



UnitedHealthcare Dental Prior Authorization Guidance

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Guía de autorización previa Dental de UnitedHealthcare

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UnitedHealthcare Dental Prior Authorization Guidance

This document provides information about prior-authorization requirements by CDT code for Children's Dental Services.

Prior-authorization of care should be requested electronically via a standard EDI transaction submission, through the UHC Dental Provider Portal at <http://www.uhc.com/dentalTX> and following the link to the Provider Sign In page for the provider portal. Prior Authorization requests may also be mailed to P.O. Box 1511, Milwaukee, WI 53201. UHC Dental will process prior-authorization requests within three (3) business days. Once a determination has been made, the prior-authorization approval will be available to view on the Provider Portal as well as written notices issued. Our Utilization Management team will mail a hard copy of the prior-authorization approval within three (3) business days of the determination for standard requests and within one (1) business day for emergency requests. If the prior-authorization request is denied, the member and provider will receive an adverse determination notice.

Approved prior-authorization requests are valid for 90 days from the date of approval. Both the member and provider will receive notification of which services were approved, as well as the expiration date of the authorization for the approved services. If orthodontic treatment does not begin within the valid 180-day period, the provider must submit a new pre-authorization request for approval.

All approvals for services are assigned a unique authorization number, which must be submitted with the claim after services are rendered. UHC Dental will not return x-rays, periodontal charting, or other related documents. Please submit duplicate sets of these documents when required to be submitted with a prior-authorization request.

Please review the UHC Dental Texas Provider Manual at the link: [Provider Manual](#) for additional information by CDT code including frequency limitations and other specifications. Providers may contact the Provider Hotline at **1-800-527-1764** with requests for assistance with the prior authorization process. Members may contact the Member Hotline at **1-877-901-7321 TTY 7-1-1** to inquire about the status of prior authorization requests and for assistance understanding the prior authorization process. Our standard Hotline Hours of Operation is 8am to 5pm Monday-Friday. [Click to go to Procedures Grid](#)

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What is a “complete” Prior Authorization request?

A request for a service that includes all information/documents required to make and establish a medical necessity determination. The prior authorization (PA) requirements to consider a PA request complete are listed on our website for the requested service.

What are the “essential” information requirements needed to initiate a PA review?

- Member name
- Member number or Medicaid number
- Member date of birth
- Requesting provider name
- Requesting provider’s National Provider Identifier (NPI)
- Service requested - Current Dental Terminology (CDT), Current Procedural Terminology (CPT), or Healthcare Common Procedure Coding System (HCPCS)
- Service requested start and end date(s)
- Quantity of service units requested based on the CDT, CPT, HCPCS
- CDT coded procedures requested

What is an Incomplete PA Request?

A request for a service that is missing information to establish medical necessity as listed in the Prior Authorization

If an incomplete PA Request is received, UHC Dental will take the following actions:

- Notify the requesting provider and Member, in writing, that the PA contained missing information and provide a notice of extension (NOE) no later than 3 Business Days after the PA Received Date.
- UHC Dental may also contact the provider by telephone and obtain the information necessary to resolve the Incomplete PA Request.
- The MCO's written request for additional information must include the following:
 - A statement that the request has received but we are unable to decide about the requested services without the submission of additional information.
 - A clear and specific list and description of missing/incomplete/incorrect information or documentation that must be submitted in order to consider the request complete.
 - A due date for which the incomplete information must be received and how the provider may contact UHC Dental.
- If the information requested is not received by the end of the 3rd Business Day from the date of the notice to the provider, then the PA request may result in an Adverse Benefit Determination.
- Within 3 Business Days of the referral for Clinical review, but no later than the 10th Business Day after the PA Receive Date, UHC Dental will make a final decision on the PA request.
- A peer to peer consultation can occur at any time during the PA request process after a Clinical review.
- Final determinations must be made within 3 Business Days after the date missing information is provided to an MCO.

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Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D0367	Cone Beam - Both Jaws	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Cone Beam CT
D0999	Unspecified Diagnostic Procedures, By Report	Description of procedure and narrative of medical necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D2510	Inlay - Metallic - One Surface	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2520	Inlay - Metallic - Two Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2530	Inlay - Metallic - Three Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2542	Onlay - Metallic - Two Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2543	Onlay - Metallic - Three Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2544	Onlay - Metallic - Four Or More Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2650	Inlay - Resin-Based Composite - One Surface	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2651	Inlay - Resin-Based Composite - Two Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2652	Inlay - Resin-Based Composite - Three Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2662	Onlay - Resin-Based Composite - Two Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2663	Onlay - Resin-Based Composite - Three Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2710	Crown - Resin-Based Composite (Indirect)	BWX, narrative when decay is not evident on x-rays	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2720	Crown - Resin With High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2721	Crown - Resin With Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2722	Crown - Resin With Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2740	Crown - Porcelain/Ceramic	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2750	Crown - Porcelain Fused To High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2752	Crown - Porcelain Fused To Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D2780	Crown - 3/4 Cast High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2781	Crown - 3/4 Cast Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2782	Crown - 3/4 Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2783	Crown - 3/4 Porcelain/Ceramic	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2790	Crown - Full Cast High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2791	Crown - Full Cast Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2792	Crown - Full Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2794	crown – titanium and titanium alloys	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2960	Labial Veneer (Resin Laminate) - Chairside	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2961	Labial Veneer (Resin Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2999	Unspecified Restorative Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3348	Retreatment Of Previous Root Canal Therapy - Molar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3351	Apexification / Recalcification - Initial Visit	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3352	Apexification / Recalcification - Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3353	Apexification / Recalcification - Final Visit	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3410	Apicoectomy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3421	Apicoectomy - Premolar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3425	Apicoectomy - Molar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3426	Apicoectomy - Each Additional Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D3430	Retrograde Filling - Per Root	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Retrograde Filling
D3450	Root Amputation - Per Root	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Amputation
D3460	Endodontic Endosseous Implant	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Endodontic Endosseous Implant
D3470	Intentional Reimplantation (Including Necessary Splinting)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Endodontic Endosseous Implant
D3999	Unspecified Endodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid and CHIP	9/1/2020	Gingivectomy or Gingivoplasty
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Gingivectomy or Gingivoplasty
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Anatomical Crown Exposure
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Anatomical Crown Exposure
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	Full mouth x-rays, perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	Flap Procedures
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	Full mouth x-rays, perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	Flap Procedures
D4245	Apically Positioned Flap	Pre-op x-rays, narrative of medical necessity, photos optional	Medicaid	9/1/2020	Flap Procedures
D4249	Clinical Crown Lengthening - Hard Tissue	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Clinical Crown Lengthening
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Osseous Surgery
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Osseous Surgery
D4266	Guided Tissue Generation - Resorbable Barrier, Per Site	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)	Medicaid	9/1/2020	Guided Tissue Regeneration
D4267	Guided Tissue Regeneration	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)	Medicaid	9/1/2020	Guided Tissue Regeneration
D4270	Pedicle Soft Tissue Graft Procedure	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4274	Distal Or Proximal Wedge Procedure	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4285	Non-Autogenous Connective Tissue Graft Each Additional	Pre-op x-rays, perio charting, narrative of med nec photos	Medicaid	9/1/2020	Tissue Grafts
D4320	Provisional Splinting - Intracoronaral	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Provisional Splinting
D4321	Provisional Splinting - Extracoronaral	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Provisional Splinting
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	FMX, Perio charting and narrative of medical necessity	Medicaid and CHIP	9/1/2020	Scaling and Root Planing
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Scaling and Root Planing
D4999	Unspecified Periodontal Procedure, By Report	panoramic x-ray or full series, perio charting, narrative	Medicaid	9/1/2020	Unspecified Procedures, by Report
D5110	Complete Denture - Maxillary	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	Complete and Immediate Dentures
D5120	Complete Denture - Mandibular	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	Complete and Immediate Dentures
D5130	Immediate Denture - Maxillary	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5140	Immediate Denture - Mandibular	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5211	Maxillary Partial Denture - Resin Base	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5212	Mandibular Partial Denture - Resin Base	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5213	maxillary partial denture - cast metal framework with resin denture bases	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5214	mandibular partial denture - cast metal framework with resin denture bases	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5810	Interim Complete Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5811	Interim Complete Denture (Mandibular)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5820	Interim Partial Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Interim Partial Dentures

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D5821	Interim Partial Denture (Mandibular)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Interim Partial Dentures
D5899	Unspecified Removable Prosthodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D5911	Facial Moulage (Sectional)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5912	Facial Moulage (Complete)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5913	Nasal Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5914	Auricular Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5915	Orbital Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5916	Ocular Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5919	Facial Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5922	Nasal Septal Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5923	Ocular Prosthesis, Interim	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5924	Cranial Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5925	Facial Augmentation Implant Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5926	Nasal Posthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5927	Auricular Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5928	Orbital Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5929	Facial Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5931	Obturator Prosthesis, Surgical	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5932	Obturator Prosthesis, Definitive	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5933	Obturator Prosthesis, Modification	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5934	Mandibular Resection Prosthesis With Guide Flange	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5935	Mandibular Resection Prosthesis Without Guide Flange	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D5936	Obturator Prosthesis, Interim	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5937	Trismus Appliance (Not For Tmd Treatment)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5951	Feeding Aid	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5952	Speech Aid Prosthesis, Pediatric	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5953	Speech Aid Prosthesis, Adult	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5954	Palatal Augmentation Prosthesis	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5955	Palatal Lift Prosthesis, Definitive	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5958	Palatal Lift Prosthesis, Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5959	Palatal Lift Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5960	Speech Aid Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5982	Surgical Stent	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5983	Radiation Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5984	Radiation Shield	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5985	Radiation Cone Locator	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5986	Fluoride Gel Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5987	Commissure Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5988	Surgical Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5992	Adjust Maxillofacial Prosthetic Appliance, By Report	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5993	Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra Or Intraoral)	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5999	Unspecified Maxillofacial Prosthesis, By Report	Panoramic, photos, narr of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D6210	Pontic - Cast High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D6211	Pontic - Cast Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6212	Pontic - Cast Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6240	Pontic - Porcelain Fused To High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6242	Pontic - Porcelain Fused To Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6245	Pontic - Porcelain/Ceramic	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6250	Pontic - Resin With High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6251	Pontic - Resin With Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6252	Pontic - Resin With Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6720	Retainer Crown - Resin With High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6721	Retainer Crown - Resin With Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6722	Retainer Crown - Resin With Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6740	Retainer Crown - Porcelain/Ceramic	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6752	Retainer Crown - Porcelain Fused To Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6780	Retainer Crown - 3/4 Cast High Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6782	Retainer Crown - 3/4 Cast Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)

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Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6790	Retainer Crown - Full Cast High Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6791	Retainer Crown - Full Cast Predominantly Base Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6792	Retainer Crown - Full Cast Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6920	Connector Bar	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Connector Bar
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D7230	Removal Of Impacted Tooth - Partially Bony	Panoramic, narrative of medical necessity	Medicaid and CHIP	9/1/2020	Removal of Impacted Teeth
D7240	Removal Of Impacted Tooth - Completely Bony	Panoramic, narrative of medical necessity	Medicaid and CHIP	9/1/2020	Removal of Impacted Teeth
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Removal of Impacted Teeth
D7272	Tooth Transplantation (Includes Reimplantation)	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Tooth Transplantation
D7290	Surgical Repositioning Of Teeth	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Surgical Repositioning of Teeth
D7472	Removal Of Torus Palatinus	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Removal of Torus Palatinus
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Partial Ostectomy
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Maxillary Sinusotomy
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Alveolus - Closed Reduction
D7820	Closed Reduction Of Dislocation	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Alveolus - Closed Reduction
D7880	Occlusal Orthotic Device, By Report	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Occlusal Orthotic Device, by report
D7899	Unspecified Tmd Therapy, By Report	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D7910	Suture Of Recent Small Wounds Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7911	Complicated Suture - Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7912	Complicated Suture - Greater Than 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Repair of Maxillofacial Soft and/or Hard Tissue Defect

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Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D7999	Unspecified Oral Surgery Procedure, By Report	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8210	Removable Appliance Therapy	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8220	Fixed Appliance Therapy	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid	9/1/2020	Orthodontic
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	Post treatment x-ray, Photos, Statement from provider that treatment is complete	Medicaid	9/1/2020	Orthodontic
D8999	Unspecified Orthodontic Procedure, By Report	Reason member left provider, Tx status, Prior Approval, Payment history, Records	Medicaid	9/1/2020	Orthodontic
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9248	Non-Intravenous Conscious Sedation	Treatment plan, Narrative, X-rays	Medicaid	9/1/2020	Non IV Conscious Sedation
D9610	Therapeutic Parenteral Drug, Single Administration	Narrative of medical necessity	Medicaid	9/1/2020	Therapeutic Parental Drugs
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Therapeutic Parental Drugs
D9630	Drugs or Medicaments - dispensed for home use	Narrative of medical necessity	Medicaid	9/1/2020	Drugs or Medicaments Dispensed in the office for Home Use
D9920	Behavior Management, By Report	Physician note stating disability, Services, supplies, staff, duration	Medicaid	9/1/2020	Behavior Management, by report

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Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Treatment of Complications, Post surgical
D9944	Occlusal Guard-hard appliance, full arch	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Guard
D9950	Occlusion Analysis - Mounted Case	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Analysis - Mounted Case
D9951	Occlusal Adjustment - Limited	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Adjustment - Limited
D9952	Occlusal Adjustment - Complete	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Adjustment - Complete
D9999	Unspecified Adjunctive Procedure, By Report	pre and post-op x-rays, Narrative of necessity/report of procedure	Medicaid	9/1/2020	Unspecified Procedures, by Report

Category	Approval Criteria
Alveolus – Closed Reduction, May Include Stabilization of Teeth	Documentation describes accident, operative report and medical necessity

