Dental Provider Manual

UnitedHealthcare

Contact Provider Servicing at 1-800-527-1764 or visit us online at uhc.com/dentalTX

January 2025

TEXAS Health and Human Services

CHIP Children's Medicaid
We've got your kids covered.

United Healthcare Dental

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Section 1: Introduction to UnitedHealthcare

Quick reference phone list and contact list

Provider servicing for Medicaid and CHIP
UnitedHealthcare Dental Texas
6200 Northwest Parkway
San Antonio, TX 78249
Toll-free: **1-800-527-1764**
Web: **uhc.com/dentalTX**

Claims Submissions
PO Box 1471
Milwaukee, WI 53201

Prior Authorizations
PO Box 1511
Milwaukee, WI 53201
Fax: 1-866-887-4649

Provider Claims Appeals
PO Box 1427
Milwaukee, WI 53201

Corrected Claims
PO Box 481
Milwaukee, WI 53201

Member Appeals & Complaints
PO Box 1427
Milwaukee, WI 53201

Continuity of Care
PO Box 1511
Milwaukee, WI 53201

Credentialing Department
2300 Clayton Road
Suite 1000
Concord, CA 94520

Fraud reporting
Toll-free: **1-800-436-6184**
Web: **oig.hhs.texas.gov/**

Electronic clearing house submissions
Payer ID GP 133

Eligibility and verification
TexMedConnect: **tmhp.com**
UnitedHealthcare Dental: **uhc.com/dentalTX**
Provider Services: **1-800-527-1764**

Member services
Toll-free: **1-877-901-7321**

Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations, H320
PO Box 85200
Austin, TX 78708-5200
Email: **HPM_complaints@hhsc.state.tx.us**

Written complaints
Texas Department of Insurance
Consumer Protection (111-1A)
PO Box 149091
Austin, TX 78714-9091
Fax: 512-490-1007
Web: **tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**

In person complaints
Texas Department of Insurance
Consumer Protection (111-1A)
333 Guadalupe St
Austin, TX 78701

Program objectives

UnitedHealthcare's primary objective for the Texas Medicaid and CHIP Dental Services programs is to create a comprehensive and robust dental care program offering quality dental services to eligible Texas residents.

Role of First Dental Home Initiative for Medicaid members

Medicaid members from six **(6)** through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every sixty (60) days if medically necessary.

Providers must be certified to be a Texas Health Steps Dentist. To become a First Dental Home Initiative Provider (Texas Health Steps), the dentist must complete either the online module or in-person training and submit registration information.

The Texas Health Steps online First Dental Home Module is available at **txhealthsteps.com**. Go to "Start a free course now" and choose "First Dental Home" from the drop down menu.

- Complete this First Dental Home training and download the Continuing Education (CE) certificate.
- Submit a First Dental Home Certification Application, Form 1091 (fillable PDF) to be certified as a First Dental Home provider.

The completed application form and CE certificate should be emailed to THStepsOEFV.FDH@hhsc.state.tx.us. Alternatively, the completed form and CE certificate can be faxed to 512-483-3979.

For additional information regarding the Dental Home program, please connect to the UnitedHealthcare Provider Web Portal **uhc.com/dentalTX** under Related Documents – Dental Home.

Only certified, participating First Dental Home Providers may bill a D0145 for a first dental home oral evaluation. The member is only allowed one of D0120 or D0150 in a six month period. D1330, D1206, and D1208 will be denied when billed on the same date of service as D0145.

Role of Main Dental Home

As of September 1, 2020 UnitedHealthcare implemented a Dental Home program in Texas for Medicaid and CHIP members.

The Main Dental Home is a place where a child's oral health care is delivered in a complete, accessible and family-centered manner by a licensed dentist. This concept has been successfully employed by primary care physicians in developing a "Medical Home" for their members, and the "Dental Home" concept mirrors the "Medical Home" for primary dental and oral health care. If expanded or specialty dental services are required, the dentist is not expected to deliver the services, but to coordinate the referral and to monitor the outcome.

Provider support is essential to effectively employ the Dental Home program for Medicaid and CHIP Dental Program members. With assistance and support from dental professionals, a system for improving the overall health of children in the Medicaid and CHIP Programs can be achieved.

Main Dental Home assignment must be verified on the UnitedHealthcare Provider Web Portal (located in the "Providers Only" section of UnitedHealthcare website at **uhc.com/dentalTX**). You may also contact UnitedHealthcare's Customer Service Department at **1-800-527-1764** to verify Main Dental Home assignment.

Useful websites

Below are a list of websites you may find helpful as a UnitedHealthcare Dental provider serving Texas Medicaid and CHIP program members:

- **Texas Medicaid Healthcare and Partnership**
- **Texas Health and Human Services Commission**
- **Texas Health Steps Provider Information**
- **The National Guideline Clearinghouse**
- **The American Dental Association**
- **The American Academy of Pediatric Dentistry**
- **The American Academy of Periodontology**
- **Texas Medicaid or CHIP Vendor Drug Program**

Provider Online Academy

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

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy visit **uhc.com/dentalTX** and go to Providers > Provider Training.

Section 2: Quality management

2.1 Texas Health Steps dental services

Texas Health Steps is the Texas version of the Medicaid program known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Texas Health Steps dental services are mandated by Medicaid to provide for the early detection and treatment of dental health problems for Medicaid-eligible clients who are from birth through 20 years of age. Texas Health Steps dental service standards are designed to meet federal regulations and incorporate the recommendations of representatives of national and state dental professional organizations. Texas Health Steps' designated staff (Texas Department of State Health Services [DSHS], Department of Assistive and Disability Services [DADS], or contractor), through outreach and informing, encourage eligible children to use Texas Health Steps dental checkups and services when children first become eligible for Medicaid, and each time children are periodically due for their next dental checkup.

Please refer to the Texas Medicaid Provider Procedures Manual for more information regarding Texas Health Steps dental services: Go to **tmhp.com**. Click on "Medicaid Provider Manual".

2.2 Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps dental visit can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps dental checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

2.3 Quality

We adhere to the Triple Aim for the delivery of quality services for our membership:

- Improved individual experience
- Improved population oral health
- Bending the cost curve

We do this by promoting:

- Improved efficient and timely access to Dental Providers
- Addressing open care opportunities

Clinical practice guidelines

We review and update the appropriateness of our adopted clinical practice guidelines in consideration of the needs of our members. We select the guidelines that most align with our expectations of care for our members. We offer dental services in the following areas for our members:

- Preventive
- Restorative

- Endodontics
- Sealants
- Orthodontics
- Periodontics
- Prosthetics

These guidelines are intended to assist you in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment about care of a particular member rests with you as the health care provider in light of all the circumstances presented by a particular member.

Your role in quality

UnitedHealthcare Dental network providers are asked to participate in the Quality Improvement Program through his or her contractual agreement with UnitedHealthcare Dental. You may be asked to serve on any one of the committees that are part of the Quality Improvement Program or contribute to the development of clinical practice guidelines or member education programs, for example. Participation on a committee is voluntary and encouraged. You can also help us identify any issues that may directly or indirectly impact member care by reporting them. This can be submitted to UnitedHealthcare Dental via fax, email, or alternate means. The UnitedHealthcare Dental Director might contact your office regarding your incident report.

Quality improvement programs (Focus Studies)

UnitedHealthcare Dental monitors and evaluates the quality and appropriateness of care and service delivery (or the failure to provide care or deliver services) to members and providers through a variety of methods to include Performance Improvement Projects (PIPs), dental record audits, performance measures, surveys, and related activities. As a provider for Medicaid, UnitedHealthcare Dental will conduct no less than two (2) state-approved Performance Improvement Projects (PIPs) per year. The PIPs will focus on clinical and non-clinical areas and may require additional involvement on interventions to improvement selected performance measures.

Key clinical and service indicators

UnitedHealthcare Dental's Quality Improvement Program objectives are to perform a quality review of key clinical and service indicators to assess and improve member and provider satisfaction by analyzing data. These clinical and service indicators include but are not limited to reviews of:

- Member and provider complaints for care or service
- Any event involving member care that warrants further investigation for quality of care concerns
- National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®)
- Application of clinical guidelines
- Application of dental record documentation, continuity and coordination of care standards
- Dental outcome intervention studies or activities
- Member claims and encounters

- Member pre-authorization and referral requests
- Other utilization management reporting requirements.

The dental records of UnitedHealthcare Dental's members must be made available to UnitedHealthcare Dental for support of any of the above activities upon request from our representatives.

2.4 Quality Improvement Program (QIP) description

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

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

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

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

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

A complete copy of our QIP policy and procedure is available upon request by contacting Provider Services at **1-800-527-1764**.

2.5 Credentialing

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

Depending on the state in which you practice, UnitedHealthcare will review all current information relative to your license, sanctions, malpractice insurance coverage, etc. UnitedHealthcare will request a written

explanation regarding any adverse incident and its resolution and will request corrective action be taken to prevent future occurrences.

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

UnitedHealthcare contracts with the Texas Association of Health Care Plans (TAHP's) contracted Credentialing Verification Organization (CVO), as part of its credentialing and recredentialing process. The CVO is responsible for receiving completed applications, attestations and primary source verification documents. Please respond to calls or inquiries from this organization or our offices to make sure that the credentialing and.or recredentialing process is completed as quickly as possible.

The Dental Director and the Credentialing Committee review the information from the TAHP CVO in detail based on approved credentialing criteria. UnitedHealthcare will request a resolution of any discrepancy in credentialing forms submitted. Practitioners have the right to review and correct erroneous information and to be informed of the status of their application. Credentialing criteria are reviewed by advisory committees, which include input from practicing network providers to make sure that criteria are within generally accepted guidelines. You have the right to appeal any decision regarding your participation made by UnitedHealthcare based on information received during the credentialing or recredentialing process. To initiate an appeal of a credentialing or recredentialing decision, follow the instructions provided in the determination letter received from the Credentialing Department. Appeals will be accepted and reviewed for states with appeal rights.

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

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

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

Recredentialing requests are sent 6 months prior to the recredentialing due date. The CVO will make 3 attempts to procure a completed recredentialing application from the provider, and if they are unsuccessful, UnitedHealthcare will also make an additional 3 attempts, at which time if there is no response, a termination letter will be sent to the provider as per their provider agreement.

Initial credentialing

- Completed application
- Signed and dated Attestation
- Current copy of W-9
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate

- General Anesthesia training certificate/diploma, Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits – limits $1/3m
- Explanation of any adverse information, if applicable
- Five years' work in month/date format with no gaps of 6 months or more; if there are, an explanation of the gap should be submitted
- Education (which is incorporated in the application)
- Current Medicaid ID (as required by state)

Recredentialing

- Completed Recredentialing application
- Signed and dated Attestation
- Current copy of W-9
- Current copy of their state license
- Current copy of their Drug Enforcement Agency (DEA) certificate
- General Anesthesia training certificate/diploma, /Signed and dated Sedation and/or General Anesthesia Attestation, if applicable
- Malpractice face sheet which shows their name on the certificate, expiration dates and limits– limits $1/3m
- Explanation of any adverse information, if applicable
- Current Medicaid ID (as required by state)

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

We also accept the Council for Affordable Quality Healthcare (CAQH) process for credentialing/recredentialing application submissions, unless state law requires differently.

UnitedHealthcare is committed to supporting the American Dental Association (ADA) and CAQH ProView in streamlining the credentialing process, making it easier for you to complete one application for multiple insurance companies and maintain your credentials in a secure and central location at no cost to you.

If you are new to CAQH ProView, visit ADA.org/godigital to get started.

If you are already using CAQH ProView, we are able to accept your CAQH ID number provided that your profile data, credentialing documents and attestation show Complete and Current.

Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information.

Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

Substitute Dentist Process

Substitute Dentist Process in accordance with Texas Administrative Code (TAC) rules §354.1121 and §354.1221, related to Medicaid billing for the services of substitute dentists, dentists who are temporarily absent from their practice are allowed to submit claims for reimbursement of Medicaid services rendered to their Medicaid and CHIP clients by a substitute dentist.

Dentists who take a leave of absence for no more than **90 days** may bill for the services of a substitute dentist who renders services on an occasional basis when the primary dentist is unavailable to provide services. Services must be rendered at the practice location of the dentist who has taken the leave of absence. Locum tenens arrangement is not allowed for dentists.

The primary dentist (who is the billing agent dentist) may submit claims for the services of a substitute dentist for longer than 90 consecutive days if the dentist has been called or ordered to active duty as a member of a reserve component of the Armed Forces.

The billing agent dentist may recover no more than the actual administrative cost of submitting the claim on behalf of the substitute dentist. This cost is not reimbursable by UnitedHealthcare Children's Dental Plan.

The substitute dentist needs an active license in the state of Texas, enrolled through the state in Texas Medicaid, complete credentialing with UnitedHealthcare Childrens Medicaid Plan, and not on the Texas Medicaid provider exclusion list.

Billing agent dentist information must be documented on the claim, including name, address, and National Provider Identifier (NPI) entered in Blocks 53, 54, and 56 of the 2012 or newer ADA approved claim form.

The substitute dentist's NPI number must be documented in Block 35 of the 2012 or newer ADA approved claim form.

2.6 Site visits

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

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

2.7 Preventive health guideline

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

UnitedHealthcare's National Clinical Policy and Technology Committee reviews current professional guidelines and processes while consulting the latest literature, including, but not limited to, current ADA Current Dental Terminology (CDT), and specialty guidelines as suggested by organizations such as the American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association

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

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

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

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

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

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

Additional areas for prevention evaluation and intervention – Includes malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue

thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition. UnitedHealthcare may perform clinical studies and conduct interventions in the following target areas:

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

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

Sealants – When submitting claim forms for sealant procedures (D1351), the tooth surface must be identified along with the number on the 2012 or newer ADA approved claim form.

Section 3: Provider responsibilities

3.1 Required trainings

To remain compliant with the Texas Department of Medicaid, participating providers with the UnitedHealthcare Texas Medicaid and CHIP Children's Dental plans are required to complete trainings within 30 days of completion of credentialing.

To complete the trainings:

- Go to **uhc.com/dentalTX** > Providers > Provider Training > Provider Online Academy
- Choose Texas Medicaid and CHIP
- Choose course identified as "Required training*"
- Click on Get Started and complete the Attestation
- After submitting the completed Attestation, click the forward arrow in the bottom right corner to advance to the next page

Follow the steps above to complete all required trainings.

3.2 General responsibilities

Recall system

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

Appointment scheduling standards

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

- **Urgent care appointments**. . . . . .within 24 hours
- **Therapeutic and diagnostic care appointments**. . . . . .within 14 calendar days
- **Preventive care appointments** . . . . . .within 14 calendar days

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

- A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.

- Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

Dental offices that operate by "walk-in" or "first come, first served" appointments must meet the above state mandated or plan requirements, and are monitored for access and waiting times, where applicable.

Main Dental Home responsibilities

Texas defines a Main Dental Home as the dental provider who supports an ongoing relationship with the client that includes all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a client's Main Dental Home begins no later than 6 months of age and includes referrals to dental specialists when appropriate.

UnitedHealthcare Dental must develop a network of Main Dental Home Providers, consisting of Federally Qualified Health Centers and individuals who are general dentists and pediatric dentists, who will provide preventative care and refer members to specialty care as needed.

In accordance with standards of practice and policy guidelines set forth by the American Academy of Pediatric Dentistry, Main Dental Home Providers must perform a caries risk assessment as part of the comprehensive oral examination. Main Dental Home Providers must bill one of the following caries risk assessment codes: D0601, D0602, or D0603 with every comprehensive oral examination (D0150), oral examination for a patient under 3 years of age (D0145), or periodic dental evaluation (D0120). These risk codes should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150, D0145 or D0120 billing code and do not have a separate rate attached to them. The TMHP will reject any D0150, D0145 or D0120 claim submitted without a caries risk assessment code. Providers will be given the standard 120 day appeal period for the denied claim to submit proof of performing a caries risk assessment.

Each UnitedHealthcare Dental- Texas member will be assigned to a Main Dentist. The Main dentist is responsible for coordination of all oral healthcare needs for the member. The Main Dentist will refer the member to a specialist or other dentist when necessary. With the exception of the codes below, preventative and diagnostic services are only reimbursable to the Main Dentist on record.

D0140	Limited oral evaluation - problem focused
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0180	Comprehensive periodontal evaluation - new or established patient
D0220	intraoral-periapical first radiographic images
D0230	intraoral-periapical each additional radiographic images
D0270	bitewing- single radiographic image
D0272	bitewing- two radiographic image
D0273	bitewing- three radiographic image
D0274	bitewing- four radiographic image
D0330	panoramic radiographic image
D0460	pulp vitality tests

Therapeutic services are reimbursable to referred specialists or dentists. However, only the preventive and diagnostic services above will be reimbursed to the referred specialist or dentist.

First Dental Home Initiative

In addition to establishing a Network of Main Dental Home Providers, UnitedHealthcare Dental must implement a "First Dental Home Initiative" for Medicaid members. This initiative will enhance dental providers' ability to assist members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as 6 months of age and must include the following:

- Comprehensive oral examination;
- Oral hygiene instruction with primary caregiver;
- Dental prophylaxis, if appropriate;
- Topical fluoride varnish application when teeth are present;
- Caries-risk assessment; and
- Dental anticipatory guidance as defined in the Texas Medicaid Provider Procedures Manual (TMPPM), Volume 2, Children's Services Handbook and requires documentation of the specific information conveyed to the parent/guardian for at least 3 of the 8 anticipatory guidance topics found in the handbook.

Medicaid members from 6 through 35 months of age may be seen for dental checkups by a certified First Dental Home Initiative provider as frequently as every 3 months if Medically Necessary.

Updates to contact information

All network providers must inform UnitedHealthcare and HHSC's administrative services contractor of any changes to the provider's address, telephone number, group affiliations, TIN changes, etc.

This supports accurate claims processing as well as helps to make sure that member directories are up to date.

Changes should be submitted to:

UnitedHealthcare
Government Programs Provider Relations
2300 Clayton Road, Suite 1000
Concord, CA 94520

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

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

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

If you have any questions, don't hesitate to contact Provider Services for guidance.

Provider preventable conditions

"Provider-preventable condition" has the same meaning as "provider-preventable condition" provided in 42 C.F.R. 447.26 and includes the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. For purposes of this term, most dental procedures, other than preventative procedures, will be considered "invasive."

UnitedHealthcare Dental is not permitted to pay for provider-preventable conditions. Providers are required to report to UnitedHealthcare Dental the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient. Providers may self-report these events by submitting them to txacmail@uhc.com.

Provider termination

Upon notification of termination the Provider shall continue to provide Covered Services to members for a period not to exceed ninety (90) days during which time payment will be made pursuant to the United Healthcare contract.

Providers who are found to be in breach of their Provider Agreement or have demonstrated quality of care issues are subject to review, corrective action, and/or termination in accordance with approved criteria.

Breach of Provider Agreement

A provider may be found in violation of the Provider Agreement for, but not limited to, the following reasons:

1. Failure to comply with UnitedHealthcare Dental credentialing or recredentialing procedures
2. Violations of UnitedHealthcare Dental's Policies and Procedures or the provisions of the Provider Manual
3. Insufficient malpractice coverage with refusal to obtain such
4. Information supplied (such as licensure, dental school and training is not supported by primary source verification
5. Failure to report prior, present or pending disciplinary action by any government agency
6. Any federal or state sanction that precludes participation in Government Programs
7. Failure to report fraud or malpractice claims

Please refer to your Dental Provider agreement (6.1) for more information regarding termination.

Referral to specialists process

Referral process

Main Dental Home Providers must assess the dental needs of members for referral to specialty care providers and provide referrals as needed. Main Dental Home Providers must coordinate member's care with specialty care providers after referral.

UnitedHealthcare Dental does not require a provider to submit a formal referral form to the plan when referring a member to another provider or specialist for treatment. We do offer a Specialty Communication Tool as a courtesy option.

This communication form is simply a tool for a provider to utilize to send communication to another provider or specialist concerning the care of a member, if the provider chooses to utilize this tool (not required, and not to be submitted to UnitedHealthcare Dental). The referring dentist should verify that the provider or specialist that the member is being referred to is within the member's network. See Appendix H for this Specialty Communication Tool.

Routine preventive care referrals must be provided within 30 days of request.

Continuity of care

The Main Dentist program ensures ongoing dental care management for our members. Members should be provided with specialist referrals by their Main Dentists. Participating dentists must provide members with their dental records, upon written request, member or their representatives.

Copies of patient's records should also be made readily available to any other dentist treating such members. If a newly-enrolled member has an unexpired prior authorization from a non-participating provider, UnitedHealthcare Dental will continue to authorize the services until the shortest of: 90 calendar days after the member is enrolled with UnitedHealthcare Dental; until the end of the authorization period; or Until the member's records and care has been transferred to an in-network provider.

Active treatment

For newly-enrolled members with unexpired prior authorizations approved by a previous Dental carrier, UnitedHealthcare Dental will honor the approved, unexpired, prior authorization up to the quantity and validity as approved by the previous carrier.

- Participating providers: Submit unexpired prior authorization approvals using one of the options below
  - Mail:
    UnitedHealthcare Dental- Texas
    Attn: Prior Authorization Department
    PO Box 1511
    Milwaukee, WI 53201
  - Fax: 1-866-887-4649
  - Provider Web Portal: **uhc.com/dentalTX**
  - Clearing House: Payer ID GP133
- Out-of-Network providers: Please contact UnitedHealthcare Dental provider services for assistance at **1-800-527-1764**

Continuity of care for active orthodontic treatment

The following information is required for review and consideration of payment for continuation of care for Orthodontic treatment:

- Request of Continuity of care using a completed 2012 or newer ADA approved claim form using D8999 for the request
- A copy of the member's prior approval including the total approved case fee and payment structure
- Detailed payment history

Dental records standards

All dental providers must ensure that dental records are maintained for each enrolled member. The dental record shall include the quality, quantity, appropriateness, and timeliness of services performed as follows.

The provider is responsible for maintaining dental records for each member according to the following dental record standards, as appropriate:

- Record is legible and maintained in detail (i.e., staff can read the record).
- All pages in record include member name and/or member ID.
- Record contains biographical/personal data including address, phone number, legal guardianship, marital status, date of birth, and gender.
- Record contains documentation of the member's race and primary language spoken.
- All necessary forms and/or consent documentation is completed, signed, and stored within the record, including procedure/treatment consent, incident report forms, pre-authorization forms, member outreach forms, non-covered services consent, preoperative checklist for administration as required in the 22 TAC 110.13 (nitrous oxide, and levels 1, 2, 3, and 4 sedation), and criteria for dental therapy under general anesthesia forms.
- Record contains current medical and dental history including illness, medical conditions, psychological health, and substance abuse documentation.
- Record contains complete documentation of allergies (e.g., medications, latex) and adverse reactions. If no allergies exist, NKA or NKDA is clearly noted.
- Record contains documentation of clinical examination including head, neck, oral cancer screening, and TMJ examination.
- Record contains history of all identified nicotine, alcohol use, or substance abuse if the member is 12 years of age and older.
- Record contains documentation of medication list and or prescribed therapies, including medication strength, directions, dose, amount, and number of refills given.
- All entries indicate the chief complaint or purpose of the visit, objective findings, diagnosis, and proposed treatment.
- All entries are dated and signed by the provider rendering services, including credentials (e.g., DDS, DMD, RDH).
- All entries contain appropriate progress notes, lab results, and imaging studies/reports, including documentation of imaging reports reviewed and initialed by the provider.
- All entries contain documentation of dental examination.
- All entries contain documentation that studies are appropriately ordered and outcomes are fully documented as indicated.
- All entries contain documentation of working diagnosis consistent with clinical findings and treatment plan.
- All entries contain documentation of written denials for service and the reason for the denial, as appropriate.
- All entries contain documentation for return visit(s) following the AAPD Periodicity Schedule and evidence of appropriateness and timeliness of care.

