



# UnitedHealthcare Dental Prior Authorization Guidance

[Click to go to Procedures Grid](#)



## 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](#)



## UnitedHealthcare Dental Prior Authorization Guidance

### 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.

[Click to go to Procedures Grid](#)

### Procedures Grid

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

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	<a href="#">Crowns/Onlays</a>
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	<a href="#">Crowns/Onlays</a>
D2782	Crown - 3/4 Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	<a href="#">Crowns/Onlays</a>
D2783	Crown - 3/4 Porcelain/Ceramic	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	<a href="#">Crowns/Onlays</a>
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	<a href="#">Crowns/Onlays</a>
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	<a href="#">Crowns/Onlays</a>
D2792	Crown - Full Cast Noble Metal	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	<a href="#">Crowns/Onlays</a>
D2794	crown – titanium and titanium alloys	Current pre-op x-rays, Narrative of Specific tests if cracked tooth syndrome	Medicaid	9/1/2020	<a href="#">Crowns/Onlays</a>
D2960	Labial Veneer (Resin Laminate) - Chairside	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	<a href="#">Labial Veneers</a>
D2961	Labial Veneer (Resin Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	<a href="#">Labial Veneers</a>
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	Pre and post-op x-rays or Intraoral photos, Narrative	Medicaid	9/1/2020	<a href="#">Labial Veneers</a>
D2999	Unspecified Restorative Procedure, By Report	Pre-op x-rays, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Root Canal Retreatment</a>
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Root Canal Retreatment</a>
D3348	Retreatment Of Previous Root Canal Therapy - Molar	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Root Canal Retreatment</a>
D3351	Apexification / Recalcification - Initial Visit	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apexification/ Recalcification</a>
D3352	Apexification / Recalcification - Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apexification/ Recalcification</a>
D3353	Apexification / Recalcification - Final Visit	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apexification/ Recalcification</a>
D3410	Apicoectomy - Anterior	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apicoectomy/ Periradicular Surgery</a>
D3421	Apicoectomy - Premolar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apicoectomy/ Periradicular Surgery</a>
D3425	Apicoectomy - Molar (First Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apicoectomy/ Periradicular Surgery</a>
D3426	Apicoectomy - Each Additional Root)	Pre and post-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Apicoectomy/ Periradicular Surgery</a>

## 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	<a href="#">Retrograde Filling</a>
D3450	Root Amputation - Per Root	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Root Amputation</a>
D3460	Endodontic Endosseous Implant	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Endodontic Endosseous Implant</a>
D3470	Intentional Reimplantation (Including Necessary Splinting)	Pre-op FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Endodontic Endosseous Implant</a>
D3999	Unspecified Endodontic Procedure, By Report	Pre-op x-rays, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Current pre-op x-rays and photos, 6 point perio charting, narrative	Medicaid and CHIP	9/1/2020	<a href="#">Gingivectomy or Gingivoplasty</a>
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Current pre-op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	<a href="#">Gingivectomy or Gingivoplasty</a>
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	Current pre-op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	<a href="#">Anatomical Crown Exposure</a>
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	Current pre-op x-rays and photos, 6 point perio charting, narrative	Medicaid	9/1/2020	<a href="#">Anatomical Crown Exposure</a>
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	Full mouth x-rays, 6 point perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	<a href="#">Flap Procedures</a>
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	Full mouth x-rays, 6 point perio charting, Narrative, Photos if necessity not clear	Medicaid	9/1/2020	<a href="#">Flap Procedures</a>
D4245	Apically Positioned Flap	Pre-op x-rays, narrative of medical necessity, pre-op photos if necessity not clear	Medicaid	9/1/2020	<a href="#">Flap Procedures</a>
D4249	Clinical Crown Lengthening - Hard Tissue	Pre-op x-rays, 6 point perio charting, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Clinical Crown Lengthening</a>
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	FMX, 6 point perio charting and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Osseous Surgery</a>
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	FMX, 6 point perio charting and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Osseous Surgery</a>
D4266	Guided Tissue Generation - Resorbable Barrier, Per Site	Pre-op x-rays, 6 point perio charting, narrative of medical necessity, photos if necessity not clear	Medicaid	9/1/2020	<a href="#">Guided Tissue Regeneration</a>
D4267	Guided Tissue Regeneration	Pre-op x-rays, 6 point perio charting, narrative of medical necessity, photos if necessity not clear	Medicaid	9/1/2020	<a href="#">Guided Tissue Regeneration</a>
D4270	Pedicle Soft Tissue Graft Procedure	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4274	Distal Or Proximal Wedge Procedure	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>

