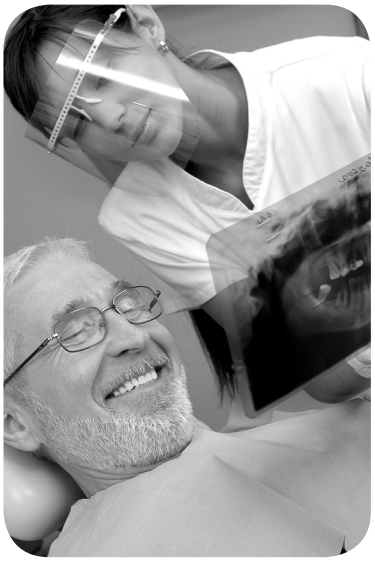
DBP | Commercial Provider Manual



Dental Benefit Providers

Rev 10/2014

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of Dental Benefit Providers, Inc.

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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1.0 Welcome to Dental Benefit Providers, Inc.

Dental Benefit Providers, Inc. (DBP) welcomes you as a participating Dental Provider in providing dental services to our members.

DBP is committed to providing accessible, quality, comprehensive dental care 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.

DBP offers a portfolio of products to its members, your patients, as well as to its participating dental offices. Products include Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), In-Network Only (INO), Dental Health Maintenance Organization (DHMO), Discount Preferred Programs, Direct Compensation (DC) and various discounted Fee for Service (FFS) plans.

The products offered and how our plans are branded vary by market, based on how the products are licensed and the associated contracting entity.

This Provider Manual is designed as a comprehensive reference guide focusing on the types of plans referenced above. Here you will find the tools and information needed to successfully administer DBP plans. As changes and new information arise, we will send these updates to you. Please store these updates with this Provider Manual for future reference.

Our Government Program plans, including Medicaid, and many of our DHMO and Direct Compensation Plans, are summarized separately. If you support one of these plans and need a manual, please contact our Provider Services team at 1-800-822-5353.

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the DBP provider services team at **1-800-822-5353.**

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

Sincerely,

Dental Benefit Providers, Professional Networks

2.1 Quick Reference Guides
Addresses and Phone Numbers

Dental Benefit Providers (DBP) is committed to providing your office with accurate and timely information about our programs, products and policies.

Our **Provider Services line** and **Provider Services teams** are available to assist you with all aspects of your involvement with our plans. Call our toll-free number during normal business hours to speak with knowledgeable specialists. They are trained to handle specific dentist issues such as **eligibility, claims, dental plan information** and **contractual questions.**

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

Resource			
Need:	**Online www.dbp.com**	**Provider Services Line – Dedicated Service Representatives** **Phone:** 1-800-822-5353 **Hours:** 8 am–9 pm EST or 7 am–10 pm CST	**Interactive Voice Response (IVR) System** **Phone:** 1-800-822-5353 **Hours:** 24 / 7
Claim Inquiry	●	●	●
Benefit / Plan Questions (including prior authorization requirements)	●	●	●
Eligibility	●	●	●
Receive EOB	●	●	
Fee Schedule Request	●	●	●
Copy of Contract		●	
Contract Questions		●	
In-Network Practitioner Listing	●	●	●
Nominate Practitioner	●	●	
Changes to Practice Information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates)		● (Please also feel free to use the Demographic Change Request Form within the Appendix section of this manual.)	
Participation Status Change		●	
Request Office Visit (e.g., staff training)		●	
Request Forms	●	●	●
Product Information	●	●	●

Resource					
Need:	**Address**	**Phone Number**	**Payer I.D.**	**Submission Guidelines**	**Form(s) Required**
Claim Submission (initial)	CLAIMS Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133 Claim Filing indicator: "CL"	Within 90 days of the date of service	ADA Claim Form, 2006 version or later
Prior Authorization Requests*	PTE/Preauthorizations Dental Benefit Providers P.O. Box 30552 Salt Lake City, UT 84130-0567	1-800-822-5353	52133		ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
Claim Adjustment Request or Requests for Reprocessing	Adjustments/ Resubmissions Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 60 days from receipt of payment	ADA Claim Form Provider narrative Reason for requesting adjustment or resubmission
Claim Disputes	Provider Disputes Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	n/a	Within 60 days from receipt of payment	ADA Claim Form Written summary of appeal
Coordination of Benefits	Claims Dental Benefit Providers P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 90 days of the date of service	ADA Claim Form Primary Payer's EOB showing the amount paid by the primary payer
Member Complaints and Appeals	Dental Benefit Providers P.O. Box 30569 Salt Lake City, UT 84130-0567	1-800-822-5353	n/a	n/a	n/a

2.2.A Integrated Voice Response (IVR) System
1-800-822-5353

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

Through this system, network dental offices can obtain immediate **eligibility information,** check the **status of claims** and receive an explanation of benefits. The system also has the ability to fax eligibility confirmation directly to the caller.

2.2.B Web Site

The Dental Benefit Providers (DBP) Web site at www.dbp.com offers many time-saving features including **eligibility verification, claims status, claim receipt acknowledgement** and **network specialist locations.** Through this site, you may also enroll in **Electronic Payments and Statements**, a free direct deposit service.

2.2.C Dental Benefit Provider's Client Reference Guide

As a participating practitioner in our National PPO Network, you have access to these members.
Updated September 26, 2011

Client	Payer ID #	Customer Service	Paper Claims Submission
Blue Shield of California	521337971	1-800-822-5353	Blue Shield of California P.O. Box 272590 Chico, CA 95927
Encore Dental/ Stonebridge Life	521337971	1-866-605-2642	Encore Dental – ATTN: Claims P.O. Box 30567 Salt Lake City, UT 84130
Health Net – Arizona	521337971	1-800-822-5353	HealthNet Attn: Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
Health Net Associates	521337971	1-800-822-5353	HealthNet Attn: Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
Health Net of California	521337971	1-800-822-5353	HealthNet Attn: Claims P.O. Box 30567 Salt Lake City, UT 84130-0567
Health Net of Oregon	521337971	1-877-410-0176	HealthNet Attn: Claims P.O. Box 30567 Salt Lake City, UT 84130-0567

Client	Payer ID #	Customer Service	Paper Claims Submission
Lincoln Financial Group (Leased Network Partner) *Effective 10/1/2011*	Electronic Claim Payer ID: CX061	1-800-423-2765	Submit claims to: Lincoln Financial Group Dental Claims Input Center P.O. Box 614008 Orlando, FL 32861 Electronic Payer ID Number: CX061 For questions regarding the administration or payment of a claim: Lincoln Financial Group Attn: Claim Service Team 8801 Indian Hills Drive Omaha, NE 68114 Email: claims@lfg.com Phone: 1-800-423-2765
Morgan White	521337971	1-877-778-4104	UnitedHealthcare Dental Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
OptumHealth Allies	n/a	1-877-441-4458	No claims need to be filed – Collect scheduled amounts from members
Peoples Benefit Life Insurance Company	521337971	1-800-822-5353	Peoples Benefit Life Ins. Co Dental Claims P.O. Box 30567 Salt Lake City, UT 84130
Secure Horizons	521337971	1-877-816-3596	UnitedHealthcare Dental Secure Horizons P.O. Box 30567 Salt Lake City, UT 84130-0567
Unimerica Dental	521337971	1-800-822-5353	UnitedHealthcare Dental Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
UnitedHealth One	n/a	1-866-560-8541	No claims need to be filed – Collect scheduled amounts from members
UnitedHealthcare Dental	521337971	1-800-822-5353	UnitedHealthcare Dental Claims Unit P.O. Box 30567 Salt Lake City, UT 84130-0567
UMR/Fiserv Health Managed Dental/ Wausau Benefits	39026	1-800-826-9781	UMR P.O. 30541 Salt Lake City, UT 84130-0541

2.3 Electronic Payments and Statements

What is Electronic Payments and Statements (EPS)?

Electronic Payments and Statements (EPS) is a no cost, practical solution to provide electronic delivery of payments and explanations of benefits (EOBs) to dental providers and other health care professionals.

EPS is fast, easy and secure. You will be notified by email the day deposits are made. No more time wasted on trips to the bank to make deposits. Claims payments will be made directly to your bank account, five to seven days faster than paper checks.

With Electronic Payments and Statements (EPS), your claim payments, explanations of benefits, and Pre-Treatment Estimates (PTEs) are delivered electronically, allowing your office faster payment, easier reconciliation, less paperwork and much greater efficiency.

EPS eliminates:

- Check clearing wait time
- Check processing fees
- Searching through files for claim and payment information
- Frustrating reconciliation tasks
- Endless piles of paper and mail

EPS provides:

- Secure, direct deposit
- Online payment and claim information
- Fast and easy information searches
- Simplified reconciliation
- Reduced paper usage and waste

The Electronic Payments and Statements service is fast, easy and free.

How to Enroll:

Log onto www.dbp.com and select the Electronic Payments and Statements tab from the left navigation menu. Once you've reached the EPS portal, select your TIN from the drop-down box and then complete the required enrollment fields — the entire process shouldn't take more than five minutes. Or call 1-877-620-6194.

Once enrolled you can:

- Receive payments electronically
- Electronically view or print hard copies of your remittance advice
- Search for payments and claims information by date of service, account number, member name, payment number and more
- Maintain your enrollment, update contacts, change banking information

3.1 Plan Eligibility

Members and their dependents are eligible to receive dental benefits as long as the member's employer eligibility guidelines are met.

An eligible dependent consists of:

- Spouse
- Domestic Partner
- Dependent Child – up to the age set forth by applicable federal and/or state law
- Child Who Is a Full-Time Student – up to the age set forth by applicable federal and/or state law

It is recommended that eligibility be verified for each individual prior to the delivery of services. To verify eligibility, please call our Provider Services line at 1-800-822-5353 or go to www.dbp.com.

Important note: 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.*

3.2 Member Identification Card

Members are issued an identification (ID) card to all recipients enrolled in benefits. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the Plan logo and include the toll-free customer service number. For DHMO plans, the primary care dentist name and telephone number is also included. ID cards also include the member's group ID number.

The ID card has instructions for both members (how to access care) and providers (eligibility verification). ID cards should be presented by members when services are rendered.

Presentation by a person with an ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

3.3 Eligibility Verification

As outlined in your provider agreement, member eligibility must be verified prior to rendering services. This section contains helpful tips on how to establish eligibility quickly and easily through our Provider Services line.

Eligibility may be verified one of three ways:

1. At our Web site (**www.dbp.com**)
2. Through our Interactive Voice Response (IVR) available through the Provider Services line
3. By speaking with a Provider Services line representative

The Interactive Voice Response (IVR) system

Our Provider Services line provides IVR features that enable you to obtain up-to-the minute eligibility information with one quick telephone call. Eligibility may be verified for one or more members at a time by using either voice or touch-tone keypad, or a combination. This 24-hour-a-day, seven-day-a-week, toll-free access delivers immediate eligibility information directly by fax to your office.

It's easy to get started.

All you need is the following:

- A touch-tone phone
- The member's name, subscriber ID number and date of birth
- Your dental office fax number

When calling the Provider Services line, here's what you'll receive:

- Confirmation of the member's name
- Dependent information
- Plan details

Upon your request, our IVR system will automatically fax to your office all the information needed to effectively and efficiently serve your patients.

Use the touch-tone option if you are encountering problems with speech recognition.

The IVR is never busy and there is never a wait. The IVR is available 24 hours a day, seven days a week. Provider Services line telephone number: 1-800-822-5353

Important note: *A member's ID card is not proof of eligibility. 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 exclusion*s.

Web site: www.dbp.com

You can also verify eligibility on our Web site at www.dbp.com 24 hours a day, seven days a week. In addition to current eligibility verification, our Web site offers other functionality for your convenience such as claims status, procedure level pricing, fee schedules, benefit information and a provider search.

We Make It Easy to Get Started

You can use our Online Guided Tour under the dentist site to take you through the registration process. Once you have registered on our provider Web site at www.dbp.com, you can verify your patients' eligibility online with just a few clicks.

Please contact our Customer Service line if you have additional questions or need help registering on our Web site.

Note: *Passwords are the responsibility of the dental office (see agreement during the registration process).*

3.4 Specialty Care Referral Guidelines

No authorization is needed for participating dentists to refer members to a specialist. However, we do expect our participating general dentists to perform a wide range of services including anterior root canals, root planing/scaling and simple extractions.

If specialty care is necessary, please refer members to a participating specialist, whenever possible, as it will be less costly for the member. Members covered under an "in-network only" plan **must** only be referred to participating specialists to receive benefits.

You may obtain a listing of participating specialists in your area through our Web site, www.dbp.com, or by calling 1-800-822-5353 and using the Interactive Voice Response (IVR) system. If you are unable to locate a participating specialist in your area, contact a provider services representative at 1-800-822-5353 for assistance.

4.1.A Diagnostic Services Guidelines

A full-mouth series of X-rays (ADA Code D0210) may be taken for new adolescent and adult patients at the same visit as their initial exam, as well as every three to five years, depending on the condition of the patient's oral health. Often, a panoramic X-ray, plus two or four bitewings, is substituted for a full-mouth series. The dentist may or may not take X-rays during periodic exams, depending on the patient's oral health. Because this benefit may not be covered through every member's plan, it is recommended that the member's eligibility be verified prior to taking X-rays.

At the request of the patient, copies of films must be sent to a specialist or dentist to whom the patient has transferred. A reasonable fee may be assessed to the patient to copy and forward films (regulations around this vary by state). NOTE: Do not send ORIGINAL X-rays. Send only duplicates or copies.

Payment for an initial (or comprehensive) oral examination (ADA Code D0150) includes:

- Comprehensive examination of the patient by the dentist
- Tooth charting (record of patient's existing fillings, missing teeth, etc.)
- Periodontal charting, including documentation of a Periodontal Screening Record (PSR) or six-point pocket depth measurement, attachment loss, recession, and inflammation record
- Review of patient's medical and dental history
- Examination of X-rays necessary to diagnose any dental problems
- Blood pressure reading
- Diagnosis of any dental problems/diseases
- Treatment plan (written plan of procedures to perform to correct any dental problems found)

All information gathered by the dentist during a comprehensive oral examination should be documented in the patient's chart. Periodontists and pediatric dentists should use D0150 when performing a comprehensive examination and D0180 when a periodontal exam is performed.

A periodic oral examination (ADA Code D0120) includes:

- Examination of the patient by the dentist, including periodontal exam or screening
- Documentation of any changes in the patient's medical history
- Documentation of any changes in the patient's oral history
- Diagnosis of any dental problems/diseases
- Update of treatment plan

All information gathered by the dentist during a periodic oral examination should be documented in the patient's chart. Periodontists and pediatric dentists (pedodontists) should use D0120 when performing a periodic examination and D0180 when a periodontal exam is performed.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Clinical Oral Evaluations				
D0120	Periodic Oral Examination	All	•Twice within12 consecutive months •Periodic exams cannot be performed on the same date of service as D0150. •Limitation includes any D0120, D0150 done within a year's time	Patient must pay for more frequent periodic exams.
D0140	Limited/Emergency Oral Evaluation – problem focused	All	•Cannot be submitted by the dentist who also submits a D0120, D0150, or D9310 for the same condition or on the same date	•As needed per dental/oral emergency •May be billed only once within a one- to two-month period for the same dental problem

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2	•Twice within 12 consecutive months	
D0150	Comprehensive/Initial Oral Evaluation	All	•Limited to once within a consecutive 36-month period •Provider may bill in less than 36 months for new patients and is included in the two total exams per consecutive 12-month period. •Limitation includes any D0120, D0150 done within the 12-month consecutive period.	May not be billed in conjunction with D0120, D0140 or D0180
D0160	Detailed and Extensive Oral Evaluation, by report	All	•May be billed only once within a one- to two-month period for the same dental problem. •Limitation includes any D0120, D0150 done within the 12 month consecutive period.	By report, including detail of condition being evaluated. Only to be used for complex conditions.
D0170	Reevaluation – limited, problem focused	All		•By report – Not for post-op visits •As needed per dental/oral emergency
D0180	Comprehensive periodontal evaluation – new or established patient	All	Limited to once within a consecutive 36-month period	May not be billed on same date of service as D0120, D0140, D0150, D0160 or D0170
Radiographs / Diagnostic Imaging (Including Interpretation)				X-rays should be taken based on clinical need, not purely based on a timetable.
D0210	Intra-oral – complete series (including bitewings)	All	•Limited to once within a consecutive 36-month period •May not be billed in conjunction with D0220, D0230, D0270, D0272, D0273, D0274 •Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations	Panoramic (D0330) and bitewings (D0272, D0273, D0274) may be substituted for D0210
D0220	Intra-oral – periapical X-ray, first film	All	•One per day •May not be billed in conjunction with D0210	Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0230	Intra-oral – periapical X-ray, each additional film	All	•Must be billed with D0220 (periapical, first film) •May not be billed in conjunction with D0210 (complete series) or D3310-3330 or D3346-3348 (root canal). Considered integral to the procedure.	Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0240	Intra-oral – occlusal film	All	Limited to four per 12 consecutive months	
D0250	Extra-oral – first film	All	Limited to two per 12 consecutive months	

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D0260	Extra-oral – each additional film	All	•Must be billed with D0250 (Extra-oral first film) •Limited to two per 12 consecutive months	
D0270	Bitewings – single film (usually performed on a patient with multiple missing teeth, if there are not enough teeth to take two or four films)	All	Limited to one series of films per calendar year	•Bitewings should be taken in conjunction with D0120 (periodic exam) only for diagnosis of dental problem. •Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0272	Bitewings – two films	All	One D0272/D0273/D0274 per calendar year	•Bitewings should be taken in conjunction with D0120 (periodic exam) only for diagnosis of dental problem. •Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0273	Bitewings – three films	All	One D0272/D0273/D0274 per calendar year	•Bitewings should be taken in conjunction with D0120 (periodic exam) only for diagnosis of dental problem. •Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0274	Bitewings – four films	All	One D0272/D0274 per calendar year	•Bitewings should be taken in conjunction with D0120 (periodic exam) only for diagnosis of dental problem. •Any combination of eight or more D0220, D0230, D0270, D0272, D0273, D0274, D0277 must be rebundled to D0210 and subject to fee and frequency limitations.
D0277	Vertical bitewings (seven to eight)	All	•One per three years •May not be billed in conjunction with D0210, D0220, D0230, D0270, D0272, D0273, or D0274	May be billed with D0220, D0230 D0270, D0272, D0274; however, the total combined fee allowed may not exceed the allowed fee for a D0210, D0277 or D0330.
D0290	Post-Ant or Lat skull and facial bone survey	NB		

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D0310	Sialography	NB		
D0320	TMJ arthrogram, including injection	NB		For patients with TMJ coverage, limitation is one film per joint every 36 months
D0321	Other TMJ films by report	NB		For patients with TMJ coverage, limitation is one film per joint every 36 months
D0330	Panoramic film	All	•Limited to once within a consecutive 36-month period as a substitute for D0210 or D0277 •One time for diagnosis of specific issue •One D0210, D0277 or D0330 per 36 months	•D0210, D0277, D0330 are all considered full mouth X-rays in benefit administration. Billing for any one subjects all to the three-year frequency limitation. •May be billed with D0220, D0230 D0270, D0272, D0273, D0274; however, the total combined fee allowed may not exceed the allowed fee for a D0210, D0277, or D0330.
D0340	Cephalometric film		•NB as a separate procedure •For orthodontic patients, limited to one per 12 consecutive months	Included in the fee for orthodontic records
D0350	Oral/facial images	All	Up to four per day, by report	•Images taken from an analog, digital, or intra-oral video camera •Does not include radiographic images
D0360	Cone beam ct – craniofacial data capture	NB		
D0362	Cone beam – two dimensional image reconstruction using existing data, includes multiple images	NB		
D0363	Cone beam – three dimensional image reconstruction using existing data, includes multiple images	NB		
Test and Examinations				
D0415	Bacterial studies for determination of pathologic agents		Limited to one time per 12 consecutive months	
D0416	Viral culture		Limited to one time per 12 consecutive months	
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	NB		

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D0418	Analysis of saliva sample	NB		
D0421	Genetic test for susceptibility to oral diseases	NB		For patients who have coverage, one time per 12 consecutive months
D0425	Caries susceptibility tests	NB		For patients who have coverage, one time per 12 consecutive months
D0431	Adjunctive pre-diagnosis test that aids in detection of mucosal abnormalities, precluding pre-malignant and malignant lesions, not to include cytology or biopsy procedures	NB		For patients who have coverage, one time per 12 consecutive months
D0460	Pulp vitality tests	All	One charge for this procedure per visit, regardless of how many teeth are tested	May include multiple teeth and comparison of same teeth on the other side
D0470	Diagnostic casts	All	• Often incidental to other procedures (i.e., fixed/removable prosthetics, ortho) • Where allowable as a separate charge, limited to one time per 24 consecutive months	Included in records fee for orthodontics
Oral Pathology Laboratory				
D0472	Gross exam, prep and report	NB		Usually covered under Medical plan
D0473	Micro exam, prep and report	NB		Usually covered under Medical plan
D0474	Micro exam of surgical margins	NB		Usually covered under Medical plan
D0475	Decalcification procedure	NB		For patients who have coverage, one time per 12 consecutive months
D0476	Special stains for microorganisms	NB		For patients who have coverage, one time per 12 consecutive months
D0477	Special stains, not for microorganisms	NB		For patients who have coverage, one time per 12 consecutive months
D0478	Immunohistochemical stains	NB		For patients who have coverage, one time per 12 consecutive months
D0479	Tissue in-situ hybridization, including interpretation	NB		For patients who have coverage, one time per 12 consecutive months
D0480	Processing and interpretation of exfoliative cytologic smears	NB		For patients who have coverage, one time per 12 consecutive months
D0481	Electron microscopy	NB		For patients who have coverage, one time per 12 consecutive months

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D0482	Direct immunofluorescence	NB		For patients who have coverage, one time per 12 consecutive months
D0483	Indirect immunofluorescence	NB		For patients who have coverage, one time per 12 consecutive months
D0484	Consultation on slides prepared elsewhere	NB		For patients who have coverage, one time per 12 consecutive months
D0485	Consultation, including prep of slides from biopsy material	NB		For patients who have coverage, one time per 12 consecutive months
D0486	Laboratory assession of brush biopsy sample, microscopic examination, preparation and transmission of written report	NB		
D0502	Other oral pathology procedures by report		• May or may not be a covered expense	• If not covered by dental, may be covered by patient's medical plan • For patients who have coverage, one time per 12 consecutive months
D0999	Unspecified diagnostic procedure, by report		• May or may not be a covered expense	• If not covered by dental, may be covered by patient's medical plan • For patients who have coverage, one time per 12 consecutive months

4.1.B Preventive Services Guidelines

Preventive services include routine prophylaxis (cleaning), Oral Hygiene Instruction (OHI), space maintenance therapy, fluoride treatment and sealants.

The goal of providing routine and periodic preventive dental services is to maintain oral health and to prevent the need for more extensive dental procedures. Topical fluoride treatment is allowed for children up to a maximum age, as determined by the plan, two times per 12 consecutive months when provided with a prophylaxis. For patients exceeding the maximum age, as determined by the plan, fluoride treatments are not covered services. Sealants are a covered service for first and second permanent molar teeth only.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Dental Prophylaxis				
D1110	Prophylaxis – Adult	>12	•Two times per 12 consecutive months •May not be billed in conjunction with D4355 (full mouth debridement) or 4341 (scaling and root planing)	
D1120	Prophylaxis – Child	<13	•Two times per 12 consecutive months •D1120 and D1203 will be alternate benefits to D1201 if performed on the same date of service	
D1203	Topical Application of Fluoride (not including prophylaxis), Child	0-12	•Two times per 12 consecutive months – limited to covered persons under the age of 16, unless otherwise specified	
D1204	Topical Application of Fluoride (not including prophylaxis), Adult	>12 per plan design	•Two times per 12 consecutive months – limited to covered persons under the age of 16, unless otherwise specified	•Topical fluoride application for adults is used to treat hypersensitive teeth and to prevent root caries and recurrent decay around existing restorations. Often used for patients who have had radiation therapy to the head and neck.
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	0-15	•Two times per 12 consecutive months – limited to covered persons under the age of 16, unless otherwise specified	
Other Preventive Services				
D1310	Nutritional Counseling	NB		
D1320	Tobacco Counseling	NB		
D1330	Oral Hygiene Instructions	NB		•Included in prophy and exam appts. (D0140, D0150, D1110, D0120, D1201, D1204)
D1351	Sealant – Per tooth	<16	•1st and 2nd permanent molars (2, 3, 14, 15, 18, 19, 30, 31) only •Once per tooth per 36 consecutive months – limited to patients under 16 unless otherwise specified	•Provider who placed sealants may not bill for repair/replacement of sealants for three years

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D1352	Preventive Resin Restoration		•1st and 2nd permanent molars (2, 3, 14 15, 18, 19, 30, 31) only •Once per tooth per 36 consecutive months – limited to patients under 16 unless otherwise specified.	For permanent teeth when caries do not extend into dentin
Space Maintenance (Passive Appliances) Lost, stolen or broken appliances are the responsibility of the patient All adjustments for six months are included. No benefit if permanent tooth is ready to erupt. If bilateral teeth are missing, benefit given for bilateral space maintainer, even if two unilateral space maintainers are requested.				
D1510	Space Maintainer – Fixed Unilateral	<16	•Once per 60 consecutive months – for patients under age 16, unless otherwise specified •Benefit includes all adjustments within six months of installation •Posterior primary teeth (A, B, I, J, K, L, S, T)	•This procedure is encouraged for patients who lose primary molars (Teeth A, B, I, J, K, L, S, T) early, as it may prevent future need for orthodontics.
D1515	Space Maintainer – Fixed Bilateral	<16 (>16, by report)	•Once per 60 consecutive months – for patients under age 16, unless otherwise specified •Benefit includes all adjustments within six months of installation •Posterior primary teeth (A, B, I, J, K, L, S, T) •Anterior primary teeth (C-H, M-Q) under 4 years old, by report	•This procedure is encouraged for patients who lose primary molars (Teeth A, B, I, J, K, L, S, T) early, as it may prevent future need for orthodontics.
D1520	Space Maintainer – Removable Unilateral	<16 (>16 by report)	•Once per 60 consecutive months – for patients under age 16, unless otherwise specified •Benefit includes all adjustments within six months of installation •Posterior primary teeth (A, B, I, J, K, L, S, T) •Anterior primary teeth (C-H, M-Q) under 4 years, by report	•This procedure is encouraged for patients who lose primary molars (Teeth A, B, I, J, K, L, S, T) early, as it may prevent future need for orthodontics.
D1525	Space Maintainer – Removable – Bilateral	<16 (>16 by report)	•Once per 60 consecutive months – for patients under age 16, unless otherwise specified •Benefit includes all adjustments within six months of installation •Posterior primary teeth (A, B, I, J, K, L, S, T) •Anterior primary teeth (C-H, M-Q) under 4 years, by report	•This procedure is encouraged for patients who lose primary molars (Teeth A, B, I, J, K, L, S, T) early, as it may prevent future need for orthodontics.
D1550	Recementation of Space Maintainer	<16 (>16 by report)	Limited to once per six consecutive months after initial insertion	If must be done more frequently, provider may charge patient UCR if loosening was not caused by provider.
D1555	Removal of Fixed Space Maintainer	<16 (>16 by report)	Limited to once per six consecutive months after initial insertion	

4.1.C Restorative Services Guidelines

Restorative services are provided to remove decay and restore teeth to a functional condition. Restorative services include: amalgam ("silver" or "metal") fillings, composite ("resin" or "white") fillings, inlays/onlays, and crowns ("caps").