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Category	Approval Criteria
Anatomical Crown Exposure	<ul style="list-style-type: none">• To facilitate the restoration of subgingival caries• To allow proper contour of restoration• To allow management of a subgingivally fractured tooth

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Category	Approval Criteria
Apexification / Recalcification	The apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

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Category	Approval Criteria
Apicoectomy / Periradicular Surgery	<ul style="list-style-type: none">• The apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; it requires a filling to be placed in the apical part of the tooth to seal that part of the root canal• Perforation of the root in the apical one-third of the canal

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Category	Approval Criteria
Behavior Management, By Report	<ul style="list-style-type: none">• Documentation (treatment history) supports indication of non-cooperative child under the age of nine (9) years• Documentation supports indication of patient with a medical condition (cardiac, cerebral palsy, epilepsy, or other condition that would render the patient non-compliant)

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Category	Approval Criteria
Clinical Crown Lengthening	<ul style="list-style-type: none">• In an otherwise periodontally healthy area to allow a restorative procedure on a tooth with little to no crown exposure• To allow preservation of the biological width for restorative procedures

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Category	Approval Criteria
Closed Reduction of Dislocation	Narrative and x-rays support medical necessity for procedure

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Category	Approval Criteria
Cone Beam CT	Documentation describes medical necessity and why radiographic images would not be appropriate/sufficient and why CBCT is needed to safely render treatment

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Category	Approval Criteria
Connector Bar	Documentation supports why it is needed to brace individual Retainer/Abutment teeth with considerable coronal length for enhanced stabilization of removable partial dentures, complete dentures and overdentures

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Category	Approval Criteria
<p>Crowns/Onlays</p>	<ul style="list-style-type: none"> • Criteria for cast crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis. • Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four (4) or more surfaces and two (2) or more cusps. • Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three (3) or more surfaces and at least one (1) cusp. • Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge. <p>To meet criteria, a crown must:</p> <ul style="list-style-type: none"> • Be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture. • The patient must be free from active and advanced periodontal disease. • The fee for cast crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. • Cast crowns on permanent teeth are expected to last, at a minimum, five years. <p>Criteria for Crowns following Root Canal Therapy:</p> <ul style="list-style-type: none"> • Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved. • The filling must be properly condensed/obtured. Filling material does not extend excessively beyond the apex. • The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3 <p>Crowns will NOT meet criteria if:</p> <ul style="list-style-type: none"> • Tooth has subosseous and/or furcation caries • Tooth has advanced periodontal disease • Tooth is a primary tooth (cast crowns not approved for primary teeth) • Crowns are being planned to alter vertical dimension

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Category	Approval Criteria
Dentures	<p>Must have all of the following:</p> <ul style="list-style-type: none">• Remaining teeth do not have adequate bone support or are not restorable• Existing denture greater than 5 years old and unserviceable (narrative must explain why any existing denture is not serviceable or cannot be relined or rebased) <p>If a replacement full denture is requested within 5 years:</p> <ul style="list-style-type: none">• Narrative from DDS must explain specific circumstances that necessitate replacement• Supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

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Category	Approval Criteria
Drugs or medicaments dispensed in the office for home use	<ul style="list-style-type: none">• May be indicated to enhance healing of surgical procedures, or reduce pain and/or risk of infection.• These include, but are not limited to oral antibiotics, oral analgesics, and topical fluoride

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Category	Approval Criteria
Endodontic Endosseous Implant	<ul style="list-style-type: none">• Medically necessary to retain tooth structure• Adequate periodontal and osseous support• Pre-op x-rays must show apex of root• Free from periodontal disease <p>Intentional Re-implantation</p> <ul style="list-style-type: none">• Persistent periradicular pathosis following endodontic treatment• Nonsurgical retreatment is not possible or has an unfavorable prognosis• Periradicular surgery is not possible or involves a high degree of risk to adjacent anatomical structures

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Category	Approval Criteria
Fixed Partial Dentures – Pontics and Retainers (bridges)	<ul style="list-style-type: none">• At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease).• The space cannot be filled with a removable partial denture.• The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch).• Each abutment or each pontic constitutes a unit in a bridge.• Retainer teeth must have a good prognosis

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Category	Approval Criteria
Flap Procedures	<ul style="list-style-type: none">• The presence of moderate to deep probing depths• Moderate/severe gingival enlargement or extensive areas of overgrowth• Loss of attachment• The need for increased access to root surface and/or alveolar bone when previous non-surgical attempts have been unsuccessful• The diagnosis of a cracked tooth, fractured root or external root resorption when this cannot be accomplished by non-invasive methods

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Category	Approval Criteria
<p>General Anesthesia and Intravenous (IV) Sedation</p>	<ul style="list-style-type: none"> • A completed Criteria for Dental Therapy Under General Anesthesia form with a minimum score of 22 • Treatment plan • Narrative describing medical necessity. For children 6 and under, a narrative unique to the client, detailing reasons for the proposed level of anesthesia (indicate procedure code D9222/D9223). The narrative must include history of prior treatment, failed attempts at other levels of sedation, behavior in the dental chair, proposed restorative treatment (tooth ID and surfaces), urgent need to provide comprehensive dental treatment based on extent of diagnosed dental caries, and/or any relevant medical condition(s). • Complete anesthesia report including start and stop times is required with claim for review of payment • Diagnostic quality radiographs or photographs • When appropriate radiographs or photographs cannot be taken prior to general anesthesia, the narrative must support the reasons for an inability to perform diagnostic services. For these special cases that receive authorization, diagnostic quality labeled radiographs or photographs will be required for payment. • Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment <p>Utilizing a Dental Anesthesiologist:</p> <ul style="list-style-type: none"> • If the treating dentist is utilizing a dental anesthesiologist, the treating dentist would have already submitted the above clinical records under a prior authorization request for D9999 for review. • If that is the case, at the time the dental anesthesiologist submits the claim for the rendered anesthesia services, the clinical consultants will be looking to review the following submission requirements from the dental anesthesiologist: <ul style="list-style-type: none"> ○ A copy of the approved prior authorization letter of D9999 ○ One unit of D9222 and appropriate units of D9223

- Complete anesthesia report with start and stop times (aligning with the requested units of anesthesia)

If the minimum score of 22 is NOT met on the Criteria for Dental Therapy Under General Anesthesia form, requests for general anesthesia or IV sedation may still be authorized (for covered procedures) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 6 years old and younger with extensive procedures to be accomplished

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Category	Approval Criteria
Gingivectomy or Gingivoplasty	Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia

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Category	Approval Criteria
Guided Tissue Regeneration	<ul style="list-style-type: none">• Intrabony/infrabony vertical defects• Class II furcation involvements• To enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries

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Category	Approval Criteria
Inlays	Documentation states why an inlay is necessary instead of a standard filling

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Category	Approval Criteria
Interim Partial Dentures	<ul style="list-style-type: none">• While tissue is healing following extractions• Maintenance of a space for future permanent treatment such as an implant, bridge or definitive fixed prosthesis• To condition teeth and ridge tissue for optimum support of a definitive removable partial denture• To maintain established jaw relation until all restorative treatment has been completed and a definitive partial denture can be constructed

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Category	Approval Criteria
Labial Veneers	<ul style="list-style-type: none">• Coverage limited to only medical necessity (not covered for cosmetic reasons), to be utilized only when other covered restorative procedures are not an option• For coverage of enamel only fractures that cannot be adequately repaired with a direct restoration• Teeth with enamel defects including but not limited to enamel hypoplasia, severe decalcification, enamel hypocalcification and fluorosis

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Category	Approval Criteria
Maxillary Sinusotomy	Documentation describes presence or description of root fracture of foreign body in maxillary antrum

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Category	Approval Criteria
Maxillofacial Prosthetics	Documentation describes accident, facial trauma, disease, facial reconstruction or other medical necessity need

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Category	Approval Criteria
Non – Intravenous Conscious Sedation (Dental Office Setting)	<ul style="list-style-type: none">• Anxiety• Individuals that are uncooperative or unmanageable

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Category	Approval Criteria
Occlusal Adjustment – Complete	Documentation describes medical necessity for complex case need (facebow, interocclusal records, tracings, diagnostic wax-up, etc.)

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Category	Approval Criteria
Occlusal Adjustment – Limited	Documentation states why an occlusal adjustment is necessary

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Category	Approval Criteria
Occlusal Analysis – Mounted Case	Documentation states why an occlusal analysis is necessary

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Category	Approval Criteria
Occlusal Guard	<ul style="list-style-type: none">• Bruxism or clenching either as a nocturnal parasomnia or during waking hours, resulting in excessive wear or fractures of natural teeth or restorations• To protect natural teeth when the opposing dentition has the potential to cause enamel wear such as the presence of porcelain or ceramic restorations <p>NOT INDICATED:</p> <ul style="list-style-type: none">• For treatment of temporomandibular disorders or myofacial pain dysfunction• As an appliance intended for orthodontic tooth movement

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Category	Approval Criteria
Occlusal Orthotic Device, by Report	<ul style="list-style-type: none">• Documentation supports history of TMJ pain / treatment efforts• Not for bruxism, grinding or other occlusal factors

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Category	Approval Criteria
Osseous Surgery	<ul style="list-style-type: none">• Patients with a diagnosis of moderate to advanced or refractory periodontal disease• When less invasive therapy (i.e., non-surgical periodontal therapy, flap procedures) has failed to eliminate disease

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Category	Approval Criteria
<p>Partial Dentures</p>	<ul style="list-style-type: none"> • Replacing one or more anterior teeth or two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. Or planned extractions as part of treatment plan provided with the narrative • Good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected. • Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone. • As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. <p>Authorizations for removable prosthesis will NOT meet criteria:</p> <ul style="list-style-type: none"> • If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable. • If there are in each quadrant at least three (3) periodontally sound posterior teeth in fairly good position and occlusion with opposing dentition. • If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present. And there is no treatment plan to correct. • If there are untreated cavities or active periodontal disease in the abutment teeth. And there is no treatment plan to correct. • If abutment teeth are less than 50% supported in bone. • If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped)

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Category	Approval Criteria
Partial Ostectomy	Documentation describes presence or description of non-vital bone or foreign body

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Category	Approval Criteria
Provisional Splinting	Multiple teeth that have become mobile due to loss of alveolar bone loss and periodontium

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Category	Approval Criteria
Removal of Impacted Teeth	<ul style="list-style-type: none">• The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology is covered subject to consultant review.• The removal of primary teeth whose exfoliation is imminent does not meet criteria.• Alveoloplasty (code D7310) in conjunction with four or more extractions in the same quadrant will be covered subject to consultant review.

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Category	Approval Criteria
Removal of Torus Palatinus	<ul style="list-style-type: none">• When a dental prosthesis will cover the palate and a large palatal torus will interfere with fit• For unusually large tori that are prone to recurrent traumatic injury• When there is a functional disturbance, including, but not limited to mastication, swallowing and speech

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Category	Approval Criteria
Repair of Maxillofacial Soft and/or Hard Tissue Defect	Narrative and x-rays support medical necessity for procedure

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Category	Approval Criteria
Retrograde Filling	<ul style="list-style-type: none">• Periradicular pathosis and a blockage of the root canal system that could not be obturated by nonsurgical root canal treatment• Persistent Periradicular pathosis resulting from an inadequate apical seal that cannot be corrected nonsurgically

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Category	Approval Criteria
Root Amputation	<ul style="list-style-type: none">• Class III Furcation involvementxxUntreatable bony defect (of one root)• Root fracture, caries, or resorption• When there is greater than 75% bone supporting remaining root(s)• The tooth has had successful endodontic treatment

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Category	Approval Criteria
<p>Root Canal Retreatment</p>	<ul style="list-style-type: none"> • Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved. • Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex. <p>Authorizations for Root Canal Retreatment therapy will NOT meet criteria if:</p> <ul style="list-style-type: none"> • Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable). • The general oral condition does not justify root canal therapy due to loss of arch integrity. • Root canal therapy is for third molars, unless they are an abutment for a partial denture. • Tooth does not demonstrate 50% bone support. • Root canal therapy is in anticipation of placement of an overdenture. • A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

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Category	Approval Criteria
Root Canal Therapy	Not all procedures require authorization. <ul style="list-style-type: none">• Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

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Category	Approval Criteria
Scaling and Root Planing	<ul style="list-style-type: none">• D4341 (Four or more teeth per quadrant) // D4342 (at least 1 tooth per quadrant)• Probing depths of at least 5 mm or greater• Radiographic evidence of bone loss

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Category	Approval Criteria
Surgical Repositioning of Teeth	The treatment of displacement injuries to permanent teethxxExtrusion of teeth with crown/root fractures to prepare for restoration of permanent teeth

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Category	Approval Criteria
Suture Repairs	<ul style="list-style-type: none">• Documentation describes accident• Not for tooth extraction or to close surgical incision

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Category	Approval Criteria
Therapeutic parenteral Drugs	<ul style="list-style-type: none">• May be indicated to enhance healing of surgical procedures, or reduce pain and/or risk of infection.• Medications include antibiotics, steroids or anti-inflammatory drugs.

