as quickly as the situation warrants necessary to relieve pain, eliminate infection, or reduce fractures.

Endodontist – A dental specialist who limits his/her practice to treating disease and injuries of the pulp and associated periradicular conditions.

Extraction – The process or act of removing a tooth or tooth parts.

Fracture – The breaking of a part, especially of a bony structure; breaking of a tooth.

General Dentist – A dentist who is not considered a specialist and can perform examinations, evaluations, diagnosing of diseases, disorder and conditions of the oral cavity, maxillofacial area and adjacent and associated structures. They can treat diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures, fabricate, repair

and alter dental prosthesis, administer anesthesia in accordance with West Virginia Code Chapter 30, Article 4a, and prescribing drugs necessary for dentistry.

General Supervision – A dentist is not required to be in the office or treatment facility when procedures are being performed by the auxiliary dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures and will evaluate the treatment provided by the dental auxiliary personnel.

Impacted tooth – An unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

Malocclusion – improper alignment of biting or chewing surfaces of upper and lower teeth.

- **Class I malocclusion** – The relationship of the first molars is normal and the upper and lower jaws are in a normal relationship to each other, but the other teeth are crowded, irregularly spaced, or overlapped.
- **Class II malocclusion** – The lower first molar is distally positioned relative to the upper first molar.
- **Class III malocclusion** – The lower molar mesially positioned relative to the upper molar.

Molar – Teeth posterior to the premolars (bicuspids) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

Mountain Health Trust – The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

Occlusion – Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

Oral and Maxillofacial Surgeon – A dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

Orthodontist – A dental specialist whose practice is limited to the interception and treatment of malocclusion and other neuromuscular and skeletal abnormalities of the teeth and their surrounding structures.

Orthognathic – The functional relationship of maxilla and mandible.

Pediatric Dentist (Pedodontist—old terminology) – A dental specialist whose practice is limited to treatment of children from birth through adolescence (including those with special health care needs, at any age), providing primary and comprehensive preventive and therapeutic oral healthcare.

Periapical – The area surrounding the end of the tooth root.

Peridontist – A dental specialist whose practice is limited to the treatment of diseases of the supporting and surrounding tissues of the teeth.

Preventive dentistry – The aspects of dentistry concerned with promoting good dental and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Primary – A current term used to describe the older verbiage of deciduous or baby teeth.

Primary Care Provider (PCP) – A practitioner associated with the medical home that is the primary contact for provision and coordination of a member's health care services or needs.

Primary Dentition- The teeth that erupt first and are usually replaced by the permanent teeth (baby teeth).

Prosthodontist – A dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

Quadrant – One of the four equal sections into which the dental arches can be divided, begins at the midline of the arch and extends distally to the last tooth.

Radiograph – An image or picture produced on a radiation sensitive film emulsion or digital sensor by exposure to ionizing radiation.

Root canal – The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

Sealant – A resinous material designed to be applied to the occlusal surfaces of posterior teeth to prevent occlusal caries.

Space maintainer – A passive appliance, usually cemented in place that holds teeth in position.

Specialty – The practice of a certain branch of dentistry.

Supernumerary teeth – extra erupted or unerupted teeth that resemble teeth of normal shape.

Symptomatic impacted tooth – Pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Transitional Dentition- Begins with the appearance of the permanent first molars and ends with the exfoliation of the deciduous (baby) teeth.

505.2 PRACTITIONER PARTICIPATION

West Virginia Medicaid recognizes Doctor of Dental Surgery (DDS) and Doctor of Dental Medicine (DDM) as eligible practitioners to provide general dental, orthodontic and oral and maxillofacial surgery services to enrolled Medicaid members. To be eligible for participation and reimbursement of services provided to Medicaid members, all providers shall:

- Meet all applicable licensing, accreditation and certification requirements;
- Have a valid signed provider enrollment application/agreement on file; and,
- Meet and maintain all BMS provider enrollment requirements.

Refer to *Common Chapter 300, Provider Participation Requirement* for additional information.

505.3 DENTAL HYGIENIST/DENTAL ASSISTANT

Licensed practitioners may assign intra-oral tasks to employed dental hygienists or dental assistants. Refer to West Virginia State Code *§30-4-17 and §30-4-18* for dental hygienists and dental assistants scope of practice. Dental hygienists and dental assistants are not eligible to enroll individually as a Medicaid provider or receive direct reimbursement for services rendered. Services are to be billed over the dentist's NPI.

505.4 COVERED SERVICES

West Virginia Medicaid reimburses for general dentistry, orthodontics, oral and maxillofacial surgery services. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, prosthodontics, maxillofacial prosthetics, oral and maxillofacial services, and orthodontics. When covered services are required and initiated before the member's 21st birthday, the service shall be completed within the timeframe established by the treatment plan. Prior authorization may apply.

Covered dental services for adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. Prior authorization and service limits may apply.

Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. (See Prior Authorization Form located at www.wvmi.org for orthodontia criteria). BMS reimburses one treatment of comprehensive orthodontia (CDT Codes D8070, D8080 and D8090) per lifetime per member. If any of the comprehensive orthodontia codes are billed then none of the remaining can be billed; they are a one per lifetime limit for any of the three and are not looked at as per code lifetime limit.

Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request.

Current Dental Terminology Procedure Codes for covered dental services for children up to 21 years of age and adults 21 years of age and older is available in *Appendices A and B*.

505.5 LIMITATIONS OF COVERAGE—ADULTS

Dental services for adults, 21 years of age and older, are limited to Emergent services necessary to treat fractures, reduce pain, or eliminate infection. An Oral evaluation for limited

fractures, pain or infection is covered. Prior authorization and service limits may apply. Refer to *Appendix B*.