Payment for an amalgam or composite restoration includes: local anesthetic, drilling the tooth, acid etching and bonding, as appropriate, application of a base or liner, filling the tooth, polishing/sealing the restoration, and any post-operative adjustments.

Payment for a crown includes: tooth preparation, temporary crown (to be worn while the permanent crown is being prepared), crown fitting, final crown cementation and any post-operative adjustments. Service date for the submission of claim is the date of insertion.

Direct restorations are expected to last at least three years. Indirect restorations are expected to last at least five years. Restorations under the plan should be replaced only for medical reasons (i.e., allergy to a material documented by a physician), or if they fall out, become undermined by decay, or break. There is no coverage when these are replaced for cosmetic reasons.

The guidelines and limitations listed below must be followed when providing restorative services:

1. For procedure codes that are billed by tooth and surface (e.g., amalgam and composite restorations), the amount billed depends on the number of surfaces covered by the procedure. When surfaces that are immediately adjacent to each other are both affected by the procedure being performed, the surface codes are combined. For example, when a dentist performs an amalgam that covers both the "M" (mesial) and "O" (occlusal) surfaces of the tooth, he/she will be reimbursed for a two-surface amalgam ("MO," ADA Code D2150). However, when he/she performs a procedure that affects two surfaces that are NOT confluent, such as an "F" (facial) amalgam and an "L" (lingual) amalgam, he/she will be reimbursed for two one-surface amalgams (ADA Code D2140).
2. Bases and liners placed under a restoration are considered part of the restoration and are not billable as separate procedures. For example, calcium hydroxide, resin, glass ionomer, or resinomer placed to increase retention of the restoration, or to decrease post-operative sensitivity, are included in the fee for the final restoration.

   For composite and/or amalgam restorations, the acid etching procedure is considered part of the restoration and may not be billed as a separate procedure. Amalgam bonding agents are considered part of the restoration and may not be billed separately.
3. Local anesthetic administered prior to restoration preparation is included in the restorative service fee and may not be billed separately.
4. Indirect pulp caps are usually considered an integral component of the restoration unless the pulp is nearly exposed and a layer of caries is covered with an appropriate dressing.
5. Reimbursement for primary tooth (A-T) restorations does not include pulpotomies. If a pulpotomy is performed on a primary tooth (A-T), it must be billed separately.
6. Benefits for composite restorations (ADA Codes D2330-D2394) are limited to:
   - I, L, M, D, B, L, P, F surfaces for teeth C-H, M-R, 6-11, and 22-27
   - For O, M, D, B, L, F, P surfaces on teeth 1-5, 12-16, 17-21, and 28-32, amalgam restoration is the benefitted service for any primary or permanent posterior tooth.
7. Precision and semi-precision attachments are not covered.
8. Laboratory-fabricated restorations are allowed only for fully developed permanent teeth (numbers 1-32) and on primary teeth (A, B, J, K, L, M, S and T) with no permanent successors.
9. If a temporary/provisional crown is replaced with a permanent crown in less than one year, the payment for the temporary crown is deducted from the permanent crown fee. If the temporary crown is in place more than one year, it is considered a permanent crown and replacement is not covered for five years.

10. **Reimbursement for indirect restorations (inlays, onlays and crowns) is based on the date of service that the tooth is prepared,** and is also contingent upon clinical review for necessity, as well as alternate benefit allocation. With crowns, there is a classification of the different types of metal used in a unit of fixed prosthetics:
    - High Noble = Gold, Palladium, and/or Platinum >60%
    - Noble = Gold, Palladium, and/or Platinum >25%
    - Predominantly Base = Gold, Palladium, and/or Platinum <25%

Additional Criteria for Crowns, Inlays and Onlays

General Clinical Criteria:

1. Extensive caries on three or more surfaces or 50% loss of clinical crown
2. Fracture of cusps
3. Endodontically treated, unless minimal access opening on anterior tooth
4. Direct restoration not possible (most one or two surface defects can be restored with a direct restoration)
5. Must be opposed by natural or prosthetic tooth
6. 50% bone support with no ligament or root pathology unless patient has undergone periodontal therapy/surgery

11. Full-Mouth Reconstruction (FMR):
    - FMR encompasses the reestablishment of the occlusal profile whereby all or most teeth are restored via laboratory fabricated crowns, onlays and/or fixed bridges.
    - Treatment plans are generally extensive and delivered in phases over an extended period of time.
    - FMR associated with a change in vertical dimension of occlusion, treatment of temporomandibular disorder, or cosmetic dentistry, is generally not covered.
    - FMR may be covered to restore teeth damaged by significant decay, fracture or lack of structural integrity, as well as to replace large defective restorations — by application of the same criteria used for the consideration of indirect restorations.
12. Endodontic Considerations:
    - Endodontic fill is dense, within 2 mm of apex and not significantly beyond (as evidenced on post-op film).
    - If adequate tooth structure exists to restore without a crown, the existence of endodontic treatment alone is not sufficient to allow a benefit.
13. Tissue Preparation:
    - Gingivectomy incidental to crown preparation or performed at the time of final preparation is not a benefit. A narrative or chart notes must document that a separate and distinct procedure was performed.
14. Criteria for Crown Buildup:
    - Evidence of extensive caries or at least three surfaces of the tooth have severe breakdown.
    - Must be necessary for retention of the crown.
    - Vertical height of clinical crown must be adequate to support a prosthetic crown. Not benefited with post/core.

Frequency is limited to when the prosthesis was placed, even if paid by another plan.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Amalgam Restorations (Including Polishing)				
The provider who placed the restoration is responsible for maintenance of these restorations for three years. Any amalgam bonding agent is considered part of the procedure and cannot be billed separately. Inclusive are: local anesthesia; tooth prep; liners/bases; restorative material; polishing/sealing; adjustments; tooth etching.				
D2140	Amalgam – 1 surface, primary or permanent	All	Once per 36 consecutive months	Multiple restorations on contiguous surfaces will be treated as a single restoration.
D2150	Amalgam – 2 surfaces, primary or permanent	All	Once per 36 consecutive months	Multiple restorations on contiguous surfaces will be treated as a single restoration.
D2160	Amalgam – 3 surfaces, primary or permanent	All	Once per 36 consecutive months	Multiple restorations on contiguous surface will be treated as a single restoration.
D2161	Amalgam – 4 surfaces, primary or permanent	All	Once per 36 consecutive months	Multiple restorations on contiguous surface will be treated as a single restoration.
Composite Resin Restorations				
Posterior composites are provided an alternate benefit to an amalgam unless patient has a documented medical reason for use of another material (unless Plan covers posterior composites).				
D2330	Resin – 1 surface, Anterior	All	•Once per 36 consecutive months •Teeth 6-11, 22-27, C-H, M-R, only	•No benefit if performed for cosmetic reasons •See rules for combining of adjacent surfaces above. Multiple restorations on contiguous surface will be treated as a single restoration.
D2331	Resin – 2 surfaces, anterior	All	•Once per 36 consecutive months •Teeth 6-11, 22-27, C-H, M-R, only	•No benefit if performed for cosmetic reasons. •Multiple restorations on contiguous surface will be treated as a single restoration.
D2332	Resin – 3 surfaces, anterior	All	•Once per 36 consecutive months •Teeth 6-11, 22-27, C-H, M-R, only	•No benefit if performed for cosmetic reasons. •Multiple restorations on contiguous surface will be treated as a single restoration.
D2335	Resin – 4+ surfaces, involving incisal angle, anterior	All	•Once per 36 consecutive months •Teeth 6-11, 22-27, C-H, M-R, only	•No benefit if performed for cosmetic reasons. •Multiple restorations on contiguous surface will be treated as a single restoration.
D2390	Resin-based composite crown, anterior	All	•Once per 36 consecutive months	
D2391	Resin-based composite – one surface, posterior	All	•Once per 36 consecutive months •Teeth 1-5, 12-16, 17-21, 28-32, A-B, I-J, K-L, S-T only	•Replacement of clinically functional restorations is not covered. •Multiple restorations on contiguous surface will be treated as a single restoration.
D2392	Resin-based composite – two surfaces, posterior	All	•Once per 36 consecutive months •Teeth 1-5, 12-16, 17-21, 28-32, A-B, I-J, K-L, S-T only	•Replacement of clinically functional restorations is not covered •Multiple restorations on contiguous surface will be treated as a single restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2393	Resin-based composite – three surfaces, posterior	All	•Once per 36 consecutive months •Teeth 1-5, 12-16, 17-21, 28-32, A-B, I-J, K-L, S-T only	•Replacement of clinically functional restorations is not covered •Multiple restorations on contiguous surface will be treated as a single restoration.
D2394	Resin-based composite – four or more surfaces, posterior	All	•Once per 36 consecutive months •Teeth 1-5, 12-16, 17-21, 28-32, A-B, I-J, K-L, S-T only	•Replacement of clinically functional restorations is not covered •Multiple restorations on contiguous surface will be treated as a single restoration.
Gold Foil Restorations				
D2410	Gold foil – one surface	All	•Limited one per 36 consecutive months •Teeth numbers 1-32 only	•Alternate benefit to equivalent amalgam restoration for posterior teeth, composite restoration for anterior teeth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2420	Gold foil – two surfaces	All	•Limited one per 36 consecutive months •Teeth numbers 1-32 only	•Alternate benefit to equivalent amalgam restoration for posterior teeth, composite restoration for anterior teeth •See rules for combining of adjacent surfaces above. Additionally, multiple restorations on one surface will be treated as a single filling.
D2430	Gold foil – three surfaces	All	•Limited one per 36 consecutive months •Teeth numbers 1-32 only	•Alternate benefit to equivalent amalgam restoration for posterior teeth, composite restoration for anterior teeth •Multiple restorations on contiguous surface will be treated as a single restoration.
Inlay/Onlay Restorations Inlays are usually alternate benefited to a direct restoration because they have not been shown to strengthen the tooth. Five-year longevity should be evident; periodontium must be healthy; and no endodontic pathology.				
D2510	Inlay, metallic – one surface	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	Multiple restorations on contiguous surface will be treated as a single restoration.
D2520	Inlay, metallic – two surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	Multiple restorations on contiguous surface will be treated as a single restoration.
D2530	Inlay, metallic – three surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	Multiple restorations on contiguous surface will be treated as a single restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2542	Onlay, metallic – two surfaces	All	•One per five years per surface combination •Must include one or more of the following surfaces: B, L (cusp replacement) •Cannot submit with D2510-2530	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2543	Onlay, metallic – three surfaces	All	•One per five years per surface combination •Must include one or more of the following surfaces: B, L (cusp replacement) •Cannot submit with D2510-2530	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2544	Onlay, metallic – 4+ surfaces	All	•One per five years per surface combination •Must include one or more of the following surfaces: B, L (cusp replacement) •Cannot submit with D2510-2530	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2610	Inlay, porcelain/ ceramic – one surface	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2620	Inlay, porcelain/ ceramic – two surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2630	Inlay, porcelain/ ceramic – 3+ surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2642	Onlay, porcelain/ ceramic – two surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2610-2630	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2643	Onlay, porcelain/ ceramic – three surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2610-2630	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2644	Onlay, porcelain/ ceramic – 4+ surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2610-2630	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2650	Inlay, composite/ resin – one surface	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2651	Inlay, composite/resin – two surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2652	Inlay, composite/resin – three+ surfaces	All	•One per 60 consecutive months •Alternate benefit to amalgam if not on the fee schedule	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2662	Onlay, composite/resin – two surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2650-2652	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2663	Onlay, composite/resin – three surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2650-2652	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
D2664	Onlay, composite/resin – four+ surfaces	All	•One per 60 consecutive months •Must involve cusp replacement •Cannot submit with D2650-2652	•Covered only when a filling cannot restore the tooth •Multiple restorations on contiguous surface will be treated as a single restoration.
Crowns – Single Restoration Only Five-year longevity should be evident; periodontium must be healthy; and no endodontic pathology. Replacement of congenitally missing teeth may not be covered under the member's plan.				
D2710	Crown – resin-based composite (indirect)	≥16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth	•Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors •If replaced with permanent crown in <1 year, payment for D2710 is deducted from permanent crown fee; if in place >one year, considered permanent crown and may not be replaced for five years. •Not to be used for lab fabricated provisional restorations – these are included in final crown fee
D2712	Crown – ¾ resin-based composite (indirect)	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2720	Crown – Resin-cast high noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2721	Crown – Resin-cast base metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2722	Crown – Resin-cast noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2740	Crown – Porcelain/ Ceramic substrate	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2750	Crown – Porcelain fused to hi noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment •Alternate benefit to noble metal	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2751	Crown – Porcelain fused to predominantly base metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2752	Crown – Porcelain fused to noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2780	Crown – ¾-cast high noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment •Alternate benefit to noble metal	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2781	Crown – ¾-cast base metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2782	Crown – ¾ noble	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2783	Crown – ¾ porcelain/ ceramic	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2790	Crown – Full-cast high noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2791	Crown – Full-cast base metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2792	Crown – Full-cast noble metal	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2794	Crown – titanium	>16	•One crown per tooth per 60 consecutive months •Covered only when a filling cannot restore the tooth •Pre-op X-ray required for payment •Alternate benefit to noble metal	Only for fully developed permanent teeth (1-32) and primary teeth (A-T) with no permanent successors.
D2799	Provisional crown	NB		Considered part of crown procedure.
Other Restorative Services				
D2910	Recement inlay, onlay, partial coverage restoration	All	•Once per six consecutive months per tooth •Limited to those performed more than 12 months after the initial insert	
D2915	Recement cast or prefabricated post and core	All	•Once per six consecutive months per tooth •Limited to those performed more than 12 months after the initial insert	
D2920	Recement crown	All	•Once per six consecutive months per tooth •Limited to those performed more than 12 months after the initial insert	

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2930	Prefabricated Stainless Steel Crown (SSC) – primary tooth	<13	•Primary tooth numbers A-T •Once per 60 consecutive months per tooth •Covered only when a filling cannot restore the tooth	Restoration of choice for primary molars in need of three+ surface restoration.
D2931	Prefabricated Stainless Steel Crown (SSC) – permanent tooth	>6	•Tooth numbers 1-5, 12-20, 28-32 •After one year in place, it is considered a permanent restoration •Once per 60 consecutive months per tooth	•If replaced with permanent crown in < one year, payment for D2391 is deducted from permanent crown fee. •If in place > one year, considered permanent crown and may not be replaced for 60 consecutive months.
D2932	Prefabricated resin crown	<7	•Primary teeth C-H, M-R only •Once per consecutive 36 months per tooth	Not for emergency treatment.
D2933	Prefabricated stainless steel crown with resin window	≤7	•Primary teeth C-H, M-R only •Once per 60 consecutive months per tooth •Prefabricated esthetic coated stainless steel crowns are limited to primary teeth	
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	≤7	•Primary teeth C-H, M-R only •Once per 60 consecutive months per tooth •Prefabricated esthetic coated stainless steel crowns are limited to primary teeth	
D2940	Protective Restoration	≥2	•Covered as a separate benefit only if no other service other than X-rays and exam were performed on the same tooth on the same day	
D2950	Core buildup, including any pins (Restoration used to build up patient's tooth so that there will be enough tooth structure to hold crown in place)	≥7	•Tooth numbers 1-32 •Once per 60 consecutive months per tooth •May not be billed with any other buildup or post and core code •May not be billed instead of, or in addition to, D2140-2161 or D2330-2394 •Pre-op X-ray required for DDS Review	Evidence of extensive caries or at least three surfaces of the tooth have severe breakdown. Must be essential for crown retention.
D2951	Pin retention, per tooth, in addition to restoration (Metal pin placed in an area where there is not enough tooth structure to hold restoration in place)	≥6	•Tooth numbers 1-32 •Once per restoration, regardless of number of pins used •Cannot be billed with D2950, D2952, or D2954	Not covered in addition to cast restoration

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2952	Cast post and core in addition to crown	≥16	•Tooth numbers 1-32 •Once per 60 consecutive months per tooth •May not be billed with any other buildup or post and core code (except D2953) •May not be billed instead of, or in addition to, D2140-2161 or D2330-2394 •Pre-op X-ray required for DDS Review	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D2953	Cast post, each additional	≥16	•Tooth numbers 1-32 •Once per 60 consecutive months per tooth •May not be billed with any other buildup or post and core code, except D2952 •May not be billed instead of, or in addition to, D2140-2161 or D2330-2394 •Pre-op X-ray required for DDS Review	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D2954	Prefabricated post and core in addition to crown	≥16	•Tooth numbers 1-32 •Once per 60 consecutive months per tooth •May not be billed with any other buildup or post and core code, except D2957 •May not be billed instead of, or in addition to, D2140-2161 or D2330-2394 •Pre-op X-ray required for DDS Review	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D2955	Post removal (not in conjunction with endodontic therapy)		NB	Considered part of the post and core procedure fee.
D2957	Prefabricated post and core in addition to crown, each additional	≥16	•Tooth numbers 1-32 •Once per 60 consecutive months per tooth •May not be billed with any other buildup or post and core code, except D2954 •May not be billed instead of, or in addition to, D2140-2161 or D2330-2394 •Pre-op X-ray required for DDS Review	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D2960	Labial veneer (laminate) – chair side	≥6	•Once per 60 consecutive months per tooth •Cannot be billed with D2335	Cosmetic procedures are not covered.
D2961	Labial veneer (resin laminate) – laboratory	≥6	•Once per 60 consecutive months per tooth •Cannot be billed with D2335, inlay, onlay or crown codes	Cosmetic procedures are not covered.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D2962	Labial veneer (porcelain laminate) – laboratory	≥6	•Once per 60 consecutive months per tooth •Cannot be billed with D2335, inlay, onlay or crown codes	Cosmetic procedures are not covered.
D2970	Temporary crown (fractured tooth)	All	Once per 60 months	Not to be used as a provisional crown during crown fabrication.
D2971	Additional procedures to construct new crown under an existing partial denture framework	>16	•Teeth 1-32 •Once per 60 consecutive months per tooth •Must have an existing partial denture that is functional and in good repair	No additional benefit allowance. Considered incidental to crown prep and fabrication.
D2975	Coping	>16	•Once per 60 consecutive months per tooth •Cannot be submitted with D2950-2954 (post and cores) for same tooth •The coping benefit is allowed only when there is insufficient natural tooth structure to retain the abutment crown or alignment is a problem.	
D2980	Crown repair, by report	All	•Once per six consecutive months per tooth •Laboratory or chair side repair of crown •May not submit in conjunction with D2140-2161, D2330-2335	Limited to repairs and/or adjustments performed more than 12 months after initial insertion.
D2999	Unspecified restorative procedure, by report	All	By report	

4.1.D Endodontic Services Guidelines

Endodontic services are provided to maintain teeth damaged by trauma or deep decay. Apical therapies and endodontic surgeries (D3410-3450) require pre- and post-operative films and date of initial root canal treatment as appropriate documentation.

The fee for root canal therapy (D3310, D3320, D3330, 3346-3348) includes all operative films taken during the procedure (the initial diagnostic X-ray (ADA Code D0220) may be billed separately) – diagnosis, removal of infected pulp (pulpectomy/pulpotomy), canal medication, temporary fillings, progress films and post-operative treatment. Service date for submission of the claim is the same as the date of final fill.

Pulpotomy is included in the fee for root canal therapy for permanent teeth (1-32) and may not be billed separately (as D3220). If the patient does not return for completion of treatment within a reasonable time period (<six months), dentist may bill for problem-focused exam (D0140), diagnostic X-ray (D0220), and palliative treatment (D9110) or pulpal debridement (D3221).

The guidelines below must be followed when providing endodontic services:

1. The standard of acceptability for payment of benefits for endodontic procedures requires that the canal(s) be completely filled (within 2 mm of the radiographic apex). In cases where a Dental Benefit Providers (DBP) Clinical Consultant determines that the root canal filling does not meet treatment standards, DBP can require the dentist to redo the procedure at no additional cost to the patient or to DBP.
2. Root canal procedures performed for elective purposes (i.e., that are not necessary because of infection or injury) are not covered.
3. Endodontic procedures should not be performed on teeth with a poor long-term restorative or periodontal prognosis (< five years).

4. Root canal therapy may be billed separately when performed in conjunction with D7270 (reimplantation and splinting).
5. Conventional, non-surgical endodontic treatment/retreatment (i.e., D3310, D3320, D3330, D3346-48) should be attempted before endodontic surgery is performed (D3410-3430).
6. Retreatment will not be reimbursed for the first 12 months after initial treatment to the dentist who performed the original endodontic procedure.
7. If, after clinical review, retreatment is required within one year due to unsatisfactory endodontic therapy, the patient may request retreatment and a refund of the original fee from the first practitioner. The patient will be financially responsible for all applicable fees for the retreatment.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Pulp Caps				
D3110	Pulp cap – direct (excluding final restoration)	All	•Once per three years per tooth •Cannot be submitted with D3220, D3310, D3320, D3330 •Not reimbursable if utilized solely as a liner or base underneath a restoration	Exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.
D3120	Pulp cap – indirect (excluding final restoration)	All	•Once per three years per tooth •Cannot be submitted with D3220, D3221, D3310, D3320, D3330 •Not reimbursable if utilized solely as a liner or base underneath a restoration	Not covered unless there is nearly exposed pulp that is covered with a dressing or cement that protects the pulp and promotes healing and repair.
Pulpotomy				
D3220	Therapeutic pulpotomy (excluding final restoration). This procedure is used to remove and fixate partially or fully infected pulp in the coronal (top) section of permanent (teeth in adults) and primary teeth in young children.	All	•Once per tooth per lifetime •Cannot be submitted with D2940, D3221, D3230, D3240, or on the same date or by the same dentist for D3310, D3320, D3330	Typically considered part of endodontic treatment, except when performed as definitive therapy for primary teeth or for incompletely developed permanent teeth in children. When used to relieve pain on an emergency basis, cannot be billed by the same dentist performing definitive root canal therapy on the tooth under treatment.
D3221	Gross pulpal debridement, primary and permanent teeth	All	•Teeth numbers 1-32 only •Cannot be submitted with D3220 or on the same date or by the same dentist as D3310-D3330	Considered part of definitive endodontic therapy, but this code is specifically identified for cases that are not completed by the initial practitioner (e.g., patients do not return to complete treatment or are referred to an endodontist for completion of treatment).
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	All	•Once per tooth per lifetime •Cannot be submitted with D2940, D3221, D3230, D3240, or on the same date or by the same dentist for D3310, D3320, D3330	