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Category	Approval Criteria
Tissue Grafts	<p>Pedicle Soft tissue Graft, Autogenous Connective Tissue Graft, Non-Autogenous connective tissue Graft, Combined connective tissue and double pedicle Graft, Free soft tissue Graft procedure (including donor site surgery)</p> <ul style="list-style-type: none">• Unresolved sensitivity in areas of Recession• Progressive recession or chronic inflammation• Teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control

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Category	Approval Criteria
Tooth Transplantation	Subluxation injuries to permanent teeth

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Category	Approval Criteria
Treatment of Complications (Post-Surgical)	Documentation describes what this treatment is and why it is medical necessity

[Return to Procedures Grid](#)

Category	Approval Criteria
Unspecified Procedures, by Report	Procedure cannot be adequately described by an existing code Documentation supports medical necessity

[Return to Procedures Grid](#)

Comprehensive Medically Necessary Orthodontic Services

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Comprehensive medically necessary orthodontic services are a covered benefit for:

Texas Children's Medicaid Members:

Members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

CHIP Members:

CHIP members would **only** qualify for Orthodontic treatment under this program if:

- 1) Member's record clearly identifies a cleft palate or craniofacial anomaly involving the oral cavity, or
- 2) Member has history of, or is scheduled for, orthognathic surgery to correct a severe malocclusion, **and** meet, at a minimum, the criteria requirements for Level III orthodontic treatment (see Level III section below)

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

Approved orthodontic treatment plans must be initiated before the client's loss of Medicaid eligibility or the 21st birthday. Services cannot be added or approved after Texas Medicaid/Texas Health Steps (THSteps) eligibility has expired.

Members enrolled in the Dental Contractor's plan for at least one month and are receiving orthodontic treatment and either ages out or loses eligibility; the Dental Contractor is responsible for completion of payment for the course of treatment. The only exception is if the Member is disenrolled with cause but is still Medicaid eligible.

Clients who are 14 years of age or younger must be accompanied to all medical and dental checkups/visits by the client's parent, legal guardian, or an adult authorized by the parent or legal guardian. The authorized adult may be the client's relative. The individual accompanying the client must wait for the client while the appointment takes place. This policy does not apply to services provided by a school health clinic, Head Start program, or child-care facility if the clinic, program, or facility providing the services (Human Resources Code):

- Obtains valid written consent for services from the client's parent or legal guardian within the one-year period prior to the date the services are provided.
- Encourages parental involvement in, and the management of, the health care of the children receiving services from the clinic, program, or facility.

As with all Medicaid services, a provider acknowledges compliance with all Medicaid requirements when he or she submits a claim for reimbursement.

Orthodontic terminology and extent of orthodontic services are based on the American Dental Association's Current Dental Terminology (CDT) definitions and explanations of the orthodontic codes utilized within this policy. The following definitions of dentition established by the CDT manual are recognized by the Children's Medicaid dental services:

- Primary Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Place of Service

1 Office

Prior Authorization

Prior authorization is required for all Levels of orthodontic treatment. Prior authorization includes the number of monthly visits and expected completion time according to the corresponding treatment level.

A pre-orthodontic treatment examination to monitor growth and development (D8660) is considered part of any comprehensive oral evaluation (D0150) or periodic oral evaluation (D0120).

The following documentation must be submitted with the request for prior authorization for Level I, II, III and IV orthodontic services:

- ADA 2012 or newer claim form with service codes noted
- Digital diagnostic models or other type of 3D diagnostic images
- Radiographs (x-rays)
- Cephalometric radiographic image with tracings
- Photographs
- Treatment plan
- **For CHIP Clients Only** – a copy of the medical prior authorization approval letter for surgery

Levels of Orthodontia Services

UHC Dental recognizes four orthodontic service levels for severe handicapping malocclusion, and each requires a different amount of time for treatment.

Severe handicapping malocclusion is defined as an occlusion that is severely functionally compromised and is described in

detail in Levels I, II, III and IV.

Orthodontia Provider Type(s) Based on Levels:

All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of Dentist.

Dentists (DDS, DMD) who want to provide any of the four levels of orthodontic services addressed in this policy must be enrolled as a dentist or orthodontist in Texas Health Steps (THSteps) and must have the qualifications listed below for the relevant level of service:

Provider Type	Level of Orthodontic Service That Can Be Provided	Qualifications
Provider Type 90	Level I or II	<ul style="list-style-type: none"> • Completion of pediatric dental residency; or • A minimum of 200 hours of continuing dental education in orthodontics.
Provider Type 48	Level I, II, III, or IV	Dentists who are Board eligible or board certified by an ADA recognized orthodontic specialty board.

Orthodontia Levels I, II, III and IV:

LEVEL I:				
<p>❖ Completion of Level I orthodontic services does not disqualify future Level II, III or IV orthodontic services.</p> <p>❖ Level I orthodontic services will not be prior authorized if there is an indication that the client will qualify for Level II, III or IV orthodontic services in the future.</p>				
CDT Codes	Provider Type	Eligible Age Group	Treatment Length	Exceptions to Expected Treatment Time
<p>D8210 Removable Appliance Therapy</p> <p>D8220 Fixed Appliance Therapy</p>	Type 48 Type 90	3-13	Up to 10 monthly visits and are expected to be completed within 12 months unless an exception is	<p>May allow for additional treatment months for one of the following circumstances:</p> <ul style="list-style-type: none"> •The client is the child of a migrant farm worker.

			granted.	<ul style="list-style-type: none"> •The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).
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Criteria

<p>Level I: Dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework. (Presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth shall constitute the early mixed dentition.)</p> <p>**Exceptions for cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.</p> <ul style="list-style-type: none"> • Anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession, or severe enamel wear. • Posterior crossbite with an associated midline deviation and asymmetric closure pattern.

LEVEL II:

<ul style="list-style-type: none"> ❖ Clients are eligible for either Level II, III or IV orthodontic services once per lifetime. ❖ Clients identified as cleft/craniofacial cases are eligible for more than one level of orthodontic services (Level II, III and IV) per lifetime.

CDT Codes	Provider Type	Age Group	Treatment Length	Exceptions to Expected Treatment Time
<p>D8050 Interceptive orthodontic treatment of the primary dentition</p> <p>D8060 Interceptive orthodontic treatment of the transitional dentition</p> <p>D8070 Comprehensive orthodontic</p>	<p>Type 48 Type 90</p>	<p>3-13</p>	<p>Up to 22 monthly visits and are expected to be completed within 24 months unless an exception is granted.</p>	<p>May allow for additional treatment months for one of the following circumstances:</p> <ul style="list-style-type: none"> •The client is the child of a migrant farm worker. •The client's orthodontic services were delayed as a result of temporarily being in state custodial care

treatment of the transitional dentition				(foster care).
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Criteria

Level II: Dedicated to the resolution of handicapping malocclusion in the transitional dentition; the final phase of the transition from primary to adolescent dentition wherein the succadaneous permanent teeth are emerging or about to emerge.

FOUR of the following conditions must be clearly apparent in the supporting documentation:

- Full cusp Class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar.
- Full cusp Class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of mandibular molar distal buccal cusp.
- Overbite measurement shall be in excess of 5 mm.
- Overjet measurement shall be in excess of 8 mm.
- More than four congenitally absent teeth, one or more of which shall include an anterior tooth/or teeth.
- Anterior crowding shall be in excess of 6 mm. in the mandibular arch.
- Anterior cross bite of at least two of the four maxillary incisors.
- Generalized spacing in both arches of greater than 6 mm. in each arch.
- Recognition of early impacted maxillary canine or canines. Radiographs shall support the diagnosis demonstrating a severe mesial angulation of the erupting canine and the crown of the canine superimposed and crossing the image of the maxillary lateral incisor.

Additional Services

There may be extenuating circumstances that warrant additional treatment time, including but not limited to cases of craniofacial anomalies and cleft palate. In the event that the client requires additional treatment, the provider may request prior authorization for additional services. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

Providers must complete and submit the following for consideration for additional services:

- A 2012 or newer ADA claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the ADA Claim form identify the reason for the needed additional monthly visits and identify the number of visits being requested.
- The name of the additional appliance in the case of a cleft palate treatment plan, if needed.
- Recent radiographs (x-rays) showing the progress made to date.
- Current photographs
- Current treatment plan

LEVEL III

❖ Clients are eligible for either Level II, III or IV orthodontic services once per lifetime.

❖ Clients identified as cleft/craniofacial cases are eligible for more than one level of orthodontic services (Level II, III and IV) per lifetime.

CDT Codes	Provider Type	Age Group	Treatment Length	Exceptions to Expected Treatment Time
<p>D8080 Comprehensive orthodontic treatment of the adolescent dentition</p>	<p>Type 48</p>	<p>13-20</p>	<p>Up to 22 monthly visits and are expected to be completed within 36 months unless an exception is granted.</p>	<p>May allow for additional treatment months for one of the following circumstances:</p> <ul style="list-style-type: none"> •The client is the child of a migrant farm worker. •The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

Criteria

Level III: Dedicated to resolution of handicapping malocclusion in the adolescent or adult dentition; complete eruption of the permanent dentition with the possible exception of full eruption of the second molars.

FOUR of the following conditions must be clearly apparent in the supporting documentation.

- Full cusp Class II molar malocclusion as described in Level II.
- Full cusp Class III molar malocclusion as described in Level II.
- Anterior tooth impaction; unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth which may be malposed but has erupted into the oral cavity and is not a qualifying element.
- Anterior crowding shall be in excess of 6mm in the mandibular arch.
- Anterior open bite shall demonstrate that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement in excess of 6 mm.
- Posterior open bite shall demonstrate a vertical separation by a measurement in excess of 5 mm. of several posterior teeth and not be confused with the delayed natural eruption of a few teeth.
- Posterior cross bite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally linguallly malpositioned to the mandibular arch shall qualify.
- Anterior cross bite shall include more than two incisors in cross bite and demonstrate gingival inflammation, gingival recession, or severe enamel wear.
- Overbite shall be in excess of 5 mm.

- Overjet shall be in excess of 8 mm.

Additional Services

There may be extenuating circumstances that warrant additional treatment time, including but not limited to cases of craniofacial anomalies and cleft palate. In the event that the client requires additional treatment, the provider may request prior authorization for additional services. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

Providers must complete and submit the following for consideration for additional services:

- A 2012 or newer ADA claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the ADA Claim form identify the reason for the needed additional monthly visits and identify the number of visits being requested.
- The name of the additional appliance in the case of a cleft palate treatment plan, if needed.
- Recent radiographs (x-rays) showing the progress made to date.
- Current photographs
- Current treatment plan

LEVEL IV

- ❖ Clients are eligible for either Level II, III or IV orthodontic services once per lifetime.
- ❖ Clients identified as cleft/craniofacial cases are eligible for more than one level of orthodontic services (Level II, III and IV) per lifetime.

CDT Codes	Provider Type	Age Group	Treatment Length	Exceptions to Expected Treatment Time
D8090 Comprehensive orthodontic treatment of the adult dentition	Type 48	13-20	Up to 22 monthly visits and are expected to be completed within 36 months unless an exception is granted.	May allow for additional treatment months for one of the following circumstances: <ul style="list-style-type: none"> •The client is the child of a migrant farm worker. •The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).

Criteria

Level IV: Dedicated to resolution of handicapping malocclusion in the adult dentition; complete eruption of the permanent dentition. Documentation shall be submitted by an Oral Surgeon justifying the medical necessity of a surgical approach to treatment.

- Non-functional Class II malocclusion.
- Non-functional Class III malocclusion

The correction of the malocclusion shall be beyond that of orthodontics alone and shall require pre-orthodontic and post-orthodontic procedures in conjunction with orthognathic surgery. The patient's medical needs shall be based on function and not esthetics.

Additional Services

There may be extenuating circumstances that warrant additional treatment time, including but not limited to cases of craniofacial anomalies and cleft palate. In the event that the client requires additional treatment, the provider may request prior authorization for additional services. Each case will be reviewed and evaluated on a case by case basis for medical necessity.

Providers must complete and submit the following for consideration for additional services:

- A 2012 or newer ADA claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the ADA Claim form identify the reason for the needed additional monthly visits and identify the number of visits being requested.
- The name of the additional appliance in the case of a cleft palate treatment plan, if needed.
- Recent radiographs (x-rays) showing the progress made to date.
- Current photographs
- Current treatment plan

Reimbursement

Reimbursement for orthodontic treatment is based on submission of the appropriate procedure code(s).

Prior authorized procedure codes: D8210, D8220, D8050, D8060, D8070, D8080 or D8090

- Will be considered for payment as the initial reimbursement when all bands, brackets and/or appliances have been placed and active treatment has been initiated.
- The diagnostic workup is considered part of this initial reimbursement.

Procedure code D8670: Periodic Orthodontic Treatment Visit

- Limited to one service per month.
- The total number of monthly adjustments allowed will vary by approved level of orthodontic treatment.
- May not be submitted for an observational visit only.

Procedure code D8680: Orthodontic retention - removal of appliances, construction and placement of retainer(s)

- Will be considered for payment as the last payment when orthodontic treatment is complete and has been prior authorized.

Denied cases will not be reimbursed.

Completion of All Levels of Orthodontic Treatment

- Prior authorization is required for completion of treatment (last payment) and must be reviewed for proof of completion of case.
- Providers must use procedure code D8680 for the removal of all bands, brackets and appliances. Orthodontic services Levels II, III and IV must include the construction of both maxillary and mandibular retainers.
- The following documentation must be submitted with the request for prior authorization:
 - A 2012 or newer ADA claim form with procedure code D8680
 - Post treatment panoramic radiographic image
 - Photographs
 - A signed statement from the treating Provider indicating that treatment is complete

Transfer/Continuation of Orthodontic Care

There are 3 main scenarios that this document will address as far as continuation or transfer of a member's on-going orthodontic treatment:

- 1) Provider to Provider (within UHC Dental)
- 2) Other DMO to UHC Dental
- 3) Private/Commercial Arrangement to UHC Dental

1) Provider to Provider (within UHC Dental):

This section is for situations in which the Orthodontic care of a Medicaid eligible member is transferred from one UHC Dental provider to another UHC Dental provider (in which there is record of the approval of the original orthodontic treatment)

Prior authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the treatment initiated by the original provider.