- Record contains documentation of any emergency services and care and any medically necessary follow-up indicated.
- Record contains documentation that unresolved problems from previous visits are resolved (e.g., referral forms and diagnostic tests).
- Record contains documentation of member comments or statements of dissatisfaction.

Record content and format

The member dental record must include the following components:

- General patient information, medical history, and periodic updates
- Permanent display of all medical alerts and allergies, along with names and phone numbers of related healthcare professionals
- Documentation of all communication with related healthcare professionals along with any comments or recommendations resulting from the communication
- Documentation of dental history and any existing restorations
- Description and results of clinical examination including head, neck, oral cancer screening, and TMJ examination
- Radiographs
- Diagnosis
- Treatment plan(s) and where applicable, alternate treatment plan(s)
- Dated and signed consent form
- Referral information, along with reason for referral
- Progress notes
- Anesthesia/analgesia notations (including requirements of the Texas Administrative Code)
- Termination, completion, or discharge notes
- Documentation of patient comments/dissatisfaction

Access to dental records

As a participating provider, you are required to ensure that an accurate and complete member dental record is established and maintained and allow authorized personnel, its designated representatives, review organizations, and government agencies on-site access to such records during regular business hours. If requested, you must provide with the following records according to timelines, definitions, formats, and instructions specified.

- All information required under the Provider Agreement, including but not limited to records, reports, and other information related to the performance of your obligations under the agreement

In addition, you are required to provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider Agreement and any records, books, documents, and papers that are related to the agreement and/or your performance of responsibilities under the agreement:

- UnitedHealthcare Dental authorized personnel
- State of Texas and/or federal regulatory agencies
- HHSC authorized personnel

You must also provide access to the location or facility where such records, books, documents, and papers are maintained and you must provide reasonable comfort, furnishings, equipment, and other conveniences necessary to fulfill any of the following described purposes:

- Audits and investigations
- Contract administration
- The making of copies, excerpts, or transcripts
- Any other purpose UnitedHealthcare Dental deems necessary for contract enforcement or to perform our regulatory functions

Transfer of dental records

Please request that the member authorize the release of his or her dental records to you from practitioners who treated the member prior to visiting your office.

There will be no charge for the copying of charts and/or radiographs subject to Texas' state requirements and UnitedHealthcare Dental policies. All copies must be provided to the member within five **(5)** days of the request per your Provider Agreement.

The Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI)

The Plan adheres to all required HIPAA requirements in the use and disclosure of member's protected health information. The Plan maintains HIPAA Policies and Procedures and performs the required training for all employees.

As a healthcare provider, your office is a covered entity as defined under HIPAA. Your office is required to comply with all aspects of the HIPAA regulations and rules that are in effect or that will go into effect as indicated in the final publications of the various HIPAA rules.

Medical records reflect all aspects of patient care, including ancillary services. Members have a right to privacy and confidentiality of all records and information about their health care. If a member requests specific medical record information, we refer the member to you as the primary holder of the medical records. Applicable regulatory requirements need to be observed, including but not limited to those related to privacy and confidentiality of information. All contracted providers agree to comply in all relevant respects with the applicable HIPAA requirements and associated regulations, including applicable state laws and regulations. As covered entities, providers are subject to their own Federal obligations under HIPAA and other state and federal privacy laws and regulations.

Access to second opinion

All aspects of a member's treatment plan should be discussed by the provider prior to beginning treatment to ensure all of the member's concerns and questions have been answered. If a second opinion is requested by the member, the provider informs the member that UnitedHealthcare Dental will need to authorize the second opinion visit to a provider in the UnitedHealthcare Dental network. UnitedHealthcare Dental will also cover the cost of seeing a non-network provider if an in-network option is not available. Upon request, the referring provider is responsible for providing copies of the member's dental record, radiographs, and any other information to the provider performing the second opinion.

Out of network referrals

Out of network referrals will be considered on a single case arrangement basis. Treatment will only be covered if the services being requested meet medical necessity and are not available through a participating network provider. Reimbursement for Medicaid Out-of-network providers will be based on an agreed upon amount between UnitedHealthcare Dental and the provider.

Please contact provider services at **1-800-527-1764** for assistance with locating an in-network provider.

Informed consent for utilization of papoose boards

The need to diagnose, treat, and protect the safety of the patient, practitioner, staff, and parent should be considered prior to the use of protective stabilization. The decision to use protective stabilization must take into consideration:

- Alternative behavior guidance modalities
- Dental needs of the patient
- The effect on the quality of dental care
- The patient's emotional development
- The patient's medical and physical considerations

Contraindications:

- Patients who cannot be immobilized safely due to associated medical, psychological, or physical conditions
- Patients with a history of physical or psychological trauma due to immobilization (unless no other alternatives are available)

A parent has the right to terminate restraint at any time. If termination is requested, the practitioner should complete the necessary steps to bring the procedure to a safe conclusion before ending the appointment. Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child's positive attitude toward oral/dental health

Protective stabilization, with or without a restrictive device, led by the dentist and performed by the dental team requires informed consent from a parent. Informed consent must be obtained and documented in the patient's record prior to use of protective stabilization. Furthermore, when appropriate, an explanation to the patient regarding the need for restraint, with an opportunity for the patient to respond, should occur.

Written and informed consent from a legal guardian must be obtained and documented in the patient record prior to protective stabilization. The patient's record must include:

- Informed consent (should occur on a day separate from the treatment, if possible)
- Type of stabilization used
- Indication for stabilization
- Behavior during stabilization
- Any untoward outcomes, i.e. skin markings

- The duration of the application

Routine use of restraining devices to stabilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.

Dentists must not restrain children without formal training in protective stabilization.

General dentists should consider referring to dental specialists those members who they consider to be candidates for protective stabilization.

Dental auxiliaries must not use restraining devices to immobilize children.

*American Academy of Pediatric Dentistry/Oral Health Policies and Recommendations (The Reference Manual of Pediatric Dentistry)/Behavior Guidance for the Pediatric Dental Patient 2019 - 2020/P. 266 - 279

3.3 Routine, therapeutic/diagnostic, and urgent care dental services

Definitions

- Routine – Standard dental services which include preventive and diagnostic visits.
- Therapeutic – Services such as crowns, fillings, root canals and extractions.
- Urgent/Emergency – Typically procedures necessary to relieve pain, control bleeding, and control acute infection. Additionally, treatment for injuries to teeth and supporting structures. Lastly, operative procedures required to prevent imminent tooth loss.

Requirements for scheduling of appointments

UnitedHealthcare Dentists are expected to meet minimum standards with regards to appointment availability. Dental appointments are to be made during normal business hours and within a reasonable time from the date of the member's request.

Appointment standards are:

- **Urgent care appointments**. . . . . .within 24 hours
- **Therapeutic and diagnostic care appointments**. . . . . .within 14 calendar days
- **Preventive care appointments** . . . . . .within 14 calendar days

3.4 Coordination of non-capitated services

Medicaid services not covered by UnitedHealthcare Dental

The following Texas Medicaid programs and services are paid for by HHSC's claims administrator instead of UnitedHealthcare Dental. Medicaid members can get these services from Texas Medicaid providers.

1. Early Childhood Intervention (ECI) case management/service coordination;
2. DSHS case management for Children and Pregnant Women;
3. Texas School Health and Related Services (SHARS); and

Either the member's medical plan or HHSC's claims administrator will pay for treatment and devices for craniofacial anomalies, and for Emergency Dental Services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;

- treatment of oral abscess of tooth or gum origin; and
- treatment of craniofacial anomalies.

Nonemergency medical transportation (NEMT) services may be used to access Covered Dental Services provided by the Dental Contractor. NEMT Services are coordinated by the member's Medicaid medical plan.

CHIP services not covered by UnitedHealthcare Dental

Some services are paid by CHIP medical plans instead of UnitedHealthcare Dental. These services include treatment and devices for craniofacial anomalies, and emergency dental services that a member gets in a hospital or ambulatory surgical center. This includes hospital, physician, and related medical services (e.g., anesthesia and drugs) for:

- treatment of a dislocated jaw, traumatic damage to teeth, and removal of cysts;
- treatment of oral abscess of tooth or gum origin; and
- treatment of craniofacial anomalies.

3.5 Nonemergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to Covered Dental Services for patients who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips or transportation while receiving long-term services and supports (LTSS).

What do NEMT services include?

- Passes or tickets for transportation such as mass transit within and between cities or states, to include rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vans, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) to a Covered Dental Service. The ITP can be the patient, the patient's family member, friend, or neighbor.
- Patients aged 20 or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a Covered Dental Services. The per diem rate for meals is $25 per day, per person.
- Patients aged 20 or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a Covered Dental Services. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Patients aged 20 or younger may be eligible to receive funds in advance of a trip to pay for authorized NEMT services.

If you have a patient needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of Medical Necessity for transportation of the attendant to be approved. The attendant must remain at the

location where Covered Dental Services are being provided but may remain in the waiting room during the patient's appointment.

Children 14 years of age and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone.

If you have a patient you think would benefit from receiving NEMT services, please refer him or her to their Medicaid managed care organization for more information.

Section 4: Children's Medicaid Dental Services provider complaint and appeal process

UnitedHealthcare Dental must notify providers of the Provider Complaint and Appeals Process. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

4.1 Provider disputes

An In-Network Provider Contractual Dispute is a dispute regarding the rate or amount paid on a claim. Members are not financially responsible or impacted by the outcome of such a dispute.

A Reprocessing or Adjustment Request is a request to reprocess a claim. Examples include submitting a corrected bill, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status. Claim denials must be appealed within 120 days from the date the denial was issued.

Reprocessing Requests and Contractual Disputes may be initiated verbally or in writing to the number and address below:

1-800-527-1764

UnitedHealthcare Dental – Texas
PO Box 1427
Milwaukee, WI 53201

When a claim is reprocessed as a result of a Reprocessing or Adjustment Request or Contractual Dispute, providers will receive a new remittance advice within 30 calendar days of receipt of the Reprocessing/ Adjustment Request or Contractual Dispute.

If the Reprocessing or Adjustment Request or Contractual Dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 calendar days of receipt of the Reprocessing or Adjustment Request or Contractual Dispute.

Medicaid Providers have the right to file a complaint directly with HHSC:

Texas Health and Human Services Commission - Provider Complaints
Health Plan Operations - H-320
PO Box 85200
Austin, Texas 78708-5200
Email: **HPM_Complaints@hhsc.state.tx.us**

Section 5: Children's Medicaid Dental Services member complaint and appeal process

5.1 Member complaint process

A complaint is an expression of dissatisfaction about any aspect of the health plan that is not related to an adverse determination.

All members have the right to file a complaint regarding any aspect of their treatment. There is no time limitation for filing a complaint.

Complaints may be filed orally or through written correspondence. For oral complaints, members are requested to call member services at **1-877-901-7321**. Written complaints may be mailed to:

UnitedHealthcare Dental Texas
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

If a member needs assistance filing a complaint, we have member advocates available to assist the member. Member advocates may be reached by calling our customer service toll-free at **1-877-901-7321** and requesting to speak to a member advocate. Members may have a representative file their complaint for them. To become a member representative, written consent must be received from the member designating another individual to act on their behalf.

Members will receive a letter acknowledging their complaint within five business days of receipt of the complaint. Members will receive a letter detailing the results of the investigation into their complaint within 30 calendar days of resolution.

A panel is assigned to decide or recommend a decision of the member's appeal. Members have the right to appear in person, or through correspondence.

Complaint appeal request are acknowledged within five business days of receipt. The process is completed no later than 30 calendar days after the date of receipt.

Members may also file complaints to the appropriate regulatory agency. Medicaid members may also file a complaint with Texas HHSC after going through the complaint process at UnitedHealthcare Dental.

Written complaints may be mailed to:

Texas Health and Human Services Commission
Attn: Resolution Services
Health Plan Operations, H320
P.O. Box 85200
Austin, TX 78708-5200

Complaints may also be emailed to: **HPM_complaints@hhsc.state.tx.us**

Written complaints may be mailed to:

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714 -9091

Fax: 512-490-1007

Online at **tdi.texas.gov**

Email: **ConsumerProtection@tdi.texas.gov**

In person:

Texas Department of Insurance
Consumer Protection (111-1A)
333 Guadalupe St.
Austin, TX 78701

Should the member need assistance in filing a complaint, the health plan has member advocates available to assist the member. Member advocates may be reached by calling Customer Service at **1-877-901-7321** and requesting to speak to a member advocate.

What is the MDCP/DBMD Escalation Help Line?

The MDCP/DBMD Escalation Help Line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about Medicaid fair hearings and continuing services while appealing.

When should I call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD escalation help line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representative or your legal representative can call.

Can I call any time?

The escalation line is available Monday through Friday from 8 a.m.–8 p.m. After these hours, please leave a message and one of our trained on-call staff will call you back.

5.2 Member appeal process

If the health plan denies or limits a member's request for a covered service, members will receive written correspondence informing them of the denial and the reason the service was denied. Members may also request an appeal for the denial of payment for services in whole or in part.

The member or the member's representative can file an appeal requesting the case be reviewed again. Member appeals may be filed by contacting member services at **1-877-901-7321** or through written correspondence. Written correspondence should be mailed to the following address:

UnitedHealthcare Dental
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

In order to ensure continuity of current authorized services, the member must file the Appeal on or before the later of: 10 days following UnitedHealthcare Dental's mailing of the notice of the Action.

Should the member need assistance in filing their appeal, the dental plan has member advocates available to assist the member. Member advocates may be reached by calling Customer Service at **1-877-901-7321** and requesting to speak to a member advocate. Appeals are accepted orally or in writing.

Member appeals for Medicaid members must be filed within 60 calendar days of the date of the notice of denial. Medicaid members may continue to receive current authorized services if their appeal is filed on or before the later of 10 days following the UnitedHealthcare Dental mailing of the notice of the action or the intended effective date of the proposed action.

The member may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the member.

Standard appeals

Once received, the member is forwarded an acknowledgment letter within five business days of receipt. A physician of the same or a similar specialty performs the review of member's appeal. Once completed, the member receives written correspondence containing the appeal decision within 30 days after receipt of the initial written or oral request for Appeal.

Extensions

Members or their representative may request up to an additional 14 calendar days for the decision to be made for an appeal. Additionally, UnitedHealthcare Dental can request up to 14 calendar days for an extension if able to show that there is a need for additional information and how the delay is in the member's best interest. UnitedHealthcare Dental will send written notice to the member, including the reason for the delay.

As a notification to all members, that in order to ensure continuity of current authorized services, the member must file the Appeal on or before the later of: 10 business days following UnitedHealthcare Dental's mailing of the notice of the Action, or the intended effective date of the proposed Action.

If a member needs assistance filing an appeal, we have member advocates available to assist the member. Member advocates may be reached by calling our customer service toll-free at **1-877-901-7321** and requesting to speak to a member advocate.

The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

The member must wait until after the appeal process has been completed before they can request a State Fair Hearing.

Expedited appeals

Expedited appeals can be requested when the health plan determines (for a request from a member) or the care provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health.

As with standard appeals, an independent physician of the same or similar specialty performs the review. A decision will be made within 72 hours for expedited appeals. For appeals related to ongoing emergencies or continued hospitalization, we make a decision within one business day.

To request an expedited appeal, and or to get help to file an expedited appeal, contact Customer Service to request the expedited appeal at **1-800-527-1764**. The request may also be written and sent to:

UnitedHealthcare Dental
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

Upon review of the circumstances surrounding the expedited appeal, the health plan determines if the request meets the expedited appeal criteria. Should the request not meet the criteria, the appeal is downgraded to a standard appeal.

The member or the member's representative receives written correspondence stating that the appeal has been downgraded and will follow the standard appeal guidelines.

What else can I do if I am still not happy?

If you disagree with UnitedHealthcare Dental 's appeal decision, you have the right to ask for an External Medical Review with State Hearing. Your request may either be in written or oral form. You can also request a State Fair Hearing without requesting an External Medical Review no later than 120 days during or after the Dental Contractor mails the internal appeal decision notice.

You, your parent, your authorized representative, or your legally authorized representative (LAR) must ask for the Fair Hearing with or without an External Medical Review within 120 days of the date the health plan mails the letter with the decision. You may request a standard External Medical Review with a State Fair Hearing or an emergency External Medical Review with State Fair Hearing either in written or oral form.

You must complete the UnitedHealthcare Dental 's appeal process before you can ask for a State Fair Hearing or External Medical Review.

5.3 Member state fair hearings and external medical review information

A state fair hearing is when the Texas Health and Human Services Commission (HHSC) directly reviews our decisions with your dental care.

If you ask for a state fair hearing, you can also ask for an external medical review where independent healthcare experts review your request to receive services. This review is an optional, extra step you can

take to get your case reviewed for free before your state fair hearing. It doesn't change your right to a state fair hearing.

Can I ask for a state fair hearing?

If you, as a member of the dental plan, disagree with the dental plan's decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the dental plan telling them the name of the person you want representing you. A provider may be your representative. You or your representative must ask for the State Fair Hearing within 120 days of the date on the dental plan's letter that tells of the decision you are challenging. If you do not ask for the State Fair Hearing within 120 days, you may lose your right to a State Fair Hearing. To ask for a State Fair Hearing, you or your representative should either send a letter to the dental plan at the address noted below or call **1-877-901-7321**. The mailing address for State Fair Hearings is:

UnitedHealthcare Dental - Texas
Attn: State Fair Hearings
PO Box 740224
Atlanta, GA 30374-0224

If you ask for a State Fair Hearing within 10 days from the time you get the hearing notice from the dental plan, you have the right to keep getting any service the dental plan denied, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 days from the time you get the hearing notice, the service the dental plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the dental plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Can a member ask for an external medical review?

If a Member, as a member of the dental plan, disagrees with the dental plan's decision, the Member has the right to ask for an External Medical Review. An External Medical Review is an optional, extra step the Member can take to get the case reviewed for free before the State Fair Hearing. The Member may name someone to represent him or her by writing a letter to the dental plan telling the Dental Contractor the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the External Medical Review within 120 days of the date the dental plan mails the letter with the internal appeal decision. If the Member does not ask for the External Medical Review within 120 days, the Member may lose his or her right to an External Medical Review. To ask for an External Medical Review, the Member or the Member's representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of Dental Contractor Internal Appeal Decision letter and mail or fax it to UnitedHealthcare Dental by using the address or fax number at the top of the form.;
- Call UnitedHealthcare Dental at 1-877-901-7321;
- Email UnitedHealthcare Dental at txdentaladvocates@uhc.com, or;

If the Member asks for an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the Member has the right to keep getting any service the dental

plan denied, at least until the final State Fair Hearing decision is made. If the Member does not request an External Medical Review within 10 days from the time the Member gets the appeal decision from the dental plan, the service the dental plan denied will be stopped.

If the Member or the Member's representative decides to withdraw the EMR request, the Member or the Member's representative must initiate an EMR request withdrawal communication to the Dental Contractor. The Member or the Member's representative, must submit the request to withdraw the EMR to the Dental Contractor using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the Member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

The external medical review decision will be mailed to you in 15 calendar days or less.

Can a member ask for an emergency external medical review?

If a Member believes that waiting for a standard External Medical Review will seriously jeopardize the Member's life or health, or the Member's ability to attain, maintain, or regain maximum function, the Member or Member's representative may ask for an emergency External Medical Review and emergency State Fair Hearing by writing or calling UnitedHealthcare Dental. To qualify for an emergency External Medical Review and emergency State Fair Hearing review through HHSC, the Member must first complete UnitedHealthcare Dental's internal appeals process.

If you request an emergency external medical review with your emergency state fair hearing, you'll get the external medical review decision within two business days. You can choose whether you want to have the state fair hearing you requested.

Section 6: CHIP Dental Services provider complaint/appeal process

UnitedHealthcare Dental must notify providers of the Provider Complaint and Appeals Process. The submitted documentation must specify the relevant subject (i.e. Appeal/Complaint). All documentation regarding an appeal/complaint must be submitted for processing. Submission copies must be retained for the provider's record.

6.1 Provider disputes

An In-Network Provider Contractual Dispute is a dispute regarding the rate or amount paid on a claim. Members are not financially responsible or impacted by the outcome of such a dispute.

A Reprocessing or Adjustment Request is a request to reprocess a claim. Examples include submitting a corrected bill, resubmitting a claim with requested information, data entry errors made on the claim or errors in participation status.

Reprocessing Requests and Contractual Disputes may be initiated verbally or in writing to the number and address below:

1-800-527-1764

UnitedHealthcare Dental – Texas
PO Box 1427
Milwaukee, WI 53201

When a claim is reprocessed as a result of a Reprocessing or Adjustment Request or Contractual Dispute, providers will receive a new remittance advice within 30 calendar days of receipt of the Reprocessing/ Adjustment Request or Contractual Dispute. If the Reprocessing or Adjustment Request or Contractual Dispute does not result in the reprocessing of a claim, providers will receive written notification of the outcome within 30 calendar days of receipt of the Reprocessing or Adjustment Request or Contractual Dispute.

Medicaid Providers have the firth to file a complaint directly with HHSC:

Texas Health and Human Services Commission - Provider Complaints
Health Plan Operations - H-320
PO Box 85200
Austin, Texas 78708-5200
Email: **HPM_Complaints@hhsc.state.tx.us**

Providers may also submit complaints and appeals to the Texas Department of Insurance (TDI).

Written complaints may be mailed to

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714 -9091
Fax: 512-490-1007
Online at **tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**

Section 7: CHIP Dental Services member complaint and appeal process

7.1 Member complaint process

All members have the right to file a complaint regarding any aspect of their treatment. There is no time limitation for filing a complaint.

Complaints may be filed orally or through written correspondence. For oral complaints, members are requested to call member services at **1-877-901-7321**. Written complaints may be mailed to:

UnitedHealthcare Dental Texas
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

If a member needs assistance filing a complaint, we have member advocates available to assist the member. Member advocates may be reached by calling our customer service toll-free at **1-800-527-1764** and requesting to speak to a member advocate. Members may have a representative file their complaint for them. To become a member representative, written consent must be received from the member designating another individual to act on their behalf.

Members will receive a letter acknowledging their complaint within five business days of receipt of the complaint. Members will receive a letter detailing the results of the investigation into their complaint within 30 calendar days of resolution.

CHIP members have the option to request complaint appeal panel should they disagree with the resolution of their complaint. A panel is assigned to decide or recommend a decision of the member's appeal. Members have the right to appear in person, or through correspondence. Complaint appeal request are acknowledged within five business days of receipt. The process is completed no later than 30 calendar days after the date of receipt.

Members may also file complaints to the appropriate regulatory agency.

CHIP members also have the right to submit complaints and appeals to the Texas Department of Insurance (TDI). Written complaints may be mailed to

Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714 -9091

Fax: 512-490-1007

Online at **tdi.texas.gov**

Email: **ConsumerProtection@tdi.texas.gov**

In person: **Texas Department of Insurance**
Consumer Protection (111-1A)
333 Guadalupe St.
Austin, TX 78701

7.2 Member appeal process

If the health plan denies or limits a member's request for a covered service, members will receive written correspondence informing them of the denial and the reason the service was denied. Members may also request an appeal for the denial of payment for services in whole or in part.