505.6 ANESTHESIA

Anesthesia in the form of general anesthesia, conscious sedation, and anxiolysis is covered when basic behavior guidance techniques have not been successful or for members who cannot cooperate due to lack of psychological or emotional maturity and/or mental, physical or medical disability. In addition it may be required for members where the use of sedation may protect the developing psyche and/or reduce medical risk.

No dentist may induce central nervous system anesthesia without first having obtained an anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners or from the State Board of Dental Examiners in the state in which they practice for the level of anesthesia being induced.

Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately.

505.7 NON-COVERED SERVICES

Dental services not covered by West Virginia Medicaid include, but are not limited to, the following. Non-covered services are not eligible for a DHHR fair hearing or a desk/document review.

- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Dental services for which PA has been denied or not obtained
- Dental services for the convenience of the member, the member's caretaker, or the provider of service
- Procedures for cosmetic purposes
- Temporomandibular Joint (TMJ) for adults
- Anesthesia services when solely for the convenience of the member, the member's caretaker or the provider of service
- Local anesthesia and oral sedation are considered part of the treatment procedures and may not be billed separately
- Dental services for residents of Intermediate Care and Nursing Facilities i.e., Nursing Home, ICF/MR, and PRTF
- Dental services for participants enrolled in the Division of Rehabilitation Services or when services are covered under a Workers Compensation plan
- Dental services provided by providers not enrolled with West Virginia Medicaid
- Use of an unlisted code when a national CDT code is available
- Unbundled CDT codes

505.8 PRIOR AUTHORIZATION

Effective with this manual, medical necessity review criteria may be based on adaptations of dental standards developed by the Periodicity and Anticipatory Guidance Recommendations by the American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Dental Association (ADA), and research-based, nationally accredited medical appropriateness criteria, such as InterQual, OR other appropriate criteria approved by BMS. Prior authorization request forms are available at the BMS' Utilization Management Contractor (UMC) website www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx Prior authorization does not guarantee approval or payment.

The UMC reviews all requests for services requiring prior authorization. It is the responsibility of the treating/prescribing practitioner to submit the appropriate Prior Authorization Request Form with medical documentation to the UMC. The treating practitioner is responsible to assure the assigned prior authorization number is documented on the appropriate claim form when submitting the claim for payment consideration. Refer to *Common Chapter 800*, *General Administration*, for additional information.

When a request for service is denied based on medical necessity, the denial is communicated with the reason(s) of denial to the provider of service and the member or their legal guardian by the UMC. Information related to the member's right to a fair hearing and the provider's right to a reconsideration of the denial is included in the communication.

The use of an unlisted code is prohibited when an appropriate code is available. Therefore, unlisted codes for procedures/services require prior authorization by the UMC. The practitioner shall provide medical documentation and the reason(s) why an unlisted code shall be utilized for the specific procedure/service requested. The aforementioned prior authorization process shall be followed. When an assigned code is identified, the request for the unlisted code shall be denied.
Refer to *Appendices A* and *B* for specific procedure codes requiring prior authorization and service limits for covered services.

Retrospective authorization is available in the following circumstances:

- A procedure/service denied by the member's primary payer providing all requirements for the primary payer have been followed, including appeal processes; or
- Retroactive Medicaid eligibility; or
- Retrospective review is available for Medicaid members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary and per recommended dental practices delaying the procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted. In these instances, a request for prior authorization must be made by the provider within 10 business days of the date the service is performed. If the procedure(s) does not meet medical necessity criteria upon review by the Utilization Management Contractor (UMC) the prior authorization request will be denied and the provider will not be reimbursed for the service by Medicaid or the member. Prior authorization is also available for medical necessity review before the service is provided.

- A request for retrospective authorization is submitted the next business day following an Emergent procedure/service occurring on weekends, holidays, or at times when the UMC is unavailable.

A request for consideration of retrospective authorization does not guarantee approval or payment.

505.9 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in *Common Chapter 300, Provider Participation Requirements, Section 320.5, Document and Retain Records*, practitioners submitting claims for Medicaid reimbursement shall maintain complete, individual, accurate, and legible medical records. Records shall include documentation of medical necessity procedures/services provided and must be available to BMS or its designee upon request. When documentation is not available, BMS will request repayment.

Documentation requirements include, but are not limited to:

- A referral for treatment
- The primary diagnosis and appropriate CDT code for service to be provided
- A treatment plan (Orthodontics)
- Radiographs
- Photos, when appropriate
- Dental molds, when appropriate
- Documentation to justify medical necessity
- Copy of Prior Authorization Request Form, when applicable
- Copy of ADA claim form submitted for payment consideration, when appropriate.

Supporting documentation for prior authorization review cannot be older than 6 months.

505.10 EARLY PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members less than 21 years of age. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services. Based on medical necessity, prior authorization is required when service limits are exceeded.

Dental screenings are covered to any child under the age of 21 years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Refer to www.aap.org for the American Academy of Pediatrics Dental (AAPD) periodicity schedule.

505.11 RESIDENTIAL FACILITIES

A. Nursing Facility

Dental services are not eligible for reimbursement as a direct billing to Medicaid if the Medicaid member is a resident of the nursing facility at the time the dental service is provided.

B. Intermediate Care Facility for Mental Retardation (ICF/MR)

Any service required by the member is reimbursed as an all inclusive rate. However, if the ICF/MR does not provide the required service on-site, such as dental, a mutual dental agreement between the ICF/MR and an outside source shall be developed and implemented. Services provided by outside sources are included in the ICF/MR rate and shall not be billed separately.