The new provider must obtain his/her own records, which must be submitted with the request for transfer of services.

- Documentation submission requirements:
 - All the documentation that is required for the original request
 - ADA 2012 or newer claim form with procedure code D8999 and the number of remaining visits (D8670) needing to be rendered.
 - The reason the client left the previous provider and a Narrative noting the treatment status.

2) Other DMO to UHC Dental:

This section is for situations in which the Orthodontic care of a Medicaid eligible member is transferred from another TX Dental Medicaid organization (DMO) to the UHC Dental DMO.

Continuation of a case for a client that began with another DMO will be considered for those members with an active unexpired prior authorization for orthodontic treatment, up to the quantity and validity as approved by the previous carrier.

- Documentation submission requirements:
 - A completed Orthodontic Continuation of Care Form. See Appendix K for this form.
 - ADA 2012 or newer claim form with procedure code D8999 and the number of remaining visits (D8670) needing to be rendered.
 - A copy of the Member's prior approval including the total approved case fee and payment structure
 - Detailed payment history

3) Private/Commercial Arrangement to UHC Dental:

This section is for situations in which the Orthodontic care of a currently Medicaid eligible member is transferred to from a Private/Commercial Arrangement to UHC Dental DMO, only if the client began treatment prior to becoming Medicaid eligible.

Continuation of an orthodontic case for a client that began treatment through a private arrangement will not be considered for prior authorization if the client began treatment while Medicaid eligible and will be denied.

Continuation of an orthodontic case for a client that began through a private/commercial arrangement will also need medical necessity review, and must meet Medicaid criteria for medical necessity of orthodontic treatment

- Documentation submission requirements:
 - A completed Orthodontic Continuation of Care Form. See Appendix K for this form.
 - ADA 2012 or newer claim form with procedure code D8999 and the number of remaining visits (D8670) needing to be rendered.
 - A copy of the Member's prior approval including the total approved case fee and payment structure
 - Detailed payment history
- These additional submission documents will also be required in order to review for medical necessity when an ortho case initiated in a private/commercial arrangement is being considered for continuation of care coverage:
 - Digital diagnostic models or other type of 3D diagnostic images
 - Radiographs (x-rays)
 - Cephalometric radiographic image with tracings
 - Photographs
 - Treatment plan
 - **For CHIP Clients Only** – a copy of the medical prior authorization approval letter for surgery

Premature Termination of Comprehensive Orthodontic Services

Premature termination of comprehensive orthodontic treatment by the originally treating provider is included in the

comprehensive services.

Premature termination of orthodontic services includes all of the following:

- Removal of brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers

Premature removal of an orthodontic appliance must be prior authorized, and requests must include:

- A 2012 or newer ADA claim form with procedure code D8680, to identify that all bands, brackets and appliances have been removed and applicable orthodontic retainers have been delivered.

- A release form (or copy of) that must be signed by the parent or legal guardian, or by the client if he/she is 18 years of age or older or an emancipated minor.

- One of the following must be documented on the prior authorization request:
 - The client is uncooperative or is non-compliant
 - The client requested the removal of the orthodontic appliance(s)
 - The client has requested the removal due to extenuating circumstances to include, but not limited to:
 - Incarceration
 - Mental health complications with a recommendation from the treating physician
 - Foster Care placement
 - Child of a Migrant Farm Worker, with the intent to complete treatment at a later date if Medicaid eligibility for orthodontic services continues

*NOTE: A Member for whom removal of an appliance has been authorized due to the above, will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while Medicaid eligible. Should the Member choose to have the appliances removed for reasons other than those listed above as due to extenuating circumstances the client **may not** be eligible for any additional Medicaid orthodontic services.*

- The requesting provider is responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of retainers at the time of premature removal or at any future time should the client present to the treating provider's office.
- In the case of an authorized premature termination of treatment, the provider should submit procedure code D8680 to identify that all bands, brackets and appliances have been removed and applicable orthodontic retainers have been delivered.

Documentation

All orthodontic treatment visits must be documented in the client's dental record and available for review.

[Return to Procedures Grid](#)



Guía de autorización previa Dental de UnitedHealthcare

Este documento proporciona información sobre los requisitos de autorización previa por código CDT para servicios dentales infantiles.

La autorización previa de la atención debe solicitarse electrónicamente a través del Portal de Proveedores Dentales UHC en <http://www.uhc.com/dentalTX> y siguiendo el vínculo a la página Inicio de sesión del Proveedor para el portal del proveedor. Las solicitudes de autorización previa también se pueden enviar por correo a P.O. Box 1511, Milwaukee, WI 53201. UHC Dental procesará solicitudes de autorización previa en un plazo de tres (3) días hábiles. Una vez que se haya tomado una determinación, la aprobación previa de la autorización estará disponible para ver en el Portal del Proveedor, así como avisos escritos emitidos. Nuestro equipo de Gestión de Utilización enviará por correo una copia impresa de la aprobación previa a la autorización dentro de los tres (3) días hábiles siguientes a la determinación de solicitudes estándar y dentro de un (1) día hábil para las solicitudes de emergencia. Si se deniega la solicitud de autorización previa, el miembro y el proveedor recibirán un aviso de determinación adversa.

Las solicitudes de autorización previa aprobadas son válidas durante 90 días a partir de la fecha de aprobación. Tanto el miembro como el proveedor recibirán una notificación de qué servicios fueron aprobados, así como la fecha de vencimiento de la autorización para los servicios aprobados. Si el tratamiento de ortodoncia no comienza dentro del período válido de 180 días, el proveedor debe presentar una nueva solicitud de aprobación previa a la autorización.

A todas las aprobaciones de servicios se les asigna un número de autorización único, que debe enviarse con la reclamación después de prestar los servicios. UHC Dental no devolverá radiografías, gráficos periodontales u otros documentos relacionados. Envíe conjuntos duplicados de estos documentos cuando sea necesario que se envíen con una solicitud de autorización previa.

Por favor revise el Manual del Proveedor UHC Dental Texas en el enlace: [Manual del proveedor](#) para información adicional por código CDT incluyendo limitaciones de frecuencia y otras especificaciones. Los proveedores pueden comunicarse con la línea directa del proveedor al **1-800-527-1764** con solicitudes de asistencia con el proceso de autorización previa. Los Miembros pueden comunicarse con la Línea Directa para Miembros al **1-877-901-7321 TTY 7-1-1** para preguntar sobre el estado de las solicitudes de autorización previa y para obtener asistencia para entender el proceso de autorización previa. Nuestra línea directa estándar horario de operación es de 8am a 5pm De lunes a viernes.

[Haga clic para ir a cuadrícula de procedimientos](#)

Guía de autorización previa dental de UnitedHealthcare

¿Qué es una solicitud de autorización previa "completa"?

Una solicitud de un servicio que incluya toda la información/documentos necesarios para tomar y establecer una determinación de necesidad médica. Los requisitos de autorización previa (PA) para considerar una solicitud de pa completa se enumeran en nuestro sitio web para el servicio solicitado.

¿Cuáles son los requisitos de información "esenciales" necesarios para iniciar una revisión de la AP?

- Nombre del miembro
- Número de miembro o número de Medicaid
- Fecha de nacimiento de los miembros
- Solicitar el nombre del proveedor
- Solicitud del Identificador Nacional de Proveedores (NPI) del proveedor.
- Servicio solicitado - Terminología dental actual (CDT), terminología procesal actual (CPT) o sistema de codificación de procedimientos comunes de atención médica (HCPCS)
- Fecha(s) de inicio y finalización solicitada(s) del servicio
- Cantidad de unidades de servicio solicitadas sobre la base del CDT, CPT, HCPCS
- Procedimientos codificados por CDT solicitados

¿Qué es una solicitud de PA incompleta?

Una solicitud de un servicio a la cual le falta información para establecer la necesidad médica como se indica en la Autorización Previa

Si se recibe una solicitud de PA incompleta, UHC Dental con tomar las siguientes acciones:

- Notifique al proveedor solicitante y al Miembro, por escrito, que la AP contenía información que faltaba y proporcionar un aviso de extensión (NOE) a más tardar 3 días hábiles después de la fecha de recepción de la AP.
- UHC Dental también puede ponerse en contacto con el proveedor por teléfono y obtener la información necesaria para resolver la solicitud de PA incompleta.
- La solicitud escrita de información adicional del MCO debe incluir lo siguiente:
 - Una declaración que la solicitud ha recibido, pero no podemos decidir sobre los servicios solicitados sin la presentación de información adicional.
 - Una lista clara y específica y una descripción de la información o documentación faltante/incompleta/incorrecta que debe presentarse para considerar completa la solicitud.
 - Una fecha de vencimiento para la cual se debe recibir la información incompleta y cómo el proveedor puede comunicarse con UHC Dental.
- Si la información solicitada no se recibe al final del tercer día hábil a partir de la fecha del aviso al proveedor, entonces la solicitud de PA puede resultar en una determinación adversa de beneficios.
- Dentro de los 3 días hábiles siguientes a la remisión para la revisión clínica, pero a más tardar el décimo día hábil después de la fecha de recepción de la PA, UHC Dental tomará una decisión final sobre la solicitud de pa.
- Una consulta de doctor a doctor puede ocurrir en cualquier momento durante el proceso de solicitud pa después de una revisión clínica.
- Las determinaciones finales deben realizarse dentro de los 3 días hábiles posteriores a la fecha en que se proporciona la información que falta a un MCO.

[Haga clic para ir a cuadrícula de procedimientos](#)

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D0367	Cone Beam - Both Jaws	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Cone Beam CT
D0999	Unspecified Diagnostic Procedures, By Report	Description of procedure and narrative of medical necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D2510	Inlay - Metallic - One Surface	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2520	Inlay - Metallic - Two Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2530	Inlay - Metallic - Three Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2542	Onlay - Metallic - Two Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2543	Onlay - Metallic - Three Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2544	Onlay - Metallic - Four Or More Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2650	Inlay - Resin-Based Composite - One Surface	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2651	Inlay - Resin-Based Composite - Two Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2652	Inlay - Resin-Based Composite - Three Surfaces	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Inlays
D2662	Onlay - Resin-Based Composite - Two Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2663	Onlay - Resin-Based Composite - Three Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	Pre and post op xrays, narrative, specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2710	Crown - Resin-Based Composite (Indirect)	BWX, narrative when decay is not evident on x-rays	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2720	Crown - Resin With High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2721	Crown - Resin With Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2722	Crown - Resin With Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2740	Crown - Porcelain/Ceramic	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2750	Crown - Porcelain Fused To High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2751	Crown - Porcelain Fused To Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2752	Crown - Porcelain Fused To Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D2780	Crown - 3/4 Cast High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2781	Crown - 3/4 Cast Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2782	Crown - 3/4 Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2783	Crown - 3/4 Porcelain/Ceramic	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2790	Crown - Full Cast High Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2791	Crown - Full Cast Predominantly Base Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid and CHIP	9/1/2020	Crowns/Onlays
D2792	Crown - Full Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2794	crown – titanium and titanium alloys	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	Crowns/Onlays
D2960	Labial Veneer (Resin Laminate) - Chairside	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2961	Labial Veneer (Resin Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	Labial Veneers
D2999	Unspecified Restorative Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3348	Retreatment Of Previous Root Canal Therapy - Molar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Canal Retreatment
D3351	Apexification / Recalcification - Initial Visit	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3352	Apexification / Recalcification - Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3353	Apexification / Recalcification - Final Visit	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apexification/ Recalcification
D3410	Apicoectomy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3421	Apicoectomy - Premolar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3425	Apicoectomy - Molar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery
D3426	Apicoectomy - Each Additional Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Apicoectomy/ Periradicular Surgery

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D3430	Retrograde Filling - Per Root	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Retrograde Filling
D3450	Root Amputation - Per Root	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Root Amputation
D3460	Endodontic Endosseous Implant	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Endodontic Endosseous Implant
D3470	Intentional Reimplantation (Including Necessary Splinting)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Endodontic Endosseous Implant
D3999	Unspecified Endodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid and CHIP	9/1/2020	Gingivectomy or Gingivoplasty
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Gingivectomy or Gingivoplasty
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Anatomical Crown Exposure
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	Current pre and post op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	Anatomical Crown Exposure
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	Full mouth x-rays, perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	Flap Procedures
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	Full mouth x-rays, perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	Flap Procedures
D4245	Apically Positioned Flap	Pre-op x-rays, narrative of medical necessity, photos optional	Medicaid	9/1/2020	Flap Procedures
D4249	Clinical Crown Lengthening - Hard Tissue	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Clinical Crown Lengthening
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Osseous Surgery
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Osseous Surgery
D4266	Guided Tissue Generation - Resorbable Barrier, Per Site	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)	Medicaid	9/1/2020	Guided Tissue Regeneration
D4267	Guided Tissue Regeneration	Pre-op x-rays, perio charting, narrative of medical necessity, photo (optional)	Medicaid	9/1/2020	Guided Tissue Regeneration
D4270	Pedicle Soft Tissue Graft Procedure	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4274	Distal Or Proximal Wedge Procedure	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional	Pre-op x-rays, perio charting, narrative of med nec, photos	Medicaid	9/1/2020	Tissue Grafts
D4285	Non-Autogenous Connective Tissue Graft Each Additional	Pre-op x-rays, perio charting, narrative of med nec photos	Medicaid	9/1/2020	Tissue Grafts
D4320	Provisional Splinting - Intracoronal	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Provisional Splinting
D4321	Provisional Splinting - Extracoronal	Pre-op X-rays of the tooth/area, Complete 6 point perio chart, narrative	Medicaid	9/1/2020	Provisional Splinting
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	FMX, Perio charting and narrative of medical necessity	Medicaid and CHIP	9/1/2020	Scaling and Root Planing
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	FMX, Perio charting and narrative of medical necessity	Medicaid	9/1/2020	Scaling and Root Planing
D4999	Unspecified Periodontal Procedure, By Report	panoramic x-ray or full series, perio charting, narrative	Medicaid	9/1/2020	Unspecified Procedures, by Report
D5110	Complete Denture - Maxillary	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	Complete and Immediate Dentures
D5120	Complete Denture - Mandibular	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	Complete and Immediate Dentures
D5130	Immediate Denture - Maxillary	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5140	Immediate Denture - Mandibular	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5211	Maxillary Partial Denture - Resin Base	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5212	Mandibular Partial Denture - Resin Base	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5213	maxillary partial denture - cast metal framework with resin denture bases	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5214	mandibular partial denture - cast metal framework with resin denture bases	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid and CHIP	9/1/2020	Partial Dentures
D5810	Interim Complete Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5811	Interim Complete Denture (Mandibular)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Complete and Immediate Dentures
D5820	Interim Partial Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Interim Partial Dentures