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D3230	Pulpal therapy (resorbable filling), anterior, primary tooth (excluding final restoration)		•Teeth C-H, M-Q only •Once per tooth per lifetime • Cannot be submitted with D2940, D3220, or D3310	
D3240	Pulpal therapy (resorbable filling), posterior, primary tooth (excluding final restoration)		•Teeth A, B, I, J, K, L, S, T only •Once per tooth per lifetime •Cannot be submitted with D2940, D3220, or D3330	
D3310	Anterior root canal (excluding final restoration)	≥6	•Teeth numbers 6-11, 22-27 •Once per tooth, per lifetime (for retreatment, see D3346) •Cannot be submitted with D2940 •Same dentist cannot bill for D3320 and D3220, or D3240 •Post-op X-ray required for payment	Reason for performing treatment should be clearly documented in patient chart.
D3320	Bicuspid Root Canal (Excluding Final Restoration)	>6	•Teeth numbers 4, 5, 12, 13, 20, 21, 28, 29 •Once per tooth, per lifetime (for retreatment, see D3347) •Cannot be submitted with D2940 •Same dentist cannot bill for D3320 and D3220, or D3240 •Post-op X-ray required for payment	Reason for performing treatment should be clearly documented in patient chart.
D3330	Molar Root Canal (Excluding Final Restoration)	≥6	•Teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32 •Once per tooth, per lifetime (for retreatment, see D3348) •Cannot be submitted with D2940 •Same dentist cannot bill for D3330 and D3220, or D3240 •Post-op X-ray required for payment	Reason for performing treatment should be clearly documented in patient chart.
D3331	Treatment of root canal obstruction; non-surgical	≥8	•Teeth numbers 1-32 only •Limit one per tooth per lifetime	By report.
D3332	Incomplete endo therapy – inoperable/fractured tooth	≥8	•Teeth numbers 1-32 only •Limit one per tooth per lifetime	By report.
D3333	Internal root repair of perforation	≥8	•Teeth numbers 1-32 only	By report.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D3346	Retreatment of previous root canal therapy – anterior. This procedure may include the removal of a post and/or old root canal filling material, the procedures necessary to prepare and place the new material, and complete root canal therapy.	≥13	•Teeth numbers 6-11, 22-27 •Cannot be submitted with D2940, D3110-D3221 •Cannot be billed by same dentist doing D3310 in the first 12 months after initial treatment.	•Pre- and post-op X-rays are required for Clinical Consultant review of adequate canal fill. •If it is determined that the failure was due to original dentist error, the dentist who originally performed the procedure is responsible for payment.
D3347	Retreatment of previous root canal therapy – anterior. This procedure may include the removal of a post and/or old root canal filling material, the procedures necessary to prepare and place the new material, and complete root canal therapy.	≥13	•Teeth numbers 4, 5, 12, 13, 20, 21, 28, 29 •Once per tooth, per lifetime •Cannot be submitted with D2940, D3110-D3221 •Cannot be billed by same dentist doing D3320 in the first 12 months after initial treatment	•Pre- and post-op X-rays are required for Clinical Consultant review of adequate canal fill. •If it is determined that the failure was due to original dentist error, the dentist who originally performed the procedure is responsible for payment.
D3348	Retreatment of previous root canal therapy – molar. This procedure may include the removal of a post and/or old root canal filling material, the procedures necessary to prepare and place the new material, and complete root canal therapy.	≥8	•Teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32 •Once per tooth, per lifetime •Cannot be submitted with D2940, D3110-D3221 •Cannot be billed by same dentist doing D3330 in the first 12 months after initial treatment	•Pre- and post-op X-rays are required for Clinical Consultant review of adequate canal fill. •If it is determined that the failure was due to original dentist error, the dentist who originally performed the procedure is responsible for payment.
D3351	Apexification/recalcification – initial visit	>6	•Teeth numbers 2-15, 18-31 only •Cannot be submitted with D2940, D3220, D3230, or D3240	
D3352	Apexification/recalcification – interim visit	>6	•Teeth numbers 2-15, 18-31 only •Cannot be submitted with D2940, D3220, D3230, or D3240	
D3353	Apexification/recalcification – final visit (includes completed root canal therapy)	>6	•Teeth numbers 2-15, 18-31 only •Cannot be submitted with D2940, D3220, D3230, or D3240	
D3354	Pulpal regeneration			For completion of regenerative treatment in an immature permanent tooth with a necrotic pulp.
Apicoectomy / Periradicular Service				
Retreatment is usually considered before surgical intervention. Considered if apex cannot be reached due to calcification or other anomaly.				
D3410	Apicoectomy/Periradicular Surgery – anterior	≥8	•Teeth numbers 6-11, 22-27 •Once per root, per lifetime •May not be billed in conjunction with root canal (D3310)	•Must be post-treatment reviewed; Must include pre- and post-op films, and date of RCT (D3310, D3346) •Long-term prognosis for restoration of tooth must be at least 5 years •N2O, IV sedation, and GA allowed.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D3421	Apicoectomy/Periadicular Surgery - Bicuspid	≥13	•Teeth numbers 4, 5, 12, 13, 20, 21, 28, 29 •Once per root, per lifetime •May not be billed in conjunction with root canal (D3320)	•Must be post-treatment reviewed; Must include pre- and post-op films, and date of RCT (D3320, D3347). •Long-term prognosis for restoration of tooth must be at least 5 years •N2O, IV sedation, and GA allowed.
D3425	Apicoectomy/Periadicular Surgery – Molar	≥8	•Teeth numbers 3, 4, 14, 15, 18, 19, 30, 31 •Once per root, per lifetime •Tooth numbers 2, 3, 14, 15, 18, 19, 30, 31 by report •May not be billed in conjunction with root canal (D3330)	•Must be post-treatment reviewed; Must include pre- and post-op films, and date of RCT (D3330, D3348) •Long-term prognosis for restoration of tooth must be at least five years •N2O, IV sedation, and GA allowed.
D3426	Apicoectomy/Periadicular Surgery – (each additional root)	≥8	•Teeth numbers 2-5, 12-15, 18-21, 28-31 •Teeth numbers 1, 16, 17, 32 by report •Once per root, per lifetime •May not be billed in conjunction with root canal (D3320, D3330)	•Must be post-treatment reviewed; Must include pre- and post-op films, and date of RCT (D3320, D3330, D3347, D3348). •Long-term prognosis for restoration of tooth must be at least five years •N2O, IV sedation, and GA allowed.
D3430	Retrograde filling – per root	≥8	•Teeth numbers 2-15, 18-31 •Once per root, per lifetime •Teeth numbers 1, 16, 17, 32 (wisdom teeth) by report •May not be billed in conjunction with root canal therapy (D3310- 30)	•Must be post-treatment reviewed; Must include pre- and post-op films, and date of RCT (D3310-3330, D3346-48). •Long-term prognosis for restoration of tooth must be at least five years •Must note material used, if not readily discernable from X-ray •N2O, IV sedation, and GA allowed.
D3450	Root amputation – per root (including any root removal) (If crown is sectioned, see D3920)	≥8	•Teeth numbers 2, 3, 14, 15, 18, 19, 30, 31 only •Teeth numbers 1, 16, 17, 32 (wisdom teeth) by report •Once per root, per lifetime •Root removal (D7140, D7250) may not be billed separately	•Long-term prognosis for restoration of tooth must be at least five years •Not to be considered as part of complex rehabilitative treatment •N2O, IV sedation, and GA allowed.
D3460	Endodontic endosseous implant	NB		
D3470	Intentional reimplantation (including splinting)	NB		
Other Endodontic Services				
D3910	Surgical procedure for isolation with rubber dam	NB		

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D3920	Hemisection (including any root removal), not including root canal therapy	≥8	•Teeth numbers 2, 3, 14, 15, 18, 19, 30, 31 only •Teeth numbers 1, 16, 17, 32 (wisdom teeth) by report •Once per root, per lifetime •Root removal (D7140, D7250) may not be billed separately	•Long-term prognosis for restoration of tooth must be at least five years •Not to be considered as part of complex rehabilitative treatment •N2O, IV sedation, and GA allowed
D3950	Canal preparation for dowel post	NB		Considered part of the post and core procedure
D3999	Unspecified endodontic procedure, by report			By report

4.1.E Periodontal Services Guidelines

The guidelines listed below must be followed when providing periodontal services:

If the patient has pocket depths greater than or equal to 4 mm, accumulations of subgingival calculus, bleeding points and/or radiographic bone loss, then scaling and root planing (D4341) must be performed initially. Four to six weeks after scaling and root planing is performed, the dentist should remeasure pocket depths. If pocket depths at this re-evaluation are greater than or equal to 5 mm, the patient may be approved for adjunctive antimicrobial therapy or periodontal surgery.

Additional Criteria for Grafts:

Soft tissue grafts are benefitted twice per quadrant in a 36-month period. Evidence of mobility, bruxism and/or hyperocclusion may contraindicate grafting.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Periodontal Surgical Services				Only covered if the long-term prognosis is favorable and pockets cannot be maintained non-surgically
D4210	Gingivectomy/ gingioplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	>13	•One surgery per quadrant or site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	•Allowed for medical necessity or to treat reaction to medications (hyperplastic tissue) •No benefit for cosmetic purposes •Gingivectomy incidental to crown preparation or performed at time of final preparation is not benefited.
D4211	Gingivectomy/ gingivoplasty – one to three teeth	>13	•One surgery per site per 36 consecutive months •Cannot be submitted in addition to D7970 •Used when one to three teeth in the quad are affected •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	•Allowed for medical necessity or to treat reaction to medications (hyperplastic tissue) •No benefit for cosmetic purposes •Gingivectomy incidental to crown preparation or performed at time of final preparation is not benefited.
D4230	Anatomical crown exposure – four or more contiguous teeth per quadrant	>17	•One surgery per quadrant or site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	Narrative is required to document the condition is causing disease. Not covered for cosmetic purposes.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D4231	Anatomical crown exposure – one to three teeth per quadrant	>17	•One surgery per site per 36 consecutive months •Used when one to three teeth in the quad are affected •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	>17	•Once per quadrant or site per 36 consecutive months •May not be billed in conjunction with D4341 or D4342 •Used when more than three teeth in the quad are affected	
D4241	Gingival flap procedure, including root planing – one to three teeth	>17	•Once per quadrant per 36 consecutive months •May not be billed in conjunction with D4341 or D4220 •Used when one to three teeth in the quad are affected	
D4245	Apically positioned flap	>17	Limited to one surgery per site per 36 consecutive months	
D4249	Clinical crown lengthening – hard tissue (Performed in a healthy periodontal environment)	>17	•Once per tooth per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	•There should be adequate healing prior to crown preparation. •Not for pockets 5 mm or > or if periodontal disease is evident.
D4260	Osseous surgery – four or more contiguous teeth or bounded teeth spaces per quadrant (Performed in the presence of periodontal disease)	>17	•One per quadrant per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment •Used when more than three teeth in the quad are affected	•All post-operative care is included in the fee for this procedure. •Only teeth with pocket depths > or equal to 6 mm upon re-evaluation after scaling and root planing will be considered for this procedure.
D4261	Osseous surgery – one to three teeth	>17	•One per quadrant per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment •Used when one to three teeth in the quad are affected	•All post-operative care is included in the fee for this procedure. •Only teeth with pocket depths > or equal to 6 mm upon re-evaluation after scaling and root planing will be considered for this procedure.
D4263	Bone replacement graft – first site in quadrant	>17	•Once per site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	This code is not appropriate for bone preservation grafts after an extraction.
D4264	Bone replacement graft – each additional site in quadrant	>17	•Once per site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	This code is not appropriate for bone preservation grafts after an extraction

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D4265	Biologic materials to aid soft tissue and osseous tissue regeneration	>17	•Once per site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	Narrative should be submitted to describe materials used and their rationale.
D4266	Guided tissue regeneration – resorbable barrier, per site, per tooth	>17	•Once per site per 36 consecutive months •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	All surgical procedures to place the barrier are included in the fee for this procedure, as are all post-operative care costs.
D4267	Guided tissue regeneration – resorbable barrier, per site, per tooth	>17	•Once per site per 36 consecutive months •Cannot be billed with D6010-6199 •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment	All surgical procedures to place the barrier are included in the fee for this procedure, as are all post-operative care costs.
D4268	Surgical revision procedure, per tooth	>17	Once per site per 36 consecutive months	Frequency limitations from original surgery typically do not allow for payment of this code (one surgery per site per 36 months).
Soft Tissue Grafts			Twice per quadrant per 36 consecutive months	•Significant loss of attached gingival •Unresolved sensitivity •Progressive recession or chronic inflammation •Little or no attached tissue
D4270	Pedicle soft tissue graft procedure	>17	Only one surgery per site per 36 consecutive months	
D4271	Free soft tissue graft procedure (including donor site surgery)	>17	Only one surgery per site per 36 consecutive months	
D4273	Subepithelial connective tissue graft procedure (including donor site surgery) used to cover an exposed root	>17	•Only one surgery per site per 36 consecutive months •Per tooth	
D4274	Distal or proximal wedge procedure	>17	•Once per quadrant per 36 consecutive months •May not be billed in conjunction with other soft tissue surgeries for same site/tooth range (D4240, D4270, D4271, D4273)	Performed in an edentulous area adjacent to a periodontal involved tooth to correct the underlying osseous defect
D4275	Soft tissue allograft	>17	•Only one surgery per site per consecutive 36 months •Per tooth	•Not covered for cosmetic purposes
D4276	Combined connective tissue and double pedicle graft, per tooth	>17	•Once per quadrant per 36 consecutive months •May not be billed in conjunction with other soft tissue surgeries for same site/tooth range (D4240, D4270, D4271, D4273)	•Not covered for cosmetic purposes

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Non-Surgical Periodontal Services				
D4320	Provisional splinting – intracoronal	All	•Once per quadrant per 36 consecutive months •Requires tooth number/range •Cannot be submitted with D7270 or D7670	•Need teeth numbers and type of material used •Cannot be used to restore vertical dimension or as part of full mouth rehabilitation – should not include use of laboratory fabricated crowns or bridges •Limited to multiple teeth per site
D4321	Provisional splinting – extracoronal	>16	•Once every 36 consecutive months •Cannot be submitted with D7270 or D7670	•Need teeth numbers and type of material used •Cannot be used to restore vertical dimension or as part of full mouth rehabilitation – should not include use of laboratory fabricated crowns or bridges •Limited to multiple teeth per site
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	>15	•Once per quadrant per 24 consecutive months •May not be billed in conjunction with D1110, D1120, D4240, D4260-4261 or D4355 •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment. •Used when 4 or more teeth in the quadrant are affected	•Two quadrants per visit maximum •Should be billed only for patients who have periodontal disease with pocket depths > or equal 4 mm •Usually performed with local anesthesia
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	>15	•Once per quadrant per 24 consecutive months •May not be billed in conjunction with D1110, D1120, D4240, D4260-4261 or D4355 •Pre-op X-rays and recent perio charting of affected area(s) required for review and payment. •Used when one, two or three teeth in the quadrant are affected	•Two quadrants per visit maximum •Should be billed only for patients who have periodontal disease, with pocket depths >4 mm •Should be performed with local anesthesia
D4355	Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis	>15	•Benefit frequency limit is once per 36 consecutive months •Allowed only when oral hygiene is so poor that debridement is required for oral evaluation •Cannot be submitted with D1110, D1120 or D4341/4342	The removal of sub-gingival and/or supra-gingival calculus obstructs the ability to perform an oral evaluation – no other services can be performed until this preliminary procedure is completed, except for oral hygiene instructions.
D4381	Localized delivery of antimicrobial agents, per tooth, by report	All	•Must have history of D4341, D4342, D4260-4261 performed in the same tooth range within 90 days •Once per site per 24 consecutive months •FMX-rays and new perio charting of affected area(s) required for review and payment	•Residual pocket depths are between 5-6 mm (greater than that indicates that surgery may be necessary) •Benefit may be allowed after scaling and root planing, before or after surgery for refractory pockets •A maximum of three teeth/quadrant, or a total of 12 teeth for all quadrants, will be allowed per course of treatment. More teeth may indicate that another treatment approach is appropriate.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D4910	Periodontal Maintenance	>17	•Allowed twice per consecutive 12 months within the first 24 months following active periodontal therapy (exclusive of D4355-debridement) •Not allowed within the first six weeks following periodontal treatment excluding 4355	•Exam (D0120) can be billed in conjunction with D4910, but plan only covers two exams per calendar year
D4920	Unscheduled periodontal dressing change (not by treating dentist)	All	No benefit	
D4999	Unspecified periodontal procedure, by report	All		Submit with narrative explaining specific procedure, rationale, and appropriate diagnostic information

4.1.F Removable Prosthodontic Services Guidelines

The guidelines listed below must be followed when providing removable prosthodontic services:

1. Prosthodontic services are intended to restore oral form and function in patients with missing teeth.
2. **Service date for the purpose of submitting the claim is the same as the date of insertion.**
3. Complete or partial dentures are covered when teeth are extracted while the patient is participating with the plan. If teeth were extracted prior to membership in the plan, prosthetic appliances will be covered after 12 months of continuous membership, unless otherwise specified in patient's fee schedule footnotes.
4. Partial dentures are covered only for patients with good hygiene, good periodontal health, and a reasonable five-year prognosis for the partial denture and the supporting teeth.
5. Relining (chair side or laboratory) of complete and partial upper and lower dentures is limited to once every 12 consecutive months. For new full/partial dentures, the dentist who fabricated the denture is responsible for relines for the first six months after insertion of immediate dentures.
6. Palatal lift prosthesis, obturator for cleft palate, and other maxillofacial prostheses are not covered services.
7. As part of any removable prosthetic services, dentists are expected to instruct the patient in the proper care of the prosthesis. Six months of post-insertion follow-up care (adjustments to dentures) is included for complete and partial dentures and relining complete and partial dentures.
8. Complete denture repairs include repair of major fractures, broken flanges or replacement of single or multiple lost or fractured denture teeth. Dental Benefit Providers (DBP) requires the dentist to use discretion with denture repairs.
9. Repairs to damaged partial dentures include repair of fractured flanges, repair of major or minor case connectors, cast clasps, replacing a broken clasp with wrought wire clasps, and selective repair or addition of teeth. Adding teeth and/or a clasp to a partial denture is a covered service if the addition makes the denture functional. If three repairs are needed within six months, a new denture/partial should be considered.
10. Extensive repairs of marginally functional partial dentures, and repairs when a new partial denture would be better for the health of the recipient, are non-covered repairs. Conversion of a partial denture to a temporary or permanent complete denture is not covered.
11. Complete dentures (including routine post-delivery care) are limited to one per arch, regardless of procedure code, every 60 consecutive months, provided the denture is not repairable or reline/rebase will not result in a fully functional, well-adapted appliance or as allowed by plan.
12. Partial dentures (including routine post-delivery care) are limited to one denture per arch per 60 consecutive months, regardless of code, or as allowed by plan.
13. Any denture or partial, previously paid as a benefit by DBP, that is either lost or stolen, will not be replaced unless the 60-consecutive-month requirement has been met. No denture or partial will be replaced more often than once every 60 consecutive months.
14. Immediate dentures/partials are approved at the discretion of a Clinical Consultant. Extractions done to allow for better aesthetics via removable prosthetic appliances are not a covered expense. The extracted teeth must be deemed unsalvageable. Soft tissue conditioning is included in the first six months following immediate denture delivery, and after relines/rebases.

15. Areas of missing teeth directly across from each other on the same arch ("bilaterally missing teeth") will be approved for the alternate benefit of a partial denture, as opposed to bilateral fixed bridgework. Patients may elect to receive bridgework at a fee agreed upon by both the provider and patient. The patient will then be responsible for any additional costs related to the more complex and agreed upon treatment plan. Alternate benefits for the partial denture may be used to help defray the cost of a fixed prosthesis.
16. Some removable prosthetic procedures may not be covered, including any procedures required for overdentures, claspless partial dentures, semi-precision or precision attachment partial dentures.
17. Any revisions to conventional removable prosthetics, such as precision attachments, metallic overlays on posterior teeth, revisions designed to change the vertical dimension of occlusion, custom-designed major connectors, etc., are not covered by the plan. Any additional lab costs (such as for gold) or unusual lab costs are the financial responsibility of the patient who has agreed to the procedure or prosthetic.
18. Splinting of teeth for periodontal purposes solely via the prosthesis or to increase retention of a fixed prosthesis is not covered.
19. No benefit will be allowed to replace non-functioning teeth (teeth with no opposing tooth).
20. Benefits are available to replace natural teeth that are missing. No benefit is allowed to place a tooth in a space that was not created by the loss of a tooth or by a congenitally missing tooth.
21. Reimbursement for removable prosthetics (complete and partial dentures) is based on the date of service for delivery of the prosthesis. It is also contingent upon alternate benefit allocation. Frequency is limited to when the prosthesis was placed, even if paid by another plan.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Removable Prosthodontics				
D5110	Complete Upper Denture	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered •No additional allowance for overdentures or customized dentures
D5120	Complete Lower Denture	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered •No additional allowance for overdentures or customized dentures
D5130	Immediate (Complete) Upper	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Extractions are billed separately on same visit date. •Soft tissue conditioning is included in procedure. •Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5140	Immediate denture – mandibular	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Extractions are billed separately on same visit date. •Soft tissue conditioning is included in procedure. •Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Partial Dentures (Including Routine Post-Delivery Care)				
D5211	Upper Partial Denture Resin Base (including any conventional clasps, rests, and teeth)	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5212	Lower Partial Denture Resin Base (including any conventional clasps, rests, and teeth)	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5213	Maxillary Partial Denture – Cast Metal	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5214	Mandibular Partial Denture – Cast Metal	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5225	Maxillary partial denture – flexible base	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
D5226	Mandibular partial denture – flexible base	All	•Limited to once every 60 consecutive months •For replacement, the prosthesis must be irreparable or beyond correction by reline or rebase. •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage.	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	All	•Limited to once every 60 consecutive months •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan, unless otherwise stated in the certificate of coverage. •Only one allowed per arch (#1-16 or #17-32) •If two separate D5281's are submitted for same arch, alternate benefit to appropriate partial denture code (D5213 or D5214)	•Replacement of an accidentally broken, lost, or stolen denture is not covered. •No additional allowance for overdentures or customized dentures
Adjustments to Dentures				
D5410	Adjust Complete Denture – Upper	All	•Once per six consecutive months per prosthesis •May not be billed for 12 months after denture placed	Adjustments within 12 months of initial insertion are included in the fee for the prosthesis.
D5411	Adjust Complete Denture – Lower	All	•Once per six consecutive months per prosthesis •May not be billed for 12 months after denture placed	Adjustments within 12 months of initial insertion are included in the fee for the prosthesis.
D5421	Adjust Partial Denture – Upper	All	•Once per six consecutive months per prosthesis •May not be billed for 12 months after denture placed	Adjustments within 12 months of initial insertion are included in the fee for the prosthesis.
D5422	Adjust Partial Denture – Lower	All	•Once per six consecutive months per prosthesis •May not be billed for 12 months after denture placed	Adjustments within 12 months of initial insertion are included in the fee for the prosthesis.
Repairs to Complete Dentures				
D5510	Repair Broken Complete Denture Base	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5520	Repair Missing or Broken Teeth – Complete Denture (each tooth)	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
Repairs to Partial Dentures Extensive repair of marginally functional dentures may not be covered. More than three repairs for same problem may not be benefited.				
D5610	Repair Resin Saddle or Base – Partial	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5620	Repair Cast Framework – Partial Denture	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5630	Repair or Replace Broken Clasp – Partial Denture	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5640	Replace Broken Teeth – Per Tooth – Partial Denture	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5650	Add Tooth to Existing Partial Denture	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5660	Add Clasp to Existing Partial Denture	All	•Once per 12 consecutive months per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	All	•Once per five consecutive years per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		•Once per five consecutive years per prosthesis •May not be billed for 12 months after denture placed	Repairs within 12 months of initial insertion are included in the fee for the prosthesis.
Dentures Reline / Rebase Procedures				
D5710	Rebase complete maxillary denture	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	For refitting the entire denture base
D5711	Rebase complete mandibular denture	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	For refitting the entire denture base
D5720	Rebase partial maxillary denture	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	For refitting the entire denture base
D5721	Rebase partial mandibular den-ture	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	For refitting the entire denture base
D5730	Reline Upper Complete Denture (chair side)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5731	Reline Lower Complete Denture (chair side)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
D5740	Reline Upper Partial Denture (chair side)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
D5741	Reline Lower Partial Denture (chair side)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
D5750	Reline Complete Upper Denture (laboratory)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
D5751	Reline Complete Lower Denture (laboratory)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5760	Reline Upper Partial Denture (laboratory)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
D5761	Reline Lower Partial Denture (laboratory)	All	•Once per 12 consecutive months per procedure •May not be billed for six months after denture placed	•Patient must pay for more frequent relines if reline made necessary by issues unrelated to denture fabrication. •Provider must pay for more frequent relines if reline made necessary by a problem with denture fabrication. •All reline adjustments are included in reline procedure. •Relines within six months of delivery are included in the fee for the prosthesis.
Interim Prosthesis				
D5810	Interim Complete Denture (upper)	All	Once per 60 consecutive months	•NB if used as provisional or temporary restoration. After one year in place, this is considered the final restoration. •No additional allowance for over-denture or customized denture
D5811	Interim Complete Denture (lower)	All	Once per 60 consecutive months	•NB if used as provisional or temporary restoration. After one year in place, this is considered the final restoration. •No additional allowance for over-denture or customized denture
D5820	Interim Maxillary Partial Denture	All	Once per 60 consecutive months	•NB if used as provisional or temporary restoration. After one year in place, this is considered the final restoration. •No additional allowance for over-denture or customized denture
D5821	Interim Mandibular Partial Denture	All	Once per 60 consecutive months	•NB if used as provisional or temporary restoration. After one year in place, this is considered the final restoration. •No additional allowance for over-denture or customized denture
Other Removable Prosthetic Services				
D5850	Tissue conditioning, maxillary	All	•Once per 12 consecutive months per prosthesis •Cannot be submitted within six months of delivery of new full or partial denture or relined/rebased prosthesis	Soft tissue conditioning is included in the first six months following immediate denture fabrication and after relines/rebases.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5851	Tissue conditioning, mandibular	All	•Once per 12 consecutive months per prosthesis •Cannot be submitted within six months of delivery of new full or partial denture or relined/rebased prosthesis	Soft tissue conditioning is included in the first six months following immediate denture fabrication and after relines/ rebases.
D5860	Overdenture – complete, by report	All	•Once per 60 consecutive months per prosthesis •An alternate benefit of a complete denture (D5110 or D5120) may apply unless the group or plan covers D5860	•No benefits for any precision or semi-precision attachments unless covered by the group or plan •Benefit equal to the equivalent complete denture may apply
D5861	Overdenture – partial, by report	All	•Once per 60 consecutive months per prosthesis •An alternate benefit of a complete denture (D5110 or D5120) may apply unless the group or plan covers overdentures	•No benefits for any precision or semi-precision attachments unless covered by the group or plan •Benefit equal to the equivalent partial denture may apply
D5862	Precision attachment, by report	NB		No benefits for any additional attachment to prostheses
D5867	Replacement of precision attachment	NB		No benefits for any additional attachment to prostheses
D5875	Prostheses modification	NB		No benefits for any additional attachment to prostheses
D5899	Unspecified removable prosthetic procedure, by report	NB		By report
D5911	Facial moulage (sectional)	NB		Not covered under dental plan – check with medical
D5912	Facial moulage (complete)	NB		Not covered under dental plan – check with medical
D5913	Nasal prosthesis	NB		Not covered under dental plan – check with medical
D5914	Auricular prosthesis	NB		Not covered under dental plan – check with medical
D5915	Orbital prosthesis	NB		Not covered under dental plan – check with medical
D5916	Ocular prosthesis	NB		Not covered under dental plan – check with medical
D5919	Facial prosthesis	NB		Not covered under dental plan – check with medical
D5922	Nasal septal prosthesis	NB		Not covered under dental plan – check with medical
D5923	Ocular prosthesis, interim	NB		Not covered under dental plan – check with medical
D5924	Cranial prosthesis	NB		Not covered under dental plan – check with medical
D5925	Facial augmentation implant prosthesis	NB		Not covered under dental plan – check with medical
D5926	Nasal prosthesis, replacement	NB		Not covered under dental plan – check with medical
D5927	Nasal prosthesis, replacement	NB		Not covered under dental plan – check with medical
D5928	Orbital prosthesis, replacement	NB		Not covered under dental plan – check with medical
D5929	Facial prosthesis, replacement	NB		Not covered under dental plan – check with medical

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D5931	Surgical obturator	NB		Not covered under dental plan – check with medical
D5933	Refitting of obturator	NB		Not covered under dental plan – check with medical
D5934	Resection device with guide flange	NB		Not covered under dental plan – check with medical
D5935	Resection device without guide flange	NB		Not covered under dental plan – check with medical
D5936	Obturator prosthesis, interim	NB		Not covered under dental plan – check with medical
D5937	Trismus appliance (not for TMJ)	NB		Not covered under dental plan – check with medical
D5951	Feeding aid	NB		Not covered under dental plan – check with medical
D5952	Pediatric speech aid	NB		Not covered under dental plan – check with medical
D5953	Adult speech aid	NB		Not covered under dental plan – check with medical
D5954	Palatal augmentation prosthesis	NB		Not covered under dental plan – check with medical
D5955	Palatal lift prosthesis, definitive	NB		Not covered under dental plan – check with medical
D5958	Palatal lift prosthesis, interim	NB		Not covered under dental plan – check with medical
D5959	Palatal lift prosthesis, modification	NB		Not covered under dental plan – check with medical
D5960	Speech aid prosthesis, modification	NB		Not covered under dental plan – check with medical
D5982	Surgical stent	NB		Not covered under dental plan – check with medical
D5983	Radiation carrier	NB		Not covered under dental plan – check with medical
D5984	Radiation shield	NB		Not covered under dental plan – check with medical
D5985	Docking device cone locator	NB		Not covered under dental plan – check with medical
D5986	Fluoride appliance, per arch	NB		Not covered under dental plan – check with medical
D5987	Commissure splint	NB		Not covered under dental plan – check with medical
D5988	Surgical splint	NB		Not covered under dental plan – check with medical
D5991	Topical medicament carrier	NB		
D5999	Unspecified maxillofacial prosthesis, by report			Not covered under dental plan – check with medical

4.1.G Implant and Fixed Prosthetic Services Guidelines

Fixed prosthetic services refer to bridgework (fixed partial dentures) for the replacement of single or multiple missing teeth. The appliance is cemented onto remaining teeth (abutments) and may not be removed by the patient.