### 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, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional	Pre-op x-rays, 6 point perio charting, narrative of med nec, photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4285	Non-Autogenous Connective Tissue Graft Each Additional	Pre-op x-rays, 6 point perio charting, narrative of med nec photos	Medicaid	9/1/2020	<a href="#">Tissue Grafts</a>
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	Current preop x-rays 6 point perio charting Narrative	Medicaid	1/1/2022	<a href="#">Provisional Splinting</a>
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	Current preop x-rays 6 point perio charting Narrative	Medicaid	1/1/2022	<a href="#">Provisional Splinting</a>
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	FMX, 6 point perio charting and narrative of medical necessity	Medicaid and CHIP	9/1/2020	<a href="#">Scaling and Root Planing</a>
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	FMX, 6 point perio charting and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Scaling and Root Planing</a>
D4999	Unspecified Periodontal Procedure, By Report	Panoramic x-ray or full series, 6 point perio charting, narrative	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D5110	Complete Denture - Maxillary	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	<a href="#">Dentures</a>
D5120	Complete Denture - Mandibular	FMX or panoramic x-rays	Medicaid and CHIP	9/1/2020	<a href="#">Dentures</a>
D5130	Immediate Denture - Maxillary	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Dentures</a>
D5140	Immediate Denture - Mandibular	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Dentures</a>
D5211	Maxillary Partial Denture - Resin Base	Panoramic x-ray or full mouth series, missing teeth identified	Medicaid and CHIP	9/1/2020	<a href="#">Partial Dentures</a>
D5212	Mandibular Partial Denture - Resin Base	Panoramic x-ray or full mouth series, missing teeth identified	Medicaid and CHIP	9/1/2020	<a href="#">Partial Dentures</a>
D5213	maxillary partial denture - cast metal framework with resin denture bases	Panoramic x-ray or full mouth series, missing teeth identified	Medicaid and CHIP	9/1/2020	<a href="#">Partial Dentures</a>
D5214	mandibular partial denture - cast metal framework with resin denture bases	Panoramic x-ray or full mouth series, missing teeth identified	Medicaid and CHIP	9/1/2020	<a href="#">Partial Dentures</a>
D5810	Interim Complete Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Dentures</a>
D5811	Interim Complete Denture (Mandibular)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Dentures</a>
D5820	Interim Partial Denture (Maxillary)	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Interim Partial Dentures</a>



### 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	<a href="#">Interim Partial Dentures</a>
D5899	Unspecified Removable Prosthodontic Procedure, By Report	Pre op x-rays, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D5911	Facial Moulage (Sectional)	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5912	Facial Moulage (Complete)	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5913	Nasal Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5914	Auricular Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5915	Orbital Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5916	Ocular Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5919	Facial Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5922	Nasal Septal Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5923	Ocular Prosthesis, Interim	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5924	Cranial Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5925	Facial Augmentation Implant Prosthesis	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5926	Nasal Posthesis, Replacement	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5927	Auricular Prosthesis, Replacement	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5928	Orbital Prosthesis, Replacement	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5929	Facial Prosthesis, Replacement	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5931	Obturator Prosthesis, Surgical	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5932	Obturator Prosthesis, Definitive	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5933	Obturator Prosthesis, Modification	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5934	Mandibular Resection Prosthesis With Guide Flange	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5935	Mandibular Resection Prosthesis Without Guide Flange	Pre-op x-rays, pre-op photos, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>