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D5821	Interim Partial Denture (Mandibular)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Interim Partial Dentures
D5899	Unspecified Removable Prosthodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D5911	Facial Moulage (Sectional)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5912	Facial Moulage (Complete)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5913	Nasal Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5914	Auricular Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5915	Orbital Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5916	Ocular Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5919	Facial Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5922	Nasal Septal Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5923	Ocular Prosthesis, Interim	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5924	Cranial Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5925	Facial Augmentation Implant Prosthesis	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5926	Nasal Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5927	Auricular Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5928	Orbital Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5929	Facial Prosthesis, Replacement	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5931	Obturator Prosthesis, Surgical	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5932	Obturator Prosthesis, Definitive	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5933	Obturator Prosthesis, Modification	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5934	Mandibular Resection Prosthesis With Guide Flange	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5935	Mandibular Resection Prosthesis Without Guide Flange	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D5936	Obturator Prosthesis, Interim	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5937	Trismus Appliance (Not For Tmd Treatment)	Pre-op X-rays, Pre-op Photos, Narrative of Medical Necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5951	Feeding Aid	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5952	Speech Aid Prosthesis, Pediatric	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5953	Speech Aid Prosthesis, Adult	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5954	Palatal Augmentation Prosthesis	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5955	Palatal Lift Prosthesis, Definitive	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5958	Palatal Lift Prosthesis, Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5959	Palatal Lift Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5960	Speech Aid Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5982	Surgical Stent	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5983	Radiation Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5984	Radiation Shield	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5985	Radiation Cone Locator	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5986	Fluoride Gel Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5987	Commissure Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5988	Surgical Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5992	Adjust Maxillofacial Prosthetic Appliance, By Report	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5993	Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra Or Intraoral)	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Maxillofacial Prosthetics
D5999	Unspecified Maxillofacial Prosthesis, By Report	Panoramic, photos, narr of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D6210	Pontic - Cast High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D6211	Pontic - Cast Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6212	Pontic - Cast Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6240	Pontic - Porcelain Fused To High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6242	Pontic - Porcelain Fused To Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6245	Pontic - Porcelain/Ceramic	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6250	Pontic - Resin With High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6251	Pontic - Resin With Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6252	Pontic - Resin With Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6720	Retainer Crown - Resin With High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6721	Retainer Crown - Resin With Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6722	Retainer Crown - Resin With Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6740	Retainer Crown - Porcelain/Ceramic	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6752	Retainer Crown - Porcelain Fused To Noble Metal	Panoramic x-ray or Full Mouth Series, Charting Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6780	Retainer Crown - 3/4 Cast High Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6782	Retainer Crown - 3/4 Cast Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6790	Retainer Crown - Full Cast High Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6791	Retainer Crown - Full Cast Predominantly Base Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6792	Retainer Crown - Full Cast Noble Metal	Pre-op panoramic x-ray or full series, Post op x-rays, Missing teeth identified	Medicaid	9/1/2020	Pontics and Retainers (Bridges)
D6920	Connector Bar	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Conector Bar
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D7230	Removal Of Impacted Tooth - Partially Bony	Panoramic, narrative of medical necessity	Medicaid and CHIP	9/1/2020	Removal of Impacted Teeth
D7240	Removal Of Impacted Tooth - Completely Bony	Panoramic, narrative of medical necessity	Medicaid and CHIP	9/1/2020	Removal of Impacted Teeth
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Removal of Impacted Teeth
D7272	Tooth Transplantation (Includes Reimplantation)	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Tooth Transplantation
D7290	Surgical Repositioning Of Teeth	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Surgical Repositioning of Teeth
D7472	Removal Of Torus Palatinus	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Removal of Torus Palatinus
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Partial Ostectomy
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Maxillary Sinusotomy
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	Panoramic, narrative of medical necessity	Medicaid	9/1/2020	Alveolus - Closed Reduction
D7820	Closed Reduction Of Dislocation	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Alveolus - Closed Reduction
D7880	Occlusal Orthotic Device, By Report	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Occlusal Orthotic Device, by report
D7899	Unspecified Tmd Therapy, By Report	TMJ Radiograph w/Narrative of Medical Necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D7910	Suture Of Recent Small Wounds Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7911	Complicated Suture - Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7912	Complicated Suture - Greater Than 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Suture Repairs
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Repair of Maxillofacial Soft and/or Hard Tissue Defect

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D7999	Unspecified Oral Surgery Procedure, By Report	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Unspecified Procedures, by Report
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8210	Removable Appliance Therapy	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid and CHIP	9/1/2020	Orthodontic
D8220	Fixed Appliance Therapy	Digital models or 3D diagnostic images, X-rays, Ceph film, Photos, Treatment plan	Medicaid	9/1/2020	Orthodontic
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	Post treatment x-ray, Photos, Statement from provider that treatment is complete	Medicaid	9/1/2020	Orthodontic
D8999	Unspecified Orthodontic Procedure, By Report	Reason member left provider, Tx status, Prior Approval, Payment history, Records	Medicaid	9/1/2020	Orthodontic
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	General Anesthesia and IV Sedation
D9248	Non-Intravenous Conscious Sedation	Treatment plan, Narrative, X-rays	Medicaid	9/1/2020	Non IV Conscious Sedation
D9610	Therapeutic Parenteral Drug, Single Administration	Narrative of medical necessity	Medicaid	9/1/2020	Therapeutic Parental Drugs
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	Therapeutic Parental Drugs
D9630	Drugs or Medicaments - dispensed for home use	Narrative of medical necessity	Medicaid	9/1/2020	Drugs Or Medicaments Dispensed in Office
D9920	Behavior Management, By Report	Physician note stating disability, Services, supplies, staff, duration	Medicaid	9/1/2020	Behavior Management, by report

Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	Pre op x-rays, desc. of procedure and narrative of med necessity	Medicaid	9/1/2020	Treatment of Complications, Post-surgical
D9944	Occlusal Guard-hard appliance, full arch	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Guard
D9950	Occlusion Analysis - Mounted Case	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Analysis - Mounted Case
D9951	Occlusal Adjustment - Limited	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Adjustment - Limited
D9952	Occlusal Adjustment - Complete	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	Occlusal Adjustment - Complete
D9999	Unspecified Adjunctive Procedure, By Report	pre and post-op x-rays, Narrative of necessity/report of procedure	Medicaid	9/1/2020	Unspecified Procedures, by Report

Categoría	Criterio de Aprobación
Alvéolo – Reducción Cerrada, Puede Incluir la Estabilización de Dientes	La documentación describe el accidente, el reporte operativo y la necesidad médica

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Exposición Anatómica de la Corona	<ul style="list-style-type: none">• Facilitar la restauración de caries subgingival• Permitir un contorno adecuado de la restauración• Permitir el manejo de un diente fracturado subgingival

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Apexificación / Recalcificación	El ápice de la nariz no está cerrado y necesita estar tratado para que se pueda lograr (generalmente después del trauma)

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Categoría	Criterio de Aprobación
Apicoectomía / Cirugía Periradicular	<ul style="list-style-type: none">• Es necesario remover el ápice del diente porque el área al rededor está infectada y/o tiene un absceso; requiere un relleno para ser colocado en la parte apical del diente para sellar esa parte del conducto radicular• Perforación de la raíz en el apical un tercio del canal

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Gestión del comportamiento, por informe	<ul style="list-style-type: none">• La documentación (historial de tratamiento) apoya la indicación de un niño no cooperativo menor de nueve (9) años• La documentación apoya la indicación del paciente con una afección médica (parálisis cardíaca, cerebral, epilepsia u otra afección que el paciente no conforme

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Categoría	Criterio de Aprobación
Alargamiento clínico de la corona	<ul style="list-style-type: none">• En un área por lo demás periodontal saludable para permitir un procedimiento restaurador en un diente con poca o ninguna exposición a la corona• Permitir la preservación de la anchura biológica para procedimientos restauradores

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Reducción cerrada de la dislocación	La narrativa y las radiografías apoyan la necesidad médica para el procedimiento

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Categoría	Criterio de Aprobación
CT de haz de Cono	La documentación describe la necesidad médica y por qué las imágenes radiográficas no serían apropiadas/suficientes y por qué se necesita CBCT para prestar tratamiento de forma segura

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Categoría	Criterio de Aprobación
Barra de Conectores	La documentación apoya por qué se necesita para sujetar los dientes de retención/pilar individuales con una longitud coronal considerable para una mayor estabilización de las dentaduras postizas parciales extraíbles, dentaduras postizas completas y sobre dentaduras postizas

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Categoría	Criterio de Aprobación
Coronas/Onlays	<ul style="list-style-type: none"> • Los criterios para las coronas fundidas serán sólo para los dientes permanentes que necesitan restauraciones de multiperficie donde otros materiales restauradores tienen un mal pronóstico. • Los dientes molares permanentes deben tener destrucción patológica en el diente por caries o traumatismo, y deben involucrar cuatro (4) o más superficies y dos (2) o más cúspides. • Los dientes bicúspides permanentes deben tener destrucción patológica en el diente por caries o traumatismo, y deben involucrar tres (3) o más superficies y al menos una (1) cúspide. • Los dientes anteriores permanentes deben tener destrucción patológica en el diente por caries o traumatismo, y deben implicar cuatro (4) o más superficies y al menos el 50% del borde incisal. <p>Para cumplir con los criterios, una corona debe:</p> <p>Oponerse por un diente o una prótesis en el arco opuesto o ser un pilar para una condensación parcial.</p> <ul style="list-style-type: none"> • El paciente debe estar libre de enfermedad periodontal activa y avanzada. • La tarifa de las coronas fundidas incluye la corona temporal que se coloca en el diente preparado y se usa mientras se fabrica la corona permanente para dientes permanentes. • Se espera que las coronas fundidas en dientes permanentes duren, como mínimo, cinco años. <p>Criterios para las coronas después de la terapia del conducto radicular:</p> <p>El diente debe llenarse lo suficientemente cerca del ápice radiológico para asegurarse de que se logra un sello apical.</p> <ul style="list-style-type: none"> • El relleno debe estar correctamente condensado/obturado. El material de llenado no se extiende excesivamente más allá del ápice. • El diente permanente debe apoyarse al menos al 50% en el hueso y no puede tener grados de movilidad +2 o +3 <p>Las coronas NO cumplirán con los criterios si:</p> <ul style="list-style-type: none"> • El diente tiene caries suboseos y/o de horno • El diente tiene enfermedad periodontal avanzada • El diente es un diente primario (coronas fundidas no aprobadas para dientes primarios) • Se están planeando coronas para alterar la dimensión vertical

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Categoría	Criterio de Aprobación
Dentaduras	<p>Debe tener todo lo siguiente:</p> <p>Los dientes restantes no tienen soporte óseo adecuado o no son restaurables</p> <ul style="list-style-type: none">• Prótesis existente mayor de 5 años e inservible (la narrativa debe explicar por qué cualquier prótesis existente no es útil o no puede ser realineada o rebasada)• Si se solicita una prótesis completa de reemplazo en un plazo de 5 años:• La narrativa de DDS debe explicar circunstancias específicas que requieren reemplazo• La documentación justificativa debe incluir una explicación de las medidas preventivas instituidas para aliviar la necesidad de nuevas sustituciones.