As with crowns, there is a classification of the different types of metal used in a unit of bridgework:

- High Noble = Gold, Palladium, and/or Platinum >60% with at least 40% AU
- Noble = Gold, Palladium, and/or Platinum >25%
- Predominantly Base = Gold, Palladium, and/or Platinum <25%

The guidelines listed below must be followed when providing removable prosthodontic services:

1. Fixed bridgework may be covered when teeth are extracted while the patient is participating with the plan. If teeth were extracted prior to membership in the plan, benefits for fixed prosthetic appliances will be considered after 12 months of membership, unless otherwise specified in patient's fee schedule.
2. If a patient has bilaterally missing teeth or more than two missing teeth, benefits for fixed bridgework may be allowed an alternative amount equal to a removable partial denture. Alternate benefits for the partial denture may be used to defray the cost of the fixed bridgework.
3. Benefits may be allowed for a unilateral bridge within the first 12 months of membership if the tooth/teeth to be replaced is/are extracted while covered under the plan and the other criteria listed in this section are satisfied.
4. Reimbursement for fixed prosthetics (bridgework) is based on the date of service for delivery of the prosthesis. It is also contingent upon clinical review for necessity, as well as alternate benefit allocation.
5. If a pre-treatment authorization requests one bridge, but there is an existing bridge on the opposite side of the arch with a questionable long-term (five-year) prognosis, the new bridge may be denied and a removable partial denture may be approved as an alternate benefit.
6. If fixed bridgework is allowed an alternate benefit of a removable partial denture, each abutment is adjudicated as if it were a single unit crown. If the abutment tooth requires full-coverage or crown replacement because of decay, recurrent decay, or other disease or injury, benefits for a single crown may be allowed for each affected abutment in addition to a benefit for the removable partial denture.
7. Precision and semi-precision attachments are not covered in standard plans.
8. Any fixed prosthetic procedure involving implants is not covered in standard plans.
9. Benefits for implants and associated prostheses will be denied in standard plans. Alternate benefits are not available when the implant itself is a non-covered procedure.
10. Cantilever bridges with only one pontic may be covered in instances where there are no bilaterally missing teeth.
11. Complex oral rehabilitation is not covered under the plan. Any significant alteration of vertical dimension of occlusion to be accomplished by fixed bridgework is considered complex and beyond the scope of the standard plan.
12. Restoration of teeth, crowns, bridges, veneers, etc., solely for cosmetic reasons is not covered.
13. Any elective treatment is not a covered expense.
14. Replacement of a prosthetic device fewer than five years old is not covered for any reason.
15. Replacement of prostheses five years old or more, without damage or recurrent decay, or if repairable, is not covered. The repair is a covered expense.
16. Splinting of teeth using fixed prosthetics solely to correct tooth mobility is not covered.
17. Pre-operative, full-mouth X-rays are required for review by a clinical consultant for a pre-treatment estimate or payment of claim.

Additional Criteria:

Abutment Considerations:

- Should be at least 50% bony support with no ligament or apical pathology and with favorable crown/root ratio.
- Span of bridge and angulation of abutments should be considered in terms of suitable number of abutments. Excessive number of abutments relative to the number of teeth being replaced should be reviewed for dental necessity and possible alternate benefit.
- Dental services and treatments for restoring tooth structure loss from abnormal or excessive wear or attrition, abrasion, abfraction, bruxism and/or erosion may not be covered.

Endodontic Considerations:

Endodontic fill should be dense, within 2 mm of apex and not significantly beyond (as evidenced on post-op film).

Long-Standing Missing Teeth:

Not generally covered to replace long-standing missing teeth in a stable occlusion. Example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in full or partial occlusion or contact.

Full-Mouth Reconstruction (FMR):

FMR encompasses the reestablishment of the occlusal profile whereby all or most teeth are restored via laboratory fabricated crowns, onlays and/or fixed bridges. Treatment plans are generally extensive and delivered in phases over an extended period of time. FMR associated with a change in vertical dimension of occlusion, treatment of temporomandibular disorder or cosmetic dentistry, is generally not covered. FMR may be covered to restore teeth damaged by significant decay, fracture or lack of structural integrity, as well as to replace large defective restorations — by application of the same criteria used for the consideration of indirect restorations.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Implants				
D6010	Surgical placement of an implant body (endosteal)	All	NB unless included in specific employer benefit plan	Clinical review required
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	NB		
D6040	Surgical placement (eposteal)	All	NB unless included in specific employer benefit plan	Clinical review required
D6050	Surgical placement (transosteal)	All	NB unless included in specific employer benefit plan	Clinical review required
Implant – Supported Prosthetics				
D6053	Implant/abutment supported removable denture – completely edentulous arch	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6054	Implant/abutment supported removable denture – partially edentulous arch	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6055	Dental implant supported connecting bar	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6056	Prefabricated abutment – includes placement	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6057	Custom abutment – includes placement	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6058	Abutment supported porcelain/ceramic crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6059	Abutment supported porcelain-to-high metal crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6060	Abutment supported porcelain-to-base crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6061	Abutment supported porcelain-to-noble crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6062	Abutment supported cast high noble crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6063	Abutment supported base metal crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6064	Abutment supported noble metal crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6094	Abutment supported retainer crown for FPD (titanium)	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6065	Implant supported porcelain/ceramic crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6066	Implant supported porcelain-fused to titanium/high noble metal crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6067	Implant supported titanium/high noble crown	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6068	Abutment supported retainer for porcelain/ ceramic FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6069	Abutment supported retainer for high noble FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6070	Abutment supported retainer for PFM metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6071	Abutment supported retainer for PFM metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6072	Abutment supported retainer for cast noble metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6073	Abutment supported retainer for cast metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6074	Abutment supported retainer for cast metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6194	Abutment supported retainer for FPD – titanium	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6075	Implant supported retainer for PFM titanium/high noble FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6076	Implant supported retainer for PFM titanium/high noble FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6077	Implant supported retainer for cast titanium/ high noble metal FPD	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6078	Implant/abutment supported fixed denture edentulous arch	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6079	Implant/abutment supported fixed denture partially edentulous arch	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
Other Implant Services				
D6080	Implant maintenance procedures	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6090	Repair implant supported prosthesis, by report	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6091	Replacement of semi-precision attachment of implant/abutment supported prosthesis, per attachment	NB		
D6092	Recement implant/abutment supported crown	All	•NB unless included in specific employer benefit plan•Once per six consecutive months per tooth •Limited to those performed more than 12 months after the initial insert	
D6093	Recement implant/abutment supported fixed partial denture	All	•NB unless included in specific employer benefit plan •Once per six consecutive months per tooth •Limited to those performed more than 12 months after the initial insert	
D6094	Implant supported crown – titanium	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6095	Repair implant abutment, by report	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6100	Implant removal, by report	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6190	Radiographic/surgical index, by report	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
D6199	Unspecified implant procedure, by report	All	•NB unless included in specific employer benefit plan •In cases where this is a covered benefit, limited to one per 60 consecutive months	Clinical review required
Fixed Prosthetics-Pontics				
D6205	Pontic – indirect resin-based composite	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan •Pre-op, full-mouth X-rays required for payment •Not used as provisional or temporary restoration	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6210	Pontic – cast high noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6211	Pontic – cast predominantly base metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6212	Pontic – cast noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6214	Pontic - titanium	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6240	Pontic – porcelain fused to high noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6241	Pontic – porcelain fused to predominantly base metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6242	Pontic – porcelain fused to noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6245	Pontic – porcelain/ ceramic	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6250	Pontic – resin with high noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6251	Pontic – resin with predominantly base metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6252	Pontic – resin with noble metal	All	•Once per 60 consecutive months per tooth •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit.
D6253	Provisional pontic	All	•This procedure may be subject to an alternate benefit •Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. •Pre-op, full-mouth X-rays required for payment	•Full-mouth X-rays must be included if a prior authorization is requested. •Restoration of vertical dimension of occlusion ("bite height") is not covered. •This procedure may be subject to an alternate benefit. •NB if used as provisional or temporary restoration.
Fixed Partial Dentures Retainers – Inlays / Onlays				
D6545	Retainer – cast metal for resin-bonded fixed prosthesis	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good.	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6548	Retainer – porcelain/ ceramic	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6600	Inlay – porcelain/ ceramic, two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6601	Inlay – porcelain/ceramic, three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6602	Inlay – cast high noble metal – two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6603	Inlay – cast high noble metal – three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6604	Inlay – cast base metal – two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6605	Inlay – cast base metal – three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6606	Inlay – cast noble metal – two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6607	Inlay – cast noble metal – three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6624	Inlay – titanium	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual direct restoration if bridge is denied but tooth needs restoration.
D6608	Onlay – porcelain/ ceramic, two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6609	Onlay – porcelain/ ceramic, three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6610	Onlay – cast high noble metal, two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6611	Onlay – cast high noble metal, three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6612	Onlay – base metal, two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6613	Onlay – base metal, three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6614	Onlay – cast noble metal, two surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6615	Onlay – cast noble metal, three or more surfaces	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6624	Inlay – titanium	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6634	Onlay – titanium	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Fixed Partial Denture Retainers – Crowns				
D6710	Crown – indirect resin-based composite	All		
D6720	Crown – resin with high noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6721	Crown – resin with predominantly base metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6722	Crown – resin with noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration. •High noble will be paid at same maximum allowance as noble metal.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6740	Crown – porcelain/ ceramic	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6750	Crown – porcelain fused to high noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration. •High noble will be paid at same maximum allowance as noble metal.
D6751	Crown – porcelain fused to predominantly base metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6752	Crown – porcelain fused to noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6780	Crown – 3/4-cast high noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration. •High noble will be paid at same maximum allowance as noble metal.
D6781	Crown – 3/4-cast base metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6782	Crown –3/4-cast noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6783	Crown – 3/4 porcelain/ ceramic	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration. •High noble will be paid at same maximum allowance as noble metal.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6790	Crown – full-cast high noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration. •High noble will be paid at same maximum allowance as noble metal.
D6791	Crown – full-cast predominantly base metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6792	Crown – full-cast noble metal	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
D6793	Provisional retainer – crown	All		•Considered incidental to and included in the maximum allowable charge for the fixed prosthesis •No benefit allowed for a temporary crown

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6794	Crown – titanium	All	•Patient must be on plan 12 months before this procedure is covered if teeth were missing prior to joining plan. Some plans may not have a waiting period. •Frequency limit once per 60 consecutive months, per tooth •If alternate benefit of partial denture is allowed for pontics, each abutment will be evaluated for necessity of indirect restoration. •Periodontal and endodontic prognosis must be good	•Full-mouth X-rays must be included with a claim for payment or if a prior authorization is requested. •Restoration of vertical dimension of occlusion is not covered. •This procedure may be subject to an alternate benefit. May be approved as an individual restoration if bridge is denied but tooth needs full coverage restoration.
Other Fixed Partial Denture Services				
D6920	Connector bar	NB		Precision, semi-precision attachments and modifications of conventional and resin-bonded bridges are not covered.
D6930	Recement bridge	All	Once per six consecutive months per bridge	
D6940	Stress breaker	NB		Precision, semi-precision attachments and modifications of conventional and resin-bonded bridges are not covered.
D6950	Precision attachment	NB		Precision, semi-precision attachments and modifications of conventional and resin-bonded bridges are not covered.
D6970	Cast post and core in addition to fixed partial denture retainer	All	•Frequency limit once per 60 consecutive months, per tooth •Endodontics performed on tooth and prognosis favorable	•Must include full-mouth X-rays and final endo film of abutment tooth •Can only be performed on tooth that had endodontic treatment (root canal)
D6972	Prefabricated post and core in addition to bridge retainer	All	•Frequency limit once per 60 consecutive months, per tooth •Endodontics performed on tooth and prognosis favorable	•Must include full-mouth X-rays and final endo film of abutment tooth •Can only be performed on tooth that had previous endodontic treatment (root canal)
D6973	Core buildup for retainer, including any pins	All	•Frequency limit once per 60 consecutive months, per tooth •Cannot be submitted with 6970-72 (post and cores) for same tooth •Every crown does not require a buildup. The buildup is necessary only when there is insufficient natural tooth structure to retain the abutment crown.	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D6975	Coping, metal	All	•Frequency limit once per 60 consecutive months, per tooth •Cannot be submitted with 6970-72 (post and cores) for same tooth •Very few crowns require a coping. The coping is necessary only when there is insufficient natural tooth structure to retain the abutment crown or alignment is a problem.	•Must include full-mouth X-rays and final endo film of abutment tooth •A minimum of half of the tooth structure is missing after crown preparation and the tooth cannot retain the cast crown
D6976	Each additional cast post	All	•By report •Frequency limit once per 60 consecutive months, per tooth •To be used with D6970 or D6971 •Endodontics performed on tooth and prognosis favorable	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D6977	Each additional prefabricated post	All	•By report •Frequency limit once per 60 consecutive months, per tooth •To be used with D6970 or D6971 •Endodontics performed on tooth and prognosis favorable	Limited to teeth that have had root canal therapy. Only for retention or reinforcement when inadequate tooth structure remains for retention or to resist masticatory forces.
D6980	Bridge repair, by report	All	Once per six consecutive months per bridge	Long-term prognosis must be good for bridge and supporting dentition
D6985	Pediatric partial denture, fixed	All	•Posterior primary teeth (A, B, I, J, K, L, S, T), one per quad per lifetime •Anterior primary teeth (C-H, M-Q) <4 yrs old, by report •Permanent teeth (1-32) by report	•This procedure is appropriate for patients who lose primary molars (Teeth A, B, I, J, K, L, S, T) early, as it may prevent tooth migration and severe malocclusion. •This procedure is not covered if the permanent tooth has started to erupt.
D6999	Unspecified fixed prosthodontic procedure, by report	All	By report	Send narrative, including specific procedure and appropriate diagnostics.

4.1.H Oral and Maxillofacial Surgery Services Guidelines

Oral and maxillofacial surgical services may be necessary because of trauma or diseased, painful or non-restorable teeth.

The guidelines listed below, along with the limitations described in the table below, must be followed when providing oral and maxillofacial surgery services:

1. Extraction of teeth that are painful, diseased and/or posing a risk to the overall oral health of the patient is covered. Removal of teeth for cosmetic reasons is not covered. Elective removal of teeth is not covered.
2. Local anesthesia and routine postoperative care (suture removal, irrigation, examination and prescriptions) are included in the fee for extraction.
3. Suturing may be billed separately only when not performed in conjunction with surgery (i.e., trauma). Suturing incidental to the surgical procedure (i.e., surgical extraction) may not be charged separately, as it is included in the surgical fee.
4. For the excision of hyperplastic tissue (per arch), the patient must have an area of missing teeth where a full or partial denture, or a pontic, will rest. The service includes all local anesthetic, suturing, postoperative care and soft tissue conditioning of any appliances concurrent with surgery and post-surgery during the healing phase.
5. Impacted teeth are teeth that are positioned against other teeth or positioned within the bone or soft tissue in such a manner that complete eruption is unlikely. Developing and/or erupting teeth are not impacted. Additionally, clinical evidence does not support prophylactic removal of impactions without appropriate signs and/or symptoms of current or future pathology.

Use ADA-standard nomenclature to identify supernumerary teeth on the claim form.

Bone grafting with an extraction is not a benefit unless a significant residual defect is present or if needed for implant placement for those plans that cover implants.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Extractions (Includes Local Anesthesia, Suturing and Routine Postoperative Care)				
D7111	Extraction, coronal remnants – primary teeth	All	•One per tooth per lifetime •Removal of soft tissue retained coronal remnants •Teeth A-T	
D7140	Extraction, erupted tooth, or exposed root	All	•One per tooth per lifetime •Tooth extracted with elevator and/or forceps •Includes routine removal of tooth structure, smoothing of socket bone, and closure, as necessary •Includes non-surgical removal of root or root remnants	•No clinical review performed except if ≥8 teeth are extracted in one visit
Surgical Extractions (Includes Local Anesthesia, Suturing and Routine Postoperative Care) – Clinical Consultant may alternate benefits. Not generally covered unless pathology or symptoms are present. Classification is based on anatomic position of the tooth, not the technique required for its removal. Extraction includes removal of granulomatous or minor cystic tissue associated with the tooth.				
D7210	Surgical Removal of Erupted Tooth	All	•One per tooth per lifetime •Pre-op X-rays required for payment	
D7220	Removal of Impacted Tooth – Soft Tissue	All	•One per tooth per lifetime •Pre-op X-rays required for payment	•Occlusal surface must be totally covered by soft tissue, requiring flap elevation and surgical site closure.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7230	Removal for Impacted Tooth – Partially Bony	All	•One per tooth per lifetime • Pre-op X-rays required for payment	•Occlusal surface must be partially covered by bone
D7240	Removal of Impacted Tooth – Completely Bony	All	•One per tooth per lifetime •Pre-op X-rays required for payment	•Occlusal surface must be mostly to completely covered by bone
D7241	Removal of impacted tooth, completely bony, with unusual complications	All	•One per tooth per lifetime •Pre-op X-rays required for payment	•Occlusal surface must be mostly to completely covered by bone •Narrative is helpful. Describe unusual difficulty or provide clinical notes.
D7250	Surgical Removal of Residual Tooth Roots	All	•One per tooth per lifetime •Pre-op X-rays required for payment	•Removal of bone and gum tissue must be necessary. Retained root fragments must only be accessible through surgery (i.e., not visible above the gum tissue).
Other Surgical Procedures				
D7260	Oroantral fistula closure	All	•One time per tooth per clinical incident •Specify site (UR/UL), location or tooth number, as appropriate •No additional benefit for suturing (D7911, D7912)	•Excision of fistulous tract between maxillary sinus and oral cavity, and close by advancement flap
D7261	Primary closure of sinus perforation	All	•Limited to one per tooth per lifetime •Specify site (UR/UL), location or tooth number, as appropriate •No additional benefit for suturing (D7911, D7912)	•Subsequent to surgical removal of tooth, exposure of sinus requiring repair in absence of fistulous tract
D7270	Tooth re-implantation	All	•Tooth numbers 2-15 and 18-31 •Limited to one per site per lifetime •Cannot submit with D4320 or 4321 •Specify site (UR/UL), location or tooth number, as appropriate	
D7272	Tooth transplantation	NB		
D7280	Surgical access of unerupted tooth for orthodontic reasons	All	•One per tooth per lifetime •Tooth numbers 2-15, 18-31 only •No orthodontic bracket, band or other device is placed on the tooth	•Allowed in conjunction with an approved orthodontic case •Supernumerary (extra) and third molars (wisdom teeth, 1, 16, 17, 32) are not covered.
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	All	•One per tooth per lifetime •Tooth numbers 2-15, 18-31 •Tooth is moved/luxated to eliminate ankylosis	•Supernumerary teeth are not covered. •Nitrous oxide, IV sedation, or general anesthesia may be allowed, based upon the patient's age and/or medical necessity. •Subject to review and alternate benefit

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7283	Placement of device to facilitate eruption of impacted tooth	All	•One per tooth per lifetime •Tooth numbers 2-15, 18-31, only •Orthodontic bracket, band or other device is placed on the tooth •Done in conjunction with D7280	•Supernumerary teeth are not covered.
D7285	Biopsy of oral tissue – hard	All	•One biopsy per site per visit •Not to be used for or with D3410-3450 •Specify site (UR/UL), location or tooth number, as appropriate •Biopsy of bone or tooth	
D7286	Biopsy of oral tissue – soft	All	•One biopsy per site per visit •Not to be used for or with D3410-3450 •Specify site (UR/UL), location or tooth number, as appropriate •Biopsy of soft tissue	
D7287	Exfoliative cytological sample collection	All	•One biopsy per site per visit •Not to be used for or with D3410-3450 •Specify site (UR/UL), location or tooth number, as appropriate •Biopsy of soft tissue	
D7288	Brush biopsy – transepithelial sample collection	All	•One biopsy per site per visit •Not to be used for or with D3410-3450 •Specify site (UR/UL), location or tooth number, as appropriate •Biopsy of soft tissue	
D7290	Surgical repositioning of teeth	NB		
D7291	Transseptal fiberotomy, by report	All	•Cannot be submitted with 4240, 4260 •One per tooth per lifetime •Specify site (UR/UL), location or tooth number, as appropriate	•The connective tissue attachment around involved teeth is severed •When there are adjacent teeth, the transseptal fibertomy of a single tooth will involve a minimum of three teeth.
D7292	Surgical placement: temporary anchorage device (screw retained plate) requiring surgical flap	NB		
D7293	Surgical placement: temporary anchorage device requiring surgical flap	NB		
D7294	Surgical placement: temporary anchorage device without surgical flap	NB		
D7295	Harvest of bone for use in autogenous grafting procedure	NB		

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Aveoloplasty – Surgical Preparation of Ridges for Dentures				
D7310	Alveoloplasty in conjunction with extractions – per quadrant	All	•Tooth numbers 1-32 •Not covered for single tooth extractions; bone recontouring should be included in the extraction fee •Pre-op X-rays and narrative required for payment •Specify site (UR/UL), location or tooth number, as appropriate •Four or more teeth per quadrant	•Area must appear to require extensive recontouring to support prosthesis following normal extraction site contouring •May not be allowed in addition to surgical extractions in same site
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	All	•Tooth numbers 1-32 •Three or fewer teeth per quadrant •Not covered for single tooth extractions – bone recontouring should be included in the extraction fee •Must be in addition to or distinct from the extraction procedure •Pre-op X-rays and narrative required for payment •Specify site (UR/UL), location or tooth number, as appropriate	•Area must appear to require extensive recontouring to support prosthesis following normal extraction site contouring •May not be allowed in addition to surgical extractions in same site
07320	Alveoloplasty not in conjunction with extractions – per quadrant	All	•Not covered for single tooth extractions sites – bone recontouring should be included in the extraction fee •Not done in conjunction with D7110-7250 S •Four or more teeth per quadrant •Alveoloplasty is done in an edentulous area •Specify site (UR/UL), location or tooth number, as appropriate	•Performed to prepare area for partial or full denture
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	All	•Not covered for single tooth extractions sites – bone recontouring should be included in the extraction fee •Not done in conjunction with D7110-7250 •Three or fewer teeth per quadrant •Alveoloplasty is done in an edentulous area that is less than a full quadrant (<4 teeth). •Specify site (UR/UL), location or tooth number, as appropriate	•Performed to prepare area for partial or full denture

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7340	Vestibuloplasty – ridge extension	All	•Limited to one time per site per 60 consecutive months •Specify site (UR/UL), location or tooth number, as appropriate •Healing by secondary epithelialization	•Performed to prepare area for partial or full denture
D7350	Vestibuloplasty – ridge extension	All	•Limited to one time per site per 60 consecutive months •Specify site (UR/UL), location or tooth number, as appropriate •Includes tissue grafts muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue	•Performed to prepare area for partial or full denture
Surgical Excision of Soft Tissue Lesions				
D7410	Excision of benign lesion up to 1.25 cm	All	•Limited to one time per site per 36 consecutive months •Specify site (UR/UL), location or tooth number, as appropriate •Soft tissue	•May be denied for medical benefits
D7411	Excision of benign lesion greater than 1.25 cm	All	•Limited to one time per site per 36 consecutive months •Specify site (UR/UL), location or tooth number, as appropriate •Soft tissue	•May be denied for medical benefits
D7412	Excision of benign lesion – complicated	All	•Limited to one time per site per 36 consecutive months •Specify site (UR/UL), location or tooth number, as appropriate •Requires extensive undermining with advancement	•May be denied for medical benefits
D7413	Excision of malignant lesion up to 1.25 cm	NB		Submit to medical plan
D7414	Excision of benign tumor – diameter up to 1.25 cm	NB		Submit to medical plan
D7415	Excision of benign tumor – diameter greater than 1.25 cm	NB		Submit to medical plan
D7465	Destruction of lesion(s) by physical or chemical method, by report	All	Cryosurgery laser electro surgery	No additional benefit is allowed for use of special devices or instrumentation. Refer to D7410–D7415.
Surgical Excision Of Intra-Osseous Lesions				
D7440	Excision, malignant tumor ≤1.25 cm	NB		Often covered under medical plan
D7441	Excision, malignant tumor >1.25 cm	NB		Often covered under medical plan