C. Psychiatric Residential Treatment Facility (PRTF)

Any service required by the member is reimbursed an all inclusive rate. However, if the PRTF does not provide the required service on-site, such as dental, a mutual dental agreement between the PRTF and an outside source shall be developed and implemented. Services provided by outside sources are included in the PRTF rate and shall not be billed separately.

505.12 TOBACCO CESSATION

West Virginia Medicaid in partnership with the Bureau for Public Health (BPH) operates a tobacco cessation program to assist members to discontinue use of tobacco products. In order for members to have access to drugs and other tobacco cessation services, they are required to see their primary care provider and enroll in the program. Participants are screened for their readiness to quit the use of tobacco. Written materials and phone coaching are also available through the program. All tobacco cessation products must be prescribed by a licensed practitioner within the scope of his/her license under West Virginia law. Prior authorization is required for coverage of tobacco cessation medications and is coordinated through the tobacco quit line.

Members are limited to one 12-week treatment period per calendar year. Pregnant females are eligible for additional course(s) of treatment, when appropriate. Refer to *Chapter 518, Pharmacy Services,* for covered tobacco cessation drug products.

Additional information regarding the tobacco cessation program can be accessed through www.wvdtp.com or www.wvquitline.com. The Bureau for Public Health may also assist in providing services for those who are uninsured or under-insured.

505.13 BILLING and REIMBURSEMENT

505.13.1 Billing

West Virginia Medicaid utilizes Current Dental Terminology (CDT) procedure codes for billing of dental services provided to Medicaid members. Only enrolled providers shall be eligible for reimbursement of services provided. Billing prior to providing services is prohibited. Providers shall not directly bill a Medicaid member for any service without first informing the member that the service is not covered by Medicaid AND a written signed agreement by the member signifying that he/she accepts responsibility for payment.

Medical doctors who possess a medical or osteopathic license in addition to a dental licensed will be assigned both a medical and dental provider number for billing services. Current Procedural Terminology (CPT) codes must be billed on a CMS 1500 claim or an 837P electronic claim format with the medical provider number. Current Dental Terminology (CDT) codes must be billed on an ADA claim or an 837D electronic format with the dental provider number. If both CPT and CDT codes exist for the services, CPT codes must be utilized for the service. Refer to Appendix C for Infant and Child Oral Health Fluoride Varnish Policy.

At the initiation of the approved orthodontic treatment plan, BMS reimburses a one-time total payment to the orthodontist. In the event the initial orthodontist is unable to complete the approved treatment plan, he/she must refund the monies for uncompleted portions of the treatment plan through the reversal/replacement process. Through this process, reimbursement is available to the orthodontist who ultimately completes the treatment plan.

BMS does not require a prior authorization for most services when the member has a primary insurance and that insurance approved and reimbursed for the service. Orthodontic services shall require a Medicaid prior authorization from the UMC regardless of primary insurance.

In instances where procedure/service codes are bundled, unbundling of individual codes is prohibited.

The ADA claim form or electronic form 837D is required for billing general dentistry and specialty dental services.

Refer to *Common Chapter 600, Reimbursement Methodology*, for additional information

505.13.2 Reimbursement Methodology

Medicaid is the payer of last resort. Third-Party Liability, (TPL) is a method of ensuring that BMS is the last payer to reimburse for covered services. Refer to *Common Chapter 600, Reimbursement Methodology,* for additional information.

Reimbursement for general and specialty dental services is based on:

- American Dental Association Survey of Dental Fees for Southern Atlantic Regional Norms

- American Society of Anesthesiology guidelines
- Lesser of the established fees or the provider's usual customary charge to the general public
- Unaltered cost invoice.

Refer to *Common Chapter 600, Reimbursement Methodologies,* for additional information.

505.14 MANAGED CARE

If the Medicaid member is enrolled in a Managed Care Organization (MCO), the MCO is responsible for covered emergent dental services to treat fractures, reduce pain, or eliminate infection for adults 21 years of age and older. These dental services are covered under Mountain Health Trust and reimbursed by the MCO.

505.15 PAAS PROGRAM

If a Medicaid member is enrolled in the PAAS Program, no referral by the PAAS provider is necessary for the member to receive dental services; however, all applicable prior authorization requirements remain and age restrictions apply. Based on medical necessity, prior authorization is required when service limits are exceeded.

505.16 MOUNTAIN HEALTH CHOICES

Mountain Health Choices program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit package and primary care provider (PCP), encourages personal responsibility, and provides care coordination for its members through the member's medical home.

Providers can view the member's benefit plan designation on the member's Medicaid card, call the provider eligibility telephone line or utilize the Medicaid Management Information System (MMIS) vendor web portal to determine member eligibility and benefit package. The following will be noted on the member's card to identify the benefit plan in which the member is enrolled:

- "TR" Traditional Medicaid Benefit Package
- "BA" Basic Adult Benefit Package
- "EA" Enhanced Adult Benefit Package
- "BC Basic Child Benefit Package
- "EC" Enhanced Child Benefit Package.

See *Chapter 527, Mountain Health Choices*, for information on the Basic and Enhanced Benefit Packages.