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Categoría	Criterio de Aprobación
Medicamentos o medicamentos dispensados en la oficina para uso doméstico	<ul style="list-style-type: none">• Puede indicarse para mejorar la curación de los procedimientos quirúrgicos, o reducir el dolor y/o el riesgo de infección.• Estos incluyen, pero no se limitan a antibióticos orales, analgésicos orales y flúor tópico

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
<ul style="list-style-type: none"> • Implante Endoso Endodóntico 	<ul style="list-style-type: none"> • Medicamento necesario para retener la estructura dental • Soporte periodontal y osseous adecuado • Los rayos X preoperatorios deben mostrar ápice de raíz • Libre de enfermedad periodontal <p>Re-implantación Intencional</p> <ul style="list-style-type: none"> • Patosis periradicular persistente tras el tratamiento endodóntico • El retratamiento no quirúrgico no es posible o tiene un pronóstico desfavorable • La cirugía periradicular no es posible o implica un alto grado de riesgo para las estructuras anatómicas adyacentes

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Dentaduras postizas parciales fijas – Pontics y retenedores (puentes)	<ul style="list-style-type: none">• Al menos un diente de pilar requiere una corona (basado en los requisitos tradicionales de necesidad médica y enfermedad dental).• El espacio no se puede llenar con una prótesis parcial extraíble.• El propósito es prevenir la deriva de los dientes en todas las dimensiones (anterior, posterior, lateral y el arco opuesto).• Cada pilar o cada pontico constituye una unidad en un puente.• Los dientes de retención deben tener un buen pronóstico

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Categoría	Criterio de Aprobación
Procedimientos de solapa	<ul style="list-style-type: none">• La presencia de profundidades de sondeo moderadas a profundas• Agrandamiento gingival moderado/grave o extensas áreas de crecimiento excesivo• Pérdida de apego• La necesidad de un mayor acceso a la superficie radicular y/o alveolar hueso cuando los intentos no quirúrgicos anteriores han sido infructuosos• El diagnóstico de un diente agrietado, una raíz fracturada o una resorción externa de la raíz cuando esto no se puede lograr mediante métodos no invasivos

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Categoría	Criterio de Aprobación
Anestesia General y Sedación Intravenosa (IV)	<p>Un formulario completo de Criterios para la Terapia Dental Bajo Anestesia General con una puntuación mínima de 22</p> <p>Plan de Tratamiento</p> <p>Narrativa que describe la necesidad médica. Para niños menores de 6 años, una narrativa única para el cliente, que detalla las razones del nivel propuesto de anestesia (indicar el código de procedimiento D9222/D9223). La narración debe incluir antecedentes de tratamiento previo, intentos fallidos en otros niveles de sedación, comportamiento en la silla dental, tratamiento restaurador propuesto (identificación dental y superficies), necesidad urgente de proporcionar tratamiento dental integral basado en el alcance de las caries dentales diagnosticados, y /o cualquier condición médica relevante.</p> <ul style="list-style-type: none"> • Se requiere un informe completo de anestesia que incluya horarios de inicio y de parada con reclamación de revisión del pago • Radiografías o fotografías de calidad diagnóstica • Cuando no se puedan tomar radiografías o fotografías apropiadas antes de la anestesia general, la narración debe apoyar las razones de la incapacidad de realizar servicios de diagnóstico. Para estos casos especiales que reciben autorización, se requerirán radiografías o fotografías con etiqueta de calidad diagnóstica para el pago. • El tratamiento prestado en condiciones de emergencia, cuando no sea posible la autorización, todavía requerirá la presentación del plan de tratamiento y la narración de la necesidad médica con la reclamación de revisión para el pago <p>Utilizando un anesthesiólogo dental:</p> <ul style="list-style-type: none"> • Si el dentista tratante está utilizando un anesthesiólogo dental, el dentista tratante ya habría presentado los registros clínicos anteriores bajo una solicitud de autorización previa para D9999 para su revisión. • Si ese es el caso, en el momento en que el anesthesiólogo dental presente el reclamo por los servicios de anestesia prestados, los

consultores clínicos buscarán revisar los siguientes requisitos de presentación del anestesiólogo dental:

- Una copia de la carta de autorización previa aprobada de D9999
- Una unidad de D9222 y unidades apropiadas de D9223
- Informe completo de anestesia con los tiempos de inicio y parada (alineándose con las unidades de anestesia solicitadas)

Si la puntuación mínima de 22 NO se cumple en el formulario Criterios para la terapia dental bajo anestesia general, las solicitudes de anestesia general o sedación intravenosa aún pueden autorizarse (para procedimientos cubiertos) si se cumple alguno de los siguientes criterios:

Procedimientos quirúrgicos orales extensos o complejos como:

- Muelas del juicio impactadas.
- Recuperación quirúrgica de la raíz del antro maxilar.
- Exposición quirúrgica de cúspides impactadas o no erupciales.
- Escisión radical de lesiones superiores a 1,25 cm.

Y/o una de las siguientes condiciones médicas:

- Condiciones médicas que requieren monitoreo (por ejemplo, problemas cardíacos, hipertensión severa).
- Condición médica peligrosa subyacente (parálisis cerebral, epilepsia, retraso mental, incluido el síndrome de Down) que haría que el paciente no fuera conforme.
- Sedación fallida documentada o una afección en la que una infección periapical grave haría que la anestesia local fuera ineficaz.
- Pacientes de 6 años o menos con procedimientos extensos que deben realizarse

Categoría	Criterio de Aprobación
Gingivectomía o Gingivoplastía	Presencia de una malformación o exceso de tejido gingival debido a una enfermedad o hiperplasia gingival inducida farmacológica

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Categoría	Criterio de Aprobación
• Regeneración guiada de tejidos	<ul style="list-style-type: none">• Defectos verticales intrahuesoso/infrahuesoso• Implicaciones de función de clase II• Mejorar la regeneración y curación del tejido periodontal para defectos mucogingival junto con cirugías mucogingival

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Categoría	Criterio de Aprobación
• Incrustaciones	La documentación indica por qué una incrustación es necesaria en lugar de un relleno estándar

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Categoría	Criterio de Aprobación
Dentaduras parciales provisionales	<ul style="list-style-type: none">• Mientras que el tejido se está curando después de las extracciones• Mantenimiento de un espacio para futuros tratamientos permanentes como un implante, puente o prótesis fijas definitivas• Acondicionar los dientes y el tejido de la cresta para un soporte óptimo de una prótesis parcial extraíble definitiva• Mantener la relación de mandíbula establecida hasta que se haya completado todo tratamiento restaurador y se pueda construir una prótesis parcial definitiva

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
• Chapas labiales	<ul style="list-style-type: none">• Para la cobertura de esmalte sólo fracturas que no se pueden reparar adecuadamente con una restauración directa• Dientes con defectos de esmalte incluyendo, pero no limitado a hipoplasia de esmalte, descalcificación grave, hipo calcificación del esmalte y fluorosis

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Sinusotomía maxilar	La documentación describe la presencia o descripción de la fractura radicular de cuerpo en un átrium maxilar

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Categoría	Criterio de Aprobación
Prótesis Maxilofaciales	La documentación describe accidentes, traumatismos faciales, enfermedades, reconstrucción u otra necesidad médica

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Categoría	Criterio de Aprobación
No – Sedación consciente intravenosa (configuración en oficina dental)	<ul style="list-style-type: none">• Ansiedad• Individuos que son poco cooperativos o inmanejables

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Ajuste oclusal – íntegro	La documentación describe la necesidad médica para la necesidad compleja de casos (arco facial, registros interoclusales, seguimientos, cera diagnóstica, etc.)

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Ajuste oclusal – Limitado	La documentación indica por qué es necesario un ajuste oclusal

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Categoría	Criterio de Aprobación
Análisis oclusal – Caso Montado	La documentación indica por qué es necesario un análisis oclusal

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Categoría	Criterio de Aprobación
Protector oclusal	<ul style="list-style-type: none">• Bruxismo o apretón ya sea como parasomnia nocturna o durante las horas de vigilia, lo que resulta en un desgaste excesivo o fracturas de dientes naturales o restauraciones• Proteger los dientes naturales cuando la dentición opuesta tiene el potencial de causar desgaste del esmalte, como la presencia de porcelana o restauraciones cerámicas <p>NO INDICADO:</p> <ul style="list-style-type: none">• Para el tratamiento de trastornos temporomandibulares o disfunción del dolor miofascial• Como un aparato destinado al movimiento de dientes de ortodoncia

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Dispositivo ortopédico oclusal, por Informe	<ul style="list-style-type: none">• La documentación apoya la historia de los esfuerzos de dolor / tratamiento de TMJ• No por bruxismo, molienda u otros factores oclusales

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Cirugía de Osea	<ul style="list-style-type: none">• Pacientes con diagnóstico de enfermedad periodontal moderada y avanzada o refractaria• Cuando la terapia es menos invasiva (es decir, la terapia periodontal no quirúrgica, procedimientos de solapa) no ha logrado eliminar la enfermedad

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Dentaduras Parciales	<ul style="list-style-type: none"> • Sustitución de uno o más dientes anteriores o dos o más dientes posteriores unilateralmente o reemplaza tres o más dientes posteriores bilateralmente, excluyendo los terceros molares, y se puede demostrar que la función masticatoria se ha visto gravemente deteriorada. O extracciones planificadas como parte del plan de tratamiento proporcionado con el narrativo • Buena salud e higiene bucal, buena salud periodontal (AAP Tipo I o II), y un pronóstico favorable donde no se espera un deterioro continuo. • Las radiografías no deben mostrar caries no tratadas o enfermedad periodontal activa en los dientes de pilar, y los pilares deben apoyarse al menos en un 50% en el hueso. • Como parte de cualquier servicio de prótesis extraíbles, se espera que los dentistas instruyan al paciente en el cuidado adecuado de la prótesis. <p>Las autorizaciones para prótesis extraíbles NO cumplirán con los criterios:</p> <ul style="list-style-type: none"> • Si hay una prótesis preexistente que no tiene al menos 5 años de antigüedad e inservible. • Si hay en cada cuadrante al menos tres (3) dientes posteriores periodontalmente sanos en bastante buena posición y oclusión con dentición opuesta. • Si buena salud e higiene bucal, buena salud periodontal, y un pronóstico favorable no están presentes. Y no hay un plan de tratamiento que corregir. • Si hay caries no tratadas o enfermedad periodontal activa en los dientes de pilar. Y no hay un plan de tratamiento que corregir. • Si los dientes de pilar son menos del 50% apoyados en el hueso. • Si el receptor no puede acomodar y mantener correctamente la prótesis (es decir, reflejo gag, potencial para tragar la prótesis, gravemente discapacitado)

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Ostectomia parcial	La documentación describe la presencia o descripción de huesos no vitales o organismo extraño

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Categoría	Criterio de Aprobación
Férula provisional	Múltiples dientes que se han vuelto móviles debido a la pérdida de hueso alveolar y periodonto

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Extracción de dientes impactados	<ul style="list-style-type: none">• La extirpación profiláctica de dientes asintomáticos (es decir, terceros molares) o dientes que no presentan patología clínica excesiva está cubierta sujeta a revisión de consultores.• La extracción de dientes primarios cuya exfoliación es inminente no cumple con los criterios.• La alveoloplastia (código D7310) junto con cuatro o más extracciones en el mismo cuadrante serán cubiertas sujetas a revisión de consultores.

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Categoría	Criterio de Aprobación
Eliminación de Torus Palatino	<ul style="list-style-type: none">• Cuando una prótesis dental cubrirá el paladar y un gran toro palatal interferirá con el ajuste• Para un toro inusualmente grandes que son propensos a lesiones traumáticas recurrentes• Cuando hay una alteración funcional, incluyendo, pero no limitado a la masticación, la deglución y el habla

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Reparación de Maxilofacial Suave y/o defecto de tejido duro	La narrativa y las radiografías apoyan la necesidad médica para el procedimiento

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Relleno Retrógrado	<ul style="list-style-type: none">• Patetosis peri radicular y un bloqueo del sistema de conducto radicular que no podía ser obturado por el tratamiento no quirúrgico del conducto radicular• Patosis peri radicular persistente resultante de un sello apical inadecuado que no se puede corregir No quirúrgicamente

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Amputación de Raíz	<ul style="list-style-type: none">• Participación de la clase III implicación XX Intratable defecto óseo (de una raíz)• Fractura de raíz, caries o resorción• Cuando hay más del 75% de hueso que soporta las raíces restantes• El diente ha tenido un tratamiento endodóntico exitoso

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Retratamiento del conducto radicular	<ul style="list-style-type: none"> • El relleno debe estar lo suficientemente cerca del ápice radiológico para asegurarse de que se logra un sello apical. • El relleno debe estar correctamente condensado/obturado. El material de llenado no se extiende excesivamente más allá del ápice. <p>Las autorizaciones para la terapia de retiro de conductos radiculares NO cumplirán con los criterios si:</p> <ul style="list-style-type: none"> • La Patosis periapical o periodontal bruta se demuestra radiográficamente (caries subcrestal o a la furcación, considerando que el diente no es restaurable). • La afección oral general no justifica la terapia de conducto radicular debido a la pérdida de integridad del arco. • La terapia con conducto radicular es para terceros molares, a menos que sean un pilar para una prótesis dental parcial. • El diente no demuestra un apoyo óseo del 50%. • La terapia de conducto radicular está en previsión de la colocación de una sobre dentadura. • Se utiliza un material de llenado no aceptado por la Administración Federal de Alimentos y Medicamentos (por ejemplo, material de llenado sargenti).

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Terapia de canal radicular	No todos los procedimientos requieren autorización. <ul style="list-style-type: none">• Se realiza la terapia de conducto radicular con el fin de mantener los dientes que han sido dañados a través de trauma o exposición cariosa.

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Escalado y planificación de raíces	<ul style="list-style-type: none">• D4341 (Cuatro o más dientes por cuadrante) // D4342 (al menos 1 diente por cuadrante)• Profundidades de sondeo de al menos 5 mm o más• Evidencia radiográfica de pérdida ósea

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Reposicionamiento quirúrgico de los dientes	El tratamiento de las lesiones de desplazamiento a dientes permanentes xx Extrusión de los dientes con fracturas de corona / raíz para prepararse para la restauración de Dientes

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Reparaciones de sutura	<ul style="list-style-type: none">• La documentación describe el accidente• No para la extracción dental o para cerrar la incisión quirúrgica

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Medicamentos parenterales terapéuticos	<ul style="list-style-type: none">• Puede indicarse para mejorar la curación de los procedimientos quirúrgicos, o reducir el dolor y/o el riesgo de infección.• Los medicamentos incluyen antibióticos, esteroides o antiinflamatorios.