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7450	Removal of benign odontogenic cyst or tumor – up to 1.25 cm in diameter	All	•One per site per visit •Specify site (UR/UL), location or tooth number, as appropriate	•May be denied for medical benefits
D7451	Removal of benign odontogenic cyst or tumor greater than 1.25 cm in diameter	All	•One per site per visit •Specify site (UR/UL), location or tooth number, as appropriate •Pre-op X-rays and pathology report required for payment	•May be denied for medical benefits
D7460	Removal of benign non-odontogenic cyst or tumor – up to 1.25 cm in diameter	All	One per site per visit	•May be denied for medical benefits
D7461	Removal of benign non-odontogenic cyst or tumor – over 1.25 cm in diameter	All	One per site per visit	•May be denied for medical benefits
Excision of Bone Tissue				
D7471	Removal of lateral exostosis, maxilla or mandible	All	•Cannot be submitted with 4260, D7310-D7321 •One per site per visit •Specify site (UR, UL, LR, LL), location or tooth number, as appropriate	•Must be symptomatic or involved in prosthesis (pre-prosthetic surgery) •No additional benefit if performed in conjunction with osseous surgery or alveoloplasty
D7472	Removal of torus palatinus	All	One per site per visit	•Must be symptomatic or involved in prosthesis (pre-prosthetic surgery) •No additional benefit if performed in conjunction with osseous surgery or alveoloplasty
D7473	Removal of torus mandibularis	All	•One per site per visit •Specify site (LR, LL), location or tooth number, as appropriate	•Must be symptomatic or involved in prosthesis (pre-prosthetic surgery) •No additional benefit if performed in conjunction with osseous surgery or alveoloplasty
D7485	Surgical reduction of osseous tuberosity	All	•One per site per visit •Specify site (UR/UL), location or tooth number, as appropriate	•Must be symptomatic or involved in prosthesis (pre-prosthetic surgery) •No additional benefit if performed in conjunction with osseous surgery or alveoloplasty
D7490	Radical resection of mandible with bone graft	NB		Often covered under medical plan
Surgical Incision				
D7510	Incision/Drain abscess – intra-oral soft tissue	All	•One per site per visit •May not be billed in conjunction with extraction at same or adjacent site (D7140-D7250) on same date of service •Includes follow-up care •Includes any suturing and drain tubes/ materials	

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7511	Incision/Drain abscess – intra-oral soft tissue – complicated		•One per site per visit •Includes drainage of multiple facial spaces •May not be billed in conjunction with extraction at same or adjacent site (D7140-D7250) on same date of service •Includes follow-up care •Includes any suturing and drain tubes/ materials	•If performed in conjunction with an extraction at same or adjacent site, provide narrative or rationale for the landD
D7520	Incision/Drain abscess – extraoral soft tissue	All	•One per site per visit •Includes drainage of multiple facial spaces •May not be billed in conjunction with extraction at same or adjacent site (D7140-D7250) on same date of service •Includes follow-up care •Includes any suturing and drain tubes/ materials	•If performed in conjunction with an extraction at same or adjacent site, provide narrative or rationale for the landD
D7521	Incision/Drain abscess – extraoral soft tissue – complicated	All	•One per site per visit •Includes drainage of multiple facial spaces •May not be billed in conjunction with extraction at same or adjacent site (D7140-D7250) on same date of service •Includes follow-up care •Includes any suturing and drain tubes/ materials	•If performed in conjunction with an extraction at same or adjacent site, provide narrative or rationale for the landD
D7530	Removal of foreign body	All	•Cannot be billed in conjunction with D4260, D7310, D7320 or D7550 •Submit with pre-op X-ray for review and reimbursement	
D7540	Removal of foreign bodies	All	•Cannot be billed in conjunction with D4260, D7310, D7320 or D7550 •Submit with pre-op X-ray for review and reimbursement	
D7550	Sequestrectomy for osteomyelitis	All	•Cannot be billed in conjunction with D4260, D7310, D7320 or D7540	Often covered by medical plan
D7560	Maxillary sinusotomy	NB		Often covered by medical plan

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Treatment Of Fractures – Simple				
D7610	Maxilla – open reduction – simple	NB		Often covered by medical plan
D7620	Maxilla – closed reduction – simple	NB		Often covered by medical plan
D7630	Mandible – open reduction – simple	NB		Often covered by medical plan
D7640	Mandible – closed reduction – simple	NB		Often covered by medical plan
D7650	Malar/zygomatic arch – open reduction – simple	NB		Often covered by medical plan
D7660	Malar/zygomatic arch – closed reduction – simple	NB		Often covered by medical plan
D7670	Alveolus – closed reduction/ stabilization of teeth	NB		Often covered by medical plan
D7671	Alveolus – open reduction, may include stabilization of teeth	NB		
D7680	Facial bones – complicated reduction with fixation	NB		Often covered by medical plan
Treatment of Fractures – Compound				
D7710	Maxilla – open reduction – compound	NB		Often covered by medical plan
D7720	Maxilla – closed reduction – compound	NB		Often covered by medical plan
D7730	Mandible – open reduction – compound	NB		Often covered by medical plan
D7740	Mandible – closed reduction – compound	NB		Often covered by medical plan
D7750	Malar/zygomatic arch – open reduction – compound	NB		Submit to medical plan
D7760	Malar/zygomatic arch – closed reduction – compound	NB		Submit to medical plan
D07770	Alveolus – open reduction/ stabilization of teeth	NB		Submit to medical plan
D7771	Alveolus, closed reduction stabilization of teeth	NB		Submit to medical plan
D7780	Facial bones – complicated reduction	NB		Submit to medical plan
Reduction of Dislocation and Management of Other TMJ Dysfunctions				
D7810	Open reduction of dislocation	NB		May be covered by medical plan
D7820	Closed reduction of dislocation	NB		May be covered by medical plan
D7830	Manipulation under anesthesia	All	• Typically NB • If a covered benefit, then limit one per visit	May be covered by medical plan
D7840	Condylectomy	NB		May be covered by medical plan
D7850	Surgical discectomy	NB		May be covered by medical plan

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7852	Disc Repair	NB		May be covered by medical plan
D7854	Synovectomy	NB		May be covered by medical plan
D7856	Myotomy	NB		May be covered by medical plan
D7858	Joint reconstruction	NB		May be covered by medical plan
D7860	Arthrotomy	NB		May be covered by medical plan
D7865	Artroplasty	NB		May be covered by medical plan
D7870	Arthrocentesis	NB		May be covered by medical plan
D7871	Non-arthroscopic lysis and lavage with catheters	NB		May be covered by medical plan
D7872	Arthroscopy – diagnosis	NB		May be covered by medical plan
D7873	Arthroscopy – surgical/lavage and lysis	NB		May be covered by medical plan
D7874	Arthroscopy – surgical disc repositioning and stabilization	NB		May be covered by medical plan
D7875	Arthroscopy – surgical/ synovectomy	NB		May be covered by medical plan
D7876	Arthroscopy – surgical/ discectomy	NB		May be covered by medical plan
D7877	Arthroscopy – surgical/ debridement	NB		May be covered by medical plan
D7880	Occlusal orthotic appliance	All	•Coverage is plan-specific •If a covered benefit, then limit one per 24 consecutive months	•Provide specific diagnosis and diagnostic information for review •Submit to automobile medical plan if TMD is caused by auto accident
D7899	Unspecified TMD therapy, by report	NB		May be covered by medical plan
Complicated Suturing				
D7910	Complicated suture – up to 5 cm	All	•Suturing is included in the fee for, and is incidental to, most oral surgery and periodontal procedures (D4240-D4274, D7140-D7999) in the same site	Suturing must be the only procedure performed at this site.
D7911	Complicated suture – greater than 5 cm	All	•Suturing is included in the fee for, and is incidental to, most oral surgery and periodontal procedures (D4240-D4274, D7140-D7999) in the same site	Suturing must be the only procedure performed at this site.
D7912	Suture complex wounds up to 5 cm	NB		May be covered by medical plan

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Other Repair Procedures				
D7920	Skin grafts	NB		May be covered by medical plan
D7940	Osteoplasty – for orthognathic deformities	NB		May be covered by medical plan
D7941	Osteotomy – mandibular rami	NB		May be covered by medical plan
D7943	Osteotomy – mandibular rami – with bone graft	NB		May be covered by medical plan
D7944	Osteotomy – segmented or subapical – per sextant	NB		May be covered by medical plan
D7945	Osteotomy – body of mandible	NB		May be covered by medical plan
D7946	LeFort 1 – maxilla – total	NB		May be covered by medical plan
D7947	LeFort 1 – maxilla – segmented	NB		May be covered by medical plan
D7948	LeFort II or III without bone graft	NB		May be covered by medical plan
D7949	LeFort II or III with bone graft	NB		May be covered by medical plan
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones, by report	NB		Often covered by medical plan
D7951	Sinus augmentation with bone or bone substitutes	NB		
D7953	Bone replacement graft for ridge augmentation – per-site	All	• Typically NB • If covered, then limit one per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	The healing process normally repairs the defect following an extraction. In cases such as a large defect after lesion removal, the graft may be allowed.
D7955	Repair of maxillofacial defects	NB		Often covered by medical plan
D7960	Frenulectomy/frenectomy	All	• One per site per 36 consecutive months • Must be a separate procedure • May be considered incidental to alveoloplasty or ridge augmentation when performed at same time	• Must be pre-prosthetic, or tissue must hinder fit of prosthesis • Limit tongue movement
D7963	Frenuloplasty	All	• One per site per consecutive 36 months • Must be a separate procedure • May be considered incidental to alveoloplasty or ridge augmentation when performed at same time	• Z-plasty • Must be pre-prosthetic, or tissue must hinder fit of prosthesis • Limit tongue movement

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D7970	Excision of hyperplastic tissue – per arch	All	•One per site per 36 consecutive months •Tooth number, site, quadrant, or arch must be indicated on claim form •Cannot be submitted with D7960, D7280, D7971 or D4249 on same teeth	Must be pre-prosthetic, or tissue must hamper home care (oral hygiene) or hinder fit of prosthesis
D7971	Excision of pericoronal gingival	All	•One per site per 36 consecutive months •Cannot be submitted with D7280, D7971 or D4249 on same teeth/range	•Excision of inflamed tissue surrounding an incompletely erupted tooth •May not be billed in addition to removal of the tooth
D7972	Surgical reduction of fibrous tuberosity	All	One per site per 36 consecutive months	
D7980	Sialolithomy	NB		May be covered by medical plan
D7981	Excision of salivary gland, by report	NB		May be covered by medical plan
D7982	Sialodochoplasty	NB		May be covered by medical plan
D7983	Closure of salivary fistula	NB		May be covered by medical plan
D7990	Emergency tracheotomy	NB		May be covered by medical plan
D7991	Coronoidectomy	NB		May be covered by medical plan
D7995	Synthetic graft – mandibular/ facial bones, by report	NB		May be covered by medical plan
D7996	Mandibular implant for augmentation, by report	NB		Often covered by medical plan
07997	Appliance removal (not by dentist who placed appliance)	All	Typically NB if covered, then limit to one per appliance per lifetime	•Often covered by medical plan •Includes removal of arch bar
D7999	Unspecified oral surgery, by report	NB		May be covered by medical plan

4.1.I Orthodontic Services Guidelines

Commercial PPO plans do not require prior authorization for orthodontic services. Orthodontic services may be performed by either a board-certified or board-eligible orthodontist who has completed a post-doctoral program accepted by the American Board of Orthodontics, or a general dentist or pediatric dentist who has gained specific training in orthodontic treatment. Dental Benefit Providers (DBP) will list only dentists who have successfully completed post-doctoral orthodontic training programs, and who are board eligible or board certified, as "orthodontists" in our Practitioner Directory.

The starting and billing date of orthodontic services is defined as the date when the bands, brackets or appliances are inserted. The member must be eligible on this date of service to receive the benefit. All benefits for approved cases will be prorated for the actual time that the member was eligible for plan copayments, up until the date of member termination. Orthodontic benefits will terminate within 30 days of plan termination, for any reason.

The following guidelines must be adhered to when providing orthodontic services:

1. A member must be eligible at the time of delivery of care in order to be eligible for benefits with reimbursements to be made to the practitioner. If a member becomes ineligible during treatment, the practitioner may seek compensation from the member. In the instance a member becomes eligible again, DBP will continue to compensate the practitioner for the orthodontic care only for the time period that the member is eligible. The dentist may charge fee-for-service for remaining months if the member is no longer eligible.
2. If DBP pays for interceptive therapy, the DBP payment for interceptive therapy will be deducted from the DBP payment for comprehensive orthodontic treatment.
3. All orthodontic treatment is reimbursed up to the plan orthodontic payment maximum allowable charge, the related coinsurance, and applicable deductible, if any. In no case will more than the lifetime maximum orthodontic benefit be allowed.
4. Replacement of retainers lost or damaged because of member negligence is not covered.
5. Retainer charges are included in the fee for all comprehensive orthodontic services, as they are considered part of the comprehensive treatment. All retainer and maintenance visits are part of and incidental to comprehensive orthodontic care.
6. Generally, orthodontic benefits are limited to dependents under the age of 21.
7. A claim form is required to receive reimbursement for each scheduled plan payment, to confirm that the member is still in active treatment and is still eligible for dental coverage. Only current, valid ADA CDT codes should be used for reporting services.
8. For all orthodontic cases, DBP strongly recommends a signed financial agreement between the dentist and the member be placed in the member's chart to prevent a dispute regarding fees charged during the case. The practitioner may charge the member for any additional adjunctive appliances, fixed or removable, beyond the included bracketing and retention required, to successfully complete the case.

Procedure Code	Description of Service	Allowable Member Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Limited Orthodontic Treatment				
D8010	Limited treatment of the primary dentition	By plan	One per lifetime, applied toward ortho lifetime max	
D8020	Limited treatment of the transitional definition	By plan	One per lifetime, applied toward ortho lifetime max	
D8030	Limited treatment of the adolescent dentition	By plan	One per lifetime, applied toward ortho lifetime max	
D8040	Limited orthodontic treatment of the adult dentition	By plan	One per lifetime, applied toward ortho lifetime max	

Procedure Code	Description of Service	Allowable Member Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Interceptive Orthodontic Treatment				
D8050	Interceptive orthodontic treatment of the primary dentition	By plan	One per lifetime, applied toward ortho lifetime max	
D8060	Interceptive orthodontic treatment of the primary dentition	By plan	One per lifetime, applied toward ortho lifetime max	
Comprehensive Orthodontic Treatment				
D8070	Comprehensive Orthodontic Treatment – Transitional (Phase I treatment beginning in mixed dentition, before member has lost all primary teeth)	By plan	One per lifetime, applied toward ortho lifetime max	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	By plan	One per lifetime, applied toward ortho lifetime max	
D8090	Comprehensive orthodontic treatment – adult	By plan	One per lifetime, applied toward ortho lifetime max	
Minor Treatment to Control Harmful Habits				
D8210	Removable appliance therapy	By plan	• One per 60 consecutive months • Applied toward ortho lifetime max	
D8220	Fixed appliance therapy	By plan	• One per 60 consecutive months • Applied toward ortho lifetime max	
D8660	Pre-ortho treatment visit (Orthodontic Records)	By plan	Includes X-rays, diagnostic casts, photographs, tracings and treatment plan	Paid separately ONLY if orthodontic treatment benefits are denied
D8670	Periodic ortho treatment visit (as part of contract)	By plan		
D8680	Ortho retention (removal of appliances, construction and placement of retainers)	By plan	Included in the fee for comprehensive orthodontic therapy	Can be considered for approval if teeth need extra stabilization through bonded retainers (acid etch)
D8690	Ortho treatment (alternate billing to contract fee)	By plan		
D8691	Repair of orthodontic appliance	By plan		
D8692	Replacement of lost or broken retainer	By plan		
D8999	Unspecified orthodontic procedure, by report		By report	

4.1.J Adjunctive Services Guidelines

Adjunctive general services include analgesia, IV sedation, general anesthesia and emergency services provided for relief of dental pain.

The guidelines and limitations listed below must be followed when billing for adjunctive general services:

1. Palliative treatment is defined by the American Dental Association (ADA) in its Current Dental Terminology (CDT) handbook as treatment (i.e., a dental procedure) rendered to a patient for the immediate relief of pain. This treatment cannot be a step in the definitive treatment of the dental problem. If the procedure performed has its own CDT code and is covered on the patient's fee schedule (for example, placement of a sedative filling, D2940), the procedure may not be billed as palliative treatment in addition to this other CDT Code.
2. Telephoning in a prescription does not qualify for payment.
3. Local anesthesia is included in the fee for specific procedures and may not be separately billed.
4. General anesthesia and intravenous conscious sedation administered by a dentist is covered only for patients:
   - Under the age of six who require extensive dental treatment and/or exhibit rampant caries where patient management is a concern
   - Over the age of six who have a documented special need or who are medically compromised
   - Over the age of six for whom general anesthesia is necessary to provide adequate relief or control of pain in order to perform necessary dental treatment
   - When the dentist administering anesthesia has the appropriate certifications and permits

All equipment and fees for monitoring of vital signs are included in the fees for general anesthesia IV sedation.

Duration, type and dosage of anesthetic administered must be identified on the claim form or attachment.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Unclassified Treatment				
D9110	Palliative (emergency) treatment of dental pain – minor procedures	All	Can only be submitted with codes <1,000	•Only for immediate relief of pain •No procedures with code numbers greater than 1000 may be billed for the same tooth on same DOS. •The same dentist performing definitive endodontics therapy cannot bill pulpectomy/pulpotomy of permanent tooth.
D9120	Fixed partial denture sectioning	All	One per bridge per 60 months	
Anesthesia				
D9210	Local anesthesia	All	Cannot be submitted with codes >1,000	For diagnosis of pain only, or pain relief in the absence of any other treatment
D9211	Regional block anesthesia	NB		
D9212	Trigeminal division block anesthesia	NB		
D9215	Local anesthesia		Included in procedure fee	•Local anesthesia is incidental to all restorative and surgical dental procedures. No additional benefit allowance is available.

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D9220	Deep sedation / general anesthesia (first 30 minutes)	All	•If required for patients under 6 years of age or patients with behavioral or physical disabilities, or it is medically necessary. Covered for patients over age 6 if it is medically necessary. •All monitoring equipment and fees are included. •Duration and type of anesthetic used must be specified	•May be administered only by oral surgeon, dental anesthesiologist, or other trained dentist, per state law and permit •Agents and dosages, as well as length of procedure(s), must be listed on claim form or attachment. •All monitoring equipment, drugs, and supplies are included in the benefit allowance.
D9221	Deep sedation / general anesthesia (each additional 15 minutes)	All	•If required for patients less than six years of age or patients with behavioral or physical disabilities, or if it is medically necessary. Covered for patients over age of six if it is medically necessary. •All monitoring equipment and fees are included. •Duration and type of anesthetic used must be specified	•May be administered only by oral surgeon, dental anesthesiologist, or other trained dentist, per state law and permit •Agents and dosages, as well as length of procedure(s), must be listed on claim form or attachment. •All monitoring equipment, drugs, and supplies are included in the benefit allowance.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	All	•If required for patients less than six years of age or patients with behavioral or physical disabilities, or if it is medically necessary. Covered for patients over age six if it is medically necessary. •Only one charge allowed, regardless of the time involved, per DOS	•Practitioner must be trained to administer nitrous oxide/oxygen analgesia •Permit is required in some states
D9241	Intravenous conscious sedation – first 30 minutes	All	•If required for patients less than six years of age or patients with behavioral or physical disabilities, or it is medically necessary. Covered for patients over age six if it is medically necessary. •All monitoring equipment and fees are included. •Duration and type of anesthetic used must be specified.	•May be administered only by oral surgeon, dental anesthesiologist, or other trained dentist, per state law and permit •Agents and dosages, as well as length of procedure(s), must be listed on claim form or attachment. •All monitoring equipment, drugs, and supplies are included in the benefit allowance.
D9242	Intravenous conscious sedation – each additional 30 minutes	All	•If required for patients less than six years of age or patients with behavioral or physical disabilities, or if it is medically necessary. Covered for patients over age six if it is medically necessary •All monitoring equipment and fees are included. •Duration and type of anesthetic used must be specified.	•May be administered only by oral surgeon, dental anesthesiologist, or other trained dentist, per state law and permit •Agents and dosages, as well as length of procedure(s), must be listed on claim form or attachment. •All monitoring equipment, drugs, and supplies are included in the benefit allowance.
D9248	Non-IV conscious sedation	All	•If required for patients less than six years of age or patients with behavioral or physical disabilities, or if it is medically necessary. Covered for patients over age of six if it is medically necessary	•Only one charge allowed, regardless of the time involved, per DOS •All monitoring equipment and fees are included •Duration and type of anesthetic used must be specified

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
Professional Consultation				
D9310	Consultation (diagnostic service provided by a dentist other than the practitioner providing treatment)	All	•By report •Not covered if submitted with exams or professional visit •Only additional codes D0220-0999 may be submitted by the consulting provider on that date of service •If codes >1,000 are submitted along with 9310, an alternate benefit of D0140 may be allowed	•Specialist must supply narrative along with claim •Designated specialists or general dentists who provide second opinions or provide consultative services •No definitive treatment can be accomplished on that DOS
Professional Visits				
D9410	House/extended care facility calls	All	By report	
D9420	Hospital call	NB		
D9430	Office visit for observation	NB		Incidental to and a follow-up to a prior procedure or visit
D9440	Office visit – after regularly scheduled hours	NB		
D9450	Case presentation, detailed and extensive treatment planning	NB		
Drugs				
D9610	Therapeutic drug injection, by report parenteral	All	One per visit	
D9612	Therapeutic parenteral drug, two or more administrations, different medications	All	One per visit	
D9630	Other drugs and/or medicaments, by report	All	•One per visit •Cannot be billed in conjunction with D9220-D9248, D9631 •Narrative with rationale required	•Includes, but is not limited to, oral antibiotics, oral analgesics, oral sedatives, and topical fluoride dispensed in the office for home use •NB for writing a prescription
D9910	Application of desensitizing medicament	All	•Allowed one time per tooth per six consecutive months •Tooth number/range must be submitted •Cannot be submitted with D1202 or D1204 on same DOS •Cannot be billed in conjunction with D9630	•Per tooth for adhesive resins or varnishes •Per visit for topical fluoride
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	All	See D9910	

Procedure Code	Description of Service	Allowable Patient Age	General Limitation(s) and Adjudication Logic	Policies and Procedures (if any)
D9920	Behavior Management, by report	All	•Typically NB •Cannot be billed in conjunction with D9220, D9240, D9631, or D9230 on same DOS	•Appropriate to report in cases where substantial time and effort is expended in allaying the patient's fear and apprehension •Do not use with codes D9220-D9248
D9930	Treatment of complication – (post surgical – unusual complications, by report)	All	One time per incident (excluding dry socket or removal of bony sequestrum)	Must submit narrative and other appropriate documentation of the unusual complication with claim
D9940	Occlusal guard, by report	All	Limited to one per 36 consecutive months	•For bruxism (habitual grinding) •Not covered for TMJ treatment, unless TMJ benefits are included in the specific plan
D9941	Fabrication of athletic mouth guards	NB		
D9942	Repair and/or reline of occlusal guard	All	•Once per 12 consecutive months per guard •May not be billed in addition to D9940 or within six months of delivery of D9940	
D9950	Occlusal analysis – mounted case	All	•Limit once per 12 consecutive months •If more often, may be allowed alternate benefit of D0170 •Cannot be billed in conjunction with D0470 (included in the procedure)	•Not covered for TMJ treatment unless TMJ benefits are included in the specific plan •Precedes complete occlusal adjustment
D9951	Occlusal adjustment, limited	All	Limit once per 12 consecutive months	Not covered for TMJ treatment unless TMJ benefits are included in the specific plan
D9952	Occlusal adjustment, complete	All	•Limit once per 12 consecutive months •Cannot be billed with D9951 •Must be billed in conjunction with or preceded by D9950	Not covered for TMJ treatment unless TMJ benefits are included in the specific plan
D9970	Enamel Microabrasion	NB		
D9971	Odontoplasty 1-2 teeth	NB		
D9972	External bleaching, per arch	All	•NB •If covered, limit is once per 12 consecutive months	
D9973	External bleaching, per tooth	All	•NB •If covered, limit is once per 12 consecutive months	
D9974	Internal bleaching, per tooth	All	•NB •If covered, limit is once per 12 consecutive months	
D9999	Unspecified adjunctive procedure, by report	All	By report	

4.2 Exclusions & Limitations

Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not covered:

A. Dental Services that are not necessary.
B. Hospitalization or other facility charges.
C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
D. 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.
E. Any Dental Procedure not directly associated with dental disease.
F. Any Dental Procedure not performed in a dental setting.
G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) 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.
H. Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services.
I. Drugs/medications, obtainable with or without a prescription.
J. Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
L. Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
M. Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
P. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
Q. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction. **Employer benefit contracts may vary. Please call 1-800-822-5353 or log on to www.dbp.com to verify benefits for a specific patient.**
R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
T. Replacement of crowns, bridges, and fixed or removable prosthetic appliances, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors) inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
U. Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
V. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
W. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
X. 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 spouse, brother, sister, parent or child.
Y. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage

under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

Z. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

AA. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

BB. In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.

CC. Foreign Services are not Covered unless required as an Emergency.

DD. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

EE. Any Dental Services or Procedures not listed in the *Schedule of Covered Dental Services*.