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
CHILDREN UP TO AGE 21 YEARS

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
DIAGNOSTIC			
CLINICAL ORAL EVALUATION			
D0120	Periodic oral examination - established patient	2 per calendar year	Not billable with D0140, D0145, D0150 or D9310
D0140	Limited oral evaluation - problem focused	Emergent	Not billable with D0120, D0145, D0150 or D9310
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	1 per 6 months	Age restriction up to 36 months. Not billable with D0120, D0140, D0150 or D9310
D0150	Comprehensive oral evaluation - new or established patient	1 per calendar year	Not billable with D0120, D0140, D0145, D9310
RADIOGRAPH/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)			
D0210	Intraoral-complete series (including bitewings)	1 per 2 years	Not billable with D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274
D0220	Intraoral-periapical, first film	1 per day	Not billable with D0210 and D0240
D0230	Intraoral-periapical, each additional film	8 per 3 months	Not billable with D0210 and D0240. Must be billed with D0220
D0240	Intraoral- occlusal film	2 per calendar year	Not billable with D0210 and D0220, D0230
D0250	Extraoral- first film	1 per 3 years	
D0260	Extraoral- each additional film	3 per 3 years	Must be billed with D0250
D0270	Bitewing-single film	4 per calendar year	Not billable with D0210, D0272, D0273, D0274
D0272	Bitewings -two films	1 per calendar year	Not billable with D0210, D0273, D0274
D0273	Bitewings – three films	1 per calendar year	Not billable with D0210, D0272, D0274
D0274	Bitewings- four films	1 per calendar year	Not billable with D0210, D0272, D0273
D0290	Posterior - anterior or lateral skull and facial bone survey films	2 per calendar year	

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D0310	Sialography		
D0320	Temporomandibular joint arthrogram, including injection		
D0321	Other temporomandibular joint films, by report		Requires PA with documentation to identify type of radiograph requested.
D0322	Tomographic survey		
D0330	Panoramic film	1 per 3 years	
D0340	Cephalometric film	1 per calendar year	
D0350	Oral/facial photographic images		This code excludes conventional radiographs - For orthodontics only.
TESTS AND EXAMINATIONS			
D0470	Diagnostic casts	2 per calendar year	
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.		
ORAL PATHOLOGY LABORATORY			
GENERALLY PERFORMED IN A PATHOLOGY LABORATORY AND DOES NOT INCLUDE THE REMOVAL OF THE TISSUE SAMPLE FROM THE PATIENT.			
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report		To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.
PREVENTIVE			
DENTAL PROPHYLAXIS			

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D1110	Prophylaxis-adult	1 per 6 months	13 to 21 years of age; Not reimbursable with D1120
D1120	Prophylaxis-child	1 per 6 months	up to 13 years of age; Not reimbursable with D1110
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)			
D1203	Topical application of fluoride - child	2 per calendar year	3 to 13 years of age; Not reimbursable with D1204 or D1206
D1204	Topical application of fluoride-adult	2 per calendar year	13 to 21 years of age; Not reimbursable with D1203 or D1206
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries	2 per calendar year	Not reimbursable with D1203 or D1204. Age restriction of 6 months to 3 years.
OTHER PREVENTIVE SERVICES			
D1320	Tobacco counseling for the control and prevention of oral disease	2 per calendar year	12 to 21 years of age
D1351	Sealant	1 sealant per tooth per 3 years	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration Requires dental areas configuration.
SPACE MAINTENANCE (PASSIVE APPLIANCES)			
D1510	Space maintainer-fixed-unilateral	4 per calendar year	Per quadrant –UR, UL, LL, LR must be included on claim form for payment consideration.
D1515	Space maintainer-fixed-bilateral	2 per calendar year	Upper arch or lower arch must be included on claim form for payment consideration.
D1520	Space maintainer-removable- unilateral	4 per calendar year	See D1510
D1525	Space maintainer-removable- bilateral	2 per calendar year	See D1515
D1550	Recementation of space maintainer	1 per calendar year	
RESTORATIVE			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
AMALGAM RESTORATIONS (INCLUDING POLISHING)			
D2140	Amalgam- one surface, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, & local anesthesia are included the fee & may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2150	Amalgam- two surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2160	Amalgam-three surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2161	Amalgam-four or more surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
RESIN-BASED COMPOSITE RESTORATIONS – DIRECT			
D2330	Resin-based composite-one surface, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2331	Resin-based composite- two surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D2332	Resin-based composite-three surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2390	Resin-based composite crown, anterior	1 tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2391	Resin-based composite, one surface posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2392	Resin-based composite, two surfaces posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2393	Resin-based composite, three surfaces posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
			Radiographs with documentation must be documented in the medical record for date of service
D2394	Resin-based composite, four or more surfaces	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service
CROWNS - SINGLE RESTORATIONS ONLY			
D2751	Crown- porcelain fused to predominately base metal	1 tooth number per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S & T. Tooth numbers must also be documented on the claim form for payment consideration.
D2791	Crown- full cast predominately base metal	1 tooth number per 5 years	Requires PA with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S, & T. Tooth numbers must also be documented on the claim form for payment consideration.
OTHER RESTORATIVE SERVICES			
D2920	Recement crown	1 per tooth number per 1 calendar year	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration.
D2930	Prefabricated stainless steel crown-primary tooth	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2931	Prefabricated stainless steel crown-permanent tooth	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth number 1-32 must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2932	Prefabricated resin crown	1 per tooth number per 1 calendar year	Requires PA with radiographs. Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.
D2933	Prefabricated stainless steel crown with resin window		Requires PA with radiographs. Tooth numbers1-32 must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D2940	Protective restoration	2 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy or on the same date of services as a restoration.
D2950	Core buildup, including any pins	1 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.
D2951	Pin retention- per tooth, in addition to restoration	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2952	Cast and core in addition to crown (indirectly fabricated)	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2954	Prefabricated post & core in addition to crown	1 per 3 years per tooth number	Tooth numbers 1-32 or A-T must be documented on claim form for payment consideration.
ENDODONTICS - INCLUDES LOCAL ANESTHESIA			
PULPOTOMY			
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 per 3 years per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not reimbursable with D3310, D3320, or D3330. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis.
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3320, or D3330
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 or C, H, Q, N must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3330. To be performed on primary or permanent teeth.
D3330	Endodontic therapy, molar (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, 30-32 and primary teeth # A,B,I,J,K,L,S, and T, if no permanent successor present, must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3320
ENDODONTIC RETREATMENT			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D3346	Retreatment of previous root canal therapy-anterior	1 tooth number per lifetime	Tooth numbers 6-11 and 22-27, must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
D3347	Retreatment of previous root canal therapy-bicuspid	1 tooth number per lifetime	Tooth numbers 4,5,12,13,20,21,28, and 29 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
D3348	Retreatment of previous root canal therapy-molar	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, and 30-32 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post operative treatments and may not be billed separately.
APEXIFICATION/RECALCIFICTION PROCEDURES			
D3351	Apexification/recalcification/ pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)		Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
D3352	Apexification/recalcification/ pulpal regeneration-interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	3 treatment per tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcify repair of perforations, root resorption, etc.)	1 tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.
APICOECTOMY/PERIRADICULAR SERVICES			
D3410	Apicoectomy/periradicular surgery-anterior	1 tooth number per lifetime	Requires PA with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration.