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	<a href="#">Maxillofacial Prosthetics</a>
D5937	Trismus Appliance (Not For TMD Treatment)	Pre-op x-rays, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5951	Feeding Aid	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5952	Speech Aid Prosthesis, Pediatric	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5953	Speech Aid Prosthesis, Adult	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5954	Palatal Augmentation Prosthesis	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5955	Palatal Lift Prosthesis, Definitive	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5958	Palatal Lift Prosthesis, Interim	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5959	Palatal Lift Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5960	Speech Aid Prosthesis, Modification	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5982	Surgical Stent	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5983	Radiation Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5984	Radiation Shield	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5985	Radiation Cone Locator	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5986	Fluoride Gel Carrier	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5987	Commissure Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5988	Surgical Splint	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5992	Adjust Maxillofacial Prosthetic Appliance, By Report	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5993	Maintenance And Cleaning Of A Maxillofacial Prosthesis (Extra Or Intraoral)	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillofacial Prosthetics</a>
D5999	Unspecified Maxillofacial Prosthesis, By Report	Pre-op panoramic x-ray, photos, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D6210	Pontic - Cast High Noble Metal	Pre-op panoramic x-ray or full mouth series, missing teeth identified	Medicaid	9/1/2020	<a href="#">Pontics and Retainers (Bridges)</a>

Procedures Grid

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

### 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, missing teeth identified	Medicaid	9/1/2020	<a href="#">Pontics and Retainers (Bridges)</a>
D6790	Retainer Crown - Full Cast High Noble Metal	Pre-op panoramic x-ray or full series, missing teeth identified	Medicaid	9/1/2020	<a href="#">Pontics and Retainers (Bridges)</a>
D6791	Retainer Crown - Full Cast Predominantly Base Metal	Pre-op panoramic x-ray or full series, missing teeth identified	Medicaid	9/1/2020	<a href="#">Pontics and Retainers (Bridges)</a>
D6792	Retainer Crown - Full Cast Noble Metal	Pre-op panoramic x-ray or full series, missing teeth identified	Medicaid	9/1/2020	<a href="#">Pontics and Retainers (Bridges)</a>
D6920	Connector Bar	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Connector Bar</a>
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	Current pre-op x-rays of area, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D7230	Removal Of Impacted Tooth - Partially Bony	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid and CHIP	9/1/2020	<a href="#">Removal of Impacted Teeth</a>
D7240	Removal Of Impacted Tooth - Completely Bony	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid and CHIP	9/1/2020	<a href="#">Removal of Impacted Teeth</a>
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Removal of Impacted Teeth</a>
D7272	Tooth Transplantation (Includes Reimplantation)	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Tooth Transplantation</a>
D7290	Surgical Repositioning Of Teeth	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Surgical Repositioning of Teeth</a>
D7472	Removal Of Torus Palatinus	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Removal of Torus Palatinus</a>
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Partial Ostectomy</a>
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Maxillary Sinusotomy</a>
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	Pre-op panoramic x-ray, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Alveolus - Closed Reduction</a>
D7820	Closed Reduction Of Dislocation	Pre-op TMJ radiographs, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Alveolus - Closed Reduction</a>
D7880	Occlusal Orthotic Device, By Report	Pre-op TMJ radiographs, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Occlusal Orthotic Device, by report</a>
D7899	Unspecified Tmd Therapy, By Report	Pre-op TMJ radiographs, narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>
D7910	Suture Of Recent Small Wounds Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Suture Repairs</a>
D7911	Complicated Suture - Up To 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Suture Repairs</a>
D7912	Complicated Suture - Greater Than 5 Cm	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Suture Repairs</a>
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect	Pre-op x-rays and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Repair of Maxillofacial Soft and/or Hard Tissue Defect</a>