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Injertos de tejido	<p>Injerto de tejido blando pediculado, injerto de tejido conectivo autógeno, injerto de tejido conectivo no autógeno, tejido conectivo combinado e injerto de pedículo doble, procedimiento de injerto de tejido blando libre (incluyendo cirugía en el sitio del donante)</p> <ul style="list-style-type: none">• Sensibilidad no resuelta en áreas de recesión• Recesión progresiva o inflamación crónica• Dientes con restauraciones subgingival donde hay poca o ninguna gingiva adjunta para mejorar el control de la placa

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Trasplante de dientes	Lesiones por subluxación en dientes permanentes

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Tratamiento de complicaciones (Postquirúrgico)	La documentación describe qué es este tratamiento y por qué es necesidad médica

[Volver a la Tabla de Procedimientos](#)

Categoría	Criterio de Aprobación
Procedimientos no especificados, por informe	El procedimiento no puede describirse adecuadamente mediante un código existente La documentación apoya la necesidad médica

[Volver a la Tabla de Procedimientos](#)

Servicios integrales de ortodoncia médicamente necesarios

[Volver a la cuadrícula de procedimientos](#)

Los servicios integrales de ortodoncia médicamente necesarios son un beneficio cubierto para:

Miembros de Medicaid para Niños de Texas:

Miembros que tienen una maloclusión de hándicap grave o condiciones médicas especiales, incluyendo paladar hendido, lesión de trauma post-cabeza que involucra la cavidad oral, y / o anomalías esqueléticas que involucran la cavidad oral.

Miembros de CHIP:

Los miembros de CHIP **solo** calificarían para el tratamiento de ortodoncia bajo este programa si:

1. El expediente del Miembro identifica claramente un paladar hendido o anomalía craneofacial que involucra la cavidad oral, o
2. Miembro tiene antecedentes de, o está programado para, cirugía ortognática para corregir una maloclusión grave, **y** cumplir, como mínimo, los requisitos de criterios para el tratamiento ortodoncia de nivel III (ver sección de nivel III a continuación)

Los servicios de ortodoncia que se realizan únicamente con fines cosméticos no son un beneficio de Texas Medicaid.

Los planes de tratamiento de ortodoncia aprobados deben iniciarse antes de la pérdida de elegibilidad para Medicaid por parte del cliente o el 21 cumpleaños. Los servicios no se pueden agregar ni aprobar después de que la elegibilidad de Texas Medicaid/Texas Health Steps (THSteps) haya expirado.

Los miembros inscritos en el plan del Contratista Dental durante al menos un mes y están recibiendo tratamiento de ortodoncia y envejecen o pierden elegibilidad; el Contratista Dental es responsable de completar el pago por el curso del tratamiento. La única excepción es si el Miembro está dado de baja por causa, pero sigue siendo elegible para Medicaid.

Los clientes que tengan 14 años o menos deben estar acompañados a todos los chequeos/visitas médicas y dentales por el padre del cliente, tutor legal o un adulto autorizado por el padre o tutor legal. El adulto autorizado puede ser el pariente del cliente. La persona que acompaña al cliente debe esperar al cliente mientras se lleva a cabo la cita. Esta política no se aplica a los servicios proporcionados por una clínica de salud escolar, programa Head Start o centro de cuidado infantil si la clínica, programa o instalación que proporciona los servicios (Código de Recursos Humanos):

- Obtiene un consentimiento por escrito válido para los servicios del padre o tutor legal del cliente dentro del período de un año antes de la fecha en que se proporcionan los servicios.

Alienta la participación de los padres en la atención médica de los niños que reciben servicios de la clínica, programa o centro. Al igual que con todos los servicios de Medicaid, un proveedor reconoce el cumplimiento de todos los requisitos de Medicaid

cuando envía una reclamación de reembolso.

La terminología ortodoncia y el alcance de los servicios de ortodoncia se basan en las definiciones y explicaciones de la Terminología Dental Actual (CDT) de la Asociación Dental Americana y las explicaciones de los códigos ortodoncia utilizados dentro de esta política. Las siguientes definiciones de dentición establecidas por el manual de CDT son reconocidas por los servicios dentales de Medicaid para Niños:

- Dentición primaria: Los dientes se desarrollaron y estallaron primero en orden de tiempo.
- Dentición transicional: La fase final de la transición de los dientes primarios a los dientes adultos, en la que los molares y caninos caducifolios están en proceso de desprendimiento y los sucesores permanentes están emergiendo.
- Dentición adolescente: La dentición que está presente después de la pérdida normal de dientes primarios y antes del cese del crecimiento que afectaría el tratamiento ortodoncia.
- Dentición para adultos: La dentición que está presente después del cese del crecimiento que afectaría el tratamiento ortodoncia.

Lugar de servicio

1 oficina

Autorización previa

Se requiere autorización previa para todos los niveles de tratamiento de ortodoncia. La autorización previa incluye el número de visitas mensuales y el tiempo de finalización previsto según el nivel de tratamiento correspondiente. Un examen de tratamiento pre-ortodoncia para monitorear el crecimiento y el desarrollo (D8660) se considera parte de cualquier evaluación oral integral (D0150) o evaluación oral periódica (D0120).

La siguiente documentación debe presentarse con la solicitud de autorización previa para los servicios de ortodoncia de nivel I, II, III y IV:

- ADA 2012 o formulario de reclamación más nuevo con códigos de servicio señalados
- Modelos de diagnóstico digital u otro tipo de imágenes diagnósticas 3D
- Radiografías (radiografías)
- Imagen radiográfica cefalométrica con trazados
- Fotografías
- Plan de tratamiento
- **Solo para Clientes con CHIP** – una copia de la carta de aprobación de autorización previa médica para la cirugía

Niveles de Servicios de Ortodoncia

UHC Dental reconoce cuatro niveles de servicio de ortodoncia para la maloclusión de hándicap grave, y cada uno requiere una cantidad diferente de tiempo para el tratamiento. La maloclusión hándicap se define como una oclusión que está gravemente comprometida funcionalmente y se describe en los niveles I, II, III y IV

Tipos de proveedor de ortodoncia basados en niveles:

Todos los proveedores dentales deben cumplir con las reglas y regulaciones de la Junta Estatal de Examinadores Dentales de Texas (TSBDE), incluyendo los estándares de documentación y mantenimiento de registros que se establecen en las Reglas TSBDE 108.7 Estándares Mínimos de Atención, General y 108.8 Registros de Dentista. Los Dentistas (DDS, DMD) que deseen proporcionar cualquiera de los cuatro niveles de servicios de ortodoncia abordados en esta política deben estar inscritos como dentista u ortodoncista en Texas Pasos de salud (THSteps) y deben tener las calificaciones enumeradas a continuación para el nivel de servicio relevante:

Tipo de proveedor	Nivel de servicio de ortodoncia que se puede Proporcionado	Calificaciones
Tipo de proveedor 90	Nivel I o II	<ul style="list-style-type: none"> • Finalización de la residencia dental pediátrica; o • Un mínimo de 200 horas de educación dental continua en ortodoncia.
Tipo de proveedor 48	Level I, II, III, or IV	Dentistas que son elegibles de la Junta o la junta certificada por una junta especializada de ortodoncia reconocida por ADA.

Niveles I, II, III y IV de Ortodoncia:

NIVEL I:				
<ul style="list-style-type: none"> ❖ La finalización de los servicios de ortodoncia de nivel I no descalifica los futuros servicios de ortodoncia de nivel II, III o IV. ❖ Los servicios de ortodoncia de nivel I no estarán autorizados previamente si hay una indicación de que el cliente calificará para los servicios de ortodoncia de nivel II, III o IV en el futuro. 				
Códigos CDT	Tipo de proveedor	Grupo de edad elegible	Duración del tratamiento	Excepciones al tiempo de tratamiento esperado
D8210 Terapia de electrodomésticos extraíbles D8220 Fijo Terapia de electrodo	Tipo 48 Tipo 90	3-13	Hasta 10 visitas mensuales y se espera que se completen en un plazo de 12 meses a menos que una excepción es concedida	Puede permitir meses de tratamiento adicionales para una de las siguientes circunstancias: El cliente es el niño de un trabajador agrícola migrante. Los servicios de ortodoncia del cliente se retrasaron como resultado de estar

mésticos				temporalmente en el cuidado de la custodia estatal (cuidado de crianza).
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Criteria
<p>Nivel I: Dedicado a la resolución de los primeros signos de maloclusión hándicap en la dentición mixta temprana que puede afectar significativamente la salud de la dentición en desarrollo, el hueso alveolar y el crecimiento simétrico del marco esquelético. (La presencia de los molares permanentes maxilares y mandibulares, así como los incisivos maxilares y mandibulares completamente en erupción, y los dientes caducifolios constituirán la dentición mixta temprana.)</p> <p>**Las excepciones para los casos de dentición mixta pueden considerarse cuando el plan de tratamiento incluye extracciones de dientes primarios restantes o en el caso del paladar hendido.</p> <ul style="list-style-type: none"> • Travesía anterior que se asocia con inflamación gingival grave clínicamente aparente y/ o recesión gingival, o desgaste severo del esmalte. • Travesía posterior con una desviación de línea media asociada y patrón de cierre asimétrico.

LEVEL II:				
<ul style="list-style-type: none"> ❖ Los clientes son elegibles para los servicios de ortodoncia de nivel II, III o IV una vez por vida. ❖ Los clientes identificados como casos hendidos/craneofaciales son elegibles para más de un nivel de servicios de ortodoncia (nivel II, III y IV) por vida. 				
Códigos CDT	Tipo de proveedor	Grupo de edad	Duración del tratamiento	Excepciones al tiempo de tratamiento esperado
<p>D8050 Tratamiento ortodoncia interceptivo de la dentición primaria</p> <p>D8060 Tratamiento ortodoncia interceptivo de la dentición transicional</p> <p>D8070 Ortodoncia integral tratamiento de la dentición transicional</p>	<p>Tipo 48 Tipo 90</p>	<p>3-13</p>	<p>Hasta 22 visitas mensuales y se espera que se completen en un plazo de 24 meses a menos que se conceda una excepción.</p>	<ul style="list-style-type: none"> • Puede permitir meses de tratamiento adicionales para una de las siguientes circunstancias: • El cliente es hijo de un trabajador agrícola migrante. • Los servicios de ortodoncia del cliente se retrasaron como resultado de estar temporalmente en cuidado de custodia estatal (orfanato)

Criteria
<p>Nivel II: Dedicado a la resolución de maloclusión de minusválidos en la dentición transicional; la fase final de la transición de la dentición primaria a adolescente en la que los dientes permanentes sucedáneos están emergiendo o a punto de emerger.</p> <p>CUATRO de las siguientes condiciones deben ser claramente evidentes en la documentación justificativa:</p> <ul style="list-style-type: none"> • Maloclusión completa de la cúspide clase II con la cúspide bucal distal del primer molar maxilar ocluyendo en el surco bucal mesial del primer molar mandibular. • Maloclusión completa de la cúspide clase III con el primer molar maxilar ocluyendo en la cúspide bucal distal molar mandibular primero o en la inclinación distal de la cúspide bucal molar de mandibular. • La medida de la sobremordida deberá de ser superior a 5 mm. • La medida de sobrejet deberá de ser superior a 8 mm. <ul style="list-style-type: none"> • Más de cuatro dientes congénitamente ausentes, uno o más de los cuales incluirán un diente/o dientes anteriores. • El hacinamiento anterior deberá de ser superior a 6 mm. en el arco mandibular. • Mordedura cruzada anterior de al menos dos de los cuatro incisivos maxilares. • Espaciado generalizado en ambos arcos de más de 6 mm. en cada arco. <ul style="list-style-type: none"> • Reconocimiento de caninos maxilares o caninos de impacto temprano. Las radiografías apoyarán el diagnóstico que demuestre una angulación mesial grave del canino en erupción y la corona del canino superpuesto y cruzando la imagen del incisivo lateral maxilar.
Servicios Adicionales
<p>Puede haber circunstancias atenuantes que justifiquen un tiempo de tratamiento adicional, incluyendo pero no limitado a casos de anomalías craneofaciales y paladar hendido. En caso de que el cliente requiera tratamiento adicional, el proveedor puede solicitar autorización previa para servicios adicionales. Cada caso será revisado y evaluado caso por caso por necesidad médica.</p> <p>Los proveedores deben completar y presentar lo siguiente para su consideración por servicios adicionales:</p> <ul style="list-style-type: none"> • Un formulario de reclamación ADA 2012 o posterior con el código de procedimiento D8670 para visitas adicionales mensuales de ortodoncia, si es necesario. • En el formulario de reclamo de ADA identifique el motivo de las visitas mensuales adicionales necesarias e identifique el número de visitas que se solicitan. • El nombre del aparato adicional en el caso de un plan de tratamiento de paladar hendido, si es necesario. • Radiografías recientes (radiografías) que muestran los progresos realizados hasta la fecha. • Fotografías actuales • Plan de Tratamiento actual
NIVEL III
<p>❖ Los clientes son elegibles para los servicios de ortodoncia de nivel II, III o IV una vez por vida.</p>

❖ Los Clientes identificados como casos hendidura/craneofacial son elegibles para más de un nivel de servicios de ortodoncia (Nivel II, III y IV) por vida.

Código's CDT	Tipo de Proveedor	Grupo de Edad	Duración del Tratamiento	Excepciones al tiempo de tratamiento esperado
D8080 Tratamiento de ortodoncia integral de la dentición adolescente	Tipo 48	13-20	Hasta 22 visitas mensuales y se espera que se completen dentro de los 36 meses a menos que se conceda una excepción.	Puede permitirse meses de tratamiento adicionales para una de las siguientes circunstancias: <ul style="list-style-type: none"> • El cliente es hijo de un trabajador agrícola migrante. • Los servicios de ortodoncia del cliente se retrasaron como resultado de estar temporalmente en la custodia estatal (orfanato).