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D3421	Apicoectomy/periradicular surgery-bicuspid (first root)	1 tooth number per lifetime	Requires PA with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 must be documented on the claim form for payment consideration.
D3999	Unspecified endodontic procedure, by report		This code should be used only if a more specific CDT code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
PERIODONTICS			
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)			
D4210	Gingivectomy or Gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant(s) and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4211.
D4211	Gingivectomy or Gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210.
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210. Must be billed with the number codes.
D4261	Osseous surgery (including flap entry and closure) one to three contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires PA with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4210.
NON-SURGICAL PERIODONTAL SERVICE			
D4341	Periodontal scaling and root planing- four/more teeth per quadrant	1 quadrant per 1 calendar year	Requires PA. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4342.
D4342	Periodontal scaling and root planing- one - three teeth, per quadrant	1 quadrant per 1 calendar year	Requires PA. Quadrants are defined as UR, UL, LL, LR. Not reimbursed with D4341.
D4355	Full mouth debridement to enable comprehensive	1 per 6 months	Requires PA. Only covered when there is substantial gingival inflammation (gingivitis in all 4 quadrants).

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	evaluation and diagnosis		
OTHER PERIODONTAL SERVICES			
D4999	Unspecified periodontal procedure, by report		This code should be used only if a more specific CDT code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
PROSTHODONTICS (REMOVABLE)			
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
D5110	Complete denture- maxillary	1 per 5 years	Requires PA
D5120	Complete denture- mandibular	1 per 5 years	Requires PA
D5130	Immediate denture – maxillary	1 per 5 years	Requires PA
D5140	Immediate denture – mandibular	1 per 5 years	Requires PA
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 per 5 years	Requires PA Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
ADJUSTMENTS TO DENTURES			
D5410	Adjust complete denture-maxillary	3 per calendar year	Adjustments not covered within 3 months of placement
D5411	Adjust complete denture-mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
D5421	Adjust partial denture –	3 per calendar year	Adjustments not covered within 3 months of placement

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	maxillary		
D5422	Adjust partial denture – mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
REPAIRS TO COMPLETE DENTURES			
D5510	Repair broken complete denture base	2 per calendar year per arch	Upper arch, Low arch must be documented on the claim form for payment consideration.
D5520	Replace missing or broken teeth- complete denture (each tooth)	2 per calendar year per tooth number	Tooth numbers 1-32 must be documented on the claim form for payment consideration.
REPAIRS TO PARTIAL DENTURES			
D5610	Repair resin denture base	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the number codes.
D5620	Repair cast framework	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the number codes.
D5630	Repair or replace broken clasp	2 per calendar year	
D5640	Replace broken teeth- per tooth	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration.
D5650	Add tooth to existing partial denture	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration
D5660	Add clasp to existing partial denture		
DENTURE REBASED PROCEDURES			
D5710	Rebase complete maxillary denture	1 per 5 years	
D5711	Rebase complete mandibular denture	1 per 5 years	
D5720	Rebase maxillary partial denture	1 per 5 years	
D5721	Rebase mandibular partial denture	1 per 5 years	
DENTURE RELINE PROCEDURES			
D5730	Reline complete maxillary denture (chairside)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.
D5731	Reline complete mandibular	1 per 2 years	Not covered within first 6 months of placement unless it is for an

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	denture (chairside)		immediate denture.
D5740	Reline maxillary partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5741	Reline mandibular partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5750	Reline complete maxillary denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5751	Reline complete mandibular denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5760	Reline maxillary partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5761	Reline mandibular partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5899	Unspecified removable prosthodontics procedure, by report		Require PA with documentation and radiographs as appropriate. Procedure must be documented on the claim form.
MAXILLOFACIAL PROSTHETICS			
D5911	Facial moulage (sectional)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5912	Facial moulage (complete)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5913	Nasal prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5914	Auricular prosthesis	1 in 5 years	Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5915	Orbital prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5916	Ocular prosthesis Prosthetic eye, plastic, custom Prosthetic eye, other type		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5919	Facial prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.
D5924	Cranial prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.
D5925	Facial augmentation implant prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D5931	Obturator prosthesis, surgical		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5932	Obturator prosthesis, definitive (post-surgical)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5933	Obturator prosthesis, modification (re-fitting)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5934	Mandibular resection pros-thesis with guide flange		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5935	Mandibular resection prosthesis without guide flange		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5937	Trismus appliance (not for temporomandibular joint dysfunction treatment)		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5951	Feeding aid		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5952	Speech aid prosthesis, pediatric		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5954	Palatal augmentation prosthesis		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5955	Palatal lift prosthesis, definitive		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5982	Surgical stent		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5983	Radiation carrier		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5984	Radiation shield		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5985	Radiation cone locator		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5986	Fluoride gel carrier		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5987	Commissure splint		Requires PA with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5999	Unspecified maxillofacial prosthesis, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed. Oral and maxillofacial or prosthodontist certification required.
PROSTHODONTIC FIXED			