Limitations

a. Dental services are covered at the least costly, clinically accepted treatment.

b. Oral examinations are covered with a limit of two times per 12 consecutive months.

c. Complete series or panoramic radiographs are limited to one time per 36 consecutive months. Exception to the 36-month limit on panoramic radiographs will be made if taken for diagnosis of third molars, cysts or neoplasms.

d. Bitewing radiographs are limited to one series of films per plan year.

e. Extraoral radiographs are limited to two films per plan year.

f. Dental prophylaxes are limited to two times per 12 consecutive months.

g. Diagnostic casts are limited to one per 24 consecutive months.

h. Fluoride treatment is limited to covered persons under the age of 16 years, and limited to two times per 12 consecutive months. Treatment should be performed in conjunction with dental prophylaxis.

i. Sealants are limited to covered persons under the age of 16 years, and once per first or second permanent molar every 36 consecutive months.

j. Space maintainers are limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within six months of placement.

k. Multiple restorations submitted for the same tooth with contiguous surfaces will be treated as a single multi-surface restoration.

l. Pin retention is limited to two pins per tooth; not covered in addition to cast restorations.

m. Inlays and onlays are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.

n. Crowns are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.

o. Post and cores are covered as a separate benefit only for teeth that have had root canal therapy.

p. Sedative fillings are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.

q. Scaling and root planing is limited to one time per quadrant per 24 consecutive months.

r. Periodontal maintenance is limited to two times per 12 consecutive months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.

s. For full dentures, there are no additional allowances for over-dentures or customized dentures.

t. For partial fixed and removable dentures, there are no additional allowances for precision or semi-precision attachments.

u. Relining or rebasing dentures is limited to relining performed more than six months after the initial insertion. Limited to one time every 12 consecutive months.

v. Repairs and adjustments to full dentures or partial fixed or removable dentures are limited to those performed more than 12 months after the initial insertion.

w. Palliative treatment is covered as a separate benefit only if no other service, other than X-rays and exam, was performed on the same tooth during that visit.

x. Occlusal guards are limited to one guard every 36 consecutive months.

y. Full-mouth debridement is limited to once every 36 consecutive months.

z. General anesthesia is covered only when medically necessary.

4.3 Member Appeals and Inquiries

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 60 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing, by telephone, or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated time frames upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within two days unless otherwise prescribed by state law, statute, or act.

Expedited Appeals:

In time-sensitive circumstances in which the time frame for issuing determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member in writing, telephonically, or by fax.

Determinations will be completed within 48 hours of receipt of all required documentation or within the time frame required by state law, statute, or act.

Please refer to the Resources and Services section of this manual for appeal address and fax number information. Our Provider Services line is also available for any questions.

5.1 Radiographs

5

A full-mouth series of X-rays (ADA Code D0210) may be taken for new adolescent and adult patients at the same visit as their initial exam for diagnostic purposes, as well as every three to five years, depending on the condition of the patient's oral health. Often, a panoramic X-ray, plus two or four bitewings, is substituted for a full-mouth series. The dentist may or may not take bitewing or periapical X-rays during periodic exams, depending on the patient's oral health.

For some procedures, it is required that copies of radiographs are submitted prior to payment. Those radiographs must be properly mounted and labeled with the practice name, patient name and exposure date. When a radiograph *does not adequately demonstrate the clinical condition, an intraoral photo* and/or narrative are suggested as additional diagnostic aides.

Requirements for pre- and postoperative radiographs are listed in section *6.1.a which lists the X-rays required for the various procedures. Providers should refer to this section for documentation guidelines before performing a procedure.*

6.1 Claim Submission Required Elements & Best Practices

Dental Claim Form

The most current Dental ADA claim form must be submitted for payment of services rendered or to obtain a Pre-Treatment Estimate.*

**It is recommended that pre-treatment estimates be obtained for high-dollar procedures such as crowns, bridges and dentures.*

Claim Submission Options

Electronic Claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the Internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected. Electronic submission is private as the information being sent is encrypted. Please call 1-800-822-5353 for more information regarding electronic claims submission.

Paper Claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of the most recently revised American Dental Association (ADA) format is recommended. However, other formats will be accepted as long as all of the required information is included.

Dental Claim Form Required Information

One claim form should be used for each member and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields populated as outlined below.

Header Information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

Subscriber Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

Member Information

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Member ID number

Primary Payer Information

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

Other Coverage

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

- Name of subscriber / policy holder (Last, First, and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the Member

Billing Dentist or Dental Entity

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

- Name
- Address, City, State, ZIP Code
- License number
- SSN or TIN
- Phone number

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
- SSN or TIN
- Address, city, state, ZIP code
- Phone number

Record of Services Provided

Most claim forms have 10 field rows 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.

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Fee – report the dentist's full fee for the procedure
- Total sum of all fees

Missing Teeth Information

When submitting for periodontal or prosthodontic 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.

Subscriber / Member Authorization

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member record.

Paper Claims

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. Please refer to the Exclusions & Limitations section of this manual to find the recommendations for dental services.

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 Web site at www.adacatalog.org.

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 member 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.

Tips on Claim Submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Attending dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.
- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are an essential ingredient to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.
- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing. A common note added to claims is "Please pay promptly." Adding this note actually has the opposite effect – delaying the claim.

6.1. A Dental Claim Attachment Requirements

Procedure Code	Description	Documentation Required
Restorative		
D2510-2664 D2710-2799 D2950	Inlays/Onlays Crowns Crown buildup	Pre-operative X-rays, including opposing dentition. If endodontic therapy has been performed, a periapical of the completed treatment is required; otherwise, bitewing X-rays may be sufficient at the discretion of the reviewer. A narrative or photograph may provide additional information, especially for replacement of existing crowns. "Cracked tooth syndrome" requires adequate documentation of extent of fracture, location and how it was diagnosed.
D2952, 2953, 2954, 2957	Post/Core	Post-op endodontic film showing adequate root canal treatment.
D2960-2962	Labial veneer	X-ray and narrative of necessity other than cosmetic purposes. Photograph may be helpful.
Endodontics		
D3351-3353	Apexification/Recalcification	Pre-operative film
D3410-3450	Apicoectomy/Periradicular Services	Pre-surgical X-ray showing that a radiolucency remains after non-surgical treatment. Date of last root canal treatment.
D3470	Reimplantation	Pre-operative film
D3920	Hemisection	Pre-operative film
Periodontics		
D4210-4268	Surgical services	Full pre-operative X-rays (panorex with bitewings or full periapical series) taken within 24 months. *Periodontal charting performed after re-evaluation of initial preparation, but not older than 12 months, including six-point probing, furcation, mucogingival relationship, bleeding, case type, oral hygiene status.* *Date of scaling/root planing.*
D4270-4276	Tissue grafts	The above, with emphasis on the mm of recession and remaining attached gingiva. Photographs may be helpful.
D4381	Localized delivery of antimicrobial agents	Pre-operative X-rays and periodontal charting.
Implant Services		Full X-rays. Teeth numbers for missing teeth to be replaced, and other missing teeth. Date of extractions. Age of existing prosthetic.

Procedure Code	Description	Documentation Required
Fixed Prosthetics		
D6205-6794	Bridge procedures	Pre-operative X-rays of involved teeth, as well as contralateral and opposing sites. Date of extractions. Tooth numbers of all missing teeth. Age of existing prosthesis.
D6970, 6972, 6976, 6977	Post/Core	Post-op endodontic film showing adequate root canal treatment.
D6973	Core buildup	Pre-operative X-ray
Oral Surgery		
D7220-7250	Removal of impacted teeth and residual roots	Dated and labeled X-rays, usually taken within one year and appropriate to document the case. Narrative detailing the symptomatology or rationale for removal.
D7260, 7261	Oroantral fistula closure and closure of sinus perforation	Dated and labeled X-rays, usually taken within one year and appropriate to document the case. Narrative of rationale for procedure.
D7270, 7272	Reimplantation and transplantation	Dated and labeled X-rays, usually taken within one year and appropriate to document the case. Narrative of rationale for procedure.
D7411, D7412	Removal of benign lesion greater than 1.25 cm, or complicated	Documentation of size, narrative, pathology report.
D7953	Graft for ridge preservation	Dated and labeled X-rays, usually taken within one year and appropriate to document the case. Narrative of rationale for procedure.
D7960, 7963	Frenulectomy and frenuloplasty	Narrative of rationale for procedure
D7970	Excision of hyperplastic tissue	Narrative of rationale for procedure
Adjunctive Services		
D9220, 9221	Deep sedation/General anesthesia	Duration, type of anesthetic, dosage. Narrative documenting medical necessity, including description of underlying medical problem; description of behavior problem and age of patient.
D9241, 9242	IV conscious sedation	Duration, type of anesthetic, dosage. Narrative documenting medical necessity, including description of underlying medical problem; description of behavior problem and age of patient.
D9940	Occlusal guard	Narrative of rationale for procedure.
D9950	Occlusal analysis	Narrative of rationale for procedure.
D9951, D9952	Occlusal adjustment	Narrative of rationale for procedure.

6.1.B Pre-Treatment Estimate (PTE)

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member's plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the DBP Web site (www.dbp.com) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements (as applicable) for services you provide to our Medicare Advantage enrollees:

The provider must cooperate with our requests for information, documents or discussions for purposes of a prior authorization review. We may need the provider to submit additional information to us so that we can make a decision on a prior authorization request. In such instances, the provider must respond to our request for additional information within 10 business days.

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services

6.2 Claims Processing Systems

DBP processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code on Dental Procedures and Nomenclature. There are no modifiers associated with this code set.

Claims are edited and paid according to the specific plan design for a member's employer group. Please refer to the Exclusions and Limitations section of this manual for further information or access one of the resources outlined in Section 2.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

6.3 Electronic Claims Submissions

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 Funds Transfer, which is the ability to be paid electronically directly into your bank account).

DBP partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the DBP **number is 52133.** Please refer to the Important Addresses and Phone Numbers section and Distributor Client List for additional information as needed.

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 either sign up with one to initiate this process or simply register with our preferred vendor.

6.4 HIPAA Compliant 837D File

The 837D is a HIPAA compliant EDI transaction format for the submission of dental claims. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers via established claims clearinghouses.

6.5 HIPAA Compliant 835 File

An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.

For practitioners participating in Electronic Payments and Statements (EPS), the 835 file can be accessed via EPS. You must be an EPS participant to access this information.

If you're not already participating with EPS and would like to take advantage of this cost-savings opportunity, simply visit www.dbp.com. The Electronic Payments and Statements section in this manual provides a detailed overview of this service and how to enroll.

For general questions, eligibility and/or claim status inquiries, please call 1-800-822-5353. Additional tools and resources can also be found online at www.dbp.com.

6.6 Paper Claims Submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2006 version or later).

Please refer to section 6.1 for more information on claims submission best practices and required information.

Our Quick Reference Guide will provide you with the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

6.7 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved — this is not a payer choice. The objective is to ensure that the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

When a claim is being submitted to us as the secondary payer for Coordination of Benefits (COB), a fully completed claim form must be submitted along with the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

6.8 Dental Claim Filing Limits and Adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling Dental Health Providers at **(800) 822-5353.**

6.9 Claim Adjudication and Periodic Overview

In accordance with DBP's standard practice, clean claims will be adjudicated and paid within five to ten days of receipt (this may vary by state and claim submission and/or payment method).

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 in general, 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.

Invalid or incomplete claims:

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or accepted with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.
- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

6.10 Explanation of Provider Remittance Advice

The Provider Remittance Advice is a claim detail of each member and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that Remittance Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

PROVIDER OR MBR NAME AND ID NO
Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

GROUP NO
Group ID number assigned to the member's plan

CLAIM NO
Number assigned to the claim

ADA CODE
Procedure code submitted pertaining to the service

DESCRIPTION
Description of the procedure code

DATE OF SERVICE
Date when services were rendered

TOOTH NO
Tooth number or the quadrant pertaining to the procedure

AMOUNT CLAIMED
Amount submitted by provider

AMOUNT ALLOWED
Provider's contracted fee amount

DEDUCT APPLIED
Applicable plan deductible

OTHER INS
Member's primary insurance if applicable

MEMBER RESP
Member's copayment that pertains to the procedure

AMOUNT PAID
Claim paid amount

EOB CODE
Refers to the explanations provided within the EOB that explain how the procedure adjudicated

6.11 Provider Claim Appeal and Inquiry Process

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the EOB for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

Utilization Management (UM) Appeal: Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

Administrative Appeal: Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative and copy of the Provider Remittance Advice.

Refer to the Quick Reference Guide section for appeal submission addresses.

7.1 Quality Improvement Program (QIP) Description

DBP 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 ensure that quality of care is being reviewed; that problems are being identified; and that follow up is planned where indicated. The program is directed by all state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure they meet professionally recognized standards of care. The program is reviewed and updated annually.

The QIP includes, but is not limited to, the following goals:

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

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line.

7.2 Credentialing

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

Depending on the state in which you practice, DBP will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. DBP will request a written explanation regarding any adverse incident and its resolution, and corrective action 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 some plans and/or markets. This typically applies to DHMO plans based on the West coast as well as some Medicaid plans. Your Professional Networks Representative will inform you of any facility visits needed during the recruiting process. Where required, the office must pass the facility review prior to activation. DBP will request a resolution of any discrepancy in credentialing forms submitted.

The Dental Director and the Credentialing Committee review the information submitted in detail based on approved credentialing criteria. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to ensure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by DBP based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision, please follow the instructions provided in the determination letter received from the Credentialing department.

Please refer to the Appendix of this manual for additional details regarding practitioner rights.

DBP may contract with an affiliated Credentialing Verification Organization (CVO) to assist with collecting the data required for the credentialing and recredentialing process. Please respond to calls or inquiries from this organization or our offices to ensure that the credentialing and/or recredentialing process is completed as quickly as possible.

It is important to note that the recredentialing process is a requirement of both the provider agreement and continued participation with DBP. Any failure to comply with the recredentialing process constitutes termination for cause under the provider agreement.

So that a thorough review can be completed at the time of recredentialing, in addition to the items verified in the initial credentialing process, DBP 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 six months prior to the recredentialing due date. The CVO will make three attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, DBP will also make an additional three attempts. If there is still no response, a termination letter will be sent to the provider in accordance with the provider agreement.

A list of the documents required for Initial Credentialing and Recredentialing is as follows:

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows the provider name on the certificate, expiration dates and limits — limits $1/3m
- Explanation of any adverse information, if applicable
- Five years of work history in month/date format with no gaps of six months or more; if there are gaps, an explanation should be submitted
- Education (which is incorporated in the application)

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of state license
- Current copy of Drug Enforcement Agency (DEA) certificate
- Current copy of Controlled Dangerous Substance (CDS) certificate, if applicable
- Malpractice face sheet which shows the provider name on the certificate, expiration dates and limits — limits $1/3m
- Explanation of any adverse information, if applicable

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

7.3 Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted and non-contracted providers.

Issues are accepted via telephone, fax, email, letter, written grievance form, or through our Web portal. Grievance forms may be requested from our Member Service Department, Web site or from a contracted dental provider office. DBP does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client specific requirements both in terms of the notifications sent and the time frames allowed.

Your office is required to cooperate with DBP's Policies and Procedures; Member rights and Responsibilities; (including grievances) and Dental Records.

DBP shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with DBP's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

DBP recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors.

DBP's Grievance policies are filed with the necessary regulatory agencies when required.

7.4 Preventive Health Guideline

DBP takes an integrated, multi-focused approach to preventive health. The following guidelines are for informational purposes for the provider and will be referred to in a general way, in evaluating clinical appropriateness.

DBP's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while researching the latest literature, including but not limited to ADA's CDT-2011/2012 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 *Healthy People 2020* and 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.

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 be 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 those suggested by CAMBRA (Caries Management by Risk Assessment), where the lesion is non-cavitating, slowly 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, 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.
- 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 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 includes 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. DBP 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 dentists and other clinical professionals and members via manuals, Web sites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of DBP to educate dentists and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease, oral cancer screening and the impacts or oral health on overall health.

8.1 Utilization Management Introduction

Through Utilization Management practices, DBP strives to provide members with cost-effective, quality dental care. Utilization is largely managed through retrospective review at both the group and individual provider level. By integrating data from a variety of sources including individual Financial Analysis reporting, Utilization Review, claims data and individual audit reporting, DBP can evaluate group and individual practice patterns and identify those patterns which deviate from the norm.

By identifying and correcting aberrant provider practice patterns, DBP can reduce the overall impact of such behavior on the cost of care and improve the quality of dental care delivered.

8.2 Community Practice Patterns

Utilization analysis is completed using data from a variety of sources such as the individual Financial Analysis reporting and/or claims data.

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 percentage of procedures performed in any given category relative to total procedures are compared with benchmarks such as similarly designed Dental Benefit Providers (DBP) plans, all DBP plans and national norms, to determine if utilization for that category is within expected levels. This method, which looks at the mix of procedures and incurred claims, was chosen in part because it is consistent with other forms of reporting at DBP. In addition, this is a fairly common approach when analysis is done at the national level by outside experts.

Aberrations 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. This type of analysis can quickly point to areas of potential quality improvement, which can be shared internally or externally with clients.

8.3 Evaluation

Following the initial analysis of utilization data, the performance of any dentists identified as having potentially aberrant practice patterns is further reviewed at the individual claims level. For each specific dentist, an audit report is run that identifies all procedures performed on all patients for a specified time period. For those dentists who practice at multiple sites, these reports are typically done on a site-by-site basis.

The report is examined by a licensed dentist reviewer who looks for aberrant patterns such as upcoding, unbundling, miscoding, excessive treatments per patient (for example, doing 15 restorations at one sitting), duplicate billing, duplicate payments, etc. Once completed, a sample of patients is identified for chart audit. The number varies depending on the number of patients on the dentist's panel in the time period being studied and the severity of the problems noted.

See Section 8.5 for outcomes of chart audits.

8.4 Results

Final reports of aberrant utilization are shared with the individual practitioners to identify variances from the performance of their peers and to provide recommendations for appropriate performance adjustments.

Feedback and recommended follow up may also be communicated to the provider group 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 and Focus Groups
- Proactive Provider Contact
- Provider *Newsflash*
- **Corporate Web site**

Interventions may also be suggested to the client. This can be done through existing client reporting or through the mutual creation of follow-up studies and/or specific interventions.

Finally, internal interventions may be indicated. These can include improvements to existing policies and procedures, specific interventions and creation of feedback mechanisms to ensure that corrections are implemented.

In all instances, practitioners will be provided with contact information that they can call to review results and ask any questions they may have.

8.5 Fraud and Abuse

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action, ranging from reimbursement of overpayments to additional consideration by DBP's Peer Review Committee or further action, including potential termination, may be imposed.

If mandated by the state in question, the appropriate state dental board will be notified. If the account is Medicaid or Medicare, the Office of the Inspector General or the State Attorney General's office will also be notified.

If at any time your office suspects fraud and abuse, please contact our Provider Services line or the appropriate state dental board.

8.6 Utilization Review

DBP 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. DBP 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 Clinical Policy and Technology Committee, Clinical Affairs 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.

(See section 6 for Documentation Requirements)

Examples of Procedures Requiring Review:

- Inlays, Onlays, Crowns
- Core Buildup and Post/Core
- Labial Veneers (not for cosmetic purposes)
- Endodontic Re-Treatment
- Endodontic Surgery, Root Amputation, Hemisection
- Periodontal Surgery, including Hard and Soft Tissue Grafts and Related Procedures
- Localized Delivery of Antimicrobial Agents
- Implants and Related Procedures (when covered)
- Fixed Prosthetic Pontics and Retainers
- Core Buildup, Post/Core for Fixed Prosthetics
- Removal of Impacted Teeth
- Closure of Sinus Perforation
- Removal of benign lesion greater than 1.25cm, or complicated
- Frenulectomy, Frenectomy, Frenotomy, Frenuloplasty
- Excision of Hyperplastic Tissue and Pericoronal Tissue
- Surgical Reduction of Fibrous Tuberosity
- IV and Non-IV Anesthesia or Sedation
- Nitrous Oxide Analgesia
- Therapeutic Drug Injection
- Occlusal Guard
- Occlusal Analysis and Occlusal Adjustment

9.1 Evidence-Based Dentistry & the Clinical Policy & Technology Committee

According to the American Dental Association, evidence-based dentistry can be 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."*

The search for evidence usually begins with a clinical question. The process for answering that question can be described by the acronym P.I.C.O., which stands for:

- **P**roblem or **P**opulation
- **I**ntervention under Investigation
- How it is being **C**ompared
- The expected **O**utcome

In determining the answers to a given clinical question, evidence is most commonly gathered from scientific journals, either "hard copy" or online. Nevertheless, not all evidence is created equal. The "ladder of evidence" (from least to most reliable) is as follows:

- Anecdote/Expert Opinion
- Case Study
- Case Series
- Retrospective Study
- Randomized Controlled Trial (RCT)
- Systematic Review (a review of RCTs)

Systematic reviews or randomized controlled trials are not available to answer all clinical questions we might have, although the number of these reviews is rapidly growing. This is why it is important to indicate that we are using the "best available current evidence." In some cases, anecdotal evidence is all that is available.

In searching for evidence, we can consult a variety of sources including:

- Electronic indices – Medline, PubMed, Cochrane Library, National Guideline Clearinghouse (AHRQ)
- Hand search of the scientific literature
- Reference listings in other articles
- Alternative sources — theses, dissertations, conference reports, abstracts, unpublished studies ("gray literature")

Once data is collected, we want to review its usefulness in answering our question(s):

- How the study was designed
- How subjects for the study were chosen and grouped
- How statistics were applied — did it lead to the correct conclusions

Sometimes a technique called meta-analysis is used. Meta-analysis is a term used to describe combining the analysis and summarizing the results of several individual studies into one analysis. Systematic reviews often make use of meta-analysis.

Once we have reviewed our data, we need to interpret the evidence, considering the strength of evidence, limitations of the review, implications for additional research and clinical implications. We also want to build consensus — bringing different expertise and opinions into the interpretation and working toward buy-in by as many stakeholders as possible.

How can evidence-based dentistry be used? It can be used in clinical practice to:

- Define a clinical problem or question
- Search for the best evidence
- Evaluate the evidence
- Determine how it would apply to the patient
- Determine treatment

At Dental Benefit Providers, we use evidence-based guidelines as the foundation of many of our own clinical efforts, including:

- Practice guidelines, parameters, algorithms and technology evaluations based on evidence and consensus
- Comparing dentist quality and utilization data against guidelines
- Chart auditing, site visits, credentialing
- Developing recommendations on new clinical benefits and clinical products, including our disease management and wellness programs

The development of evidence-based guidelines at DBP is the job of our Clinical Policy and Technology Committee.

The committee consists of a mixture of employed and participating dentists. The participating dentists represent several specialties including general practice, endodontics, periodontics and oral surgery. In addition, we have access to academic institutions and other professional experts.

The committee meets quarterly and reviews the evidence-based literature, making recommendations on clinical practice guidelines and new technologies. Our goal is not to create new guidelines but to review existing guidelines and scientific literature from sources such as specialty societies (for example the American Academy of Periodontology, The American Academy of Pediatric Dentistry, The American Association of Oral and Maxillofacial Surgeons), guidelines clearinghouses such as the Cochrane Oral Health Group and National Guideline Clearinghouse, government agencies such as AHQR and NIDCR, electronic sites such as PubMed and the Centre for Evidence-Based Dentistry, and evidence-based journals such as the *Journal of Evidence-Based Dental Practice*.

Determinations are shared with dentists in our provider newsletter *Newsflash*, and do influence a variety of business functions, including new product development, Utilization Management and claims criteria, marketing and underwriting collateral, and the provider manual.

Recommendations can result in new products or enhanced benefits. Recent examples include our new oral cancer screening benefit, our new implant benefit, and enhanced benefits for periodontal maintenance, delivery of locally placed antibiotics, and enhanced benefits for pregnant patients. Our programs in disease management and wellness are all developed using evidence-based criteria.

The search and application of evidence is not without its challenges:

- Limited by the lack of good research in many areas
- The presence of sometimes contradictory evidence
- Complexity of researching and developing
- Dentist uncertainty about the impact on their practices
- Different approaches between various groups in dental practice and the benefits industry

Nevertheless, evidence-based dentistry is a methodology to help reduce variation and determine "what works." It can be utilized on the individual patient, practice, plan or population levels. Best of all, it's more than a process — it's a way of thinking about care.

10 10.1 Practice Capacity & Appointment Scheduling Standards

Dental Benefit Providers (DBP) is committed to ensuring that its providers are accessible and available to their members for the full range of services specified in the DBP Provider Agreement and Provider Manual.

Participating providers must comply with any state-mandated appointment scheduling requirements for Emergency Care as well as Elective or Routine Care Appointments.[1]

In states where there are specified access and availability standards, Dental Benefit Providers will monitor the access and availability of our participating providers through a variety of methods, including member feedback/surveys, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any noted concerns are discussed with the participating provider(s), and corrective action may be taken.

Walk-In Appointment Standards

Dental offices that operate by "walk-in" or "first come, first served" appointments are monitored for access and waiting times, where applicable.

Missed Appointments

Offices should inform patients of office policies relating to missed appointments and any fees that will be incurred.

1. *Appointment scheduling guidelines may vary by state. It is recommended that you confirm whether or not the state in which you're providing services has any state-specific mandates.*
2. *Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.*
3. *Providers are encouraged to schedule member appointments appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.*

10.2 Emergency Coverage

All network dental providers must be available to members during normal business hours. Providers will provide members access to emergency care 24 hours a day, seven 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.

Member Services, Provider Services and Quality Management staff monitor and document all instances of provider unavailability to ensure continuity of care. Dental Benefit Providers (DBP) conducts periodic surveys to ensure that access and availability standards for members are in compliance with state requirements and DBP standards.

Network dentists are required to participate in all activities related to these surveys. Offices out of compliance will be required to submit a corrective action plan to DBP.