The member or the member's representative can file an appeal requesting the case be reviewed again. Member appeals may be filed by contacting member services at **1-877-901-7321** or through written correspondence. Appeals are accepted orally or in writing. Written correspondence should be mailed to the following address:

UnitedHealthcare Dental
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

In order to ensure continuity of current authorized services, the member must file the Appeal on or before the later of: 10 business days following the UnitedHealthcare Dental's mailing of the notice of the Action.

Should the member need assistance in filing their appeal, the health plan has member advocates available to assist the member. Member advocates may be reached by calling Customer Service at **1-877-901-7321** and requesting to speak to a member advocate.

Member appeals for Medicaid members must be filed within 60 calendar days of the date of the notice of denial. Medicaid members may continue to receive current authorized services if their appeal is filed on or before the later of 10 days following the UnitedHealthcare Dental mailing of the notice of the action or the intended effective date of the proposed action.

The member may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the member.

Standard appeals

Once received, the member is forwarded an acknowledgment letter within five business days of receipt. A physician of the same or a similar specialty performs the review of member's appeal. Once completed, the member receives written correspondence containing the appeal decision.

Extensions

Members or their representative may request up to an additional 14 calendar days for the decision to be made for an appeal. Additionally, UnitedHealthcare Dental can request up to 14 calendar days for an extension if able to show that there is a need for additional information and how the delay is in the member's best interest.

If a member needs assistance filing an appeal, we have member advocates available to assist the member. Member advocates may be reached by calling our customer service toll-free at **1-877-901-7321** and requesting to speak to a member advocate.

7.3 Member expedited UnitedHealthcare Dental appeal

Expedited appeals

Expedited appeals can be requested when the health plan determines (for a request from a member) or the care provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health.

As with standard appeals, an independent physician of the same or similar specialty performs the review. A decision will be made within 72 hours for expedited appeals. For appeals related to ongoing emergencies or continued hospitalization, we make a decision within one business day. To request an expedited appeal, and or to get help to file an expedited appeal, contact Customer Service to request theexpedited appeal at **1-877-901-7321**. The request may also be written and sent to:

UnitedHealthcare Dental
Attn: Appeals and Grievances
PO Box 1427
Milwaukee, WI 53201

Every oral appeal received must be confirmed by a written, signed appeal by the member or their representative, unless an expedited appeal is requested.

Upon review of the circumstances surrounding the expedited appeal, the health plan determines if the request meets the expedited appeal criteria. Should the request not meet the criteria, the appeal is downgraded to a standard appeal. The member or the member's representative receives written correspondence stating that the appeal has been downgraded and will follow the standard appeal guidelines.

What happens if UnitedHealthcare Dental denies the request for an expedited appeal?

If UnitedHealthcare Dental does not think delay in care is life threatening, we will notify the member and the member's representative within 72 hours. The appeal will be processed through the standard appeal process. We will notify the member and the member's representative of a decision within 30 days.

Who can help file an expedited appeal?

If you need to help filing an expedited appeal on behalf of a member, call us toll free at **1-877-901-7321, TTY 711.** A UnitedHealthcare Dental member services advocate will be available to assist you.

7.4 Member independent review organization process

CHIP members have the opportunity to request an external review if UnitedHealthcare Dental denies a benefit, refuses to pay for a service that has already been received, or rescinds coverage, this is called an adverse benefit determination. This process is administered by The Center for Medicare & Medicaid Services CMS.

A member or authorized representative may file a written request for an external review.

A member may file a request with MAXIMUS within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. Members may send requests by mail, facsimile, email, or through a secure, online portal. While CMS will still continue to accept

external review requests submitted by email, mail, or facsimile, they strongly encourage all members who are able to do so to use the online portal to submit their review requests.

After MAXIMUS receives an external review request, MAXIMUS contacts us, UnitedHealthcare Dental. We must provide all documents related to the adverse benefit determination to MAXIMUS within five business days.

Members may also submit any additional information they want MAXIMUS to consider during the external review.

MAXIMUS will review all of the information and documents that are submitted with your request, as long as they are submitted on or before the four-month deadline.

For a standard external review, the MAXIMUS examiner must provide written notice of the final external review decision as expeditiously as possible and no later than 45 days after the examiner receives the request for the external review. Members will receive external review determinations in writing.

For urgent care situations, members may file an expedited external review for either an adverse benefit determination or a final internal adverse benefit determination if:

1. An adverse benefit determination involves a medical condition of the member for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, or would jeopardize the member's ability to regain maximum function and the member has filed a request for an expedited internal appeal; or
2. A final internal adverse benefit determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the member received emergency services, but has not been discharged from a facility.

For an expedited external review, the MAXIMUS examiner must provide notice of the final external review decision as expeditiously as the medical circumstances require and within 72 hours once the examiner receives the request for the external review. MAXIMUS must deliver the notice of final external review decision to the member and UnitedHealthcare Dental as soon as possible.

Decisions made by MAXIMUS are final, and there is no further review available under the HHS-Administered Federal External Review Process after a member receives a decision. This decision is binding on both the member and UnitedHealthcare Dental, except when there are other remedies available for the member under federal or state law, such as filing a lawsuit.

To learn more about the HHS-Administered Federal External Review Process, please visit the CMS External Appeals web page at: /cciio/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals or call toll-free at 1-888-866-6205.

Disenrollment

Retaliation will not be tolerated against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents an appeal, grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect, or exploitation. Retaliation is an action, including refusal to renew or termination of a contract, against a care provider because the care provider filed a complaint against the MCO or appealed a MCO action on behalf of a member.

Automatic re-enrollment

If a member loses Medicaid eligibility and then regains eligibility within six **(6)** months, the member is automatically reassigned his previous plan. The member may choose to switch plans.

Section 8: Texas Children's Medicaid Dental Services member eligibility, enrollment, disenrollment, and value-added benefits

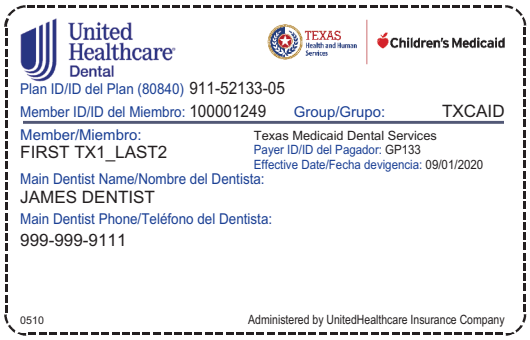
8.1 Eligibility

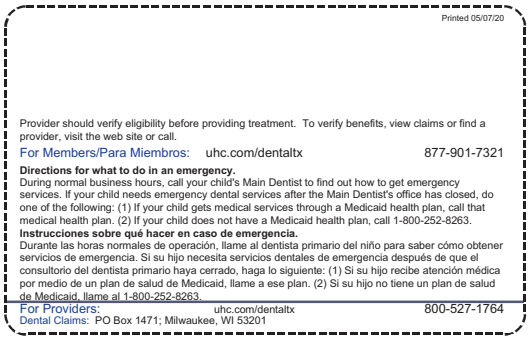
The Texas HHSC Medicaid Dental Programs provide dental coverage for children enrolled. Eligibility is determined by the HHSC.

8.2 Verifying eligibility

You must verify member eligibility and any necessary authorizations at the time of service.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the member has current Medicaid coverage. You should verify the member's eligibility for the service date before services are rendered.





There are three ways to do this:

- Use TexMedConnect on the TMHP website at **tmhp.com**.
- Call Provider Services at the member's medical or dental plan. **1-800-527-1764**
- View member eligibility online at **uhc.com/dentalTX** > Provider Sign In.

8.3 Plan changes:

You can change your child's dental plan to another by contacting the Medicaid Enrollment Broker's toll-free telephone number at **1-800-647-6558.** During the first 90 days after you are enrolled in a dental plan, you can change to another plan for any reason. After 90 days with a dental plan, you can change to another plan once for any reason. If you show good cause, you can also change dental plans at any time. An example of good cause is that you can't get the care you need through the dental plan.

If you call to change dental plans on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you ask to change plans on or before April 15, the change will take place on May 1.
- If you ask to change plans after April 15, the change will take place on June 1.

8.4 Value added services

Members can earn a gift card for taking care of their teeth.

Dental Texas Children's Medicaid and CHIP Plan

Medicaid and CHIP offers are:

$25 Walmart Gift Card — Dental Case Management Program

Who is eligible?
New members aged 19 and younger may be eligible. Limit of one gift card per lifetime.

What do members need to do?
Simply complete a risk assessment. This helps us understand the child's unique needs. If the member qualifies, we will contact them. Members must agree to enroll in our case management program within 120 days of signing up with UHC Texas Dental.

$10 Walmart Gift Card — Sealant Program (First Molars)

Who is eligible?
Members aged 9 and younger. Members who receive sealant treatment on all four first molars will receive a gift card. Limit of one gift card per lifetime.

What do members need to do?
Simply schedule an appointment with their Main Dentist. Sealing these teeth as soon as they come in can keep them cavity-free. We will mail a gift card to them! No forms to fill out!

$10 Walmart Gift Card — Sealant Program (Second Molars)

Who is eligible?
- Members aged 14 and younger. Members who receive sealant treatment on all four second molars will receive a gift card. Limit of one gift card per lifetime.

What do members need to do?
- Simply schedule an appointment with their Main Dentist. Sealing these teeth as soon as they come in can keep them cavity-free. We will mail a gift card to them! No forms to fill out!

Members who complete the requirements from 9/1/2024 to 8/31/2025 will be eligible to receive a gift card.

Section 9: CHIP Dental Services member eligibility, enrollment, disenrollment, and value-added benefits

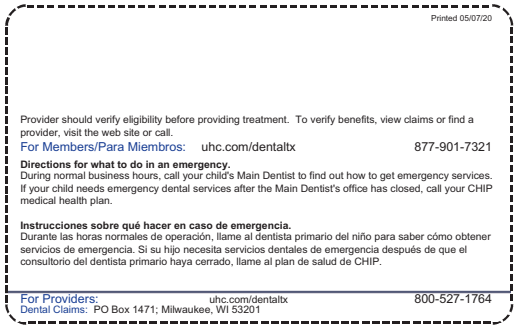
9.1 Eligibility

The Texas HHSC CHIP Dental Programs provide dental coverage for twelve (12) continuous months for children enrolled. Eligibility is determined by the HHSC.

9.2 Verifying CHIP eligibility

Verify the patient's CHIP eligibility for the date of service prior to services being rendered. There are several ways to do this:

- Ask for the member's UnitedHealthcare Dental CHIP ID Card.



- Call the UnitedHealthcare Dental Line at **1-800-527-1764**.
- View member eligibility online at **uhc.com/dentalTX** > Provider Sign In.
- If a member loses their UnitedHealthcare Dental ID card, they should call Member Services right away at **1-800-527-1764**. Member Services will send a new one.

9.3 Re-enrollment

Families must re-enroll their children in the CHIP Dental Program every twelve (12) months.

9.4 Disenrollment

A member's disenrollment request from UnitedHealthcare Dental will require documentation that indicates sufficiently compelling circumstances that merit disenrollment. Texas HHSC will make the final decision. You are strictly prohibited from taking any retaliatory action against a member for any reason, including reasons related to disenrollment.

9.5 Plan changes

If the child has been in a CHIP dental plan less than ninety (90) days, they can change dental plans. Call CHIP toll-free at **1-800-527-1764**.

Members are allowed to make plan changes under the following circumstances:

- For any reason within 90 days of enrollment in CHIP;

- For cause at any time; and
- During the annual re-enrollment period.

The member's child cannot change dental plans after being in the plan ninety (90) days unless their child is granted an exception for a "good cause." The member also cannot change dental plans if their child has reached his or her annual dental benefit limit. HHSC will make the final decision.

9.6 Value added services

Members can earn a gift card for taking care of their teeth.

Dental Texas Children's Medicaid and CHIP Plan

Medicaid and CHIP offers are:

$25 Walmart Gift Card – Dental Case Management Program

Who is eligible?
New members aged 19 and younger may be eligible. Limit of one gift card per lifetime.

What do members need to do?
Simply complete a risk assessment. This helps us understand the child's unique needs. If the member qualifies, we will contact them. Members must agree to enroll in our case management program within 120 days of signing up with UHC Texas Dental.

$10 Walmart Gift Card – Sealant Program (First Molars)

Who is eligible?
Members aged 9 and younger. Members who receive sealant treatment on all four first molars will receive a gift card. Limit of one gift card per lifetime.

What do members need to do?
Simply schedule an appointment with their Main Dentist. Sealing these teeth as soon as they come in can keep them cavity-free. We will mail a gift card to them! No forms to fill out!

$10 Walmart Gift Card – Sealant Program (Second Molars)

Who is eligible?
- Members aged 14 and younger. Members who receive sealant treatment on all four second molars will receive a gift card. Limit of one gift card per lifetime.

What do members need to do?
- Simply schedule an appointment with their Main Dentist. Sealing these teeth as soon as they come in can keep them cavity-free. We will mail a gift card to them! No forms to fill out!

Members who complete the requirements from 9/1/2024 to 8/31/2025 will be eligible to receive a gift card.

9.7 CHIP cost sharing

General information

The following table includes maximum CHIP cost sharing amounts. If the DMO and the provider have negotiated a lesser amount for a benefit than the identified copayment, then the copayment must be capped at the lesser amount.

The following examples are provided for illustrative purposes only.

Example 1: The MCO and a provider have negotiated a $23.00 rate for an office visit. If the member's family income is 185% FPL, the copayment will be capped at $20.00.

Example 2: The MCO and a pharmacy provider have negotiated a $9.30 total reimbursement (dispensing fee + product cost) for a prescription of 800mg of Ibuprofen, 50 tablets. If the member's family income is 185% FPL, the copayment will be capped at $9.30.

Co-payments do not apply, at any income level, to:

1. well-baby and well-child care services, as defined by 42 C.F.R. §457.520;
2. preventative services, including immunizations;
3. pregnancy-related services;
4. Native Americans or Alaskan Natives;
5. CHIP Perinatal Members (Perinates (unborn children) and Perinate Newborns).

An MCO is not responsible for payment of unauthorized non-emergency services provided to a CHIP member by an out-of-network provider. In such circumstances, the CHIP member will be responsible for all costs.

CHIP Cost-Sharing	Effective January 1, 2014
Enrollment Fees (for 12-month enrollment period):	**Charge**
At or below 151% of FPL*	$0
Above 151% up to and including 186% of FPL	$35
Above 186% up to and including 201% of FPL	$50
Co-Pays (per visit):	
At or below 151% FPL	Charge
Office Visit (non-preventative)	$5
Non-Emergency ER	$5
Generic Drug	$0
Brand Drug	$5
Facility Co-pay, Inpatient (per admission)	$35
Cost-sharing Cap	5% (of family's income)**
Above 151% up to and including 186% FPL	Charge
Office Visit (non-preventative)	$20
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$75
Cost-sharing Cap	5% (of family's income)**

CHIP Cost-Sharing	Effective January 1, 2014
Above 186% up to and including 201% FPL	Charge
Office Visit (non-preventive)	$25
Non-Emergency ER	$75
Generic Drug	$10
Brand Drug	$35
Facility Co-pay, Inpatient (per admission)	$125
Cost-sharing Cap	5% (of family's income)**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.

**Per 12-month term of coverage.

Section 10: Member rights and responsibilities

10.1 Children's Medicaid Dental Services member rights and responsibilities

Member rights

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
   - **a.** Be treated fairly and with respect.
   - **b.** Know that your dental records and discussions with your dentists will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a dental plan and dentist. You have the right to change to another plan or dentist in a reasonably easy manner. That includes the right to:
   - **a.** Be told how to choose and change your dental plan and your dentist.
   - **b.** Choose any dental plan you want that is available in your area and choose your dentist from that plan.
   - **c.** Change your dentist.
   - **d.** Change your dental plan without penalty.
   - **e.** Be told how to change your dental plan or your dentist.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   - **a.** Have your dentist explain your dental care needs to you and talk to you about the different ways your dental care problems can be treated.
   - **b.** Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   - **a.** Work as part of a team with your dentist in deciding what dental care is best for you.
   - **b.** Say yes or no to the care recommended by your dentist.
5. You have the right to use each available complaint and appeal process through UnitedHealthcare Dental and through Medicaid, and get a timely response to complaints, appeals, External Medical Reviews and State Fair Hearings. That includes the right to:
   - **a.** Make a complaint to your dental plan or to the state Medicaid program about your dental care, your dentist or your dental plan.
   - **b.** MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi Disability Program.
   - **c.** Get a timely answer to your complaint.
   - **d.** Use the plan's appeal process and be told how to use it.
   - **e.** Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.

   f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

   a. Have telephone access to a dental professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.

   b. Get dental care in a timely manner.

   c. Be able to get in and out of a dental care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.

   d. Have interpreters, if needed, during appointments with your dentist and when talking to your dental plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

   e. Be given information you can understand about your dental plan rules, including the dental care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that dentists, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Before any medically necessary dental services and treatment begin, the services and treatment must be fully explained to you and you must give permission in writing (informed consent). Your dental plan cannot prevent you from getting this information from dentists or hospitals, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member responsibilities

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

   a. Learn and understand your rights under the Medicaid program.

   b. Ask questions if you do not understand your rights.

   c. Learn what choices of dental plans are available in your area.

2. You must abide by the dental plan's and Medicaid's policies and procedures. That includes the responsibility to:

   a. Learn and follow your dental plan's rules and Medicaid rules.

   b. Choose your dental plan and a dentist quickly.

   c. Make any changes in your dental plan and dentist in the ways established by Medicaid and by the dental plan.

   d. Keep your scheduled appointments.

   e. Cancel appointments in advance when you cannot keep them.

   f. Always contact your dentist first for your non-emergency dental needs.

   g. Be sure you have approval from your dentist before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your dentist about your health.
   b. Talk to your dentist about your health care needs and ask questions about the different ways your dental care problems can be treated.
   c. Help your dentist get your dental records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your dental health. That includes the responsibility to:
   a. Work as a team with your dentist in deciding what dental care is best for you.
   b. Understand how the things you do can affect your dental health.
   c. Do the best you can to stay healthy.
   d. Treat dentists and staff with respect.

Additional member responsibilities while using NEMT Services

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your dental appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets o tokens only to go to your dental appointment.
6. You must only use NEMT Services to travel to and from your dental appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

10.2 CHIP Dental Services member rights and responsibilities

Member rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's dentists and other providers.
2. You have the right to know how your dentists are paid. You have a right to know about what those payments are and how they work.
3. You have the right to know how UnitedHealthcare Dental decides about whether a service is covered and/or medically necessary. You have the right to know about the people in UnitedHealthcare Dental's office who decide those things.
4. You have the right to know the names of the dentists and other providers enrolled with UnitedHealthcare Dental and their addresses.

5. You have the right to pick from a list of dentists that is large enough so that your child can get the right kind of care when your child needs it.
6. You have the right to take part in all the choices about your child's dental care.
7. You have the right to speak for your child in all treatment choices.
8. You have the right to get a second opinion from another dentist enrolled with UnitedHealthcare Dental about what kind of treatment your child needs.
9. You have the right to be treated fairly by UnitedHealthcare Dental dentists and other providers.
10. You have the right to talk to your child's dentists and other providers in private, and to have your child's dental records kept private. You have the right to look over and copy your child's dental records and to ask for changes to those records.
11. You have a right to know that dentists, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your dental plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
12. You have a right to know that you are only responsible for paying allowable copayments for covered services, up to benefit maximum limits. Dentists, hospitals, and others cannot require you to pay any other amounts for covered services.

Member responsibilities

You and UnitedHealthcare Dental both have an interest in seeing your child's dental health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits, such as encouraging your child to exercise, to stay away from tobacco, and to eat a healthy diet.
2. You must become involved in the dentist's decisions about your child's treatments.
3. You must work together with UnitedHealthcare Dental's dentists and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with UnitedHealthcare Dental you must try first to resolve it using UnitedHealthcare Dental's complaint process.
5. You must learn about what UnitedHealthcare Dental does and does not cover. You must read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the dentist's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. You must report misuse of CHIP by dental and health care providers, other CHIP members, UnitedHealthcare Dental or other CHIP plans.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at **hhs.gov/ocr**.

10.3 Fraud reporting

Do you want to report waste, abuse, or fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for Medicaid or CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a Medicaid or CHIP Dental ID.
- Using someone else's Medicaid or CHIP Dental ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184;** or
- Visit **https://oig.hhs.texas.gov/** Click on the *Report Fraud* tab, then select the *OIG Fraud Reporting Form* to complete the online form.
- You can report directly to UnitedHealthcare Dental Texas Medicaid:

  UnitedHealthcare Dental Special Investigation Unit
  170 Wood Avenue, 3rd Floor
  NJ050-1000
  Iselin, NJ 08830
  Phone: **1-844-359-7736, TDD/TTY: 711**

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider.
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it.
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation.
  - Dates of events.
  - Summary of what happened.
- When reporting about someone who gets benefits, include:
  - The person's name.
  - The person's date of birth, Social Security number, or case number if you have it.
  - The city where the person lives.
  - Specific details about the waste, abuse, or fraud.

Section 11: Children's Medicaid Dental Services /CHIP Dental Services billing and claims administration

Where to send claims

All claims must be submitted on a 2012 or newer ADA approved claim form.

Please note most CHIP eligible households are subject to a cost sharing obligation.

Please note there is no copayment for Medicaid members. This membership is not to be charged a copayment for any dental services.

Mail:
UnitedHealthcare Dental- Texas
Attn: Claims Department
PO Box 1471
Milwaukee, WI 53201

Provider Web Portal: **uhc.com/dentalTX**

Clearing House: Payer ID GP133

Billing members

- **Member Acknowledgement Statement** – Participating Providers shall hold members,UnitedHealthcare Dental and HHSC harmless for the payment of non-Covered Services except as provided in this paragraph. A provider may charge an eligible Medicaid/CHIP HHSC Dental Program member for dental services which are non-covered services. These services must be identifiable by specific CDT code. A provider may bill a member for non-covered services if the Provider obtains a written waiver from the member prior to rendering such service that indicates:
  - The services to be provided.
  - UnitedHealthcare Dental and HHSC will not pay for or be liable for said services.
  - Member will be financially liable for such services.

  Please note that prior authorization may be requested for non-covered services for eligible Medicaid members under age 21. Documentation of medical necessity must be submitted with this request. This documentation may include radiographs, treatment plan, and/or a narrative from the provider.
- **Private Pay Form Agreement** – Please use the Non-Covered Service Disclosure form located in the appendix of this manual.

Time limit for submission of claims/claims appeals

Claims payment

- Clean claims payments must be made by UnitedHealthcare within thirty (30) days of receiving the claim.
- UnitedHealthcare must receive your claim requesting payment of services within ninety five (95) days from the date of service.
- Appeals for claims denials must be received within 120 days from the claim denial date
- All claims must be submitted on a 2012 or newer ADA approved claim form.
- Claims questions/appeals please reach out to provider servicing at **1-800-527-1764**.
- Claims questions/appeals may also be addressed at **uhc.com/dentalTX**.