Criteria

Nivel III: Dedicado a la resolución de la maloclusión de discapacitados en la dentición adolescente o adulta; erupción completa de la dentición permanente con la posible excepción de la erupción completa de los segundos molares.

CUATRO de las siguientes condiciones deben ser claramente evidentes en la documentación justificativa.

- Maloclusión molar de clase II completa como se describe en el nivel II.
- Maloclusión molar de clase III completa como se describe en el nivel II.
- Impacto dental anterior; sin problemas con evidencia radiográfica para apoyar un diagnóstico de impacto (falta de espacio eruptivo, angularmente malpuesto, totalmente incrustado en el hueso) en comparación con los dientes anteriores eclípticos que pueden ser malpuestos, pero ha estallado en la cavidad oral y no es un elemento calificador.
- El hacinamiento anterior será superior a 6 mm en el arco mandibular.
- La mordedura abierta anterior demostrará que todos los incisivos maxilares y mandibulares no tienen contacto oclusal y están separados por una medida superior a 6 mm.
- La mordedura abierta posterior deberá demostrar una separación vertical mediante una medición superior a 5 mm. de varios dientes posteriores y no confundirse con la erupción natural retardada de unos pocos dientes.
- Se calificará la picadura cruzada posterior con una desviación de línea media asociada y un cambio mandibular, una mordedura de Brodie con un arco mandibular totalmente gravado por un arco maxilar que se superponga bucalmente ocluyendo, o un arco maxilar posterior totalmente mal posicionado al arco mandibular.
- La mordedura cruzada anterior incluirá más de dos incisivos en la picadura cruzada y demostrará inflamación gingival, recesión gingival o desgaste severo del esmalte.
- La sobremordida será superior a 5 mm.

- El sobrejet deberá superar los 8 mm

Servicios Adicionales

Puede haber circunstancias atenuantes que justifiquen un tiempo de tratamiento adicional, incluyendo pero no limitado a casos de anomalías craneofaciales y paladar hendido. En caso de que el cliente requiera tratamiento adicional, el proveedor puede solicitar autorización previa para servicios adicionales. Cada caso será revisado y evaluado caso por caso por necesidad médica.

Los proveedores deben completar y enviar lo siguiente para consideración a servicios adicionales:

- Un formulario de reclamación ADA 2012 o posterior con el código de procedimiento D8670 para visitas adicionales mensuales de ortodoncia, si es necesario.
- En el formulario de reclamo de ADA identifique el motivo de las visitas mensuales adicionales necesarias e identifique el número de visitas que se solicitan.
- El nombre del aparato adicional en el caso de un plan de tratamiento de paladar hendido, si es necesario.
- Radiografías recientes (radiografías) que muestran los progresos realizados hasta la fecha.
- Fotografías actuales
- Plan de Tratamiento actual

NIVEL IV

- ❖ Los Clientes son elegibles para servicios de ortodoncia de nivel II, III o IV una vez por vida.
- ❖ Los Clientes identificados como casos de hendidura/craneofacial son elegibles para más de un nivel de servicios de ortodoncia (Nivel II, III y IV) por vida.

Código's CDT	Tipo de Proveedor	Grupo de Edad	Duración del Tratamiento	Excepciones al tiempo de tratamiento esperado
D8090 Tratamiento de Ortodoncia Integral de la dentición adulta.	Tipo 48	13-20	Hasta 22 visitas mensuales y se espera que se completen en un plazo de 36 meses a menos que se conceda una excepción.	Puede permitirse meses de tratamiento adicionales para una de las siguientes circunstancias: <ul style="list-style-type: none"> • El cliente es hijo de un trabajador agrícola migrante. • Los servicios de ortodoncia del cliente se retrasaron como resultado de estar temporalmente en el cuidado de la custodia estatal (cuidado temporal).
Criteria				

- Maloclusión de clase II no funcional
- Malocclusion no funcional clase III

La corrección de la maloclusión deberá estar más allá de la de la ortodoncia por sí sola y requerirá procedimientos pre-ortodoncia y post-ortodoncia junto con la cirugía ortognática, las necesidades médicas del paciente se basarán en la función y no en la estética.

Servicios Adicionales

Puede haber circunstancias atenuantes que justifiquen un tiempo de tratamiento adicional, incluyendo pero no limitado a casos de anomalías craneofaciales y paladar hendido. En caso de que el cliente requiera tratamiento adicional, el proveedor puede solicitar autorización previa para servicios adicionales. Cada caso será revisado y evaluado caso por caso por necesidad médica.

Los proveedores deben completar y presentar lo siguiente para su consideración por servicios adicionales:

- Un formulario de reclamación ADA 2012 o posterior con el código de procedimiento D8670 para visitas adicionales mensuales de ortodoncia, si es necesario.
- En el formulario de reclamo de ADA identifique el motivo de las visitas mensuales adicionales necesarias e identifique el número de visitas que se solicitan.
- El nombre del aparato adicional en el caso de un plan de tratamiento de paladar hendido, si es necesario.
- Radiografías recientes (radiografías) que muestran los progresos realizados hasta la fecha.
- Fotografías actuales
- Plan de Tratamiento actual

Nivel IV: Dedicado a la resolución de maloclusión incapacitada en la dentición adulta; erupción completa de la dentición permanente. La documentación será presentada por un cirujano oral que justifique la necesidad médica de un enfoque quirúrgico del tratamiento.

Reembolso

El reembolso del tratamiento ortodoncia se basa en la presentación de los códigos de procedimiento apropiados:

D8210, D8220, D8050, D8060, D8070, D8080 o D8090

- Se considerará para el pago como el reembolso inicial cuando se hayan colocado todas las bandas, soportes y/o aparatos y se haya iniciado el tratamiento activo.
- El trabajo de diagnóstico se considera parte de este reembolso inicial.
- El trabajo de diagnóstico se considera parte de este reembolso inicial.

Código de procedimiento D8670: Visita periódica del tratamiento de ortodoncia

- Limitado a un servicio por mes.
- El número total de ajustes mensuales permitidos variará según el nivel aprobado del tratamiento de ortodoncia.
- No podrá presentarse únicamente para una visita observacional.

Código de procedimiento D8680: Retención de ortodoncia - eliminación de aparatos, construcción y colocación de retenedor(es).

- Se considerará para el pago como el último pago cuando el tratamiento de ortodoncia esté completo y haya sido autorizado previamente.
Los casos denegados no serán reembolsados.

Finalización de todos los niveles de tratamiento ortodoncia

- Se requiere autorización previa para completar el tratamiento (último pago) y debe ser revisada para obtener pruebas de finalización del caso.
- Los proveedores deben usar el código de procedimiento D8680 para la eliminación de todas las bandas, corchetes y dispositivos. Los servicios de ortodoncia niveles II, III y IV deben incluir la construcción de retenedores maxilares y mandibulares.
- La siguiente documentación debe presentarse con la solicitud de autorización previa:
 - Un formulario de reclamación ADA 2012 o más nuevo con el código de procedimiento D8680
 - Imagen radiográfica panorámica posterior al tratamiento
 - Fotografías
 - Una declaración firmada del Proveedor tratante que indica que el tratamiento está completo

Transferencia/Continuación de la Atención Ortodoncia

Hay 3 escenarios principales que este documento abordará en cuanto a la continuación o transferencia del tratamiento ortodoncia en curso de un miembro:

1. Proveedor a Proveedor (dentro de UHC Dental)
2. Otros DMO a UHC Dental
3. Acuerdo privado/comercial con UHC Dental

1) Proveedor a Proveedor (dentro de UHC Dental):

Esta sección es para situaciones en las que el cuidado de ortodoncia de un miembro elegible de Medicaid se transfiere de un proveedor dental de UHC a otro proveedor dental de UHC (en el que hay registro de la aprobación del tratamiento de ortodoncia original)

La autorización previa emitida a un proveedor para servicios de ortodoncia no es transferible a otro proveedor. El nuevo proveedor debe solicitar una nueva autorización previa para completar el tratamiento iniciado por el proveedor original.

El nuevo proveedor debe obtener sus propios registros, que deben presentarse con la solicitud de transferencia de servicios.

- Requisitos de presentación de la documentación:
 - Toda la documentación necesaria para la solicitud original
 - ADA 2012 o formulario de reclamación más nuevo con el código de procedimiento D8999 y el número de visitas restantes (D8670) que necesitan ser prestados.
 - La razón por la que el cliente dejó el proveedor anterior y una narrativa señalando el estado del tratamiento.

2) Otro DMO a UHC Dental:

Esta sección es para situaciones en las que la atención de ortodoncia de un miembro elegible de Medicaid se transfiere de otra organización de TX Dental Medicaid (DMO) a la DMO de UHC Dental

La continuación de un caso para un cliente que comenzó con otro DMO se considerará para aquellos miembros con una autorización previa activa no caducada para el tratamiento de ortodoncia, hasta la cantidad y validez aprobada por el transportista anterior

- Requisitos de presentación de documentación:
- Un formulario completo de continuación ortodoncia de cuidado. Consulte el Apéndice K para este formulario.
- ADA 2012 o formulario de reclamación más nuevo con el código de procedimiento D8999 y el número de visitas restantes (D8670) que deben representarse.
- Una copia de la aprobación previa del Miembro, incluida la tarifa total aprobada del caso y la estructura de pago
- Historial de pagos detallado

3) Acuerdo privado/comercial para UHC Dental:

Esta sección es para situaciones en las que la atención ortodoncia de un miembro elegible actualmente de Medicaid se transfiere de un Acuerdo Privado/Comercial a UHC Dental DMO, sólo si el cliente comenzó el tratamiento antes de convertirse en elegible para Medicaid.

La continuación de un caso de ortodoncia para un cliente que comenzó el tratamiento a través de un acuerdo privado no se considerará para la autorización previa si el cliente comenzó el tratamiento mientras Medicaid es elegible y será negado.

La continuación de un caso de ortodoncia para un cliente que comenzó a través de un acuerdo privado/comercial también necesitará revisión de la necesidad médica, y debe cumplir con los criterios de Medicaid para la necesidad médica de tratamiento de ortodoncia

- Requisitos de presentación de documentación:
 - Un formulario completo de continuación del cuidado de ortodoncia. Consulte el Apéndice K para Este formulario.
 - ADA 2012 o formulario de reclamación más nuevo con el código de procedimiento D8999 y el número de visitas restantes (D8670) que necesitan ser prestados.
 - Una copia de la aprobación previa del Miembro, incluida la tasa total aprobada del caso y la estructura de pago
 - Historial de pagos detallado
- Estos documentos de presentación adicionales también serán requeridos para revisar por necesidad médica cuando se esté considerando un caso orto etario iniciado en un acuerdo privado/comercial para la continuación de la cobertura de atención:
 - Modelos de diagnóstico digital u otro tipo de imágenes diagnósticas 3D
 - Radiografías (rayos X)
 - Imagen radiográfica cefalométrica con trazados
 - Fotografías
 - Plan de tratamiento
 - **Solo para clientes de CHIP** – una copia de la carta de aprobación de autorización previa médica para la cirugía

Terminación prematura de servicios integrales de ortodoncia

La terminación prematura del tratamiento ortodoncia integral por parte del proveedor de tratamiento servicios integrales.

La terminación prematura de los servicios de ortodoncia incluye todo lo siguiente:

- Eliminación de soportes y alambres de arco
- Otros aparatos especiales de ortodoncia
- Fabricación de aparatos especiales de ortodoncia
- Entrega de retenedores de ortodoncia

La extracción prematura de un aparato de ortodoncia debe estar autorizada previamente, y las solicitudes deben incluir:

- Se ha eliminado un formulario de reclamación ADA 2012 o posterior con el código de procedimiento D8680, para identificar que todas las bandas, corchetes y aparatos han sido eliminados y se han entregado retenedores de ortodoncia aplicables.

1. Un formulario de liberación (o copia de) que debe ser firmado por el padre o tutor legal, o por el cliente si tiene 18 años o más o un menor emancipado.

- Una de las siguientes opciones debe documentarse en la solicitud de autorización previa:
 - El cliente no coopera o no cumple
 - El cliente solicitó la eliminación de los aparatos de ortodoncia(s)
 - El cliente ha solicitado la eliminación debido a circunstancias atenuantes para incluir, pero no limitado a:
- Encarcelamiento
- Complicaciones de salud mental con una recomendación del médico tratante
- Colocación de cuidados de crianza
- Hijo de un trabajador agrícola migrante, con la intención de completar el tratamiento en una fecha posterior si continúa la elegibilidad de Medicaid para los servicios de ortodoncia

*NOTA: Un Miembro para quien se haya autorizado la eliminación de un aparato debido a lo anterior, será elegible para completar sus servicios de ortodoncia de Medicaid si los servicios se vuelven a iniciar mientras Medicaid es elegible. Si el Miembro decide que se eliminen los aparatos por razones distintas a las mencionadas anteriormente debido a circunstancias atenuantes, el cliente **puede no** ser elegible para ningún servicio adicional de ortodoncia de Medicaid.*

- El proveedor solicitante es responsable de la eliminación de los aparatos de ortodoncia, registros finales y fabricación y entrega de retenedores en el momento de la eliminación prematura o en cualquier momento futuro si el cliente se presenta a la oficina del proveedor tratante.
- En el caso de una terminación prematura autorizada del tratamiento, el proveedor debe presentar el código de procedimiento D8680 para identificar que todas las bandas, corchetes y aparatos han sido eliminados y se han entregado retenedores de ortodoncia aplicables.

Documentación

Todas las visitas de tratamiento de ortodoncia deben documentarse en el registro dental del cliente y estar disponibles para su revisión

[Volver a la cuadrícula de procedimientos](#)