10.3 New Associates

As your practice expands and changes, and as new associates are added, please contact us to request an application so that they may be credentialed and listed as participating providers.

It is important to remember that an associate may not see members as a participating provider until he/she has been credentialed by our organization.

If you have any questions or need to receive a copy of our provider application packet, please contact our Provider Services line.

10.4 Change of Address, Phone Number, Email Address, Fax or Tax Identification Number

Please see update for 2016 on following page

10.5 Office Conditions Facility Requirements

Network provider office equipment should be in good working condition. The office should be kept neat and clean. Network providers' offices and treatment accessibility should comply with the Americans with Disabilities Act. In the case of an emergency, all offices should contain a portable oxygen unit with a positive pressure devise or ambu bag as well as an emergency kit with non-expired medications.

10.6 Sterilization and Asepsis Control

Dental office sterilization protocol must meet state, Occupational Safety and Health Administration (OSHA), and Centers for Disease Control and Prevention (CDC) requirements. All instruments must be heat sterilized where possible. Weekly spore testing of sterilization units must be performed and records kept. Masks and eye protection must be worn by clinical staff where indicated; gloves must be worn during every clinical procedure. The dental office must have a sharps container for proper disposal of sharps. Disposal of medical waste must be handled per state, OSHA, and CDC guidelines.

While standard practice is for sterilization costs to be included within office procedure charges, should your office charge this fee separately, these fees must be made known to patients in advance. This may not be a covered code on our fee schedules.

10.4

As a Participating provider / office, when there are demographic changes within your office, it is important to notify us so that we may update our records. This supports accurate claims processing as well as helps to ensure that member directories are accurate.

A Participating Provider or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare is expected to review, update provider records and attest to the information available to UnitedHealthcare members, including the information listed below, on not less than a quarterly basis. You are responsible for notifying UnitedHealthcare of these changes for all of the participating providers. Requests may need to be made in writing with corresponding and/or backup documentation. For your convenience, we've included a Demographic Change Form in the Appendix section of this manual to assist in providing the required information. Examples of changes requiring notification within 30 days of change to DBP:

- The status as to whether the participating provider is accepting new patients or not,
- The address(es) of the office locations where the participating provider currently practices
- The phone number(s) of the office locations where the participating provider currently practices
- The email address of the participating provider
- If the participating provider is still affiliated with listed provider groups,
- The specialty of the participating provider,
- The license(s) of the participating provider,
- The tax identification number used by the participating provider
- The NPI(s) of the participating provider,
- The languages spoken/written by the participating provider or the staff,
- The ages/genders served by the participating provider
- Office hours (7 days a week)

DBP reserves the right to conduct an onsite inspection of any new facilities and will do so based on state and plan requirements and standards. If you have any questions, don't hesitate to contact our Provider Services line for guidance. In some instances, we can make the needed changes in real time over the phone. Changes may also be faxed to 1-855-363-9691.For your convenience, we've included a Demographic Change Form in the Appendix section of your manual to assist in providing the required information.

10.7 Recall System

As a general guideline, it is recommended that offices have an active and definable recall system to ensure that the practice maintains preventive services, including member education and appropriate access to care. The recall system should be individualized to the members' needs and should not be at fixed intervals for all members.

10.8 Transfer of Dental Records

Your office shall copy all requested member dental files for another participating dentist as designated by Dental Benefit Providers (DBP) or requested by the member. The member is responsible for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates its relationship with DBP, dismisses the member from your practice or is terminated by DBP, the cost of copying files shall be borne by your office. Your office shall maintain, and shall cooperate with Dental Benefit Providers in maintaining, the confidentiality of such member dental records at all times, in accordance with applicable state and federal law.

10.9 Cultural Sensitivity

A limited English proficient enrollee is an enrollee who has an inability or limited ability to speak, read, write or understand the English language on a level that permits that individual to interact effectively with Health Care providers.

As established by your participating Provider Agreement, you must provide Covered Services in a culturally competent manner to all UnitedHealthcare Dental enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Additional Medicare Advantage requirements:

If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements (as applicable) for services you provide to our Medicare Advantage enrollees.

- You may not discriminate against enrollees in any way based on health status.
- You must make sure that enrollees have adequate access to Covered Services.
- You must make sure that your hours of operation are convenient to enrollees and do not discriminate against enrollees and that medically necessary services are available to enrollees 24 hours a day, 7 days a week.
- You may only make available or distribute plan marketing materials to enrollees in accordance with CMS requirements.
- You must provide services to enrollees in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to inform enrollees of health care needs that require follow-up and provide necessary training to enrollees in self-care.
- You must provide Covered Services in a manner consistent with professionally recognized standards of health care.
- You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist enrollees in making an informed choice about Medicare coverage.
- You must cooperate with our processes for notifying enrollees of network participation agreement terminations.
- You must comply with our Medicare Advantage medical policies, quality improvement programs and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals.

11

11.1 Discount Plans*

Dental Benefit Providers (DBP) has a national Discount Plan. The Discount Plan differs from traditional plans in that it is not considered insurance, and there are no claims to file or submit, reducing administrative costs to your practice through the elimination of claims submissions and member billing.

The remuneration comes directly from the member at the time of service, allowing your practice to close your ledgers for those services immediately.

The discount provided to the member is in accordance with the terms of your contract with Dental Benefit Providers. The fee schedule that will be used to determine member payment amounts is exactly the same as the Dental Benefit Providers PPO fee schedule from which your compensation is determined for services rendered pursuant to PPO plans.

Members are educated through plan collateral so that they will understand that discount plans are not insurance and know that they are expected to pay in full upon delivery of service.**

Listed below is a list of entities that use the Discount Network:

- OptumHealth Allies – Located in all states.
- UnitedHealth One – Located in the following states only: AZ, IL, GA, OH, LA, WI, TX, PA

*This information is updated periodically. Please refer to our quarterly newsletter, NewsFlash, for a current list or contact our Provider Services line.

**If payment is not provided at the time of service, the member may be billed up to your usual and customary rates.

11.1.A Discount Plan Overview – Health Allies

PDF document can be located at the following link: http://uniteddocs.uhc.com/commercialbusiness/Professional_Networks/Special%20Projects%20and%20Presentations/Non-CA%20Prov%20Manual%20-%202011%20Review/Final%20Sections-For%20Editing%20by%20Carrot/11.1.a%20Discount%20Plan%20Overview-Health%20Allies_Clean%20Copy.pdf

Quick Reference Guide

OptumHealth℠
Allies

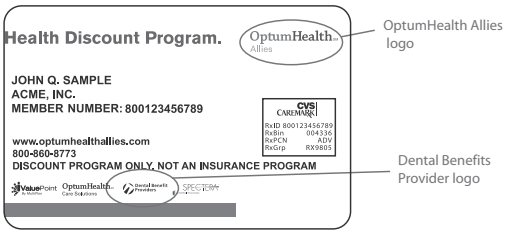
Dental Benefit Providers (DBP) network

As a participant in the Dental Benefit Providers (DBP) network you can expect to see patients who are members of the OptumHealth℠ Allies/UnitedHealth Allies® discount program. This health and medical services discount program has contracted with DBP to use their network. Here are answers to many of your questions about the discount program and your participation in it.

What is OptumHealth Allies/UnitedHealth Allies?
OptumHealth Allies (also marketed as UnitedHealth Allies) is a discount program administered by HealthAllies®, Inc., a UnitedHealth Group company. OptumHealth Allies is not insurance; rather, it is a money-saving program that offers discounts on many health and wellness products and services.

- OptumHealth Allies negotiates with provider networks (such as DBP) to give its members access to discounted rates on health services similar to the rates paid by health plans.
- OptumHealth Allies has approximately 15 million members in 50 states.
- OptumHealth Allies works with approximately 500,000 physicians and other providers from several networks, including DBP for dental services.

Members understand that OptumHealth Allies is not insurance, and know they are expected to pay in full, less the discount, on delivery of the service. (You may use other payment arrangements, at your discretion.) There are no claims to file, and no forms to fill out.



Recognizing OptumHealth Allies/UnitedHealth Allies members:
The OptumHealth Allies program is marketed under a variety of brand names, most commonly OptumHealth Allies and UnitedHealth Allies.

Members may present one of several ID cards. Some will be similar to the one above, which will bear the distinctive OptumHealth Allies logo, and you may also find the DBP logo. Another common card members might present is a UnitedHealthcare medical plan member ID card. All members are also asked to present a discount confirmation (see below for details).

OptumHealth Allies members may enroll in the discount program voluntarily, or they may receive membership through their employer, an association, or by being part of an affinity group. In some cases, they may mistakenly present themselves as having access to discounts through the sponsoring entity, rather than through OptumHealth Allies.

Quick Reference Guide

You may encounter members from some of these larger groups:

- The Home Depot
- HealthSaver
- Target
- Sam's Club
- FACT (Federation of American Consumers and Travelers)

Regardless of which card they present (or even if they present no card at all), you can verify member eligibility by calling the OptumHealth Allies Customer Care Center. Members are also asked to bring to their appointment a discount confirmation stating the network relationship and applicable fee schedule (see below).

How OptumHealth Allies Works:

1. A member in need of a dentist or other provider searches on the OptumHealth Allies Web site, or calls the Customer Care Center.
2. On finding a suitable provider and information on the discount he or she can expect to receive, the member creates and prints (or is sent) a "discount confirmation." Note that members are encouraged but not required to bring a discount confirmation to their appointment.
3. The member calls the provider and makes an appointment. The provider can establish payment arrangements and should confirm the member's ability to pay. Providers are not required to accept patients who do not meet your proof of payment requirements.
4. The member visits the provider, bringing his or her ID card (if applicable) and discount confirmation. The provider can confirm member eligibility by calling the toll-free number on the member's ID card or discount confirmation.
5. The member pays the fees from the UnitedHealthcare PPO Dental Fee Schedule directly to the provider or as otherwise arranged at the provider's discretion.

DBP Solutions Fee Structure

Patients expect to pay the fees from the UnitedHealthcare PPO Dental Fee Schedule in full at the time of service. You may wish to establish a time schedule for payment, if payment in full isn't possible. You can collect payment using any method already in place: cash, check, credit card, etc. The member should pay the fees from the UnitedHealthcare PPO Dental Fee Schedule. If you need further assistance, call OptumHealth Allies at the number shown on the ID card. Service is available Mon-Fri, 7 a.m.-8 p.m. Central Time.

Discount Program Participation:

Your participation in the OptumHealth Allies discount program is included in your agreement with DBP. If you do not wish to continue your participation in the discount program, you must contact DBP to change the terms of your agreement with them. In addition, you should contact DBP to make changes to your address, phone number, or other information.

Important Contact Information:

If you need to…	Contact:
Confirm a member's eligibility	Toll-free number on ID card or discount confirmation, or 1-877-426-2559
Obtain DBP contracted rates to collect from a member	Toll free number on ID card or discount confirmation, or 1-877-426-2559
Learn more about the OptumHealth Allies discount program	OptumHealth Allies, 1-877-426-2559
Ask about your DBP Network agreement	DBP, 1-800-822-5353

Dental Benefit Providers

OptumHealth℠ Allies

DBP QRG 9/08 Ver 2.0

11.1.B Discount Plan – Provider Letter

Dear Doctor,

Currently, more than five million enrollees nationwide have access to the Dental Benefit Providers (DBP) national PPO network — and your practice. We are now adding even more enrollees in your area!

DBP is proud to announce that it has formed a relationship with UnitedHealth One℠, a leading provider of consumer-driven health care solutions.

UnitedHealth One will be directing cash-pay patients without dental coverage to Dental Benefit Providers dentists!

Developing a relationship with UnitedHealth One members presents an exciting new way for you to market your practice and expand your member base. Additional benefits of participating in the UnitedHealth One discount program include:

- Simple eligibility verification with UnitedHealth One at 1-866-560-8541.
- No claims to file.
- No pretreatment authorizations to file.
- No review of your claims, no X-rays or perio charting to submit.
- No maximums or deductibles.
- The option to demand payment in full the day services are rendered.

Here's how it works:

1. Members will call the UnitedHealth One customer service line to identify participating providers in the network. Customers will contact you to set an appointment and identify themselves as UnitedHealth One members.
2. At the time of their appointment, the member will present their UnitedHealth One membership card and/or a voucher confirming their participation in the UnitedHealth One plan. At that time, you should contact UnitedHealth One to verify membership eligibility at 1-866-560-8541.

Charge the member the maximum allowable charge (MAC) that you would receive for your PPO members in the DBP network. You can choose to bill the member or ask for the full payment at the time of service.

As you can see, there is really nothing for you to lose with UnitedHealth One. Working with UnitedHealth One members should be both simple and profitable for you, our valued providers.

If you have any questions regarding this exciting new partnership, please do not hesitate to call UnitedHealth One at 1-866-560-8541.

Thank you for your continued participation in the Dental Benefit Providers national network!

Sincerely,

Dental Benefit Providers

11.2.A Colorado Dental Health Maintenance Organization (DHMO)

The PacifiCare of Colorado, Inc. DHMO Dental Plan is administered by Dental Benefit Providers, Inc. (DBP).

Providers who wish to join the DHMO network in Colorado must be initially credentialed and successfully pass an onsite Facility Review. As part of DBP's Quality Improvement Program, contracted providers are re-credentialed every three years and will have a periodic Facility Review and Patient Chart Audit every two years.

In order to receive benefits, eligible members must select and be assigned to a Primary Care Provider (PCP) and have all care provided by their assigned PCP. It is important that the provider verify a member's eligibility and assignment ***prior*** to providing dental services on the date of treatment.

During the first week of each month, contracted PCPs are mailed an eligibility listing that reflects all members who are currently assigned to their practice for that month. The list will also include any members who are no longer assigned to the office that month.

Along with the eligibility listing, the PCP will also receive a corresponding capitation payment. Capitation is issued on a per member per month (PMPM) basis for as long as the member is assigned to the office, and represents the plan's full "pre-payment" for dental services provided. Capitation is issued regardless of whether or not the member seeks treatment.

Depending on the plan, a copayment may be required by the member and will vary by procedure. If a service is not covered under the member's plan, the office is entitled to collect 100% of its Usual and Customary Fees.

DBP has a Direct Specialty Referral process in place for treatment beyond the scope of the PCP. It is mandatory that all specialty referral requests be initiated by the PCP and that the treatment is provided by a contracted DHMO Specialist. Inappropriate referrals or unauthorized treatment will not be reimbursed by DBP and may become the PCP's or Specialist's financial responsibility. The member is not to be charged for the PCP's or Specialist's failure to follow the Direct Specialty Referral process.

Exclusions and limitations apply and may vary by plan. For more information on DBP's DHMO plan, please contact Provider Relations at 1-800-622-6388.

11.2.B Texas Dental Health Maintenance Organization (DHMO)

National Pacific Dental, Inc. (NPD) is the legal entity of Dental Benefit Provider's (DBP's) DHMO product located in Texas.

All providers applying to become part of the NPD TX DHMO in-network plan must initially be credentialed and re-credentialed every three years. Applications are sent to Recruitment Support in Columbia, Maryland. All new locations must successfully pass a Facility Site Review prior to activation.

Members must select a Primary Care Provider (PCP) and be assigned to that provider's practice before treatment is rendered. It is important that the provider verify a member's eligibility and assignment ***prior*** to providing dental services.

All in-network providers receive copayments from members at the time of service. Copayments are payments for covered procedures based on the member's contracted Schedule of Benefits.

In-network PCPs are also reimbursed at a pre-determined fixed rate. The fixed rate, known as capitation, is paid on a per member per month (PMPM) basis, and is based on member eligibility and provider assignment. A monthly roster and corresponding capitation check is mailed the first week of each month to participating providers with membership assigned to their office. Capitation is pre-paid for the month and represents NPD's payment in full.

NPD has a Specialty Referral process in place for treatment beyond the scope of the PCP. It is mandatory that all Specialty Referral requests be initiated by the PCP and treatment is authorized by NPD to a contracted DHMO Specialist. Any unapproved referrals or unauthorized treatment will not be reimbursed by NPD and may become the Specialist's financial responsibility. The member is not to be charged for the PCP or Specialist's failure to follow the Specialty Referral process.

Plan exclusions and limitations apply. For more information on the National Pacific Dental Texas DHMO, please contact Customer Service at 1-800-232-0990.

11.3 Fallon Community Health Plan

Fallon Community Health Plan (FCHP) is an insurance company located in Worcester, Massachusetts. Dental Benefit Providers (DBP) maintains a local dental provider network on behalf of FCHP and is responsible for processing and payment of dental claims. Participating dental offices in need of assistance should contact Dental Benefit Providers directly with any questions.

There are currently four dental plan designs available to FCHP members and the following is a brief overview of each plan:

Fallon SelectCare and DirectCare

- Members are responsible for a $10 Office Visit Copay (OVC) for certain diagnostic and preventive procedures. Contact our Provider Services line or refer to your fee schedule for a complete listing of procedures that require an OVC. **NOTE:** The OVC may only be collected by the office one time per visit, regardless of how many eligible procedures a member receives during that visit.
- Diagnostic, preventive and minor restorative procedures have set member and plan payment fees.
- The majority of other covered services are paid in full by the member at a set discounted rate; please refer to your General Dentist Fee Schedule, labeled "Fallon Community Health Plan (Commercial)," or call Provider Services (1-800-822-5353) for more details.
- Covered services rendered by a Specialist (excluding Pedodontists) will be paid by the member at 80% of the office's usual and customary rate; there is no plan pay for these services.
- Exclusions and limitations for frequently used procedures: covered examinations, prophylaxis and bitewing X-rays are allowed twice per calendar year; amalgam and composite fillings are limited to once per tooth in a three-year period.
- **Changes effective in 2012:** No benefit changes, but providers should be aware that the membership has greatly decreased since January 1, 2011, and that only a handful of Municipal groups have elected to offer dental coverage through FCHP, in the form of a dental rider to their employees. New ID cards have been issued. Providers will find an indicator in the lower right corner of the ID card ("DB" is the dental benefit indicator, with the letter "Y" indicating there is a dental benefit attached, or the letter "N" if there is no dental benefit). The best way to ensure payment is to verify eligibility on the date of service, as any services performed after a member loses coverage are the full responsibility of the member.

Fallon Senior Plan Standard / Senior Plan Plus Enhanced Rx / Senior Plan Premier

- Members are responsible for a $25 Office Visit Copay (OVC) for certain diagnostic and preventive procedures. Contact our Provider Services line or refer to your fee schedule for a complete listing of procedures that require an OVC. **NOTE:** The OVC may only be collected by the office one time per visit, regardless of how many eligible procedures a member receives during that visit.
- Diagnostic, preventive and minor restorative procedures have set member and plan payment fees.
- The majority of other covered services are paid in full by the member at a set discounted rate; please refer to your General Dentist Fee Schedule, labeled "Fallon Community Health Plan (Senior) General Dentist Fee Schedule," or call Provider Services (1-800-822-5353) for more details.
- Covered services rendered by a Specialist (excluding Pedodontists) will be paid by the member at 80% of the office's usual and customary rate; there is no plan pay for these services.
- Exclusions and limitations for frequently used procedures: covered examinations, prophylaxis and bitewing X-rays are allowed twice per calendar year; amalgam and composite fillings are limited to once per tooth in a three-year period.
- There are no benefit changes planned for 2012.

Fallon Commonwealth Care Direct Care

- Coverage is only available to individuals age 19 or older, and they must meet certain eligibility criteria, set by the State of Massachusetts.
- Covered services are paid in full by DBP according to the fee schedule outlined in each practitioner's contract; members carry no financial responsibility for covered services.
- Non-covered services must be paid for by the member at the practitioner's usual and customary rate.

Fallon NaviCare SCO (Senior Care Options)

- Members eligible for this State-run program must qualify for both Medicare and Medicaid.
- Covered services are paid in full by DBP according to the fee schedule outlined in each practitioner's contract; members carry no financial responsibility for covered services.
- Non-covered services must be paid for by the member at the practitioner's usual and customary rate.
- FCHP will provide transportation for members when necessary.

Exclusions and limitations vary by plan design; it is imperative that offices call DBP Provider Services (1-800-822-5353) to confirm that a member is eligible for a procedure prior to rendering service.

11.4 Lincoln Financial Group (LFG)

Effective October 1, 2011, members will be able to visit your office to utilize their Lincoln dental benefits known as ***Lincoln DentalConnect***®.

Any provider who participates with our National PPO plan through a direct agreement with Dental Benefit Providers or another one of the partners we lease networks from will be considered an in-network provider for ***Lincoln DentalConnect***® members.

To assist you in recognizing these dental members, we've included an example of the front of Lincoln's ID card.

With ***Lincoln DentalConnect*** coverage, your office can quickly obtain patient eligibility and benefit information. Simply call the toll free number located on the back of the dental ID card and enter the patient's Social Security number. In less than five minutes, you'll receive a fax showing the patient's eligibility and benefits.

Here is some important information to help you in administering these plans:

Submit claims to:	**For questions regarding the administration or payment of a claim:**
Lincoln Financial Group Dental Claims Input Center P.O. Box 614008 Orlando, FL 32861 Electronic Payer ID Number: CX061	Lincoln Financial Group Attn: Claim Service Team 8801 Indian Hills Drive Omaha, NE 68114 Email: claims@lfg.com Phone: 1-800-423-2765

If you would like to inquire about the status of a claim electronically, you may send an email to **claims@lfg.com.**

Please call the member services line on the member's ID card to verify member eligibility and your participation status with Lincoln prior to delivering clinical services. There may be a delay between initial effective date with DBP and when Lincoln receives your information for loading into their system.

Enclosed within this section is a disclosure statement providing additional details about this new relationship. Please file with your existing services agreement.

For your convenience we've also attached a sample of the ID card that members will present at the time of service.

Should you have any questions regarding this arrangement, please contact our dedicated Provider Services line at 1-800-822-5353. Be sure to log on to dbp.com for information regarding our plans and services.

Leased Network Disclosure

Per the terms of your Participating Provider Agreement, on or after July 1, 2011, Dental Benefit Providers, Inc. (hereinafter "DBP") shall lease its network of PPO dental providers to the Lincoln National Life Insurance Company (hereinafter "Lincoln"). Lincoln shall market and sell dental PPO products to consumers in your geographic location and such consumers shall utilize DBP's PPO provider network.

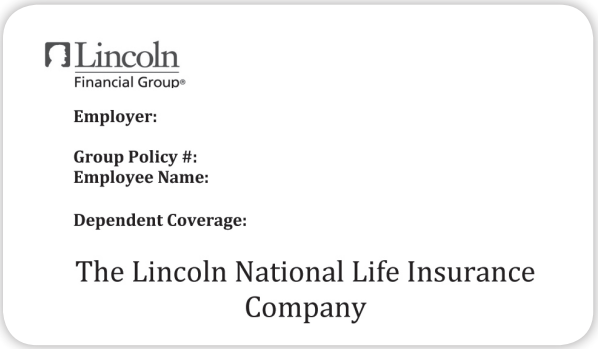
The following provides details of the arrangement between DBP and Lincoln, and your obligations to Lincoln and its members:

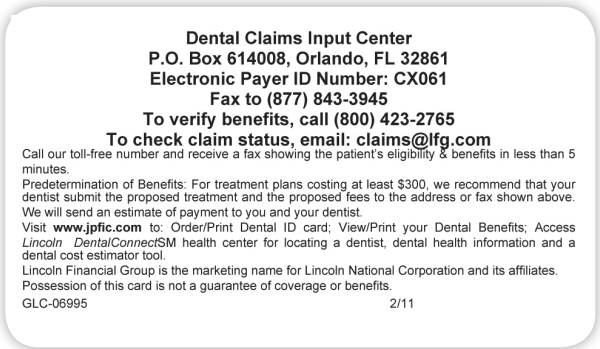
1. It is expected that you shall provide dental services to Lincoln members in the same fashion and to the same standards as you provide dental services to DBP / UnitedHealthcare Dental members.
2. The terms of your Participating Provider Agreement with DBP remains effective and controlling.
3. Lincoln actively encourages its members to utilize the DBP network by providing its members in-network discounts on covered services and provides its members access to a listing of the DBP network, which includes each provider's name and location. DBP requires that all leased network partners actively encourage its membership to utilize the DBP network.
4. The fees currently applicable to our National PPO plans are also applicable to Lincoln approved PPO products in your geographical area. You shall be compensated for services provided to Lincoln PPO members based on the same fee schedule in place for our National PPO plan.
5. All claims for services provided to Lincoln members shall be delivered to the following:

Submit claims to:	**For questions regarding the administration or payment of a claim:**
Lincoln Financial Group Dental Claims Input Center P.O. Box 614008 Orlando, FL 32861 Electronic Payer ID Number: CX061	Lincoln Financial Group Attn: Claim Service Team 8801 Indian Hills Drive Omaha, NE 68114 Email: claims@lfg.com Phone: 1-800-423-2765

6. All payments, explanation of benefits, and claims denials shall clearly indicate Lincoln as the responsible party for payment.
7. All inquiries, concerns, complaints, and grievances shall continue to be handled by DBP.
8. All Lincoln member identification cards shall identify the DBP network.
9. You may access a listing of all DBP leased network partners online at www.dbp.com, or you may request a listing at 1-800-822-5353.

ID Card Sample:





12.1 Definitions

12.1.A Preferred Provider Organizations (PPO)

In PPO plans, practitioners treat members at an agreed-upon rate for each procedure. There is an annual maximum of benefit paid out by the plan that varies by employer group. Typically, fees are paid partially by the member and partially by the insurance company.

Distinctions among the different types of plans are as follows:

Traditional PPO Plans – Members can seek care and still receive benefits if they go out of network. However, members' out-of-pocket expenses are less if they seek care from a participating dentist who charges contracted rates.

Incentive PPO Plans – Members have a richer benefit level (percentage covered) if they seek care at a participating dental office.

Passive PPO Plans – Members have the same benefit level (percentage covered) whether or not they use a participating office. However, if the member seeks care from a participating dentist, his/her out-of-pocket costs are lower.

In-Network Only (INO) Plans – Members only receive benefits if a participating dentist provides care. The plan benefits are the same as for the PPO network, with deductibles, maximums and coinsurance payments. Members must be referred to participating specialists (excluding orthodontists) under this plan to receive benefits.