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
FIXED PARTIAL DENTURE PONTICS – EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A BRIDGE			
D6211	Pontic- cast predominantly base metal	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6241	Pontic- porcelain fused to predominantly base metal	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6545	Retainer case metal for resin bonded fixed prosthesis	1 per 5 years	Requires PA Tooth numbers 1-32 must be documented on the claim form for payment consideration.
OTHER FIXED DENTURE SERVICES			
D6930	Recement fixed partial denture	1 per calendar year	
D6999	Unspecified, fixed prostho-dontic procedures, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed.
ORAL AND MAXILLOFACIAL SURGERY			
Extraction - includes local anesthesia and post operative care Any necessary suture included in fee for extraction.			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7220	Removal of impacted tooth-soft tissue	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7230	Removal of impacted tooth-partially bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7240	Removal of impacted tooth-completely bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
OTHER SURGICAL PROCEDURES			
D7260	Oral antral fistula closure		

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CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7270	Tooth reimplantation &/or stabilization of accidentally evulsed or displaced tooth. (includes splinting or stabili-zation)		Tooth numbers 1-32 and primary teeth # A, B, I, J, K, L, S, and T must also be documented on the claim form for payment consideration.
D7280	Surgical access of an unerupted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7283	Placement of device to facilitate eruption of impacted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7285	Biopsy of oral tissue - hard (bone, tooth)		
D7286	Biopsy of oral tissue - soft		
ALVELOLPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURE			
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration. Alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration.
VESTIBULOPLASTY			
D7340	Vestibuloplasty – ridge extension (2nd epithelialization)		Requires PA with documentation and radiographs as appropriate.
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment & management of hypertrophied &hyperplastic tissue)		Requires PA with documentation and radiographs as appropriate.
D7410	Excision of benign lesion up		

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	to 1.25cm		
D7411	Excision of benign lesion greater than 1.25cm		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25cm		
EXCISION OF BONE TISSUE			
D7471	Removal of lateral exostosis (maxilla or mandible)		UA, LA must be documented on the claim form for payment consideration. Must be billed with the number codes.
D7472	Removal of torus palatinus		
D7473	Removal of torus mandibularis		
D7485	Surgical reduction of osseous tuberosity		
D7490	Radical resection of maxilla or mandible		Requires PA with documentation and radiographs as appropriate.
SURGICAL INCISION			
D7510	Incision and drainage of abscess - intraoral soft		

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	tissue		
D7520	Incision and drainage of abscess - extraoral soft tissue		
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		This code should only be used if a more specific code is not available. Requires PA with documentation.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		
TREATMENT OF FRACTURES (SIMPLE)			
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones- complicated reduction with fixation and multiple surgical approaches		Requires PA with documentation and radiographs as appropriate
TREATMENT OF FRACTURES (COMPOUND)			
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7730	Mandible, open reduction		
D7740	Mandible, closed reduction		
D7750	Malar and/or zygomatic arch - open reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		Requires PA
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS			
D7810	Open reduction of dislocation		Requires PA
D7820	Closed reduction of dislocation		Requires PA
D7830	Manipulation under anesthesia		Requires PA
D7850	Surgical discectomy with/without implant		Requires PA. Not reimbursable with D7852
D7852	Disc repair		Requires PA Not reimbursable with D7850
D7858	Joint reconstruction		Requires PA
D7865	Arthroplasty		Requires PA
D7870	Arthrocentesis		Requires PA
D7872	Arthroscopy - diagnosis with biopsy or without		Requires PA
D7873	Arthroscopy - surgical; lavage & lysis of adhesions		Requires PA
D7874	Arthroscopy - surgical; disc repositioning & stabilization		Requires PA
D7876	Arthroscopy - surgical; discectomy		Requires PA
D7877	Arthroscopy - surgical; debridement		Requires PA
D7880	Occlusal orthotic device, by report		Requires PA with documentation and radiographs as appropriate. Covered only for temporomandibular pain dysfunction or associated musculature.
D7910	Suture of recent small		Excludes closure of surgical incisions

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	wounds up to 5 cm		
D7911	Complicated suture - up to 5cm	1 unit: not reimbursable with D7912	Excludes closure of surgical incisions
D7912	Complicated suture - greater than 5cm	1 unit: not reimbursable with D7911	Excludes closure of surgical incisions
D7920	Skin graft (identify defect covered, location & type of graft)		Requires PA
D7941	Osteotomy - mandibular rami		Requires PA
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft		Requires PA
D7944	Osteotomy - segmented or subapical - per sextant or quadrant		Requires PA
D7946	LeFort I (maxilla - total)		Requires PA
D7947	LeFort I (maxilla - segmented)		Requires PA
D7948	LeFort II or LeFort III (osteo-plasty of facial bones for mid-face hypoplasia or retrusion) - without bone graft		Requires PA
D7949	LeFort II or LeFort III - with bone graft		Requires PA
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report		Requires PA
D7955	Repair of maxillofacial soft and/or hard tissue defect		Requires PA
D7960	Frenuloplasty	2 per site per lifetime	Requires PA