Section 12: Children's Medicaid Dental Services/CHIP Dental Services special access requirements

12.1 Interpreter/translation services

Members with a limited English proficiency or reading skills require an interpreter. Customer service can assist with accessing these services for them over the phone. Telephone interpreting service is also available for members who are deaf, hard-of hearing, deaf-blind or speech impaired. Hearing impaired services are available at **1-800-527-1764 TDD/TTY 711.** We can also assist with sign language and Braille. To arrange these services, call customer service at **1-800-527-1764**.

We have interpreter services to help ensure effective communication for our members regarding treatment, medical history or health condition. This is at no cost to you or our members and includes written, spoken, and sign language interpretation, when the member is receiving services from you in an office or other location, or accessing emergency services.

12.2 UnitedHealthcare Dental/provider coordination

UnitedHealthcare Dental is committed to ensuring coordination of our members' care with Texas Medicaid and CHIP Dental providers. Members will be referred to specialists when the Main Dentist determines a medically necessary need. We will also provide coordination of non-capitated services.

Please call the provider services line at **1-800-527-1764** if assistance is needed in coordination care for one of our members. A provider advocate or a member advocate will be available to assist. A care coordinator will be available to provide assistance for our members with special health care needs.

12.3 Reading level consideration

Written communication, such as patient education pages, referrals and consent forms should be at a sixth grade reading level, in Spanish, Chinese or another translation, and in larger print.

12.4 Cultural sensitivity

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

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

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

This website contains valuable materials that will assist dental providers and their staff to become culturally competent. **https://www.uhcdental.com/dental/provider-academy.html**

12.5 Special health care needs

Members with special health care needs have access to specialists as appropriate to the member's condition and identified needs. UnitedHealthcare Dental's care coordinators will work with members with special health care needs and their dental or medical providers to ensure direct access to specialists and a standing referral when necessary. Providers may contact UnitedHealthcare Dental's provider line for assistance with facilitating services for members whose medical conditions classify them as special needs members. A Care Coordinator will be available to assist.

12.6 Payment by members

UnitedHealthcare, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from the member for covered services, except that CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP members for covered services.

UnitedHealthcare, must inform members of costs for non-covered services, and must require its Network Providers to:

- Inform members of costs for non-covered services prior to rendering such services; and
- Obtain a signed private pay form from such members.

Section 13: Claim submission procedures

13.1 Claim submission best practices and required elements

13.1.1 Dental claim form

A 2012 or newer ADA approved claim form must be submitted for payment of services rendered.

13.1.2 Claim submission options

Electronic claims

Electronic claims processing requires access to a computer and usually the use of practice management software. Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet. Most systems have the ability to detect missing information on a claim form and notify you when errors need to be corrected.

Electronic submission is private as the information being sent is encrypted. Call **1-800-527-1764** for more information regarding electronic claims submission.

Note: Our Payer ID is GP133.

Paper claims

Due to periodic revisions and varying practice management systems, dental insurance claim forms exist in various formats. Use of a 2012 or newer ADA approved claim form is required.

13.1.3 Dental claim form required information

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

Header information

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

Subscriber information

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

Patient information

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

Primary payer information

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

Other coverage

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

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

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

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

Billing dentist or dental entity

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

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

Treating dentist and treatment location

List the following information regarding the dentist that provided treatment.

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

Record of services provided

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

- Procedure date
- Area of oral cavity

- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Billed charges– report the dentist's full fee for the procedure
- Total sum of all fees

Remarks section

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

Timely submission

All claims should be submitted within 95 days from the date of service.

Paper claims

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

By Report procedures

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

Using current ADA codes

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

ICD-10 instructions

RECORD OF SERVICES PROVIDED

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

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

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

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

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

34a. Diagnosis Code(s) A C

(Primary diagnosis in "A") B D

31a. Other Fee(s)

32. Total Fee

35. Remarks

Instructions:

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

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

34 Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source:
B = ICD-9-CM AB = ICD-10-CM (as of October 1, 2013)
This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

34a Diagnosis Codes(s): Enter up to four applicable diagnosis codes after each letter (A. – D.). The primary diagnosis code is entered adjacent to the letter "A."
This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions.

13.2 Electronic claims submissions

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

UnitedHealthcare partners with electronic clearing houses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number for government plans is GP133. Please refer to the Important Addresses and Phone Numbers section for additional information as needed.

If you wish to submit claims electronically, contact your clearinghouse to initiate this process.

13.3 HIPAA-compliant 837D file

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

13.4 Paper claims submission

To receive payment for services, practices must submit claims via paper or electronically. Network dentists are required to submit a 2012 or newer ADA approved claim form. If an incorrect claim form is used, the claim cannot be processed and will be returned.

Refer to Section 13.1 for more information on claims submission best practices and required information.

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

13.5 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than 1 dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. Coordination of Benefits rules are mandated by the Department of Insurance and it is each provider's responsibility to correctly coordinate benefits.

The practitioner office is required to identify when a patient has coverage through multiple carriers and to inform UnitedHealthcare Dental on the claim form.

If the patient is covered by more than 1 dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than 1 entity is involved—this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

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

Medicaid payers, such as UnitedHealthcare Dental when acting on behalf of a Medicaid program, are considered the payers of last resort. When COB is present in this situation, providers should bill the appropriate primary carrier first, and then submit to UnitedHealthcare Dental for any additional payment along with primary payer's Explanation of Benefits (EOB).

13.6 Dental claim filing limits and adjustments

All Dental Claims must be submitted within 95 days of the date of service.

All claim appeals must be submitted within 60 days of the denial notice. Refer to the Quick Reference Guide for address and phone number information.

13.7 Claim adjudication and periodic overview

Claim processing standards:

- 98 percent of Clean Claims will be adjudicated within 30 days of receipt of the claim.

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

Management reviews the summarized results and correction is implemented, if necessary.

Invalid or incomplete claims:

If claims are submitted with missing information, incomplete or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent to the provider.

For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.

13.8 Explanation of dental plan reimbursement

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

Below is a list and description of each field:

PROVIDER NAME AND ID NUMBER – Treating dentist's name, practitioner ID number

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

AMOUNT BILLED – Amount submitted by provider

AMOUNT PAYABLE – Amount payable after benefits have been applied

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

OTHER INSURANCE – Amount payable by another carrier

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

NET AMOUNT (Summary Page) – Total amount paid

PATIENT NAME

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

PATIENT DOB

PLAN – Health plan through which the member receives benefits (i.e., UnitedHealthcare Dental - Texas)

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

ENCOUNTER NUMBER – Claim reference number

BENEFIT LEVEL – In our out-of-network coverage

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

DOS CDTCODE

TOOTH NO .SURFACE(S)

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

QTY OR NO. OF UNITS

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

PAYABLE AMOUNT – Contracted amount

COPAY AMOUNT – Member responsibility

COINSURANCE AMOUNT – Member responsibility of total payment amount

DEDUCTIBLE AMOUNT – Member responsibility before benefits begin

PATIENT PAY – Amount to be paid by the member

OTHER INSURANCE AMOUNT – Amount paid by other carriers

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

13.9 Government ePayment

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

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

ePayment Center allows you to:

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

To register:

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

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

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

The Zelis Payments advantage:

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

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

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

13.10 Explanation of Benefits

Explanation of Benefits sample (Page 1)

UnitedHealthcare Dental

Payee ID: 941 Payee Name: Martin Pittman Remittance Date: 12/20/2010

United Healthcare Dental

Please address questions to:

UnitedHealthcare Dental

Contact: United Healthcare Dental - Provider Services

Phone:

Fax:

Current Period: 12/20/2010

Payee ID:

Phone:

Fax:

Tax ID:

Remittance Summary

Fee For Service:	**$2,300.00**
Budget Allocation:	**$0.00**
Capitation:	**$0.00**
Case Fees:	**$0.00**
Additional Compensation:	**$0.00**
Prior Period Recovery and other Payee Adjustments:	**$0.00**
Total:	**$2,300.00**

Administrative Appeals by Practitioners: Requests for reconsideration of administrative denials of claims submi tted by practitioners must be received with required documentation within 60 days of the notice of denial. Late appeals will not be considered. Practitioners should send requests for reconsideration of administrative denials to the following address:

UnitedHealthcare
Attn: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131

IMPORTANT NOTICE: Effective with claims and pre-authorizations received July 5, 2010 and later, in order to maintain HIPAA compliance, only ADA 2012 Dental Claim forms will be accepted when submitting claims and pre-authorizations. All other forms, including ADA forms from years prior to 2012, will not be accepted and will result in a rejection of the claim or pre-authorization request. Additionally, please send clearly marked 'Corrected Claims' on ADA 2012 forms, to the Appeals mailbox. Please contact the customer service toll free number if you have questions. If you are in need of the new Dental Claim forms, please visit the ADA website at www.ada.org for ordering information.

Ref #: 679 / 3 Page 1

Explanation of Benefits sample (Page 2)

UnitedHealthcare Dental

Payee Name: Remittance Date: 12/20/2010

Fee For Service Summary

Provider / ID	Location / ID	Amount Billed	Amount Payable	Patient Pay	Other Insurance	Prior Mo. Adj	Net Amount
First Lastname / 1234	First Lastname / 5678	$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$2,300.00
	Totals: $	2,300.00	$2,300.00 $	0.00	$0.00 $	0.00 $	2,300.00

Ref #: 679 / 4 Page 2

Explanation of Benefits sample (Page 3)

UnitedHealthcare Dental -

Payee Name: Remittance Date: 12/20/2010

Services Detail

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

Patient Name:
Subscriber/Member:
DOB:
Office Reference No:

Provider Name:
Provider NPI:
Plan:
Product:

Encounter #: 20101202000737
Referral #:
Referral Date:
Benefit Level: In Network

			BILLED		ALLOWED	PAYABLE	COPAY	COINS	DEDUCT	OVER MAX	PATIENT	OTHER	NET	PAY
ITM	DOS	CODE	QTY	AMOUNT	QTY	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	PAY	INSUR	AMOUNT	CODE
1	11/29/10	D7210 1	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
2	11/29/10	D7210 2	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
3	11/29/10	D7210 19	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
4	11/29/10	D7210 20	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
5	11/29/10	D7210 21	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
6	11/29/10	D7210 22	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
7	11/29/10	D7210 26	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
8	11/29/10	D7210 27	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
9	11/29/10	D7210 28	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
10	11/29/10	D7210 29	1	$230.00	1	$230.00	$230.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$230.00	FFS
				$2,300.00		$2,300.00	$2,300.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,300.00	

Ref #: 679 / 5 Page 3

Section 14: Utilization Management program

14.1 Utilization Management

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

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

14.2 Community practice patterns

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

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

14.3 Evaluation of Utilization Management data

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

14.4 Utilization Management analysis results

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

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

- Provider Training

- Continuing Education
- Provider News Bulletins

14.5 Utilization review

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

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

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

Utilization review is completed based on the following:

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

14.6 Fraud and abuse

Every network provider and third-party contractor of UnitedHealthcare Dental is responsible for conducting business in an honest and ethical way. This entails fostering a climate of ethical behavior that does not tolerate fraud or abuse, remaining alert to instances of possible fraud and/or abuse and reporting such situations to the appropriate person(s).

We conduct programs and activities to deter, detect and address fraud and abuse in all aspects of our operations. We utilize a variety of resources to carry out these activities, including anti-fraud services from other affiliated entities, as well as outside consultants and experts when necessary.

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

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

All Network Providers and third-party contractors are expected to promptly report any perceived or alleged instances of fraud. Reporting may be made directly to the compliance helpline at 1-800-455-4521.

Section 15: Evidence-based education

15.1 Evidence-based Dentistry & the Clinical Policy & Technology Committee

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

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

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

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks

Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare, we use evidence as the foundation of our efforts, including:

- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new application of existing technology in the UnitedHealthcare dental policies, benefits, clinical programs, and business

functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes bimonthly and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealth Group Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

Section 16: Governing administrative policies

16.1 Appointment scheduling standards

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

- **Urgent care appointments**. . . . . .within 24 hours
- **Therapeutic and diagnostic care appointments**. . . . . .within 14 calendar days
- **Preventive care appointments** . . . . . .within 14 calendar days

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

- A true emergency is defined as services required for treatment of severe pain, swelling, bleeding or immediate diagnosis and treatment of unforeseen dental conditions which if not immediately diagnosed and treated, would lead to disability or death.
- Urgent care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule members appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

Dental offices that operate by "walk-in" or "first come, first served" appointments must meet the above state mandated or plan requirements, and are monitored for access and waiting times, where applicable.

16.2 Missed appointments

Offices should inform patients of office policies relating to missed appointments and any fees that may be incurred as a result.

16.3 Emergency coverage

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

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

16.4 New associates

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

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

If you have any questions or need to receive a copy of our Provider Application packet, contact our Provider Services Line at **1-800-527-1764**.

16.5 Change of address, phone number, email, fax or tax identification number (TIN)

When there are demographic changes within your office, it is important to notify us as soon as possible so that we may update our records. This supports accurate claims processing as well as helps to make sure that member directories are up to date.

Changes should be submitted to:

UnitedHealthcare
Government Programs Provider Relations
2300 Clayton Road, Suite 1000
Concord, CA 94520

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

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

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

If you have any questions, don't hesitate to contact Provider Services for guidance.

16.6 Office conditions

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

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

16.7 Sterilization and asepsis-control fees

Dental office sterilization protocols must meet OSHA requirements. All instruments should be heat sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA guidelines.

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

16.8 Recall system

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

16.9 Nondiscrimination

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

Appendix A: Attachments

A.1 Fraud, waste and abuse training

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

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

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

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

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

A.2 Practitioner rights bulletin

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

To review your information

This is specific to the information the Plan has utilized to evaluate your credentialing application and includes information received from any outside source (e.g., malpractice insurance carriers; state license boards) with the exception of references or other peer-review protected information.

To correct erroneous information

If, in the event that the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within fifteen (15) business days of receipt of the information. You will have an additional fifteen (15) business days to submit your reply in writing; within two **(2)** business days we will send a written notification acknowledging receipt of the information.

To be informed of status of your application

You may submit your application status questions in writing by emailing **dbpcredsupport@uhc.com** or calling **1-800-822-5353**.

To appeal adverse committee decisions

1. Providers applying for initial credentialing do not have appeal rights, unless required by State regulation.
2. Providers rejected for recredentialing based on a history of adverse actions, and who have no active sanctions, have appeal rights only in states that require them or due to Quality of Care concerns against UnitedHealthcare Dental members. An appeal, if allowed, must be submitted within 30 days of the date of the rejection letter. The provider has the right to be represented by an attorney or another person of the provider's choice.
3. Appeals are reviewed by Peer Review Committee (PRC). The PRC panel will include at least 1 member who is of the same specialty as the provider who is submitting the appeal.
4. PRC will consider all information and documentation provided with the appeal and make a determination to uphold or overturn the Credentialing Committee's decision. The PRC may request a corrective action plan, a Site Visit and/or chart review.
5. Within 10 days of making a determination, the PRC will send the provider, by certified mail, written notice of its final decision, including reasons for the decision.

Credentialing Supervisor
Credentialing Department
2300 Clayton Road, Suite 100
Concord, CA 94520

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

Appendix B: Texas Health Steps dental services

Providers please refer to the Texas Medicaid Provider Procedures Manual for information regarding Texas Health Steps dental services.

Children of Migrant Farmworkers

Children of Migrant Farmworkers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup.

Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup.

Appendix C: Children's Medicaid covered dental services

Covered dental services that indicate "Pre Auth" in the "Review Required" column require documentation of medical necessity and will be subject to pre-service review. These procedures must be prior authorized before services are rendered for determination of medical necessity and require submission of proper documentation (as indicated in the "Documentation Required" column) along with planned treatment listed on the 2012 or newer ADA approved claim form (dates of service are left blank on the claim form for prior authorizations). When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the 2012 or newer ADA approved claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.

Covered dental services that indicate "Post Auth" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the 2012 or newer ADA approved claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.

Although some covered services do not require any pre or post service review, those services may still be subject to retrospective review of records to determine medical necessity if deemed necessary by UnitedHealthcare Dental. Therefore documentation to support medical necessity of the service must be current and maintained in the member's chart.

Services Submitted with D9222 and, D9223 will require prior authorization. Please reference 'Criteria for General Anesthesia and Intravenous (IV) Sedation' in the Clinical Criteria section of this ORM.

Any reimbursement already made for an inadequate service may be recouped after the UnitedHealthcare Dental Consultant reviews the circumstances.

Important: UnitedHealthcare Dental's approval of a pre-authorization request does not guarantee payment. The service(s) will still be subject to retrospective review to confirm medical necessity. Additionally, "Pre-authorization Not Required" or the lack of a pre-authorization requirement is not equivalent to "medically necessary." It is not to be assumed that payment will be dispensed for a service that does not require prior authorization.

C.1 Benefits covered for TX Medicaid child (under 21)

Clinical oral evaluations/diagnostics

Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if UnitedHealthcare Dental determines the number to be redundant, excessive or not in keeping with the federal guidelines

relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

UnitedHealthcare Dental utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations. All radiographs, must be of good diagnostic quality, include member's full name, date films taken, and identify the patients left and right side.

Preventive Services

Procedure codes D1110, D1120, D1206, and D1208 will be denied when billed as an emergency claim. Procedure codes D1110, D1120, D1206, and D1208 will no longer be reimbursed to orthodontist and oral maxillofacial surgeon providers.

Procedure codes D1351 and D1352 will be denied if billed as an emergency claim. Procedure code D1351 will no longer be reimbursed to orthodontists and oral maxillofacial surgeon.

Application of caries arresting medicament (D1354) will be a benefit for Texas Health Steps for members who are birth through six years of age. D1354 will only be allowed to be rendered in an office setting. Silver Diamine Fluoride (SDF) is the only material providers may use for procedure code D1354. Silver Diamine Fluoride can cause permanent dark staining of any unhealthy tooth structure, so please advise your members of this prior to performing this treatment.

Procedure Code D1206 may be reimbursable if rendered in an office, inpatient, or outpatient hospital setting.

Procedure Codes D1208, D1330, and D1354 are limited to services rendered in an office setting only, and are not reimbursable if rendered in an inpatient or outpatient hospital setting.

Clinical criteria for codes requiring pre-service or post-service clinical review

Cone Beam CT Capture and Interpretation with Field of View of Both Jaws; With or Without Cranium

- Documentation describes medical necessity and why radiographic images would not be appropriate/ sufficient and why CBCT is needed to safely render treatment

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0120	Periodic oral evaluation - established patient	0 - 20		No		1 per 6 months per provider	**(1)** Deny D0120 when submitted on the same DOS as D0145, any provider **(2)** A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim
D0140	Limited oral evaluation - problem focused	0 - 20		No		10 per lifetime per provider	**(1)** Deny D0140 when submitted on the same DOS as D0160, same provider

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	6 months - 35 months		No		10 per lifetime per member	**(1)** Deny D0145 when used on the same DOS as procedure codes D0120, D0150, D0160, D0170, D0180, D1120, D1206, D1208, or D8660 (pre orthodontic treatment visit) for any provider. **(2)** D0145 denied if submitted within 60 days of another service paid for the same procedure (D0145): 60 day minimum between dates of service **(3)** D0145 is only reimbursable to First Dental Home providers. **(4)** A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim
D0150	Comprehensive oral evaluation - new or established patient	0 - 20		No		1 per 3 years per provider	**(1)** Deny D0150 when submitted on the same DOS as D0145 by any provider **(2)** Deny D0150 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim
D0160	Detailed and extensive oral evaluation - problem focused, by report	1 - 20		No		1 per day per provider	**(1)** Deny D0160 when submitted on the same DOS as D0145, or D8080 by any provider **(2)** Deny D0160 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0 - 20		No		1 per day per provider	**(1)** D0170 denied when submitted for the same DOS as D0140 or D0160, same provider. **(2)** D0170 denied when submitted for the same DOS as D0145, any provider **(3)** Deny D0170 if within 14 days of an extraction (D7111, D7140, D7210-D7250) **(4)** Deny D0170 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0180	Comprehensive periodontal evaluation - new or established patient	13 - 20		No			**(1)** D0180 denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160 or D0170, same provider **(2)** Deny D0180 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0210	intraoral- comprehensive series of radiographic images	2 - 20		No		1 per 3 years per provider or location	**(1)** Deny D0210 if member has Dentures (complete and immediate) in dental history. **(2)** Deny D0210 in conjunction with D8660 (Pre-Otho Tx) if billed within 90 day period after date of service: Included in Records Fee. **(3)** Deny D0210 if same day as D0330
D0220	intraoral-periapical first radiographic images	1 - 20		No		1 per day per provider	**(1)** Deny D0220 in combination with Pre-Orthodontic Treatment (D8660), requires 90 day forward for payment of services: Included in records fee.

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0230	intraoral-periapical each additional radiographic images	1 - 20		No			**(1)** Deny D0230 if on the same day as D3222, D3230, D3240, or D3310, D3320, D3330 **(2)** Deny D0230 in combination with Pre-Orthodontic Treatment (D8660), requires 90 day forward for payment of services: Included in records fee. **(3)** Deny D0230 if not submitted with D0220 for same date of service
D0240	intraoral-occlusal radiographic images	0 - 20		No		2 per day per provider	**(1)** Deny D0240 in conjunction with D8660 (Pre-Otho Tx) if billed within 90 day period after date of service: Included in Records Fee, per provider
D0250	extraoral-2D projection radiographic image created using a stationary radiation source, and detector	1 - 20		No		1 per day per provider	**(1)** D0250 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0270	bitewing- single radiographic image	1 - 20		No		1 per day per provider	
D0272	bitewing- two radiographic image	1 - 20		No		1 per day per provider	**(1)** Deny D0272 when submitted for the same DOS as D0210, any provider. **(2)** Deny D0272 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0273	bitewing- three radiographic image	1 - 20		No		1 per day per provider	**(1)** Deny D0273 when submitted for the same DOS as D0210, any provider. **(2)** Deny D0273 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0274	bitewing- four radiographic image	1 - 20		No		1 per day per provider	**(1)** Deny D0274 when submitted for the same DOS as D0210, any provider. **(2)** Deny D0274 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0277	vertical bitewings-7-8 radiographic images	2 - 20		No		1 per day per provider	**(1)** Deny D0277 when submitted for the same DOS as D0210, same provider. **(2)** Deny D0277 when submitted for the same DOS as D0330, same provider. **(3)** Deny D0277 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0310	sialography	1 - 20		No			
D0320	temporo-mandibular joint arthrogram, including injection	1 - 20		No			**(1)** D0320 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0321	other temporo-mandibular joint radiographic images, by report	1 - 20		No			**(1)** D0321 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0322	tomographic survey	1 - 20		No			**(1)** D0322 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0330	panoramic radiographic image	3 - 20		No		1 per 3 years per provider or location	**(1)** D0330 denied if performed on the same DOS as D0210. **(2)** D0330 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** The Panorex radiographic image (D0330) with four bitewing radiographic images (D0274) may be considered equivalent to the complete or full-mouth series of radiographic images (D0210), and the submitted amount for either combination is equivalent to the maximum fee. **(4)** D0330 (panoramic films) will be denied when submitted with procedure code D8070, D8080, D8210, or D8220.
D0340	2D cephalometric radiographic image-acquisition, measurement and analysis	1 - 20		No		1 per day per provider	**(1)** D0340 cannot be reimbursed as a separate procedure, when a comprehensive orthodontic or crossbite therapy workup is performed **(2)** Deny D0340 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** D0340 (panoramic films) will be denied when submitted with procedure code D8070, D8080, D8210, or D8220.
D0350	2D oral/facial photographic image obtained intraorally or extra orally	0 - 20		No		1 per day per provider	**(1)** D0350 cannot be reimbursed as a separate procedure, when a comprehensive orthodontic or crossbite therapy workup is performed **(2)** Deny D0350 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** D0350 (panoramic films) will be denied when submitted with procedure code D8070, D8080, D8210, or D8220.
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	0 - 20		Pre Auth	Panoramic x-ray Narrative of necessity	3 per year per provider	
D0415	collection of microorganisms for culture and sensitivity	1 - 20		No			
D0425	caries susceptibility tests	0 - 20		No			**(1)** D0425 is not payable as a separate procedure, considered part of another dental procedure.
D0460	pulp vitality tests	1 - 20	1-32	No		1 per day per provider	**(1)** Deny D0460 if submitted on the same DOS as any Endo procedure.
D0470	diagnostic casts	1 - 20		No		1 per lifetime	**(1)** D0470 will not be reimbursed as separate procedure when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup has been performed **(2)** Deny D0470 when submitted with procedure code D8070, D8080, D8210, or D8220.