### 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	<a href="#">Unspecified Procedures, by Report</a>
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	Digital models or 3D diagnostic images, panoramic or full series x-rays, cephalometric film, facial photos, treatment plan with narrative of necessity	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Digital models or 3D diagnostic images, panoramic or full series x-rays, cephalometric film, facial photos, treatment plan with narrative of necessity	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	Digital models or 3D diagnostic images, panoramic or full series x-rays, cephalometric film, facial photos, treatment plan with narrative of necessity	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8210	Removable Appliance Therapy	Digital models or 3D diagnostic images, panoramic or full series x-rays, cephalometric film, facial photos, treatment plan with narrative of necessity	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8220	Fixed Appliance Therapy	Digital models or 3D diagnostic images, panoramic or full series x-rays, cephalometric film, facial photos, treatment plan with narrative of necessity	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8670	Periodic Orthodontic Treatment Visit	Number of additional visits needed, panoramic or full series x-rays, facial photos, treatment plan including narrative of why additional visits are needed	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	Post treatment panoramic or full series x-ray, photos, statement from provider that treatment is complete	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D8999	Unspecified Orthodontic Procedure, By Report	Completed orthodontic continuation of care form, reason member left provider, Tx status, prior approval, payment history, records	Medicaid and CHIP	9/1/2020	<a href="#">Orthodontic</a>
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	Medicaid	9/1/2020	<a href="#">General Anesthesia and IV Sedation</a>
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	<a href="#">General Anesthesia and IV Sedation</a>
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	Treatment plan, narrative, x-rays	Medicaid	9/1/2020	<a href="#">General Anesthesia and IV Sedation</a>
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent	Treatment plan, narrative, x-rays	Medicaid	9/1/2020	<a href="#">General Anesthesia and IV Sedation</a>
D9248	Non-Intravenous Conscious Sedation	Treatment plan, Narrative, x-rays	Medicaid	9/1/2020	<a href="#">Non IV Conscious Sedation</a>
D9610	Therapeutic Parenteral Drug, Single Administration	Description of medication	Medicaid	9/1/2020	<a href="#">Therapeutic Parenteral Drugs</a>
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	Description of medication	Medicaid	9/1/2020	<a href="#">Therapeutic Parenteral Drugs</a>

### Procedures Grid

Code	Code Description	Required Documents	Program(s)	Effective Date	Link to Approval Criteria
D9630	Other drugs and/or medicaments, by report	Narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Drugs or Medicaments Dispensed in the office for Home Use</a>
D9920	Behavior Management, By Report	Physician note stating disability, Services, supplies, staff, duration	Medicaid	9/1/2020	<a href="#">Behavior Management, by report</a>
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	Pre op x-rays, narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Treatment of Complications (Post Surgical)</a>
D9944	Occlusal Guard-hard appliance, full arch	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Occlusal Guard</a>
D9950	Occlusion Analysis - Mounted Case	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Occlusal Analysis - Mounted Case</a>
D9951	Occlusal Adjustment - Limited	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Occlusal Adjustment - Limited</a>
D9952	Occlusal Adjustment - Complete	FMX or panoramic and narrative of medical necessity	Medicaid	9/1/2020	<a href="#">Occlusal Adjustment - Complete</a>
D9999	Unspecified Adjunctive Procedure, By Report	Pre and post-op x-rays, Narrative of necessity/report of procedure	Medicaid	9/1/2020	<a href="#">Unspecified Procedures, by Report</a>

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)



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

[Return to Procedures Grid](#)

<b>Category</b>	<b>Approval Criteria</b>
<b>Apicoectomy / Periradicular Surgery</b>	<ul style="list-style-type: none"><li>• 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</li><li>• Perforation of the root in the apical one-third of the canal</li></ul>

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
<b>Connector Bar</b>	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

[Return to Procedures Grid](#)

Category	Approval Criteria
Crowns/Onlays	<ul style="list-style-type: none"> <li>• Criteria for cast crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul> <p><b>To meet criteria, a crown must:</b></p> <ul style="list-style-type: none"> <li>• Be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.</li> <li>• The patient must be free from active and advanced periodontal disease.</li> <li>• 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.</li> <li>• Cast crowns on permanent teeth are expected to last, at a minimum, five years.</li> </ul> <p><b>Criteria for Crowns following Root Canal Therapy:</b></p> <ul style="list-style-type: none"> <li>• Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved.</li> <li>• The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.</li> <li>• The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3</li> </ul> <p><b>Crowns will NOT meet criteria if:</b></p> <ul style="list-style-type: none"> <li>• Tooth has subosseous and/or furcation caries</li> <li>• Tooth has advanced periodontal disease</li> <li>• Tooth is a primary tooth (cast crowns not approved for primary teeth)</li> <li>• Crowns are being planned to alter vertical dimension</li> </ul>