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D7970	Excision of hyperplastic tissue - per arch		Requires PA UALAmust be documented on the claim form for payment consideration. Must be billed with the number codes.
D7980	Sialolithotomy		Requires PA
D7981	Excision of salivary gland, by report		Requires PA
D7982	Sialodochoplasty		Requires PA
D7991	Coronoidectomy		Requires PA
D7999	Unspecified oral surgery procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation, and description of procedure to be performed.
		ORTHODONTICS	
D8010	Limited orthodontic treatment of the primary dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8020	Limited orthodontic treatment of the transitional dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8030	Limited orthodontic treatment of the adolescent dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8040	Limited orthodontic treatment of the adult dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8050	Interceptive orthodontic treatment of the primary dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8060	Interceptive orthodontic treatment of the transitional dentition	2 per calendar year	Requires PA with documentation, radiographs and dental molds.
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
D8090	Comprehensive orthodontic treatment of the adult dentition	1 per lifetime	Requires PA with documentation, radiographs and dental molds.
D8210	Removable appliance therapy	2 per lifetime	
D8220	Fixed appliance therapy	2 per calendar year	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)		Requires PA with documentation, radiographs and dental molds.
D8692	Replacement of lost or broken retainer	2 per lifetime	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	1 per lifetime	Requires PA
D8999	Unspecified orthodontic procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation, and description of procedure to be performed.
ANESTHESIA			
D9220	Deep sedation/general anesthesia – first 30 min.	Maximum 1 unit/day	Class 4 anesthesia permit required
D9221	Deep sedation/general anesthesia – each additional 15 minutes		Class 4 anesthesia permit required; Must be billed with D9220
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Maximum 1 unit/day	
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Maximum 1 unit	Class 3 or 4 permit required
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	Maximum 2 units	Class 3 or 4 permit required; Must be billed with D9241
OTHER SERVICES			
D9310	Consultation (diagnostic service provided by dentist or physician other than		Not reimbursable on same day as D1020, D1040, D1045, D0150

Appendix A
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS
Children Oral Health Procedures/Codes
PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CDT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS
	practitioner providing treatment		
D9420	Hospital or ambulatory surgical center call		
D9940	Occlusal guard, by report		Requires PA
D9951	Occlusal adjustment - limited		Requires PA
D9952	Occlusal adjustment - complete		Requires PA
D9999	Unspecified adjunctive procedure, by report		This code should be used only if a more specific code is not available. Requires PA with radiographs, documentation and description of procedure to be performed is required.

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX B
COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
ADULTS OVER 21 YEARS OF AGE

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
DIAGNOSTIC			
CLINICAL ORAL EVALUATION			
D0140	Limited oral evaluation - problem focused	EMERGENT	
RADIOGRAPH/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)			
D0220	Intraoral - periapical, first film	1 per day	
D0230	Intraoral - periapical, each additional film	8 per 3 months	
D0330	Panoramic film	1 per 3 years	
D0474	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	None	
ORAL PATHOLOGY LABORATORY			
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	None	To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.
ORAL AND MAXILLOFACIAL SURGERY (INCLUDES LOCAL ANESTHESIA AND ROUTINE POSTOPERATIVE CARE)			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 numbered tooth per lifetime	Specific tooth numbers 1-32 must be included on claim form for payment consideration. Documentation must be maintained in the member's individual file.
SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)			
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 numbered tooth lifetime	See D7140 Special Instructions
D7220	Removal of impacted tooth - soft tissue	1 numbered tooth per lifetime	See D7140 Special Instructions
D7230	Removal of impacted tooth - partially bony	1 numbered tooth per lifetime	See D7140 Special Instructions

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7240	Removal of impacted tooth - completely bony	1 numbered tooth per lifetime	See D7140 Special Instructions
OTHER SURGICAL PROCEDURES			
D7260	Oroantral fistula closure		
D7285	Biopsy of oral tissue - hard (bone, tooth)		
D7286	Biopsy of oral tissue - soft		
SURGICAL EXCISIONS OF SOFT TISSUE LESIONS			
D7410	Excision of benign lesion up to 1.25cm		
D7411	Excision of benign lesion greater than 1.25 cm		
SURGICAL EXTRACTIONS OF INTRA-OSSEOUS LESIONS			
D7440	Excision of malignant tumor - lesion diameter up to 1.25cm		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm		
D7451	Removal of benign odontogenic cyst or tumor lesion diameter greater than 1.25 cm		
D7460	Removal of benign nonodontogenic cyst or tumor lesion diameter up to 1.25 cm		
D7461	Removal of benign nonodontogenic cyst or tumor lesion diameter greater than 1.25 cm		
SURGICAL INCISION			
D7510	Incision and drainage of abscess - intraoral soft tissue		
D7520	Incision and drainage of abscess - extraoral soft tissue		

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		
TREATMENT OF FRACTURES – SIMPLE			
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones—complicated reduction with fixation and multiple surgical approaches		**Requires PA** and documentation
TREATMENT OF FRACTURES - COMPOUND			
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		
D7730	Mandible, open reduction		
D7740	Mandible, closed reduction		
D7750	Malar and/or zygomatic arch- open reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		**Requires PA** with documentation and radiographs as appropriate.
COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE) EXCLUDES CLOSURE OF SURGICAL INCISIONS.			
D7910	Suture of recent small wounds up to 5 gm		
D7911	Complicated suture - up to 5cm	1 unit: not reimbursable with D7912	Excludes closure of surgical incisions

Appendix B

Covered Dental, Orthodontic and Oral Health Services, Adults Over 21 Years of Age