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0472	accession of tissue, gross examination, preparation and transmission of written report	0 - 20		No			
D0473	accession of tissue, gross and microscopic examination, preparation and transmission of written report	0 - 20		No			
D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	0 - 20		No			
D0480	cytologic smears	0 - 20		No			
D0502	other oral pathology procedures, by report	1 - 20		No			
D0601	caries risk assessment and documentation, with a finding of low risk	0 - 20		No			**(1)** D0601 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.
D0602	caries risk assessment and documentation, with a finding of moderate risk	0 - 20		No			**(1)** D0602 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.
D0603	caries risk assessment and documentation, with a finding of high risk	0 - 20		No			**(1)** D0603 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.
D0999	unspecified diagnostic procedure by report	0 - 20		Pre Auth	Narrative of necessity/ report of procedure		

Preventative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D1110	prophylaxis- adult	13 - 20		No		1 per 6 months per member	**(1)** Deny D1110 when submitted for the same DOS as any D4000 series periodontal procedure code. **(2)** If submitted on emergency claim, procedure code will be denied.
D1120	prophylaxis- child	6 months to 12 years		No		1 per 6 months per member	**(1)** Deny D1120 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1120 when submitted on the same DOS as D0145.
D1206	topical application of fluoride varnish	6 months to 20 years		No		1 per 6 months	**(1)** Deny D1206 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1206 when submitted on the same DOS as D0145 **(3)** Deny D1206 if on the same day as another fluoride treatment performed **(4)** Deny D1206 if the patient has a dental history of: Dentures - Complete, Immediate (D5110 - D5140). **(5)** Deny D1206 if within 6 months of D1206 or D1208
D1208	topical application of fluoride- excluding varnish	6 months to 20 years		No		1 per 6 months	**(1)** Deny D1208 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1208 when submitted on the same DOS as D0145 **(3)** Deny D1208 if the patient has a dental history of: Dentures - Complete, Immediate (D5110 - D5140). **(4)** Deny D1208 if within 6 months of D1206 or D1208
D1310	nutritional counseling for control of dental disease	0 - 20		No			**(1)** D1310 denied as part of preventative, therapeutic and diagnostic dental procedures.
D1330	oral hygiene instructions	1 - 20		No		1 per year per member	**(1)** D1330 is denied when billed for the same DOS as dental prophylaxis (D1110 or D1120) or topical fluoride tx (D1206 or D1208) by any provider.
D1351	sealant per tooth	1 - 20	All teeth (surface areas B, F, L and O)	No		1 per tooth per lifetime	**(1)** D1351 is denied when billed for the same DOS as any D4000 series periodontal procedure codes. **(2)** Deny D1351 if on the same day, same tooth as a filling or composite **(3)** Deny D1351 if there is a history of an extraction, implant, implant abutment, pontic, inlay, onlay, crown, D2940, D2950, D6973, D2951, D2952, D6970, D2953, D6976, D2954, D6972, D2957, D6977, D2970, D2975, D6975, or D2980, same tooth. **(4)** Deny D1351 if there is a history of a denture or partial, same tooth as D5110, D5120, D5130, D5140 or partial D5211, D5213, D5225, D5212, D5214, D5226, or D5281 **(5)** If submitted on emergency claim, procedure code will be denied. **(6)** Deny D1351 if on same date of service as D1352, same tooth

Preventative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D1352	preventive resin restoration in a moderate to high risk patient-permanent tooth	5 - 20	All teeth	No		1 per tooth per lifetime	**(1)** Denied if a caries risk assessment (procedure code D0602 or D0603) has not been submitted, by any provider, within 180 days prior. **(2)** Deny D1352 when submitted for the same DOS as any D4000 series periodontal procedure code. **(3)** Deny D1352 if there is a history of an extraction, implant, implant abutment, pontic, inlay, onlay, crown, D2940, D2950, D6973, D2951, D2952, D6970, D2953, D6976, D2954, D6972, D2957, D6977, D2975, D6975, or D2980, same tooth. **(4)** Deny D1352 if there is a history of a denture or partial, same tooth as D5110, D5120, D5130, D5140 or partial D5211, D5213, D5225, D5212, D5214, D5226, or D5281
D1354	interim caries arresting medicament application - per tooth	0-6	A-T, 3, 14, 19, 30	No		1 per tooth per lifetime	**(1)** D1354 will be denied if billed on the same date of service for the same tooth as D1351 or D1352 by any provider **(2)** D1354 will be denied if within 6 months of D9222 by any provider
D1510	Space Maintainer - Fixed - Unilateral	1 - 12	LL, LR, UR, UL	No		1 per quadrant per lifetime	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1 - 12	A, B, I, J 3, 14	No		1 per tooth per lifetime	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1 - 12	K, L, S, T 19, 30	No		1 per tooth per lifetime	
D1520	Space maintainer - removable - unilateral	1 - 20	LL, LR, UR, UL	No		1 per quadrant per lifetime	
D1526	Space maintainer - removable - bilateral, maxillary	1 - 20	A, B, I, J 3, 14	No		1 per tooth per lifetime	
D1527	Space maintainer - removable - bilateral, mandibular	1 - 20	K, L, S, T 19, 30	No		1 per tooth per lifetime	
D1551	re-cement or re-bond bilateral space maintainer - maxillary	1 - 20	A, B, I, J 3, 14	No		1 per lifetime	**(1)** Deny D1551 if within 6 consecutive months of a space maintainer D1510 or D1516, same tooth, same provider
D1552	re-cement or re-bond bilateral space maintainer - mandibular	1 - 20	K, L, S, T 19, 30	No		1 per lifetime	**(1)** Deny D1552 if within 6 consecutive months of a space maintainer D1510 or D1517, same tooth, same provider
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	1 - 20	LL, LR, UR, UL	No		1 per quadrant per lifetime	**(1)** Deny D1553 if within 6 consecutive months of a space maintainer D1510, D1516 or D1517, same tooth, same provider

Preventative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D1556	removal of fixed unilateral space maintainer - per quadrant	1 - 20	LL, LR, UR, UL	No		1 per quadrant per lifetime	**(1)** D1556 is not payable to the provider or dental group that originally placed the device **(2)** Deny D1556 if within 60 consecutive months of a space maintainer D1510 or D1515, same tooth, same provider
D1557	removal of fixed bilateral space maintainer - maxillary Procedure performed by dentist or practice that did not originally place the appliance.	1 - 12	A, B, I, J 3, 14	No		1 per quadrant per lifetime	**(1)** D1557 is not payable to the provider or dental group that originally placed the device **(2)** Deny D1557 if within 60 consecutive months of a space maintainer D1510 or D1515, same tooth, same provider
D1558	removal of fixed bilateral space maintainer - mandibular Procedure performed by dentist or practice that did not originally place the appliance.	1 - 20	K, L, S, T 19, 30	No			**(1)** D1558 is not payable to the provider or dental group that originally placed the device **(2)** Deny D1558 if within 60 consecutive months of a space maintainer D1510 or D1515, same tooth, same provider
D1575	distal shoe space maintainer - fixed, unilateral - per quadrant	3 - 7	LL, LR, UR, UL	No		1 per quadrant per lifetime	

Restorative

Frequency limitations for fillings is once per rolling year, same tooth, same provider. However, a replacement of an identical restorative service in less than 36 months by the same office is not considered the standard of care for quality by UnitedHealthcare Dental. Providers who present as outliers (overutilization of the service) in comparison to their peers may be subject to placement on a post treatment pre-payment review program.

Reimbursement includes local anesthesia.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Pre-operative and post-operative x-rays for indirect restorations, such as crowns, should be taken and maintained in the member's chart. All dental records, including x-rays, shall be made available upon request for retrospective review.

Direct restoration of a primary tooth through the use of a prefabricated crown is considered to be a once in a lifetime restoration, same TID, any provider. Exceptions may be considered when pre-treatment X-ray images, intra-oral photos, and narrative documentation clearly support the medical necessity for the

replacement of the prefabricated crown procedure codes D2930, D2932, D2933, and D2934 during pre-payment review.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Clinical criteria for codes requiring pre-service or post-service clinical review

Inlays

- Documentation describes medical necessity

Crowns/onlays

- 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.

To meet criteria, a crown must:

- 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.

Criteria for crowns following root canal therapy:

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved.
- The filling must be properly condensed/obturated. 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.

Crowns will not meet criteria if:

- 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

Labial veneers

- 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

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2140	amalgam-one surface, primary or permanent	0 - 20	All teeth	No		1 per tooth per 12 months per provider	**(1)** Deny D2140 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2140 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2140 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2140 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2150	amalgam- two surfaces, primary or permanent	0 - 20	All teeth	No		1 per tooth per 12 months per provider	**(1)** Deny D2150 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2150 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2150 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2150 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2160	amalgam- three surfaces, primary or permanent	1 - 20	All teeth	No		1 per tooth per 12 months per provider	**(1)** Deny D2160 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2160 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2160 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2160 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2161	amalgam-four or more surfaces, primary or permanent	1 - 20	All teeth	No		1 per tooth per 12 months per provider	**(1)** Deny D2161 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2161 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2161 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2161 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2330	resin-based composite - one surface, anterior	0 - 20	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2330 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2330 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2330 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2330 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2331	resin-based composite - two surfaces, anterior	0 - 20	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2331 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2331 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2331 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2331 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2332	resin-based composite - three surfaces, anterior	1 - 20	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2332 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2332 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2332 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2332 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2335	resin-based composite - four or more surfaces (anterior)	1 - 20	C-H, M-R	No		1 per tooth per lifetime	**(1)** Deny D2335 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2335 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2335 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2335 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(5)** Will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, and D2934.
D2335	resin-based composite - four or more surfaces (anterior)	1 - 20	6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2335 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2335 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2335 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2335 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(5)** Will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, and D2934.

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2390	resin-based composite crown, anterior	0 - 20	C-H, M-R	No		1 per tooth per lifetime	**(1)** Deny D2390 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2390 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2390 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2390 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth 6) Will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, and D2934.
D2390	resin-based composite crown, anterior	0 - 20	6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2390 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2390 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2390 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2390 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth 6) Will be denied if any of the following anterior restorations have been paid within a rolling year, for the same TID, by the same provider as: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2930, D2932, D2933, and D2934.
D2391	resin-based composite - one surface, posterior	0 - 20	1-5, 12-21, 28-32, A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2391 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2391 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2391 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2391 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2392	resin-based composite - two surfaces, posterior	0 - 20	1-5, 12-21, 28-32, A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2392 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2392 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2392 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2392 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2393	resin-based composite - three surfaces, posterior	1 - 20	1-5, 12-21, 28-32, A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2393 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2393 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2393 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2393 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2394	resin-based composite - four or more surfaces, posterior	1 - 20	1-5, 12-21, 28-32, A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2394 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2394 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2394 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2394 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2510	inlay - metallic - one surface	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2510 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2510 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2510 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2510 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2520	inlay - metallic - two surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2520 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2520 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2520 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2520 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2530	inlay - metallic - three or more surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2530 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2530 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2530 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2530 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2542	onlay - metallic - two surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2542 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2542 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2542 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2542 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2543	onlay - metallic - three surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2543 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2543 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2543 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2543 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2544	onlay - metallic - four or more surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2544 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2544 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2544 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2544 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2650	inlay - resin-based composite - one surface	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2650 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2650 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2650 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2650 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2651	inlay - resin-based composite - two surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2651 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2651 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2651 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2651 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2652	inlay - resin-based composite - three or more surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative of necessity		**(1)** Deny D2652 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2652 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2652 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2652 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2662	onlay - resin-based composite - two surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2662 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2662 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2662 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2662 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2663	onlay - resin-based composite - three surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2663 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2663 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2663 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2663 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2664	onlay - resin-based composite - four or more surfaces	13 - 20	1-5, 12-16, 17-21, 29-32	Post Auth	Current pre and postop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2664 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2664 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/ Crowns (D2510-D2799) **(3)** Deny D2664 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2664 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2710	crown - resin-based composite (indirect)	13 - 20	1-32	Pre Auth	Current bitewing x-rays Narrative when decay is not evident on x-rays	1 per tooth per 10 years	**(1)** Deny D2710 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2710 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2710 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2720	crown - resin with high noble metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2720 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2720 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2720 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2721	crown - resin with predominantly base metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2721 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2721 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2721 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2722	crown - resin with noble metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2722 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2722 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2722 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2740	crown - porcelain/ ceramic substrate	13 - 20	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2740 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2740 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2740 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2750	crown - porcelain fused to high noble metal	13 - 20	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2750 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2750 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2750 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2751	crown - porcelain fused to predominantly base metal	13 - 20	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2751 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2751 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2751 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2752	crown - porcelain fused to noble metal	13 - 20	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2752 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2752 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2752 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2780	crown - 3/4 cast high noble metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2780 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2780 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2780 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2781	crown - 3/4 cast predominantly base metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2781 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2781 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2781 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2782	crown - 3/4 cast noble metal	13 - 20	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2782 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2782 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2782 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2783	crown - 3/4 porcelain/ ceramic	13 - 20	6-11, 22-27	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2783 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2783 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2783 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2790	crown - full cast high noble metal	13 - 20	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2790 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2790 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2790 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2791	crown - full cast predominantly base metal	13 - 20	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2791 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2791 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2791 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2792	crown - full cast noble metal	13 - 20	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2792 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2792 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2792 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)
D2794	crown - titanium	13 - 20	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 10 years	**(1)** Deny D2794 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2794 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2794 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799)

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2910	recement inlay, onlay, or partial coverage restoration	13 - 20	1-32	No			**(1)** Deny D2910 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2910 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2910 if within 12 months of an Inlay, Onlay (D2510-D2664), same provider **(4)** OR if there is no history of inlay, onlay - same tooth, same provider
D2915	recement cast or prefabricated post and core	4 - 20	1-32	No			**(1)** Deny D2915 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2915 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2915 if within 185 days of Crown, Abutment: Payment is included in the allowance of another service/procedure **(4)** Deny D2915 if within 12 months of an crown - same tooth, same provider
D2920	recement crown	1 - 20	1-32, A-T	No			**(1)** Deny D2920 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2920 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2920 if within 185 days of Crown, Abutment: Payment is included in the allowance of another service/procedure **(4)** Deny D2920 if within 12 months of an crown - same tooth, same provider
D2930	prefabricated stainless steel crown – primary tooth	0 - 20	A-T	No		1 per tooth per lifetime	**(1)** Deny D2930 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2930 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2930 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799). **(4)** Procedure code D2930 will be denied if there is any history of the following procedure codes for the same TID: Procedure codes D2930, D2932, D2933, D2934.

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2931	prefabricated stainless steel crown - permanent tooth	1 - 20	1-32	No		1 per tooth per 10 years	**(1)** Deny D2931 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2931 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2931 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799).
D2932	prefabricated resin crown	1 - 20	C-H, M-R, 6-11, 22-27	No		1 per tooth per lifetime	**(1)** Deny D2932 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2932 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2932 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799). **(4)** Procedure code D2932 will be denied if there is any history of the following procedure codes for the same TID: Procedure codes D2930, D2932, D2933, D2934.
D2933	prefabricated stainless steel crown with resin window	0 - 20	C-H, M-R	No		1 per tooth per lifetime	**(1)** Deny D2933 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2933 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2933 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799). **(4)** Procedure code D2933 will be denied if there is any history of the following procedure codes for the same TID: Procedure codes D2930, D2932, D2933, D2934.
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	C-H, M-R	No		1 per tooth per lifetime	**(1)** Deny D2934 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2934 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(3)** Deny D2934 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799). **(4)** D2934 will be denied if there is any history of the following procedure codes for the same TID: Procedure codes D2930, D2932, D2933, D2934.

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2940	placement of interim direct restoration	0 - 20	1-32, A-T	No			**(1)** Deny D2940 if on the same DOS as a permanent restoration. **(2)** Deny D2940 if on the same day, same tooth as a filling, composite, crown, inlay, onlay, D2910, D2915, D2920, D2940, D2950, D2951, D2952, D2953, D2954, D2957, D2980, D3450, D3920, D3220, D3221, pulpal therapy, root canal therapy, root canal retreatment, apexification, D3354, Apicoectomy, D3430, or perio. **(3)** Deny if tooth is missing (extraction, implant, denture, partial, or pontic), same tooth
D2950	core buildup, including any pins when required	4 - 20	1-32	No			**(1)** Deny D2950 if on the same day, same tooth as an Inlay, Onlay, Filling, or Composite Filling **(2)** Deny D2950 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(3)** Deny D2950 if the following codes are present in the patients history: Extractions, Pontics, Abutment, Complete Dentures (D5110/ D5120) and Immediate Dentures (D5130/ D5140).
D2951	pin retention - per tooth, in addition to restoration	4 - 20	1-32	No		2 per tooth per lifetime	**(1)** Deny D2951 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2951 if performed on the same day as: Buildup (D2950) or post & core services (D2952-54, D2957, D6970-73, D6976-7 **(7)** Payment is included in the allowance for another service/ procedure on same day. **(3)** Deny D2951 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2951 if on the same day, same tooth as an inlay, onlay
D2952	post and core in addition to crown, indirectly fabricated	13 - 20	1-32	No			**(1)** Deny D2952 if used in conjunction with D2950. **(2)** Deny D2952 if the following codes are present in the patients history: Extractions, Pontics, Abutment, Complete Dentures (D5110/D5120) and Immediate Dentures (D5130/D5140). **(3)** Deny D2952 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2952 if there is no history of a root canal (RCT) on same tooth. **(5)** Deny D2952 if billed with D2954, an inlay, onlay, filling or composite.

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2953	each additional indirectly fabricated post - same tooth	13 - 20	1-32	No			**(1)** Deny D2953 if on the same day, same tooth as an Inlay, Onlay, Filling, or Composite Filling **(2)** Deny D2953 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(3)** Deny D2953 if the following codes are present in the patients history: Extractions, Pontics, Abutment, Complete Dentures (D5110/ D5120) and Immediate Dentures (D5130/ D5140). **(4)** Deny D2953 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(5)** Deny D2953 if there is no history of a root canal on same tooth.
D2954	prefabricated post and core in addition to crown	13 - 20	1-32	No			**(1)** D2954 is not payable in conjunction with D2952 or D3950 on the same TID, same provider. **(2)** Deny D2954 if on the same day, same tooth as an Inlay, Onlay, Filling, or Composite Filling **(3)** Deny D2954 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/ Surgical Extractions (D7111-D7250) **(4)** Deny D2954 if the following codes are present in the patients history: Extractions, Implants, Pontics, Abutment, Complete Dentures (D5110/D5120) and Immediate Dentures (D5130/D5140). **(5)** Deny D2954 if there is no history of a root canal on same tooth.
D2955	post removal	4 - 20	1-32	No			**(1)** Deny D2955 if used in conjunction with endo retreatment (D3346, D3347, D3348).
D2957	each additional prefabricated post - same tooth	13 - 20	1-32	No			**(1)** D2957 must be used in conjunction with D2954.
D2960	labial veneer (resin laminate) - direct	13 - 20	1-32	Pre Auth	Pre and postop x-rays or Intraoral photos Narrative of necessity		
D2961	labial veneer (resin laminate) - indirect	13 - 20	1-32	Pre Auth	Pre and postop x-rays or Intraoral photos Narrative of necessity		
D2962	labial veneer (porcelain laminate) - indirect	13 - 20	1-32	Pre Auth	Pre and postop x-rays or Intraoral photos Narrative of necessity		

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2971	additional procedures to customize a crown to fit under an existing partial denture framework	13 - 20	1-32	No		4 per tooth per lifetime	
D2980	crown repair necessitated by restorative material failure	1 - 20	1-32	No			**(1)** Deny D2980 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(2)** Deny D2980 if the following codes are present in the patients history: Extractions, Pontics, Abutment, Complete Dentures (D5110/D5120) and Immediate Dentures (D5130/D5140). **(3)** Deny D2980 if there is no history of a crown, abutment, same tooth. **(4)** Deny D2980 if within 12 months of a crown, same tooth, same provider
D2999	unspecified restorative procedure, by report	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity/ report of procedure		

Endodontics

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Clinical criteria for codes requiring pre-service or post-service clinical review

Root Canal Therapy

Not all procedures require authorization.

- Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root Canal Retreatment

- 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.

Authorizations for Root Canal Retreatment therapy will not meet criteria if:

- 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.

Apexification / Recalcification

- The apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

Apicoectomy / Periradicular Surgery

- 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

Retrograde Filling

- 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

Root Amputation

- Class III Furcation involvement
- Untreatable 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

Endodontic Endosseous Implant

- Medically necessary to retain tooth structure
- Adequate periodontal and osseous support
- Pre-op x-rays must show apex of root
- Free from periodontal disease

Intentional Re-implantation

- 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

Endodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D3110	pulp cap - direct (excluding final restoration)	1 - 20	1-32	No			
D3120	pulp cap - indirect (excluding final restoration)	1 - 20	1-32	No			

Endodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinoce-mental junction and application of medicament	0 - 20	A -T	No		1 per tooth per lifetime	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1 - 20	C-H, M-R	No			
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1 - 20	A, B, I, J, K, L, S, T	No			
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6 - 20	6-11, 22-27	No			
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	6 - 20	4, 5, 12, 13, 20, 21, 28, 29	No			
D3330	endodontic therapy, molar (excluding final restoration)	6 - 20	1-3, 14-19, 30-32	No			
D3346	retreatment of previous root canal therapy - anterior	6 - 20	6-11, 22-27	Post Auth	Current pre and postop x-rays Narrative of necessity		
D3347	retreatment of previous root canal therapy - bicuspid	6 - 20	4, 5, 12, 13, 20, 21, 28, 29	Post Auth	Current pre and postop x-rays Narrative of necessity		
D3348	retreatment of previous root canal therapy - molar	6 - 20	1-3, 14-19, 30-32	Post Auth	Current pre and postop x-rays Narrative of necessity		
D3351	apexification/ recalcification/pupal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	6 - 20	1-32	Post Auth	Current preop x-rays Narrative of necessity		

Endodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D3352	apexification/ recalcification/pupal regeneration - interim medication visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	6 - 20	1-32	Post Auth	Current preop x-rays Narrative of necessity		
D3353	apexification/ recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	6 - 20	1-32	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3410	apicoectomy/ periradicular surgery - anterior	6 - 20	6-11, 22-27	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3421	apicoectomy/ periradicular surgery - biscupid (first root)	6 - 20	4, 5, 12, 13, 20, 21, 28, 29	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3425	apicoectomy/ periradicular surgery -molar (first root)	6 - 20	1-3, 14-19, 30-32	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3426	apicoectomy/ periradicular surgery - (each additional root)	6 - 20	1-5, 12-21, 28-32	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3430	retrograde filling – per root	6 - 20	1-32	Post Auth	Current pre and post op x-rays Narrative of necessity		
D3450	root amputation – per root	6 - 20	1-5, 12-21, 28-32	Pre Auth	Current preop x-rays Narrative of necessity		
D3460	endodontic endosseous implant	16 - 20	1-32	Pre Auth	Current preop x-rays for each tooth involved Narrative of necessity		
D3470	intentional reimplantation (including necessary splinting)	6 - 20	1-32	Pre Auth	Preop panoramic x-ray or full series Narrative of necessity		
D3910	surgical procedure for isolation of tooth with rubber dam	1 - 20	1-32	No			

Endodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D3920	hemisection (including any root removal), not including root canal therapy	6 - 20	1-3, 14-19, 30-32	No			
D3950	canal preparation and fitting of preformed dowel or post	6 - 20	1-32	No			
D3999	unspecified endodontic procedure, by report	1 - 20	1-32, A-T	Pre Auth	Current preop x-rays Narrative of necessity/ report of procedure		

Periodontics

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes, any provider.