Category	Approval Criteria
<b>Dentures</b>	<p><b>Must have all of the following:</b></p> <ul style="list-style-type: none"><li>• Remaining teeth do not have adequate bone support or are not restorable</li><li>• 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)</li></ul> <p><b>If a replacement full denture is requested within 5 years:</b></p> <ul style="list-style-type: none"><li>• Narrative from DDS must explain specific circumstances that necessitate replacement</li><li>• Supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.</li></ul>

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
<p><b>General Anesthesia and Intravenous (IV) Sedation</b> <i>(1 of 2)</i></p>	<ul style="list-style-type: none"> <li>• (For General Anesthesia / Deep IV Sedation only) a completed Criteria for Dental Therapy Under General Anesthesia form with a minimum score of 22. See Appendix I of the Dental Provider Manual for this scoring form which includes instructions on how to fill out and calculate.</li> <li>• Treatment plan</li> <li>• Narrative describing medical necessity for general anesthesia or IV sedation. For children 6 and under, a narrative unique to the client, detailing reasons for the proposed level of anesthesia (indicate procedure code D9222/D9223 or D9239/D9243). 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).</li> <li>• Complete anesthesia report including start and stop times is required with claim for review of payment</li> <li>• Diagnostic quality radiographs or photographs</li> <li>• When appropriate radiographs or photographs cannot be taken prior to general anesthesia or IV sedation, 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.</li> <li>• Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan, narrative of medical necessity, and complete anesthesia report with the claim for review for payment</li> </ul>

**General Anesthesia and  
Intravenous (IV) Sedation  
(2 of 2)**

**Utilizing a Dental Anesthesiologist:**

- 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:
  - A copy of the approved prior authorization letter of D9999
  - One unit of D9222 and appropriate units of D9223 (for general anesthesia), or one unit of D9239 and appropriate units of D9243 (for moderate IV sedation)
  - 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 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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)



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

[Return to Procedures Grid](#)

<b>Category</b>	<b>Approval Criteria</b>
<b>Inlays</b>	Documentation describes medical necessity

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)



Category	Approval Criteria
<b>Occlusal Adjustment – Limited</b>	Documentation states why an occlusal adjustment is necessary

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
<p><b>Partial Dentures</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.</li> <li>• Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.</li> <li>• As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.</li> </ul> <p><b>Authorizations for removable prosthesis will NOT meet criteria:</b></p> <ul style="list-style-type: none"> <li>• If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.</li> <li>• If there are in each quadrant at least three (3) periodontally sound posterior teeth in fairly good position and occlusion with opposing dentition.</li> <li>• If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.</li> <li>• If there are untreated cavities or active periodontal disease in the abutment teeth.</li> <li>• If abutment teeth are less than 50% supported in bone.</li> <li>• If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped)</li> </ul>

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)



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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
Root Canal Therapy	<p><b>Not all procedures require authorization.</b></p> <p>Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.</p>

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)



Category	Approval Criteria
<b>Surgical Repositioning of Teeth</b>	<ul style="list-style-type: none"><li>• The treatment of displacement injuries to permanent teeth</li><li>• Extrusion of teeth with crown/root fractures to prepare for restoration of permanent teeth</li></ul>

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
<b>Tissue Grafts</b>	<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"><li>• Unresolved sensitivity in areas of Recession</li><li>• Progressive recession or chronic inflammation</li><li>• Teeth with subgingival restorations where there is little or no attached gingiva to improve plaque control</li></ul>

[Return to Procedures Grid](#)

Category	Approval Criteria
<b>Tooth Transplantation</b>	Subluxation injuries to permanent teeth