Participating practitioners in these and other plans offered receive free advertising through online and print directory publications, and gain access to hundreds of employees within the local community.

12.1.B Dental Health Maintenance Organization (DHMO) Networks

DHMO plans offer a method of provider reimbursement wherein the insurance carrier or HMO pays the practitioner a fixed rate per month for assigned eligible members regardless of the utilization of dental services. In these plans, members select a designated primary care dentist that they access for all preventive, diagnostic and restorative care.

Practitioners who participate with these plans receive a single monthly payment (capitation amount) along with a roster of assigned members. This is paid whether the member accesses care or not.

Covered services are provided by the practitioner at no additional charge to the member unless otherwise stated on the plan fee schedule. In some instances, there are member and/or plan copayments to offset the cost of a procedure.

In a DHMO plan, the members must only visit dentists that are part of their DHMO network. Members must be assigned to a practice before treatment is rendered.

For certain procedures, referrals to a specialist may be needed. Our provider Web site and Provider Services line can help in locating specialists available within the member's plan.

12.1.C Discount Plans

Discount Plans differ from traditional plans in that there are no claims to file or submit, and they are not insurance plans. The payment comes directly and solely from the member at the time of service. The member (or spouse/dependent) is entitled to a discount in accordance with the terms of your contract with DBP. The fee schedule is exactly the same as the Dental Benefit Providers PPO fee schedule.

Members are educated to understand that the discount plans are not insurance and they are expected to pay in full upon delivery of service.

12.1.D Private Label Clients

Dental Benefit Providers (DBP) partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain their own company and/or product brand and the DBP relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.

As a participating practitioner with the National PPO Plan, you will have access to private label members using the same contracted fee schedule that is outlined in your agreement. Private label members seeking treatment may show a membership identification card that is different from the typical Dental Benefit Providers identification card. However, our name and information will appear on the back of the ID card so that you know which network the member is covered through.

Please see the Client (Distributor) Reference Guide in prior sections of this manual for examples of private label carriers we partner with.

12.1.E Distributor Clients

Distributor clients are clients who have contracted with Dental Benefit Providers (DBP) to utilize our network of dental practitioners, in much the same way as any other PPO client contracts with us to use our dental network. The distinction is that the claims are processed by the Distributor Client. The allowed amounts paid are in accordance with the terms of your agreement with Dental Benefit Providers. The fee schedule is the exact same as the Dental Benefit Providers PPO fee schedule.

An example of a Distributor Client is **UMR/Fiserv Health Managed Dental/Wausau Benefits.**

Please see the Distributor Client list in prior sections of this manual for examples of distributor carriers we partner with.

Attachments

12.2 Member EOB Sample

20000000–0009999 (UHC01R–UHC01R–000000999999999999–CA–N–M–)

UnitedHealthcare Dental®
PO Box 30567
Salt Lake City, UT 84130–0567

2436473G1G030470001

MEMBER NAME
STREET ADDRESS
CITY, ST 99999

EXPLANATION OF DENTAL PLAN REIMBURSEMENT

SHEET 1 OF 2
DATE MM/DD/YY

PROVIDER OR MBR NAME AND ID NO GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
DENTIST NAME PATIENT NAME, 99999999999 99999900; 999999999999 ADA CODE D6750 crown – porcelain fused to high	MM/DD/YY	29	888.00	888.00	.00	.00	444.00	444.00	K1A
ADA CODE D6240 pontic – porcelain fused to high	MM/DD/YY	30	888.00	888.00	.00	.00	444.00	444.00	K1A
ADA CODE D6750 crown – porcelain fused to high	MM/DD/YY	31	888.00	888.00	.00	.00	444.00	444.00	K1A
* Sub–Total *			2664.00	2664.00	.00	.00	1332.00	1332.00	
K1A Alternate benefit. Patient pays the difference between a porcelain fused to noble and the porcelain fused to high noble metal restoration. Plan underwritten by UnitedHealthcare Insurance Company									
TOTALS			2664.00	2664.00	.00	.00	1332.00	1332.00	

Not Negotiable

MB7093.GRN(093/01)

12.2 Member EOB Sample, continued

20999999–0009999 (UHC01R–UHC01R–00000099999999999–CA–N–M–)

KNOW YOUR RIGHTS

For Members:
An Insured or the Insured's authorized representative ("Insured"), has the right to appeal adverse decisions regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) Medical Necessity, effectiveness or efficiency.

The Company offers one internal review level. The review is conducted by an appropriately qualified person or persons not involved in the initial adverse decision.

Insureds may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or Insured's employee benefits representative. Insureds may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of the claim have been completed and the claim has not been approved.

Participation in any appeal process waives any privilege of confidentiality the Insured may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the appeal process.

To request an Appeal:

1. Insureds must make an oral or written appeal request at the telephone number or address provided below within one year of the receipt date of the adverse decision notice. Insureds making oral requests will be sent a form ("Appeal Form") to complete and return.
2. The Company will evaluate appeals of adverse decisions. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding Medical Necessity.
3. Insureds are responsible for providing any additional documentation supporting their reconsideration request with the written appeal request. The Company will evaluate a request based on the information in its possession.
4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

Contact and Other Important Information:

Insureds may call the Company with questions regarding the claim determination. Additionally, the Department of Insurance can assist with questions about the health care appeals process or if an Insured believes that there has been a violation of the State's unfair practices or other similar state laws.

MC9926.GRN(30709)

12.2 Member EOB Sample, continued

Insurance Company

Attention: Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

State Insurance Regulatory Agency:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
Toll Free Number: (800) 927–4357
Phone Number: (213) 897–8921
TDD (800) 482–4833
Website www.insurance.ca.gov

The above described appeals process may not apply to government dental benefit programs that are not related to employment, such as Medicare or Medicaid. If this EOB relates to Medicare or Medicaid coverage, please contact the toll–free number on your ID card for information on how to submit a request for review of this benefit determination.

For Providers:
Provider Dispute Information
Per California law, The Company is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit it to:

Attention: Appeals – Provider Appeals
P. O. Box 30569
Salt Lake City, UT 84130–0569

The dispute request must include the following information:

1. Name address and phone number of the provider of service;
2. Provider's Tax ID Number
3. Patient Name
4. Insurer's Information
6. Date of Service
7. A complete and accurate explanation of the issue

Supporting documentation including copies of claims, claim number, medical records, or supporting documentation to challenge reports, as necessary, from the initial adverse determination.

The Company will process your dispute request within 45 working days. Inquiries can be made at 1.800.822.5353 and/or website www.dbp.com.

If you feel that all or part of this claim has been wrongfully denied or rejected, you may have the matter reviewed by the California Department of Insurance at:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013
Toll Free Number: (800) 927–4357
Phone Number: (213) 897–8921
TDD (800) 482–4833
Website www.insurance.ca.gov

MC9927.GRN(30709)

Attachments and General Information

12.3 Sample Provider Remittance Advice

20000000–0000000 (–UHC01R–20100000000000000–NC–N–P–)

UnitedHealthcare Dental®
PO Box 30567
Salt Lake City, UT 84130–0567

2676473G1A001060001

DENTIST NAME
STREET ADDRESS
SUITE 999
CITY, ST 99999

EXPLANATION OF DENTAL PLAN REIMBURSEMENT

SHEET 1 OF 1
DATE MM/DD/YY

PROVIDER OR MBR NAME AND ID NO GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
DENTIST NAME NPI Submitted: 9999999999 PATIENT NAME 99999999900 99999900; 999999999900 ADA CODE D0140 limited oral evaluation – prob	MM/DD/YY	01 32	35.00	35.00	.00	.00	.00	35.00	
* Sub–Total *			35.00	35.00	.00	.00	.00	35.00	
Plan underwritten by UnitedHealthcare Insurance Company									
	TOTALS		35.00	35.00	.00	.00	.00	35.00	

MC7757.GRN(27308)

DATE
09/24/10

AMOUNT
$35.00

PAY : THIRTY–FIVE AND 00/100 DOLLARS

TO THE ORDER OF
DENTIST NAME
STREET ADDRESS
SUITE 999
CITY, ST 99999

Non-Negotiable Not Negotiable

0000999999999 999999999 999999999

12.3 Sample Provider Remittance Advice, continued

APPEALS PROCEDURE

A review of this benefit determination may be requested by you or your authorized representative by submitting your appeal to us in writing at the following address: **Attention: Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569.** The request for your review must be made within 180 days from the date you receive this statement. Ifyou request a revie of your claim denial, we will complete our review no later than 30 days after we receive your request for review. Your written request for reviw should include:

– The member's name, identification number and group policy number
– The actual service for which a no beneit coverage decision was made
– The reasons why you feel benefit coverage should be provided
– Any available medical information to support your reasons for reversing the benefit decision, if applicable

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

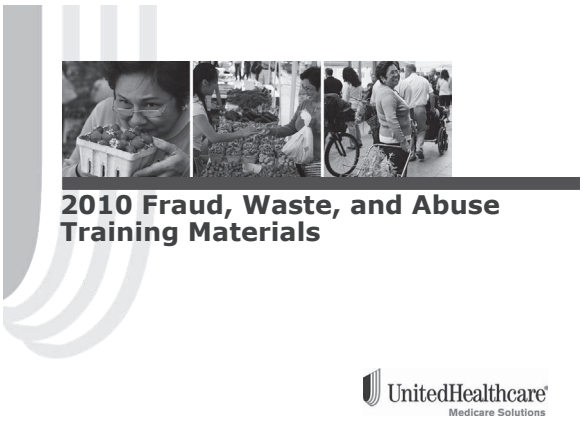
The above described appeals process may not apply to government dental benefit programs that are not related to emplyment, such as Medicare or Medicaid. If this EOB relates to Medicare or Medicaid coverage, please contact the toll-free number on your ID card for information on how to submit a request for review of this benefit determination.

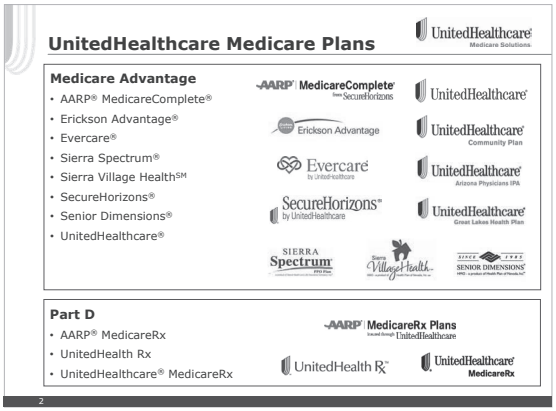
MB7203.GRN(30709)

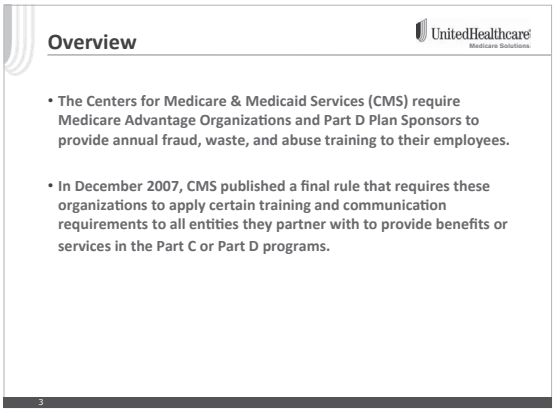
Attachments and General Information

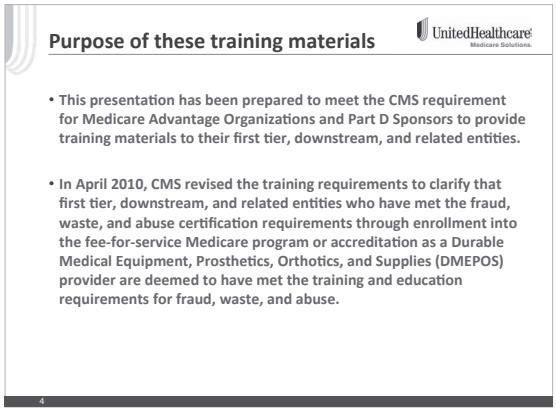
12.4 UHC Fraud, Waste and Abuse Provider Training

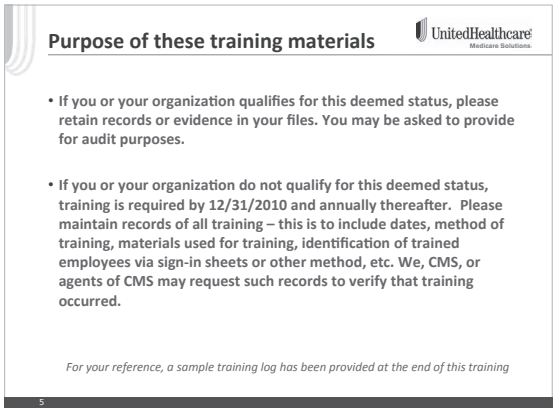
A PDF file can be located at www.dbp.com.

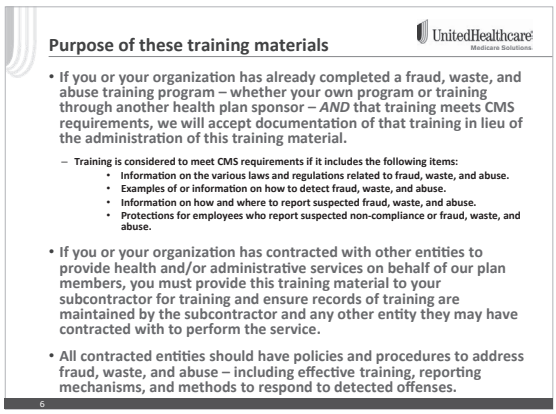












12.4 UHC Fraud, Waste and Abuse Provider Training, continued

Purpose of these training materials

- **Contracted Entity Definitions:**
  - **First Tier: Any party that enters into a written agreement with a plan sponsor to provide administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.**
    - Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals or providers.
  - **Downstream: Any party that enters into a written agreement below the level of the arrangement between a sponsor and a first tier entity for the provision administrative or health care services for a Medicare eligible individual under Medicare Advantage or Part D programs.**
    - Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.
  - **Related: Any entity that is related to the sponsor by common ownership or control and, 1) performs some of the sponsor's management of functions under contract of delegation; 2) furnishes services to Medicare enrollees under an oral or written agreement; or 3) leases real property or sells materials to the sponsor at a cost of more than $2500 during a contract period.**

7

Course Outline

- The Role of CMS
- The 7 Elements of a Compliance Program
- Fraud, Waste, and Abuse Defined
- Pertinent Laws and Regulations
- Examples of Fraud, Waste, and Abuse
- Reporting Obligation and Mechanisms
- Additional Resources

8

The Role of CMS

- **The Centers for Medicare & Medicaid Services (CMS) is a government entity within the U.S. Department of Health and Human Services.**
- **CMS is responsible for oversight of the Medicare Program – including health plans such as Medicare Advantage (MA), Medicare Advantage Prescription Drug (MAPD), and Prescription Drug Plan (PDP).**
- **The main office for CMS is located in Baltimore, MD. CMS has 10 Regional Offices – in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle.**

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The 7 Elements of a Compliance Program

- **Federal law requires Medicare Advantage and Part D plan sponsors to implement and maintain a Compliance Program that incorporates measures to detect, prevent, and correct fraud, waste, and abuse.**
- **The Office of the Inspector General (OIG) has identified seven core elements of a Compliance Program.**

1. **Written Standards of Conduct –** policies, procedures and other operating guidelines.
2. **High Level Oversight –** Designate a leader responsible for implementing and monitoring the Compliance Program.
3. **Effective Compliance Training –** development and implementation of regular and effective training, such as this one.

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The 7 Elements of a Compliance Program

- **The seven core elements of a Compliance Program, cont.:**

4. **Effective Lines of Communication –** ongoing communication and awareness about compliance expectations, including a system to receive, record and respond to compliance questions or reports of potential non-compliance.
5. **Disciplinary Mechanisms –** policies to consistently enforce standards, including enforcement of non-retaliation standards.
6. **Monitoring and Auditing –** systematic checks for compliance with requirements through monitoring and auditing activities.
7. **Procedures for Responding to Detected Offenses –** take the reasonable steps necessary to promptly respond to and prevent further non-compliance or misconduct – including corrective action as needed.

*Additional information on CMS requirements, recommendations for compliance programs and addressing fraud, waste, and abuse is available within Chapter 9 of the CMS Prescription Drug Benefit Manual. See 'Additional Resources' at the end of this presentation for a link.

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Fraud, Waste, and Abuse Defined

- **Fraud**
  - **is a false statement - made or submitted by an individual or entity - who knows that the statement is false, and knows that the false statement could result in some otherwise unauthorized benefit to the individual or entity. These false statements could be verbal or written.**
- **Waste & Abuse**
  - **in the context of health care claims are generally broader concepts than fraud. They include over-use of services or other provider, contractor, or member practices that are inconsistent with sound business, financial or medical practices, and that cause unnecessary costs to the healthcare system.**

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12.4 UHC Fraud, Waste and Abuse Provider Training, continued

Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

False Claims Act

- The federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the federal False Claims Act.
  - A "claim" is broadly defined to include any submissions that results, or could result, in payment.
  - Under the False Claims Act, 'knowing' or 'known' means that a person:
    - Has actual knowledge;
    - Acts in deliberate ignorance of truth or falsity; or,
    - Acts in reckless disregard of truth or falsity.
    - Proof of specific intent to defraud is not required to fall within the definition of knowledge.
  - Claims "submitted to the government" includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer healthcare benefits.

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Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

False Claims Act, cont.

- **Liability can also be created by the improper retention of an overpayment.**
  - The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law expanded a provision of the False Claims Act referred to as a reverse false claim.
  - Overpayments or any funds received or retained under Medicare or Medicaid that a person or organization is not entitled to must be reported and returned within 60 days of identification.
- **Whistleblower and Whistleblower Protections:**
  - The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.
  - Individuals who file such suits are known as 'whistleblowers'. The federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

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Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

False Claims Act, cont.

- **Examples include:**
  - A physician who submits a bill to Medicare for medical services not provided.
  - A government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements.
  - An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare Plan Sponsor.

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Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

Anti-Kickback Statute

- The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under Federal health care programs.
- The Anti-Kickback law is intended to ensure that referrals for healthcare services are based on medical need and not based on financial or other types of incentives to individuals or groups.
- The Patient Protection and Affordable Care Act of 2010 (PPACA) or Health Care Reform Law has added a provision to the Anti-Kickback Statute where 'knowingly and willfully' does not mean the individual had the intent to specifically violate the statute. In addition, violations of the Anti-Kickback statute can now be considered a false and fraudulent claim under the False Claims Act.

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Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

Anti-Kickback Statute, cont.

- Examples include:
  - A frequent flier campaign in which a physician may be given a credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company's product.
  - Free laboratory testing offered to health care providers, their families and their employees to induce referrals.
- In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.

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Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.
  - HIPAA Privacy
    - The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.
  - HIPAA Security
    - The Security Rule outlines specific protections and safeguards for electronic PHI.
- If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

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12.4 UHC Fraud, Waste and Abuse Provider Training, continued

Pertinent Laws and Regulations

UnitedHealthcare Medicare Solutions

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA contains provisions and rules related to protecting the privacy and security of protected health information (PHI) as well as provisions related to the prevention of health care fraud and abuse.
  - Sample HIPAA Fraud, Waste, and Abuse Provisions
    - The creation of the Fraud Abuse and Control Program for coordination of state and federal health care fraud investigation and enforcement activities.
    - The expansion of the exclusion authority so that any health care fraud conviction, even if the fraud is not related to Medicare or Medicaid, results in mandatory exclusion from participation in the Medicare or Medicaid programs.
    - The creation of a new series of federal crimes, together referred to as 'health care fraud', which make it a federal crime to defraud health care benefit programs – any benefit program, not just Medicare or Medicaid.

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Examples of Fraud, Waste, and Abuse

UnitedHealthcare Medicare Solutions

Consumer Fraud, Waste, and Abuse:

- Doctor Shopping – Consumer or other individual consults with a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.
- Prescription diversion and inappropriate use – Consumers obtain prescription drugs from a provider, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. Also can include the inappropriate consumption or distribution of a consumer's medications by a caregiver or anyone else.
- Identity Theft or Medical Identity Theft – A person uses another person's Medicare card to obtain services or prescriptions – OR – another person's information is used to bill for procedures that were never done or for supplies that were never received.

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Examples of Fraud, Waste, and Abuse

UnitedHealthcare Medicare Solutions

Pharmacy Fraud, Waste, and Abuse:

- Prescription Drug Switching – The Pharmacy or PBM receives a payment to switch a consumer from one drug to another or influence the prescriber to switch the patient to a different drug.
- Prescription Drug Shorting or Splitting – A pharmacy or PBM mail order pharmacy intentionally provides less than the prescribed quantity and does not inform the patient or make arrangements to provide the balance, but bills for the fully-prescribed amount. The pharmacy splits original prescription to receive additional dispensing fees.
- Inappropriate billing practices such as:
  - Billing for brand when generics are dispensed
  - Billing for non-covered prescriptions as covered items
  - Billing for prescriptions that are never picked up

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Examples of Fraud, Waste, and Abuse

UnitedHealthcare Medicare Solutions

Prescriber Fraud, Waste and Abuse:

- Script mills – Provider writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs. These scripts are usually written, but not always, for controlled drugs for sale on the black market, and might include improper payments to the provider.
- Illegal remuneration schemes – Prescriber is offered, or paid, or solicits, or receives unlawful remuneration (payment or items of value) to induce or reward the prescriber to write prescriptions for drugs or products.
- Prescription drug switching – Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.

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Examples of Fraud, Waste, and Abuse

UnitedHealthcare Medicare Solutions

Sales Agent Fraud, Waste and Abuse

Marketing Schemes –

- Enrollment of a consumer in a Medicare Plan without the consumer's knowledge or consent.
- Offering consumers a cash payment or other reward as encouragement to enroll in a Medicare, Medicaid, or a healthcare benefit Plan.
- Selling or marketing insurance without a license.
- Using consumer information supplied through a third party (another agent, friend, etc) to market Medicare plans.
- Agents splitting commissions or agent referral fees.
- Misrepresenting themselves as a representative of the government (Medicare / Social Security / Federal Government).

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Reporting Obligation and Mechanisms

- If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it.
- Report suspected Dental issues or concerns to:
  - 1 (800) 822-5353
- Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

12.4 UHC Fraud, Waste and Abuse Provider Training, continued

Reporting Obligation and Mechanisms

- If you identify or are made aware of potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it.
- Contracted vendors or delegates can call the UnitedHealthcare Medicare Solutions Vendor Fraud Hotline (877) 401-9430
- Callers are encouraged to provide contact information should additional information be needed. However, you may report anonymously and retaliation is strictly prohibited if a report is made in good faith.

Questions / Concerns

- If you have any question or concerns regarding the content of this training please contact:
- Optum Health Dental:
  - 1 (800) 822 -5353

Additional Resources

UnitedHealthcare Medicare Solutions

- **CMS' Prescription Drug Benefit Manual – Chapter 9:**
  - http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf
- **Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504)**
  - http://www.gpoaccess.gov/cfr/index.html
- **Office of the Inspector General**
  - http://www.oig.hhs.gov/fraud.asp
- **Medicare Learning Network (MLN) Fraud & Abuse Job Aid**
  - http://www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf

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Sample Training Log

UnitedHealthcare Medicare Solutions

Employee Name	Name of Training	Date	Employee Signature (if delivered in person)

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12.5 Demographic Change Form – Non-California Final 2011

Provider Information Demographic Change Submission Form

Dental Benefit Providers
A UnitedHealth Group Company

Description of when to use form: to be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc). ***Form must be signed at bottom to be processed.***

Providers: To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic informatio n, please ensure you submit your demographic changes PRIOR to submitting your claim(s) and within 30 days of the change taking place.

Please check ALL the demographic items that need to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right:	**Mailing Address:** Dental Benefit Providers, Inc. Attn: Provider Services 6220 Old Dobbin Lane, Ste. 100 Columbia, MD 21045 **Fax:** 855-363-9691

Current Provider Information:

☐ **Please check box if making a TIN (Tax ID Number) change.**
(Copy of updated W-9 form is required with request for change to be processed.)

Practice Name: **Current Provider Name:** **Provider ID Number (if known):** **NPI number:**	**Previous/Current TIN:**	**New TIN:**	**Effective date of new TIN:**

☐ **Please check box if making a name change.**

New Name: (Last) (First)

Effective date of new name:

☐ **Please check box if making address change.**

PRACTICE LOCATION	**REMITTANCE ADDRESS**
Previous/Current Address:	**Previous/Current Address:**
(Street #) (Suite #)	(Street #) (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)
New Address:	**New Address:**
(Street #) (Suite #)	(Street #) (Suite #)
(City) (State) (Zip)	(City) (State) (Zip)
Effective date of address change:	☐ **Please check box if same as location.**

☐ **Please check box if changing your NPI.**

New NPI:

Effective date of NPI change:

PROVIDER SIGNATURE:	**DATE:**

PLEASE NOTE: This form must be signed by the participating provider, or it will be returned.

12.6 Determination of "Necessary" Services

A review of an issue for appropriateness of dental services is a prospective or retrospective review performed by licensed dentists who examine the proposed service or submitted claim to determine if the services performed will be/were necessary.

Medical necessity is completed based on the following:

- To ascertain that the procedure meets our clinical criteria, which is approved by the Clinical Policy and Technology Committee, Clinical Affairs 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.

12.7 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.

NY 137 Rule

If you are a provider in NY who is new to the area or is joining a participating group with the plan, you have a right to provisional credentialing if the process takes more than 90 days.

All written/telephonic inquiries about credentialing or recredentialing must be sent to the following addresses or phone numbers:

All states except California	**California Only**
Credentialing Supervisor Credentialing Department 6220 Old Dobbin Lane Liberty 6, Suite 200 Columbia, MD 21045 1-443-896-0754	**Credentialing Supervisor** Credentialing Department 3110 Lake Center Drive Santa Ana, CA 92704 1-714-513-6354