Clinical criteria for codes requiring pre-service or post-service clinical review

Gingivectomy or Gingivoplasty

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia

Anatomical Crown Exposure

- To facilitate the restoration of subgingival caries
- To allow proper contour of restoration
- To allow management of a subgingivally fractured tooth

Flap Procedures

- 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

Clinical Crown Lengthening

- 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

Osseous Surgery

- 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

Guided Tissue Regeneration

- Intrabony/infrabony vertical defects
- Class II Furcation involvements
- To enhance periodontal tissue regeneration and healing for mucogingival defects in conjunction with mucogingival surgeries

Tissue Grafts (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)

- 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

Mesial/Distal Wedge

- The presence of moderate to deep probing depths (greater than 5mm) on a surface adjacent to an edentulous/terminal tooth area

Scaling and Root Planning

- **D4341** (Four or more teeth per quadrant)
  - Probing depths of at least 5 mm or greater
  - Radiographic evidence of bone loss
- **D4342** (One to three teeth per quadrant)
  - Probing depths of at least 5 mm or greater
  - Radiographic evidence of bone loss

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4230	anatomical crown exposure - four or more contiguous teeth per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4231	anatomical crown exposure - one to three teeth per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Full mouth x-rays 6 point perio charting Narrative Photos if necessity not clear		
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Full mouth x-rays 6 point perio charting Narrative Photos if necessity not clear	1 per year	
D4245	apically positioned flap	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop x-rays Narrative Preop photos if necessity not clear		
D4249	clinical crown lengthening - hard tissue	13 - 20	1-32	Pre Auth	Current preop x-rays 6 point perio charting Narrative of necessity		
D4260	osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop full mouth x-rays 6 point perio charting Narrative of necessity	1 per day per provider	
D4261	osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current preop full mouth x-rays 6 point perio charting Narrative of necessity	1 per day per provider	

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4266	guided tissue regeneration, natural teeth - resorbable barrier, per site	13 - 20	1-32	Pre Auth	Preop x-rays 6 point perio charting Narrative Photos if necessity not clear		
D4267	guided tissue regeneration, natural teeth - non-resorbable barrier, per site	13 - 20	1-32	Pre Auth	Preop x-rays 6 point perio charting Narrative Photos if necessity not clear		
D4270	pedicle soft tissue graft procedure	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4273	subepithelial connective tissue graft procedures, per tooth	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4274	distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4275	soft tissue allograft	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative	1 per day per provider	
D4276	combined connective tissue and pedicle graft, per tooth	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		**(1)** D4276 will be denied if on same DOS as D4273 or D4275
D4277	free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4278	free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		**(1)** D4278 will be denied IF NOT billed on the same DOS as D4277: Service is not payable without other procedure performed
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative	3 per day per provider	**(1)** D4283 will be denied IF NOT billed on the same DOS as D4273: Service is not payable without other procedure performed
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	13 - 20	1-32	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative	3 per day per provider	**(1)** D4285 will be denied IF NOT billed on the same DOS as D4275: Service is not payable without other procedure performed
D4341	periodontal scaling and root planing - four or more teeth per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current full mouth x-rays 6 point perio charting Narrative		**(1)** Deny D4341 if on the same day as D4355, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4342, D4270, D4271, D4273, or D4274. **(2)** Deny D4341 if there is a history of a complete denture, or Intermediate denture on the same arch. **(3)** Deny D4341 if within 36 months of D4240 or D4241 **(4)** Deny D4341 if billed within 90 days of service of D4341/D4342
D4342	periodontal scaling and root planing - one to three teeth per quadrant	13 - 20	LL, LR, UR, UL	Pre Auth	Current full mouth x-rays 6 point perio charting Narrative		**(1)** Deny D4342 if on the same day as D4355, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4342, D4270, D4271, D4273, or D4274. **(2)** Deny D4342 if there is a history of a complete denture, or Intermediate denture on the same arch. **(3)** Deny D4342 if within 36 months of D4240 or D4241 **(4)** Deny D4342 if billed within 90 days of service of D4341/D4342
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	13 - 20		No			**(1)** Deny D4355 when submitted on the same DOS as: D4210, D4211, D4230, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4381, D4910, D4920, D4999, by any provider
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	13 - 20	1-32	No			

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4910	periodontal maintenance	13 - 20		No		1 per 12 months per provider	**(1)** Deny D4910 UNLESS it is following active periodontal therapy as evidenced by a submitted claim for D4240, D4241, D4260 or D4261, any provider, or by evidence through client records of periodontal therapy while not Medicaid eligible. **(2)** Deny D4910 if billed within 90 days after D4355 **(3)** D4910 will be denied if on the same DOS as any other evaluation procedure
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	13 - 20		No			
D4999	unspecified periodontal procedure, by report	13 - 20		Pre Auth	Current preop panoramic x-ray or full series 6 point perio charting Narrative		

Prosthodontics, Removable

A preformed denture with teeth already mounted forming a denture module is not a covered service.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Clinical criteria for codes requiring pre-service or post-service clinical review

Complete Dentures and Immediate Dentures must have all of the following:

- 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)

If a replacement full denture is requested within 5 years:

- 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.

Partial Dentures

- 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.
- 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.

Authorizations for removable prosthesis will not meet criteria:

- 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)** peridontially 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.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- 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).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

Interim Partial Dentures

- 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

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5110	complete denture - maxillary	3 - 20		Post Auth	Current preop panoramic x-ray or full series		**(1)** Deny D5110 if within 60 months of denture, partial denture in the maxillary arch.
D5120	complete denture - mandibular	3 - 20		Post Auth	Current preop panoramic x-ray or full series		**(1)** Deny D5120 if within 60 months of denture, partial denture in the mandibular arch.
D5130	immediate denture - maxillary	13 - 20		Post Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5140	immediate denture - mandibular	13 - 20		Post Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	6 - 20		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	6 - 20		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	9 - 20		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	9 - 20		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5410	adjust complete denture - maxillary	3 - 20		No			**(1)** Deny D5410 if within 12 floating months of a complete maxillary denture or immediate maxillary denture, same provider **(2)** Deny D5410 if there is a history of a partial maxillary denture, same provider
D5411	adjust complete denture - mandibular	3 - 20		No			**(1)** Deny D5411 if within 12 floating months of a complete mandibular denture or immediate mandibular denture, same provider **(2)** Deny D5411 if there is a history of a partial mandibular denture, same provider
D5421	adjust partial denture - maxillary	6 - 20		No			
D5422	adjust partial denture - mandibular	6 - 20		No			
D5511	repair broken complete denture base, mandibular	3 - 20		No			**(1)** Deny D5511 if within 12 floating months of a Complete denture **(2)** Deny D5511 if there is a history of a partial denture in the same arch **(3)** Cost of repairs cannot exceed replacement costs.
D5512	repair broken complete denture base, maxillary	3 - 20		No			**(1)** Deny D5512 if within 12 floating months of a Complete denture **(2)** Deny D5512 if there is a history of a partial denture in the same arch **(3)** Cost of repairs cannot exceed replacement costs.
D5520	replace missing or broken teeth - complete denture (per tooth)	3 - 20	1-32	No			**(1)** Deny D5520 if within 12 floating months of a Complete denture **(2)** Deny D5520 if there is a history of a partial denture in the same arch **(3)** Cost of repairs cannot exceed replacement costs.
D5611	repair resin partial denture base, mandibular	3 - 20		No			**(1)** Deny D5611 if within 12 floating months of a partial denture, same arch **(2)** Deny D5611 if there is a history of a complete denture, same arch **(3)** Cost of repairs cannot exceed replacement costs. **(4)** The laboratory portion of the claim, not to exceed $137.50, must be submitted.

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5612	repair resin partial denture base, maxillary	3 - 20		No			**(1)** Deny D5612 if within 12 floating months of a partial denture, same arch **(2)** Deny D5612 if there is a history of a complete denture, same arch
D5630	repair or replace broken clasp	6 - 20	1-32	No			**(1)** Deny D5630 if within 12 floating months of a partial denture, same arch **(2)** Deny D5630 if there is a history of a complete denture, same arch
D5640	replace missing or broken teeth - partial denture - per tooth	6 - 20	1-32	No			**(1)** Deny D5640 if within 12 floating months of a partial denture, same arch **(2)** Deny D5640 if there is a history of a complete denture, same arch
D5650	add tooth to existing partial denture (per tooth)	6 - 20	1-32	No			**(1)** Deny D5650 if there is a history of a complete denture, same arch
D5660	add clasp to existing partial denture	6 - 20	1-32	No			
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	6 - 20		No			**(1)** D5670 is denied as part of D5211, D5213 and D5640
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	6 - 20		No			**(1)** D5671 is denied as part of D5211, D5213 and D5640
D5710	rebase complete maxillary denture	4 - 20		No			**(1)** D5710 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5710 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5720, D5730, D5740, D5750, and D5760, same provider.
D5711	rebase complete mandibular denture	4 - 20		No			**(1)** D5711 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5711 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5721, D5731, D5741, D5751, and D5761, same provider.
D5720	rebase maxillary partial denture	7 - 20		No			**(1)** D5720 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5720 is limited to once every three rolling years, same provider and will be denied within three rolling years of procedure codes D5710, D5730, D5740, D5750, and D5760, same provider.

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5721	rebase mandibular partial denture	7 - 20		No			**(1)** D5721 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5721 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5711, D5731, D5741, D5751, and D5761, same provider.
D5730	reline complete maxillary denture (direct)	4 - 20		No			**(1)** D5730 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5730 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5710, D5720, D5740, D5750, and D5760, same provider.
D5731	reline complete mandibular denture (direct)	4 - 20		No			**(1)** D5731 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5731 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5711, D5721, D5741, D5751, and D5761, same provider.
D5740	reline maxillary partial denture (direct)	7 - 20		No			**(1)** D5740 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5740 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5750, and D5760, same provider.
D5741	reline mandibular partial denture (direct)	7 - 20		No			**(1)** D5741 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5741 is limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5751, and D5761, same provider.
D5750	reline complete maxillary denture (indirect)	4 - 20		No			**(1)** D5750 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5750 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5760, same provider.

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5751	reline complete mandibular denture (indirect)	4 - 20		No			**(1)** D5751 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5751 is limited to once every three rolling years, same provider. Will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5761, same provider.
D5760	reline maxillary partial denture (indirect)	7 - 20		No			**(1)** D5760 will be denied when performed within one rolling year of procedure codes D5110, D5130, D5211 and D5213, any provider. **(2)** D5760 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5710, D5720, D5730, D5740, and D5750, same provider.
D5761	reline mandibular partial denture (indirect)	7 - 20		No			**(1)** D5761 will be denied when performed within one rolling year of procedure codes D5120, D5140, D5212 and D5214, any provider. **(2)** D5761 is limited to once every three rolling years, same provider and will be denied when billed within three rolling years of procedure codes D5711, D5721, D5731, D5741, and D5751, same provider.
D5810	interim complete denture (maxillary)	3 - 20		Pre Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5811	interim complete denture (mandibular)	3 - 20		Pre Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5820	Interim partial denture (Including retentive clasping materials and teeth) - maxillary	3 - 20		Pre Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5821	Interim partial denture (Including retentive clasping materials and teeth) - mandibular	3 - 20		Pre Auth	Current preop panoramic x-ray or full series Narrative of necessity		
D5850	tissue conditioning, maxillary	3 - 20		No			
D5851	tissue conditioning, mandibular	3 - 20		No			
D5862	precision attachment, by report	4 - 20	1-32	No			
D5863	Overdenture - complete maxillary	4 - 20		No			

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5864	Overdenture - complete mandibular	4 - 20		No			
D5865	Overdenture - partial maxillary	4 - 20		No			
D5866	Overdenture - partial mandibular	4 - 20		No			
D5899	unspecified removable prosthodontic procedure, by report	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity/ report of procedure		

Maxillofacial Prosthetics

Clinical criteria for codes requiring pre-service or post-service clinical review

Maxillofacial Prosthetics

- Documentation describes accident, facial trauma, disease, facial reconstruction or other medical necessity need

Maxillofacial Prosthetics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5911	facial moulage (sectional)	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5912	facial moulage (complete)	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5913	nasal prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5914	auricular prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5915	orbital prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5916	ocular prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5919	facial prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5922	nasal septal prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		

Maxillofacial Prosthetics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5923	ocular prosthesis, interim	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5924	cranial prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5925	facial augmentation implant prosthesis	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5926	nasal prosthesis, replacement	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5927	auricular prosthesis, replacement	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5928	orbital prosthesis, replacement	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5929	facial prosthesis, replacement	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5931	obturator prosthesis, surgical	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5932	obturator prosthesis, definitive	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5933	obturator prosthesis, modification	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5934	mandibular resection prosthesis with guide flange	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5935	mandibular resection prosthesis without guide flange	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5936	obturator prosthesis, interim	1 - 20		Pre Auth	Current preop x-rays Preop photos Narrative of necessity		
D5937	trismus appliance (not for TMD treatment)	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		**(1)** Not for temporo-mandibular dysfunction (TMD) treatment.
D5951	feeding aid	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5952	speech aid prosthesis, pediatric	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5953	speech aid prosthesis, adult	13 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5954	palatal augmentation prosthesis	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		

Maxillofacial Prosthetics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5955	palatal lift prosthesis, definitive	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5958	palatal lift prosthesis, interim	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5959	palatal lift prosthesis, modification	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5960	speech aid prosthesis, modification	0 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5982	surgical stent	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5983	radiation carrier	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5984	radiation shield	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5985	radiation cone locator	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5986	fluoride gel carrier	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5987	commissure splint	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5988	surgical splint	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5992	adjust maxillofacial prosthetic appliance, by report	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5993	maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D5999	unspecified maxillofacial prosthesis, by report	1 - 20		Pre Auth	Preop panoramic x-ray Preop photos Narrative of necessity/ report of procedure		

Prosthodontics, Fixed

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Clinical criteria for codes requiring pre-service or post-service clinical review

Fixed Partial Dentures – Pontics and Retainers

- 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

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

Prosthodontics, Fixed

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D6210	pontic - cast high noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6211	pontic - cast predominantly base metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6212	pontic - cast noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6240	pontic - porcelain fused to high noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6241	pontic - porcelain fused to predominantly base metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6242	pontic - porcelain fused to noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6245	pontic - porcelain/ ceramic	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6250	pontic - resin with high noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6251	pontic - resin with predominantly base metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6252	pontic - resin with noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6545	retainer - cast metal for resin bonded fixed prosthesis	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6548	retainer - porcelain/ ceramic for resin bonded fixed prosthesis	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6549	resin retainer - for resin bonded fixed prosthesis	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6720	retainer crown - resin with high noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6721	retainer crown - resin with predominantly base metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6722	retainer crown - resin with noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		

Prosthodontics, Fixed

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D6740	retainer crown - porcelain/ceramic	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6750	retainer crown - porcelain fused to high noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6751	retainer crown - porcelain fused to predominantly base metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6752	retainer crown - porcelain fused to noble metal	16 - 20	1-32	Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6780	retainer crown - 3/4 cast high noble metal	16 - 20	1-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6781	retainer crown - 3/4 cast predominantly base metal	16 - 20	1-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6782	retainer crown - 3/4 cast noble metal	16 - 20	1-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6783	retainer crown - 3/4 porcelain/ceramic	16 - 20	1-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6790	retainer crown - full cast high noble metal	16 - 20	1-5, 12-16, 17-21, 28-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6791	retainer crown - full cast predominantly base metal	16 - 20	1-5, 12-16, 17-21, 28-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6792	retainer crown - full cast noble metal	16 - 20	1-5, 12-16, 17-21, 28-32	Post Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D6920	connector bar	16 - 20		Post Auth	Current preop x-rays Narrative of necessity		
D6930	recement fixed partial denture	16 - 20	1-32	No			
D6940	stress breaker	16 - 20	1-32	No			
D6950	precision attachment	16 - 20	1-32	No			
D6980	fixed partial denture repair necessitated by restorative material failure	16 - 20		No			
D6999	unspecified fixed prosthodontic procedure, by report	16 - 20		Pre Auth	Current preop x-rays of area Narrative of necessity/report of procedure		

Oral and Maxillofacial Surgery

Reimbursement includes local anesthesia and routine post-operative care.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Clinical criteria for codes requiring pre-service or post-service clinical review

Removal of Impacted Teeth

- 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.

Tooth Transplantation

- Subluxation injuries to permanent teeth

Surgical Repositioning of Teeth

- The treatment of displacement injuries to permanent teeth
- Extrusion of teeth with crown/root fractures to prepare for restoration of permanent teeth

Removal of Torus Palatinus

- 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

Partial Ostectomy

- Documentation describes presence or description of non-vital bone or foreign body

Maxillary Sinusotomy

- Documentation describes presence or description of root fracture of foreign body in maxillary antrum

Alveolus – Closed Reduction, May Include Stabilization of Teeth

- Documentation describes accident, operative report and medical necessity

Closed Reduction of Dislocation

- Narrative and x-rays support medical necessity for procedure

Occlusal Orthotic Device, by Report

- Documentation supports history of TMJ pain / treatment efforts
- Not for bruxism, grinding or other occlusal factors

Suture Repairs

- Documentation describes accident
- Not for tooth extraction or to close surgical incision

Repair of Maxillofacial Soft and/or Hard Tissue Defect

- Narrative and x-rays support medical necessity for procedure

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7111	extraction, coronal remnants - deciduous tooth	0 - 20	A-T, AS-TS	No			**(1)** Deny D7111 with Simple/Surgical Extractions (D7111-D7250): Tooth previously extracted. **(2)** Deny D7111 with Complete Dentures (D5110/5120): Services not permitted with other procedures billed. **(3)** Deny D7111 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures. **(4)** Deny D7111 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code. **(5)** Deny D7111 if billed with Pontic, Full Dentures (D5110, D5120, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253). Based on the patient's dental history these procedure codes are not eligible with D7210. **(6)** Deny D7111 if billed on the same day as D7272, mouth level.
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0 - 20	1-32, A-T, SN	No			**(1)** Deny D7140 with Simple/Surgical Extractions (D7111-D7250): Tooth previously extracted. **(2)** Deny D7140 with Complete Dentures (D5110/5120): Services not permitted with other procedures billed. **(3)** Deny D7140 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures. **(4)** Deny D7140 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code. **(5)** Deny D7140 if billed with Pontic, Full Dentures (D5110, D5120, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253). Based on the patient's dental history these procedure codes are not eligible with D7210. **(6)** Deny D7140 if billed on the same day as D7272, mouth level.
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 20	1-32, A-T, SN	No			**(1)** Deny D7210 with Simple/Surgical Extractions (D7111-D7250): Tooth previously extracted. **(2)** Deny D7210 with Complete Dentures (D5110/5120): Services not permitted with other procedures billed. **(3)** Deny D7210 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures. **(4)** Deny D7210 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code. **(5)** Deny D7210 if billed with Pontic, Full Dentures (D5110, D5120, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253). Based on the patient's dental history these procedure codes are not eligible with D7210. **(6)** Deny D7210 if billed on the same day as D7272, mouth level. **(7)** Includes removal of the roots of a previously erupted tooth missing its clinical crown.
D7220	removal of impacted tooth - soft tissue	1 - 20	1-32, A-T, SN	No			**(1)** Deny D7220 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures.

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7230	removal of impacted tooth - partially bony	1 - 20	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		**(1)** Deny D7230 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/ D5140): Not billable after full dentures.
D7240	removal of impacted tooth - completely bony	1 - 20	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		**(1)** Deny D7240 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/ D5140): Not billable after full dentures.
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	1 - 20	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		**(1)** Deny D7241 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/ D5140): Not billable after full dentures.
D7250	surgical removal of residual tooth roots (cutting procedure)	1 - 20	1-32, A-T, SN	No			**(1)** Deny D7250 if combined with Complete Dentures (D5110/5120) and/or Immediate Dentures (D5130/D5140) : Service not billable after full dentures. **(2)** Deny D7250 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code. **(3)** Deny D7250 if billed on same date of service as D5110 and D5120. Not permitted on same day as other procedures billed. **(4)** D7250 denied/not eligible based on patient dental history if combined with Simple/Surgical Extractions (D7111-D7241). **(5)** D7250 denied/ not eligible based on patient dental history if combined with Surgical Extraction Residual Roots (D7250). **(6)** Deny D7250 if billed on the same day as D7272, mouth level. **(7)** Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred.
D7260	oroantral fistula closure	1 - 20	1-16	No			
D7261	primary closure of a sinus perforation	1 - 20	1-16	No			**(1)** D7261 will not be paid on the same DOS as D7260
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	1 - 20	1-32, A-T, SN	No			
D7272	tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	1 - 20	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7280	surgical access of an unerupted tooth	1 - 20	2-15, 18-31	No			**(1)** D7280 will be denied unless billed with an authorized procedure code W- D7283, for the same tooth, on the same day, by the same provider. **(2)** D7280 will not be paid on the same DOS as D7282

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7282	mobilization of erupted or malpositioned tooth to aid eruption	4 - 20	2-15, 18-31	No			**(1)** D7282 will not be paid on the same DOS as D7280
D7283	placement of device to facilitate eruption of impacted tooth	1 - 20	2-15, 18-31	No			
D7285	biopsy of oral tissue - hard (bone, tooth)	1 - 20		No			
D7286	biopsy of oral tissue - soft	1 - 20		No			
D7290	surgical repositioning of teeth	1 - 20	1-32	Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	4 - 20	1-32	No			
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 - 20	LL, LR, UR, UL	No			**(1)** Deny D7310 if extractions and alveoloplasty are not performed in the same visit. **(2)** Deny D7310 if there is an Alveoloplasty D7310, D7311, D7320, D7321 in history in the same quad. **(3)** D7310 denied/not billable after full dentures: Check against codes D5110, D5120, D5130, D5140
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 - 20	LL, LR, UR, UL	No			**(1)** Deny D7320 if billed in conjunction with D7111, D7120, D7130, D7140, D7210, D7220, D7230 D7240, D7241, D7250: Payment is included in the allowance for another service/procedure **(2)** Deny D7320 if there is an Alveoloplasty D7310, D7311, D7320, D7321 in history in the same quad.
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	1 - 20	LL, LR, UR, UL	No			
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	1 - 20	LL, LR, UR, UL	No			
D7410	excision of benign lesion up to 1.25 cm	1 - 20		No			
D7411	excision of benign lesion greater than 1.25 cm	1 - 20		No			

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7413	excision of malignant lesion up to 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7414	excision of malignant lesion greater than 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7465	destruction of lesion(s) by physical or chemical method, by report	1 - 20		No			**(1)** The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee.
D7472	removal of torus palatinus	1 - 20		Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7510	incision and drainage of abscess - intraoral soft tissue	1 - 20		No			
D7520	incision and drainage of abscess - extraoral soft tissue	1 - 20		No			

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	1 - 20		No			
D7540	removal of reaction producing foreign bodies, musculoskeletal system	1 - 20		No			
D7550	partial ostectomy/ sequestrectomy for removal of non-vital bone	1 - 20	LL, LR, UR, UL	Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	1 - 20		Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 20		Pre Auth	Current preop panoramic x-ray Narrative of necessity		
D7820	closed reduction of dislocation	1 - 20		Pre Auth	Current preop TMJ radiographs Narrative of necessity		
D7880	occlusal orthotic device, by report	1 - 20		Pre Auth	Current preop TMJ radiographs Narrative of necessity		
D7899	unspecified TMD therapy, by report	1 - 20		Pre Auth	Current preop TMJ radiographs Narrative of necessity		
D7910	suture of recent small wounds up to 5 cm	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D7911	complicated suture - up to 5 cm	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D7912	complicated suture - greater than 5 cm	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7955	repair of maxillofacial soft and/or hard tissue defect	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		
D7961	buccal / labial frenectomy (frenulectomy)	12 - 20		No			
D7962	lingual frenectomy (frenulectomy)	1 - 20		No			
D7970	excision of hyperplastic tissue - per arch	1 - 20	Arches (UA, LA)	No			
D7971	excision of pericoronal gingiva	1 - 20		No			
D7972	surgical reduction of fibrous tuberosity	13 - 20	1, 16, 17, 32	No			**(1)** D7972 will not be paid on the same DOS as D7971
D7980	sialolithotomy	1 - 20		No			
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	1 - 20		No			
D7999	unspecified oral surgery procedure, by report	1 - 20		Pre Auth	Current preop x-rays Narrative of necessity		

C.2 Comprehensive medically necessary orthodontic services

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.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure code D0120, D0150, or D0160).