[Return to Procedures Grid](#)

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

[Return to Procedures Grid](#)

Category	Approval Criteria
<b>Unspecified Procedures, by Report</b>	<ul style="list-style-type: none"><li>• Procedure cannot be adequately described by an existing code</li><li>• Documentation supports medical necessity</li></ul>

[Return to Procedures Grid](#)

## Comprehensive Medically Necessary Orthodontic Services

[Return to Procedures Grid](#)

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 (D8210/D8220)** orthodontic services:

- 2012 or newer ADA approved claim form with service codes noted
- Radiographs (x-rays)
- Photographs
- Treatment plan
- Narrative of Medical Necessity

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

- 2012 or newer ADA approved 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:

<b>Provider Type</b>	<b>Level of Orthodontic Service That Can Be Provided</b>	<b>Qualifications</b>
Provider Type 90	Level I or II	<ul style="list-style-type: none"> <li>• Completion of pediatric dental residency; or</li> <li>• A minimum of 200 hours of continuing dental education in orthodontics.</li> </ul>
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:**

- Completion of Level I orthodontic services does not disqualify future Level II, III or IV orthodontic services.
- 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.

CDT Codes	Provider Type	Age Group	Treatment Length	Exceptions to Expected Treatment Time
<b>D8210</b> Removable Appliance Therapy  <b>D8220</b> Fixed Appliance Therapy	Type 48 Type 90	3-13	Up to 10 monthly visits and are expected to be completed within 12 months unless an exception is granted.	May allow for additional treatment months for one of the following circumstances: <ul style="list-style-type: none"> <li>• The client is the child of a migrant farm worker.</li> <li>• The client’s orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).</li> </ul>

**Criteria**

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.)

*\*\*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.*

- 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:**

- 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
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<b>D8070</b> Comprehensive orthodontic treatment of the transitional dentition	Type 48 Type 90	3-13	Up to 22 monthly visits and are expected to be completed within 24 months unless an exception is granted.	May allow for additional treatment months for one of the following circumstances: <ul style="list-style-type: none"> <li>• The client is the child of a migrant farm worker.</li> <li>• The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).</li> </ul>
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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 approved claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the 2012 or newer ADA approved 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.

<b>CDT Codes</b>	<b>Provider Type</b>	<b>Age Group</b>	<b>Treatment Length</b>	<b>Exceptions to Expected Treatment Time</b>
<b>D8080</b> Comprehensive orthodontic treatment of the adolescent dentition	Type 48	13-20	Up to 22 monthly visits and are expected to be completed within 24 months unless an exception is granted.	May allow for additional treatment months for one of the following circumstances: <ul style="list-style-type: none"> <li>• The client is the child of a migrant farm worker.</li> <li>• The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).</li> </ul>

**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 lingually 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 approved claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the 2012 or newer ADA approved 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
<b>D8080</b> Comprehensive orthodontic treatment of the adult dentition	Type 48	13-20	Up to 22 monthly visits and are expected to be completed within 24 months unless an exception is granted.	May allow for additional treatment months for one of the following circumstances: <ul style="list-style-type: none"><li>• The client is the child of a migrant farm worker.</li><li>• The client's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care).</li></ul>

### 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 approved claim form with procedure code D8670 for additional monthly orthodontic visits, if needed.
- On the 2012 or newer ADA approved 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, 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 approved 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 United Healthcare Dental)
- 2) Other DMO to United Healthcare Dental
- 3) Private/Commercial Arrangement to United Healthcare Dental

### **1) Provider to Provider (within United Healthcare Dental):**

This section is for situations in which the Orthodontic care of a Medicaid eligible member is transferred from one United Healthcare Dental provider

to another United Healthcare 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
  - 2012 or newer ADA approved 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 United Healthcare 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 United Healthcare 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 J of the Dental Provider Manual for this form.
  - 2012 or newer ADA approved 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 United Healthcare 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 United Healthcare 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 J of the Dental Provider Manual for this form.
  - 2012 or newer ADA approved 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 approved 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](#)