Adult Oral Health Procedures/Codes

***PRIOR AUTHORIZATION MUST BE OBTAINED IF SERVICE LIMITS ARE EXCEEDED**

HCPCS Code	Description	Service Limits	Special Instructions
D7912	Complicated suture – greater than 5cm	1 unit: not reimbursable with D7911	Excludes closure of surgical incisions
D7999	Unspecified oral surgery procedure, by report	**PA**	This code should be used only if a more specific code is not available. **Requires PA** with radiographs, documentation and description of procedure to be performed.
D9220	Deep sedation/general anesthesia – first 30 minutes	Maximum 1 unit/day	Class 4 permit required
D9221	Deep sedation/general anesthesia – each additional 15 minutes		Class 4 permit required; Must be billed with D9220
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	**Maximum 1 unit/day**	
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	Maximum 1 unit	Class 3 or 4 permit required
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes.	Maximum 2 units	Class 3 or 4 permit required; Must be billed with D9241

CHAPTER 505
DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES
NOVEMBER 1, 2010

APPENDIX C
INFANT AND CHILD HEALTH FLUORIDE VARNISH POLICY FOR PRIMARY CARE PRACTITIONERS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

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Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

Bureau for Medical Services
Infant and Child Oral Health Fluoride Varnish Program for Primary Care Practitioners
Coverage Criteria

Physician fluoride varnish (FV) services are defined as preventive procedures provided by or under the supervision of a physician. This includes caries screening, recording of notable findings in the in the oral cavity, preventive oral health and dietary counseling, and administration of topical fluoride varnish. Such services shall maintain a high standard of quality and shall be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations specified below in this document. The American Dental Association (ADA) expert panels have reviewed evidence-based (class 1a) studies and concluded that "Fluoride varnish applied every six months is effective in preventing caries in the primary and permanent dentition of children and adolescents." Please see JADA executive Summary 2006 recommendations attached.

Fluoride varnish is a thin coating of resin that is applied to the tooth surface to protect it from decay. According to the Food & Drug Administration (FDA), fluoride varnish falls under the category of "drugs and devices" that presents minimal risk and is subject to the lowest level of regulation. The purpose of applying fluoride varnish is to retard, arrest, and reverse the process of cavity formation.

Fluoride varnish is easy to apply, does not require special dental equipment or a professional cleaning prior to application. It also requires minimal training, and is inexpensive. Fluoride varnish dries immediately upon contact with saliva and is safe and well tolerated by infants, young children, and individuals with special needs.

Effective January 16, 2012, the Bureau for Medical Services (BMS) will start reimbursing primary care providers who have been certified through a face-to-face training for fluoride varnish application offered through the West Virginia University School of Dentistry for the application of fluoride varnish to children ages 6 months to 36 months (3 years) who are at high risk of developing dental caries. The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist.

A child is considered at high risk of developing cavities if he or she:

- ✓ Has had cavities in the past or has white spot lesions and stained fissures
- ✓ Continues to use the bottle past one year of age or sleeps with a bottle containing liquids other than water
- ✓ Breastfeeds on demand at night
- ✓ Has a developmental disability
- ✓ Chronically uses high sugar oral medications
- ✓ Has family members with histories of caries
- ✓ Engages in prolonged or ad lib use throughout the day of a bottle or "sippy" cup containing liquids other than water

Who is not Covered:

- ✓ Children with a low risk of cavity formation who consume optimally fluoridated water or children who receive routine fluoride treatments through a dental office.

BMS recognizes the following types of primary care providers to be eligible for payment of this service:

- ✓ Pediatricians
- ✓ General and Family Practice Doctors
- ✓ Nurse Practitioners
- ✓ Physician Assistants (in FQHC settings only)

Provider Eligibility to Bill for Program Services

Providers must have completed a certified training course from the WVU School of Dentistry prior to performing and billing for these services. The WVU School of Dentistry will provide a list of all current certifications monthly in 2011 and thereafter to BMS and its fiscal agent in order to create a file of reimbursable providers. Information about this course is available at www.hsc.wvu.edu/sod/oral-health.

Reimbursement for the Services

BMS allows coverage of two fluoride varnish applications per year (one every six months). The first application must be provided and billed in conjunction with a comprehensive well-child exam as reported under the CPT codes listed in the table below. The second fluoride varnish application can be reimbursed during the 12-month subsequent period, and may be billed in conjunction with the HCPCS code outlined in the table below.

BMS will use the following codes to reimburse primary care providers for fluoride varnish application:

Code	Description	Comments
99381-99382 99391-99392	Comprehensive well-child exam codes for children less than 1 year and up to age 4 (note FV coverage under this program is only through age 3)	Oral evaluation and counseling are components of comprehensive well –child exams
T1503	Administration of medication, other than oral and/or injectable by a health care agency/professional, per visit Note: Use this code to bill for the topical fluoride varnish; therapeutic application for moderate to high caries risk patients. By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D1206-Topical fluoride varnish; therapeutic application for moderate to high caries risk patients.	Covered 2 times per year for children up to age 3; 1st application must be billed in conjunction with one of the comprehensive well child exam codes listed above
T1503-DA	Use Code T1503 with modifier-DA (Oral health assessment by a licensed health professional other than a dentist) to bill for oral evaluation of patient under three years of age and counseling with primary caregiver. Note: By mid-2012, updates to the BMS Fiscal Agent's claim processing system will allow this code to be replaced by D0145 – Oral Evaluation for patient under three years of age and counseling with primary caregiver.	Covered once per year in conjunction with 2nd fluoride varnish application; cannot be covered when comprehensive well-child exam is billed on the same day and at least 180 days after billing for the comprehensive well child-exam
V20.2	Routine infant or child health check	Primary diagnosis used when billing well-child exam
V82.89	Special screening for other specified conditions	Secondary diagnosis used when billing comprehensive well-child exam
V72.2	Dental Exam	Primary diagnosis used when billing D0145 – dental exam; cannot report in combination with V20.2

Reimbursement will be made using the dental fee schedule effective on the date of service. The current fee for T1503 (D1206) will be $20.00 and T1503-DA (D0145) will be $25.00.