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

UnitedHealthcare 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 48	Level I or II	• Completion of pediatric dental residency; or • A minimum of 200 hours of continuing dental education in orthodontics.
Provider Type 90	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
D8210 Removable Appliance Therapy **D8220** 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: 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 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
D8010 Limited orthodontic treatment of the primary dentition **D8020** Limited orthodontic treatment of the transitional dentition **D8070** Comprehensive orthodontic treatment of the transitional dentition	Type 48 Type 90	0-20	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: 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 II: Dedicated to the resolution of handicapping malocclusion in the transitional dentition; the final phase of the transition from primary to adolescent dentition during which 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.

CDT codes	Provider type	Age group	Treatment length	Exceptions to expected treatment time
D8080 Comprehensive orthodontic treatment of the adolescent dentition	Type 90	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: 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 have erupted into the oral cavity and are 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.
- 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
D8090 Comprehensive orthodontic treatment of the adult dentition	Type 90	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: 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 approved 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

C.3 Reimbursement

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

Prior authorized procedure codes: D8010, D8020, D8070, D8080, D8090, D8210, or D8220

- 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

C.4 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 UnitedHealthcare Dental)
2. Other DMO to UnitedHealthcare Dental
3. Private/Commercial Arrangement to UnitedHealthcare Dental

Provider to Provider (within UnitedHealthcare Dental):

This section is for situations in which the Orthodontic care of a Medicaid eligible member is transferred from one UnitedHealthcare Dental provider to another UnitedHealthcare 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.

Other DMO to UnitedHealthcare 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 UnitedHealthcare 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 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

Private/commercial arrangement to UnitedHealthcare 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 UnitedHealthcare 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 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

C.5 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.

C.6 Documentation

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

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D8010	Limited orthodontic treatment of the primary dentition	0-20		Yes	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 and Treatment plan	1 per lifetime	**(1)** See Ortho rules in Section C.2-C.5

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D8020	Limited orthodontic treatment of the transitional dentition	0-20		Yes	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 and Treatment plan	1 per lifetime	**(1)** See Ortho rules in Section C.2-C.5
D8070	comprehensive orthodontic treatment of the transitional dentition	0 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8070 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-D.5
D8080	comprehensive orthodontic treatment of the adolescent dentition	13 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8080 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-C.5
D8090	comprehensive orthodontic treatment of the adult dentition	13 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8090 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-C.5
D8210	removable appliance therapy	13 - 20		Pre Auth	Panoramic or full series x-rays Facial Photos Treatment plan with narrative of necessity	1 per arch per lifetime	**(1)** Deny D8210 if billed on the same DOS as D8080, same provider: Not billable on the same DOS as D8080 **(2)** See Ortho rules in Section C.2-C.5
D8220	fixed appliance therapy	13 - 20		Pre Auth	Panoramic or full series x-rays Facial Photos Treatment plan with narrative of necessity	1 per arch per lifetime	**(1)** Deny D8220 if billed on the same DOS as D8080, same provider: Not billable on the same DOS as D8080 **(2)** See Ortho rules in Section C.2-C.5
D8660	pre-orthodontic treatment visit	3 - 20		No			**(1)** D8660 is considered part of any comprehensive oral evaluation (D0150), periodic oral evaluation (D0120), or problem focused oral evaluation (D0160), and therefore is not payable as a separate procedure. **(2)** Deny D8660 when submitted with procedure code D8070 or D8080. **(3)** See Ortho rules in Section C.2-C.5

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D8670	periodic orthodontic treatment visit (as part of contract)	3 - 20		No	Number of additional visits needed Panoramic or full series x-rays Facial Photos Treatment plan including narrative of why additional visits are needed	1 per month	**(1)** D8670 is not permitted if there is a history of balance paid for D8680 - included in records fee, any provider **(2)** See Ortho rules in Section C.2-C.5
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	3 - 20		Yes	Post treatment panoramic or full series x-ray Facial Photos Statement from provider that treatment is complete	1 per arch per lifetime	**(1)** Deny D8680 if on the same date of service as D8050-D8090, same provider **(2)** See Ortho rules in Section C.2-C.5
D8999	unspecified orthodontic procedure, by report	3 - 20		Pre Auth	Completed Orthodontic Continuation of Care Form Reason member left last provider Treatment status Copy of Prior Approval Payment history Pre-Treatment Records		**(1)** Deny D8999 if on the same date of service as D8070-D8090, same provider **(2)** See Ortho rules in Section C.2-C.5

C.7 Private pay arrangement for orthodontic services

Texas Medicaid does not reimburse for orthodontic diagnostic workups when orthodontic treatment does not meet medically necessary criteria. Orthodontic providers are encouraged to evaluate and determine if a member's condition meets orthodontic coverage criteria before submitting a treatment plan and performing a diagnostic work up.

If the Orthodontic provider determines that the member does not meet the established medical necessity criteria, the provider may enter into a private pay arrangement at the member's request without being required to submit a prior authorization request only if the following items are met:

- Provider has notated clearly and in detail in the member chart records as to why the member would not meet the current medical necessity criteria for approval of services by UHC Dental, and the information is reviewed and approved by the member.
- Provider maintains a copy of the Orthodontic Private Pay Arrangement: Client Acknowledgement Statement Form (Appendix K) completed and signed by both the member and provider.

Adjunctive General Services

Clinical criteria for codes requiring pre-service or post-service clinical review

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. Adjunctive general services include: IV sedation and emergency services provided for relief of dental pain.

*For General Anesthesia and IV Sedation, there are very specific instructions on how to attain a prior authorization, depending upon who is administering the anesthesia. These detailed instructions are titled "UNITEDHEALTHCARE DENTAL INSTRUCTIONS FOR ATTAINING PRIOR AUTHORIZATION OF DENTAL THERAPY SERVICES UNDER GENERAL ANESTHESIA." See Appendix I for these instructions.

General anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure (following is required for all members regardless of age):

- (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 for this scoring form which includes instructions on how to fill out and calculate.
- Treatment plan
- Narrative (for all ages) 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).
- 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 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.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity and complete anesthesia report with the claim for review for payment

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

Non – Intravenous Conscious Sedation (Dental Office Setting)

- Anxiety
- Individuals that are uncooperative or unmanageable

Therapeutic parenteral Drugs

- 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.

Drugs or medicaments dispensed in the office for home use

- 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

Behavior Management, By Report

- 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

Treatment of Complications (Post-Surgical)

- Documentation describes what this treatment is and why it is medically necessary

Occlusal Guard

- 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
- NOT INDICATED: For treatment of temporomandibular disorders or myofacial pain dysfunction
- NOT INDICATED: As an appliance intended for orthodontic tooth movement

Occlusal Analysis – Mounted Case

- Documentation states why an occlusal analysis is necessary

Occlusal Adjustment – Limited

- Documentation states why an occlusal adjustment is necessary

Occlusal Adjustment – Complete

- Documentation describes medical necessity for complex case need (facebow, interocclusal records, tracings, diagnostic wax-up, etc.)

Unspecified Procedures, by Report

- Procedure cannot be adequately described by an existing code
- Documentation states why an occlusal adjustment is necessary

Adjunctive General Services

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D9110	palliative treatment of dental pain	0 - 20		No		1 per day	
D9120	fixed partial denture sectioning	13 - 20		No			
D9210	local anesthesia not in conjunction with operative or surgical procedures	1 - 20		No			**(1)** D9210 will be denied if submitted with D9248
D9211	regional block anesthesia	1 - 20		No			**(1)** D9211 will be denied if submitted with D9248
D9212	trigeminal division block anesthesia	1 - 20		No			**(1)** D9212 will be denied if submitted with D9248
D9222	deep sedation/general anesthesia - first 15 minutes	1 - 20		Pre Auth	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	1 per 6 months	**(1)** D9222 will be denied if submitted with D9248
D9223	Deep sedation/general anesthesia - each 15 minute increment	1 - 20		Pre Auth	Treatment plan, narrative, Criteria for Dental Therapy Under GA form, x-rays	11 per 6 months	**(1)** Deny D9223 if more than 11 per day. **(2)** Deny D9223 if billed on the same day as an exam. **(3)** Deny D9223 if submitted in conjunction with D9248.
D9230	inhalation of nitrous oxide/anxiolysis, analgesia	1 - 20		No		1 per day	**(1)** D9230 will be denied if submitted in conjunction with D9248. **(2)** Deny D9230 if more than one per day. **(3)** Deny D9230 if on the same DOS as D9222, D9223, D9239, D9243.
D9239	intravenous moderate (conscious) sedation/ anesthesia - first 15 minutes	1 - 20		Pre Auth	Treatment plan, narrative, x-rays	1 per day per provider	**(1)** D9239 will be denied if submitted with D9248. **(2)** Deny D9239 if billed on the same DOS as D9222.
D9243	Intravenous moderate (conscious) sedation/ analgesia - each 15 minute increment	1 - 20		Pre Auth	Treatment plan, narrative, x-rays	5 per day per provider	**(1)** Deny D9243 if more than 12 per day. **(2)** Deny D9243 if billed on the same day as an exam.
D9248	non-intravenous conscious sedation	1 - 20		Pre Auth	Treatment plan, narrative, x-rays	2 per 12 months	**(1)** D9248 will be denied if submitted in conjunction with D9420. **(2)** Deny D9248 if on the same day as D9248. **(3)** Deny D9248 if on the same day as D9222, D9223, D9239, D9243, D9920.
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	1 - 20		No			**(1)** An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160.
D9410	house/extended care facility call	1 - 20		No			**(1)** Narrative required on claim form.
D9420	hospital or ambulatory surgical center call	1 - 20		No		2 per 12 months	

Adjunctive General Services

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	1 - 20		No			**(1)** During regularly scheduled hours, no other services performed. Visits for routine postoperative care are included in all therapeutic and oral surgery fees.
D9440	office visit - after regularly scheduled hours	1 - 20		No			**(1)** Visits for routine postoperative care are included in all therapeutic and oral surgery fees. **(2)** narrative required on claim form
D9610	therapeutic parenteral drug, single administration	1 - 20		Post Auth	Description of medication	1 per day	**(1)** D9610 will be denied if submitted with D9248 **(2)** Deny D9610 if billed on the same DOS as D9612
D9612	therapeutic parenteral drugs, two or more administrations, different medications	1 - 20		Post Auth	Description of medication	1 per day	**(1)** Deny D9612 if billed on the same DOS as D9610
D9630	other drugs and/ or medicaments, by report	1 - 20		Post Auth	Narrative of necessity		**(1)** D9630 will be denied if submitted in conjunction with D9230, D9241, D9248, D9610, D9920.
D9910	application of desensitizing medicament	18 - 20		No		1 per 6 years	**(1)** Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations.
D9920	behavior management, by report	1 - 20		Post Auth	Physician note stating disability Services, supplies, staff, duration		**(1)** D9920 will be denied if submitted with D9248 **(2)** D9920 may not be reimbursed with an evaluation, prophylactic treatment or radiographic procedure.
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	1 - 20		Post Auth	Current preop x-rays Narrative of necessity/report of procedure		
D9944	occlusal guard-hard appliance, full arch	16 - 20		Post Auth	Current panoramic x-ray or full series Narrative of necessity		
D9950	occlusion analysis - mounted case	13 - 20		Post Auth	Current panoramic x-ray or full series Narrative of necessity		
D9951	occlusal adjustment - limited	13 - 20		Pre Auth	Current panoramic x-ray or full series Narrative of necessity	1 per 3 years	
D9952	occlusal adjustment - complete	13 - 20		Pre Auth	Current panoramic x-ray or full series Narrative of necessity	1 per lifetime	
D9970	enamel microabrasion	13 - 20	1-32	No		1 per day	
D9974	internal bleaching - per tooth	13 - 20	1-32	No			
D9999	unspecified adjunctive procedure, by report	1 - 20		Pre Auth	Current pre and postop x-rays Narrative of necessity/report of procedure		

Appendix D: CHIP covered dental services

Covered Dental Services are subject to a $564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.

CHIP members who have exhausted the $564 annual benefit limit continue to receive the following Covered Dental Services in excess of $564 annual benefit maximum:

1. the diagnostic and preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule; and
2. other Medically Necessary Covered Dental Services approved by UnitedHealthcare Dental through a prior authorization process. These services must be necessary to allow a CHIP member to return to normal, pain and infection-free oral functioning. Typically, this includes:
   - Services related to the relief of significant pain or to eliminate acute infection;
   - Services related to treat traumatic clinical conditions;
   - Services that allow the CHIP member to attain the basic human functions (e.g. eating, speech, etc.); and
   - Services that prevent a condition from seriously jeopardizing the CHIP member's health/functioning or deteriorating in an imminent timeframe to a more serious and costly dental problem.

Request to exceed CHIP $564 annual benefit limit:

When services are being requested in excess of the $564 Annual Benefit Limit for CHIP, all requests must be pre-authorized, even for services that otherwise do not require pre-authorization. Items necessary to be submitted when requesting authorization to exceed the annual max:

- 2012 or newer ADA approved claim form with keywords "EXCEPTION TO EXCEED CHIP MAX" must be included in Block 35
- X-rays and necessary records clearly showing the need for the requested service
- Clinical narrative, explaining the medical necessity for the requested service in detail
- Additional documents may be needed for those services that normally require prior-authorization if specific items are listed in the Documentation Required sections listed in the following pages.

Any prior-authorization requests submitted with insufficient information or missing documentation may be denied.

Additional information

Covered dental services that indicate "Pre Service" in the "Review Required" column require documentation of medical necessity and will be subject to pre-service review. These procedures must be prior authorized before services are rendered for determination of medical necessity and require submission of proper documentation (as indicated in the "Documentation Required" column) along with planned treatment listed on the 2012 or newer ADA approved claim form (dates of service are left blank on the claim form for prior authorizations). When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the

member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the 2012 or newer ADA approved claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.

Covered dental services that indicate "Post Service" in the "Review Required" column require documentation of medical necessity and will be subject to retrospective pre-payment review. These procedures can be rendered before determination of medical necessity but require submission of proper documentation (as indicated in the "Documentation Required" column) with the claim form. When the need for an exception to periodicity is established, a narrative explaining the reason for the exception to periodicity limitations must be documented in the member's file and on the claim submission. In order to submit a claim with an exception, the claim must have the key word "EXCEPTION" in Block 35 of the 2012 or newer ADA approved claim form. If the key word "EXCEPTION" is missing from Box 35, the claim may deny for exceeding benefit limitations.

Although some covered services do not require any pre or post service review, those services may still be subject to retrospective review of records to determine medical necessity if deemed necessary by UnitedHealthcare Dental. Therefore documentation to support medical necessity of the service must be current and maintained in the member's chart.

Any reimbursement already made for an inadequate service may be recouped after the UnitedHealthcare Dental Consultant reviews the circumstances.

D.1 Benefits covered for TX CHIP (Child under 19)

Preventive Services

Procedure codes D1110, D1120, D1206, and D1208 will be denied when billed as an emergency claim. Procedure codes D1110, D1120, D1206, and D1208 will no longer be reimbursed to orthodontist and oral maxillofacial surgeon providers.

Procedure codes D1351 will be denied if billed as an emergency claim. Procedure code D1351 will no longer be reimbursed to orthodontists and oral maxillofacial surgeon.

Procedure Code D1206 may be reimbursable if rendered in an office, inpatient, or outpatient hospital setting.

Procedure Codes D1208 is limited to services rendered in an office setting only, and are not reimbursable if rendered in an inpatient or outpatient hospital setting.

Clinical Oral Evaluations/Diagnostics

Diagnostic services include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if UnitedHealthcare Dental determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

UnitedHealthcare Dental utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations. All radiographs, must be of good diagnostic quality, include member's full name, date films taken, and identify the patients left and right side.

Clinical Oral Evaluations/Diagnostics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0120	Periodic oral evaluation - established patient	0-18		No		1 per 6 months per provider or location	**(1)** Deny D0120 when submitted on the same DOS as D0145, any provider **(2)** A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim
D0140	Limited oral evaluation - problem focused	0-18		No		1 per day per provider	**(1)** Deny D0140 when submitted on the same DOS as D0160, same provider
D0150	Comprehensive oral evaluation - new or established patient	0-18		No		1 per lifetime per provider	**(1)** Deny D0150 when submitted on the same DOS as D0145 by any provider **(2)** Deny D0150 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** A caries risk assessment procedure code (D0601, D0602, or D0603) is required on the same claim
D0210	intraoral-comprehensive series of radiographic images	2-18		No		1 per 3 years per provider or location	**(1)** Deny D0210 if member has Dentures (complete and immediate) in dental history. **(2)** Deny D0210 in conjunction with D8660 (Pre-Otho Tx) if billed within 90 day period after date of service: Included in Records Fee. **(3)** Deny D0210 if same day as D0330
D0220	intraoral-periapical first radiographic images	1-18		No		1 per day per provider	**(1)** Deny D0220 in combination with Pre-Orthodontic Treatment (D8660), requires 90 day forward for payment of services: Included in records fee.
D0230	intraoral-periapical each additional radiographic images	1-18		No			**(1)** Deny D0230 if on the same day as D3222, D3230, D3240, or D3310, D3320, D3330 **(2)** Deny D0230 in combination with Pre-Orthodontic Treatment (D8660), requires 90 day forward for payment of services: Included in records fee. **(3)** Deny D0230 if not submitted with D0220 for same date of service **(4)** The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series
D0270	bitewing- single radiographic image	1-18		No		1 per day per provider	
D0272	bitewing- two radiographic image	1-18		No		1 per day per provider	**(1)** Deny D0272 denied when submitted for the same DOS as D0210, any provider. **(2)** Deny D0272 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider
D0274	bitewing- four radiographic image	1-18		No		1 per day per provider	**(1)** Deny D0274 when submitted for the same DOS as D0210, any provider. **(2)** Deny D0274 when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider

Clinical Oral Evaluations/Diagnostics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D0330	panoramic radiographic image	5-18		No		1 per 5 years per provider or location	**(1)** D0330 denied if performed on the same DOS as D0210. **(2)** D0330 denied when performed within 90 day range after Pre-Orthodontic Treatment (D8660): Included in Records Fee, per provider **(3)** D0330 (panoramic films) will be denied when submitted with procedure code D8070, D8080, D8210, or D8220.
D0480	cytologic smears	0-18		No			
D0601	caries risk assessment and documentation, with a finding of low risk	0-18		No			**(1)** D0601 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.
D0602	caries risk assessment and documentation, with a finding of moderate risk	0-18		No			**(1)** D0602 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.
D0603	caries risk assessment and documentation, with a finding of high risk	0-18		No			**(1)** D0603 should be submitted with a charge amount of $.01 and will not be reimbursed. They will be included as part of an informational component of the D0150 or D0120 billing code and do not have a separate rate attached to them.

Preventative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D1110	prophylaxis- adult	13-18		No		1 per 6 months per member	**(1)** Deny D1110 when submitted for the same DOS as any D4000 series periodontal procedure code.
D1120	prophylaxis- child	0-12		No		1 per 6 months per member	**(1)** Deny D1120 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1120 when submitted on the same DOS as D0145.
D1206	topical application of fluoride varnish	0-18		No		1 per 6 months per member	**(1)** Deny D1206 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1206 when submitted on the same DOS as D0145 **(3)** Deny D1206 if on the same day as another fluoride treatment performed **(4)** Deny D1206 if the patient has a dental history of: Dentures - Complete, Immediate (D5110 - D5140) **(5)** Deny D1206 if within 6 months of D1206 or D1208.

Preventative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D1208	topical application of fluoride- excluding varnish	0-18		No		1 per 6 months per member	**(1)** Deny D1208 when submitted for the same DOS as any D4000 series periodontal procedure code **(2)** Deny D1208 when submitted on the same DOS as D0145 **(3)** Deny D1208 if the patient has a dental history of: Dentures - Complete, Immediate (D5110 - D5140) **(4)** Deny D1208 if within 6 months of D1206 or D1208.
D1351	sealant per tooth	1-18	1-5, 12-19, 30-32 (surface areas B, F, L and O)	No		1 per tooth per lifetime	**(1)** D1351 is denied when billed for the same DOS as any D4000 series periodontal procedure codes. **(2)** Deny D1351 if on the same day, same tooth as a filling or composite **(3)** Deny D1351 if there is a history of an extraction, implant, implant abutment, pontic, inlay, onlay, crown, D2940, D2950, D6973, D2951, D2952, D6970, D2953, D6976, D2954, D6972, D2957, D6977, D2975, D6975, or D2980, same tooth. **(4)** Deny D1351 if there is a history of a denture or partial, same tooth as D5110, D5120, D5130, D5140 or partial D5211, D5213, D5225, D5212, D5214, D5226, or D5281 **(5)** Deny D1351 if on same date of service as D1352, same tooth
D1510	Space Maintainer - Fixed - Unilateral	1-12	LL, LR, UR, UL	No		1 per lifetime per quadrant	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	1-12	A,B,I,J 3,14	No		1 per lifetime per tooth	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	1-18	K, L, S, T 19, 30	No		1 per lifetime per tooth	
D1520	Space maintainer - removable - unilateral	1-18	LL, LR, UR, UL	No		1 per lifetime per quadrant	
D1526	Space maintainer - removable - bilateral, maxillary	1-18	A,B,I,J 3,14	No		1 per lifetime per tooth	
D1527	Space maintainer - removable - bilateral, mandibular	1-18	K, L, S, T 19, 30	No		1 per lifetime per tooth	
D1575	distal shoe space maintainer - fixed, unilateral - per quadrant	3-7	LL, LR, UR, UL	No		1 per lifetime per quadrant	

Restorative

Reimbursement includes local anesthesia.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

A replacement of an identical restorative service in less than 36 months by the same provider is not considered the standard of care for quality by UnitedHealthcare Dental. If there are special circumstances requiring this repeat service, please send in a prior authorization request along with a narrative establishing medical necessity.

CLINICAL CRITERIA FOR CODES REQUIRING PRE-SERVICE OR POST-SERVICE CLINICAL REVIEW

Crowns

- 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.

To meet criteria, a crown must:

- 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.

Criteria for Crowns following Root Canal Therapy:

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved.
- The filling must be properly condensed/obturated. 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

Crowns will not meet criteria if:

- 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

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2140	amalgam- one surface, primary or permanent	0-18	1 - 32, A - T	No		1 per tooth per 12 months per provider	**(1)** Deny D2140 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2140 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2140 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2140 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2150	amalgam- two surfaces, primary or permanent	0-18	1 - 32, A - T	No		1 per tooth per 12 months per provider	**(1)** Deny D2150 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2150 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2150 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2150 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2160	amalgam- three surfaces, primary or permanent	1-18	1 - 32, A - T	No		1 per tooth per 12 months per provider	**(1)** Deny D2160 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2160 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2160 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2160 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2161	amalgam- four or more surfaces, primary or permanent	1-18	1 - 32, A - T	No		1 per tooth per 12 months per provider	**(1)** Deny D2161 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2161 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2161 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2161 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2330	resin-based composite - one surface, anterior	1-18	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2330 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2330 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2330 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2330 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2331	resin-based composite - two surfaces, anterior	0-18	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2331 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2331 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2331 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2331 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2332	resin-based composite - three surfaces, anterior	1-18	C-H, M-R 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2332 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2332 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2332 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2332 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2335	resin-based composite - four or more surfaces, anterior	1-18	C-H, M-R, 6-11, 22-27	No		1 per tooth per 12 months per provider	**(1)** Deny D2335 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2335 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2335 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2335 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2391	resin-based composite - one surface, posterior	1-18	1-5, 12-21, 28-32 A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2391 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2391 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2391 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2391 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2392	resin-based composite - two surfaces, posterior	0-18	1-5, 12-21, 28-32 A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2392 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2392 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2392 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2392 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2393	resin-based composite - three surfaces, posterior	0-18	1-5, 12-21, 28-32 A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2393 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2393 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2393 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2393 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth
D2394	resin-based composite - four or more surfaces, posterior	0-18	1-5, 12-21, 28-32 A, B, I, J, K, L, S, T	No		1 per tooth per 12 months per provider	**(1)** Deny D2394 if restoration performed less than 30 days prior to a prefabricated (D2929-D2933) or cast crown (D2780, D2781, D2782, D2790, D2791, D2792): Check Against Crowns **(2)** Deny D2394 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(3)** Deny D2394 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(4)** Deny D2394 if patient has a history of Extractions, Implants, Dentures, Crowns, Abutment, or Pontic; on the same tooth

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2710	crown - resin-based composite (indirect)	13-18	1-32	Pre Auth	Current bitewing x-rays Narrative when decay is not evident on x-rays	1 per tooth per 5 years	**(1)** Deny D2710 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2710 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2710 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2710 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2720	crown - resin with high noble metal	13-18	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2720 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2720 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2720 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2720 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2721	crown - resin with predominantly base metal	13-18	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2721 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2721 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2721 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2721 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2722	crown - resin with noble metal	13-18	1-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2722 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2722 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2722 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2722 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2740	crown - porcelain/ ceramic substrate	13-18	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2740 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2740 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2740 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2740 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2750	crown - porcelain fused to high noble metal	13-18	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2750 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2750 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2750 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2750 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2751	crown - porcelain fused to predominantly base metal	13-18	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2751 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2751 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2751 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2751 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2752	crown - porcelain fused to noble metal	13-18	4-13, 20-29	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2752 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2752 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2752 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2752 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2790	crown - full cast high noble metal	13-18	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2790 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2790 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2790 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2790 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2791	crown - full cast predominantly base metal	13-18	1-5, 12-21, 28-32	Pre Auth	Preop x-rays Narrative Specific tests if cracked tooth syndrome	1 per tooth per 5 years	**(1)** Deny D2791 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2791 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250)**(3)** Deny D2791 if the following codes are present in the patients history within 30 days: Check for Inlay/Onlay/Crowns (D2510-D2799) **(4)** Deny D2791 if the following codes are present in the patient's history within 5 years: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

Restorative

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D2930	prefabricated stainless steel crown - primary tooth	0-18	A-T	No		1 per tooth per lifetime	**(1)** Deny D2930 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2930 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(3)** Deny D2930 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799). **(4)** Procedure code D2930 will be denied if there is any history of the following procedure codes for the same TID: Procedure codes D2930, D2932, D2933, D2934
D2931	prefabricated stainless steel crown - permanent tooth	1-18	1-5, 12-21, 28-32	No		1 per tooth per lifetime	**(1)** Deny D2931 if patient has a history of Extractions, Implants, Dentures, Partials, or Pontic, on the same tooth **(2)** Deny D2931 if restoration performed less than 90 days prior to an extraction or if the tooth has been previously extracted: Check against Simple/Surgical Extractions (D7111-D7250) **(3)** Deny D2931 if the following procedure codes are present in the patients history within 30 days: Check against Inlay/Onlay (D2510-D2799).

Endodontics

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet UnitedHealthcare Dental treatment standards, UnitedHealthcare Dental can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post payment review by the UnitedHealthcare Dental Consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment.

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.

Endodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	A -T	No		1 per tooth per lifetime	**(1)** D3220 will be denied when performed within 6 months of D3230, D3240, D3310, D3320, or D3330 for the same primary TID, same provider. **(2)** D3220 denied when performed within 6 months of D3310, D3320, or D3330 on the same permanent TID, same provider. **(3)** Deny D3220 as inclusive if on same day, same tooth as a root canal **(4)** Deny D3220 if there is a root canal in history for the same tooth **(5)** D3220 denied if tooth is extracted, or if there is a history of the following procedures in the patients dental history: D5110, D5120, D5130, D5140, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253, D7111, D7120, D7130, D7140, D7210, D7220, D7230, D7240, D7241, D7250. **(6)** D3220 denied in conjunction with root canals (D3310, D3320, D3330) or retreatment of a previous root canal (D3346, D3347, D3348): payment included in the allowance of another procedure.
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	1-18	C-H, M-R	No			
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	1-18	A, B, I, J, K, L, S, T	No			
D3310	endodontic therapy, anterior tooth (excluding final restoration)	6-18	6-11, 22-27	No		1 per tooth per lifetime	**(1)** Deny D3310 if used in conjunction with Apexification/Recalcification (D3351-D3353): Included as part of another covered benefit. **(2)** D3310 is denied if the following procedures are included in patients dental history: Extraction, Pontic, Dentures **(3)** D3310 will be denied/ not billable after full dentures: Check for Immediate Dentures (D5130/D5140), Complete Dentures (D5110/5120) **(4)** Deny D3310 if tooth has been previously extraction: Check for Simple/Surgical Extractions (D7111-D7250) **(5)** Deny D3310 if a root canal (D3310) and D3220/ D3221 are on the same DOS, same tooth, deny D3220/D3221, and allow the root canal (D3310)
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	6-18	4, 5, 12, 13, 20, 21, 28, 29	No		1 per tooth per lifetime	
D3330	endodontic therapy, molar (excluding final restoration)	6-18	1-3, 14-19, 30-32	No		1 per tooth per lifetime	**(1)** Deny D3330 if tooth is missing (extraction, implant, denture, partial, or pontic), same tooth **(2)** If a root canal (D3330) and D3220/D3221 are on the same DOS, same tooth, deny D3220/ D3221, and allow the root canal (D3330).

Periodontics

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351, and D1352 will be denied when submitted for the same DOS as any D4000 series periodontal procedure codes, any provider.

CLINICAL CRITERIA FOR CODES REQUIRING PRE-SERVICE OR POST-SERVICE CLINICAL REVIEW

Gingivectomy or Gingivoplasty

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia

Scaling and Root Planing

- D4341 (Four or more teeth per quadrant)
- Probing depths of at least 5 mm or greater
- Radiographic evidence of bone loss

Periodontics

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	13-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Pre Auth	Current preop x-rays and photos 6 point perio charting Narrative		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	13-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Pre Auth	Current full mouth x-rays 6 point perio charting Narrative		**(1)** Deny D4341 if on the same day as D4355, D4240, D4241, D4260, D4261, D4263, D4264, D4265, D4266, D4267, D4342, D4270, D4271, D4273, or D4274. **(2)** Deny D4341 if there is a history of a complete denture, or Intermediate denture on the same arch.**(3)** Deny D4341 if within 36 months of D4240 or D4241 **(4)** Deny D4341 if billed within 90 days of service of D4341/D4342
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	13-18		No			**(1)** Deny D4355 when submitted on the same DOS as: D4210, D4211, D4230, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4266, D4267, D4270, D4273, D4274, D4275, D4276, D4277, D4278, D4283, D4285, D4381, D4910, D4920, D4999, by any provider

Prosthodontics, Removable

A preformed denture with teeth already mounted forming a denture module is not a covered service.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Clinical criteria for codes requiring pre-service or post-service clinical review

Complete Dentures

Must have all of the following:

- 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)

If a replacement full denture is requested within 5 years:

- 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.

Partial Dentures

- 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.
- 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.

Authorizations for removable prosthesis will not meet criteria:

- 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)** peridontially 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.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- 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).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

Prosthodontics, Removable

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D5110	complete denture - maxillary	3-18		Post Auth	Current preop panoramic x-ray or full series		**(1)** Deny D5110 if within 60 months of denture, partial denture in the maxillary arch.
D5120	complete denture - mandibular	3-18		Post Auth	Current preop panoramic x-ray or full series		**(1)** Deny D5120 if within 60 months of denture, partial denture in the mandibular arch.
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	6-18		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	6-18		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	9-18		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	9-18		Pre Auth	Current preop panoramic x-ray or full series Missing teeth identified		

Oral and Maxillofacial Surgery

Reimbursement includes local anesthesia and routine post-operative care.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Clinical criteria for codes requiring pre-service or post-service clinical review

Removal of Impacted Teeth

- 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.

Oral and Maxillofacial Surgery

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18		No			**(1)** Deny D7140 with Simple/Surgical Extractions (D7111-D7250): Tooth previously extracted. **(2)** Deny D7140 with Complete Dentures (D5110/5120): Services not permitted with other procedures billed. **(3)** Deny D7140 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures. **(4)** Deny D7140 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code.**(5)** Deny D7140 if billed with Pontic, Full Dentures (D5110, D5120, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253). Based on the patient's dental history these procedure codes are not eligible with D7210. **(6)** Deny D7140 if billed on the same day as D7272, mouth level.
D7210	surgical removal of erupted tooth requiring removal of bone and/ or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1-18	1-32, A-T, SN	No			**(1)** Deny D7210 with Simple/Surgical Extractions (D7111-D7250): Tooth previously extracted. **(2)** Deny D7210 with Complete Dentures (D5110/5120): Services not permitted with other procedures billed. **(3)** Deny D7210 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures. **(4)** Deny D7210 if billed with Partial Mandibular Dentures (D5212/D5214), Partial Maxillary Dentures (D5211/D5213), Partial Mandibular Dentures (D5281). Not billable with any other service code.**(5)** Deny D7210 if billed with Pontic, Full Dentures (D5110, D5120, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253). Based on the patient's dental history these procedure codes are not eligible with D7210. **(6)** Deny D7210 if billed on the same day as D7272, mouth level. **(7)** Includes removal of the roots of a previously erupted tooth missing its clinical crown.
D7220	removal of impacted tooth - soft tissue	1-18	1-32, A-T, SN	No			**(1)** Deny D7220 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures.
D7230	removal of impacted tooth - partially bony	1-18	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		**(1)** Deny D7230 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures.
D7240	removal of impacted tooth - completely bony	1-18	1-32, A-T, SN	Pre Auth	Current preop panoramic x-ray Narrative of necessity		**(1)** Deny D7240 with Complete Dentures (D5110/5120) and Immediate Dentures (D5130/D5140): Not billable after full dentures.

D.2 Comprehensive medically necessary orthodontic services

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.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure code D0120, D0150, or D0160).

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

D.3 Levels of orthodontia services

UnitedHealthcare 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 48	Level I or II	• Completion of pediatric dental residency; or • A minimum of 200 hours of continuing dental education in orthodontics.
Provider Type 90	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**
D8210 Removable Appliance Therapy **D8220** 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: • 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 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.) • 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.				

**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.

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
D8010 Limited orthodontic treatment of the primary dentition **D8020** Limited orthodontic treatment of the transitional dentition **D8070** Comprehensive orthodontic treatment of the transitional dentition	Type 48 Type 90	0-20	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: • 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 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 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
D8080 Comprehensive orthodontic treatment of the adolescent 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: • 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 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
D8090 Comprehensive orthodontic treatment of the adult dentition	Type 90	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: • 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 approved 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

D.4 Reimbursement

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

Prior authorized procedure codes: D8010, D8020, D8070, D8080, D8090, D8210, or D8220

- 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

D.5 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 UnitedHealthcare Dental)
2. Other DMO to UnitedHealthcare Dental
3. Private/Commercial Arrangement to UnitedHealthcare Dental

Provider to Provider (within UnitedHealthcare Dental):

This section is for situations in which the Orthodontic care of a Medicaid eligible member is transferred from one UnitedHealthcare Dental provider to another UnitedHealthcare 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.

Other DMO to UnitedHealthcare 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 UnitedHealthcare 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 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

Private/commercial arrangement to UnitedHealthcare 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 UnitedHealthcare 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 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

D.6 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.

D.7 Documentation

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

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D8010	Limited orthodontic treatment of the primary dentition	0-18		Yes	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 and Treatment plan	1 per lifetime	**(1)** See Ortho rules in Section C.2-C.5
D8020	Limited orthodontic treatment of the transitional dentition	0-18		Yes	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 and Treatment plan	1 per lifetime	**(1)** See Ortho rules in Section C.2-C.5
D8070	comprehensive orthodontic treatment of the transitional dentition	0 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8070 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-C.5
D8080	comprehensive orthodontic treatment of the adolescent dentition	13 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8080 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-C.5
D8090	comprehensive orthodontic treatment of the adult dentition	13 - 20		Pre Auth	Digital models or 3D diagnostic images Panoramic or full series x-rays Cephalometric film Facial Photos Treatment plan	1 per lifetime	**(1)** Deny D8090 if there is a history of D8050-D8090 **(2)** See Ortho rules in Section C.2-C.5
D8210	removable appliance therapy	3 - 13		Pre Auth	Panoramic or full series x-rays Facial Photos Treatment plan with narrative of necessity	1 per arch per lifetime	**(1)** Deny D8210 if billed on the same DOS as D8080, same provider: Not billable on the same DOS as D8080 **(2)** See Ortho rules in Section C.2-C.5.

Code	Description	Age limit	Teeth covered	Review req.	Documentation required	Limitations	Payment rules
D8220	fixed appliance therapy	3 - 13		Pre Auth	Panoramic or full series x-rays Facial Photos Treatment plan with narrative of necessity	1 per arch per lifetime	**(1)** Deny D8220 if billed on the same DOS as D8080, same provider: Not billable on the same DOS as D8080 **(2)** See Ortho rules in Section C.2-C.5
D8660	pre-orthodontic treatment visit	3-20		No			**(1)** D8660 is considered part of any comprehensive oral evaluation (D0150) or periodic oral evaluation (D0120), and therefore is not payable as a separate procedure. **(2)** Deny D8660 when submitted with procedure code D8070 or D8080. **(3)** See Ortho rules in Section C.2-C.5
D8670	periodic orthodontic treatment visit (as part of contract)	3-20		No	Number of additional visits needed Panoramic or full series x-rays Facial Photos Treatment plan including narrative of why additional visits are needed	1 per month	**(1)** D8670 is not permitted if there is a history of balance paid for D8680 - included in records fee, any provider **(2)** See Ortho rules in Section C.2-C.5
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	3-20		Yes	Post treatment panoramic or full series x-ray Facial Photos Statement from provider that treatment is complete	1 per arch per lifetime	**(1)** Deny D8680 if on the same date of service as D8050-D8090, same provider **(2)** See Ortho rules in Section C.2-C.5
D8999	unspecified orthodontic procedure, by report	3-20		Pre Auth	Completed Orthodontic Continuation of Care Form Reason member left last provider Treatment status Copy of Prior Approval Payment history Pre-Treatment Records		**(1)** Deny D8999 if on the same date of service as D8070-D8090, same provider **(2)** See Ortho rules in Section C.2-C.5

Appendix E: Non-covered services disclosure form

This non-covered services disclosure form is intended for use for Medicaid recipients who seek non-covered (and in some instances, nonauthorized) services under Medicaid and who are agreeing, prior to any services being rendered, to pay the service provider for such non-covered services, thereby "waiving" the recipients' rights protected generally under the Federal Regulations that prohibit providers from balance billing Medicaid recipients for services rendered.

With this MEDICAID WAIVER, the provider acknowledges that for services that are not authorized or covered by UnitedHealthcare Dental (including Medicaid sponsored health care programs), the Medicaid member must be informed of their payment responsibility prior to receiving the service and the member must consent in writing.

Member statement:

I understand that by signing this waiver form I am agreeing to be responsible to pay the provider for the services stated below as they are not covered or deemed medically necessary under my current health insurance.

That the specific service(s) sought are:

ADA Code and Description of Service _____

Fee: $ _____

That the service(s) sought is not a covered service under Medicaid guidelines;

That the service(s) is determined to be medically unnecessary before rendered;

That the provider does not participate in the Medicaid, either generally or for the services sought;

That I have been informed that one or more of the conditions listed (above) exists and, I voluntarily and knowingly agree to pay the provider for the charge they have indicated to me for these services.

By signing this waiver form, I certify that I am aware of the services covered by my health plan and of my rights under the Medicaid Program.

Member Name _____

Member Signature_____

Date _____

Appendix F: Marketing policies and rules

The MCO is required to inform its Network Providers of, and Network Providers are required to comply with, the following marketing policies.

1. Providers are permitted to inform their patients about the CHIP and Medicaid Managed Care Programs in which they participate.
2. Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, Providers must not recommend one MCO over another MCO, offer patients Incentives to select one MCO over another MCO, or assist the patient in deciding to select a specific MCO.
3. At the patients' request, Providers may give patients the information necessary to contact a particular MCO or refer the patient to an MCO Member Orientation.
4. Providers must distribute or display Health-related Materials for all contracted MCOs or choose not to distribute or display for any contracted MCO:
    a. Health-related posters cannot be larger than 16" x 24".
    b. Health-related Materials may have the MCO's name, logo, and contact information.
    c. Providers are not required to distribute or display all Health-related Materials provided by each MCO with whom they contract. A Provider can choose which items to distribute or display as long as the Provider distributes or displays one or more items from each contracted MCO that distributes items to the Provider and the Provider does not give the appearance of supporting one MCO over another.
5. Providers must display stickers submitted by all contracted MCOs or choose not to display stickers for any contracted MCOs. MCO stickers indicating the provider participates with a particular MCO cannot be larger than 5" x 7"" and cannot indicate anything more than "MCO is accepted or welcomed here."
6. Providers may choose whether to display items such as children's books, coloring books, and pencils provided by each contracted MCO. Providers can choose which items to display as long as they display one or more from each contracted MCO. Items may only be displayed in Common Areas.
7. Providers may distribute Applications to families of uninsured children and assist with completing the Application.
8. Providers may direct patients to enroll in the CHIP and Medicaid Managed Care Programs by calling the HHSC ASC.
9. Bargains, premiums, or other considerations on prescriptions may not be advertised in any manner in order to influence a member's choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the Program.

Appendix G: Fax coversheet

Fax

United Healthcare Dental

To:	UnitedHealthcare Dental TX Children's Medicaid and CHIP Services	**From:**	
Fax:	866-887-4649	**Pages:**	
Return Fax:		**Date**	
Re:		**cc:**	

PROVIDER: To ensure accurate processing, indicate the member's insurance plan and authorization priority below.

☐ **CHIP** ☐ Urgent Request OR ☐ Standard Request

☐ **Children's Medicaid** ☐ Urgent Request OR ☐ Standard Request

NOTE: *Requests that are incomplete or do not meet the requirements, will be returned unprocessed.*

Comments:

Appendix H: Specialty Communication Tool form

United Healthcare Dental

Specialty Treatment Communication Tool

☐☐ ☐☐ ☐☐☐☐

UnitedHealthcare Dental does not require a Main Dentist to obtain formal approved referral authorization from the plan when referring a member to another provider or specialist for treatment. However, all treatment by a dentist other than the member's assigned Main Dentist must be coordinated and referred by the Main Dentist.

This communication form is a tool for Main Dentist to utilize to send communication to another provider or specialist concerning the care of a member. The referring dentist should verify that the provider or specialist that the member is being referred to is within the member's network.

Member Information

Member Name (Last Name, First Name)

Date of Birth (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

Member ID Number ☐☐☐☐☐☐☐☐☐

Referring Main Dentist Information

Main Dentist Name

Provider NPI Number ☐☐☐☐☐☐☐☐☐☐

Phone Number ☐☐☐ ☐☐☐ ☐☐☐☐

Referral Overview

Select requested specialty:

- ☐ General Dentistry
- ☐ Pediatric Dentistry
- ☐ Orthodontics *
- ☐ Oral/Maxillofacial Surgery
- ☐ Periodontics
- ☐ Prosthodontics
- ☐ Endodontics
- ☐ Other:

Treating Dentist Name (Last Name, First Name)

Provider NPI Number ☐☐☐☐☐☐☐☐☐☐

Telephone Number ☐☐☐ ☐☐☐ ☐☐☐☐

Area or Tooth Number(s)

Tooth Surface(s)

Is this an urgent request? ☐ Yes

** Note: Orthodontic services are limited to those circumstances where the child's condition creates a disability and impairs physical development, not for cosmetic reasons.*

Please list reason for referral:

Does the member have a medical condition or medication that may influence scheduling or treatment? ☐ Yes ☐ No *(If yes, please list below.)*

Does the member have any special needs or developmental disabilities? ☐ Yes ☐ No *(If yes. please list below.)*

Any additional information that you would like to communicate to the provider or specialist:

Page 1 of 1 **Revised: 5/19/2020 | Effective: 9/1/2020**

Appendix I: Texas Medicaid criteria for dental therapy under general anesthesia

UnitedHealthcare Dental instructions for attaining prior authorization of dental therapy services under general anesthesia

Quick reference grid:

Scenarios	Step 1 Treating Dentist submits Prior Auth for:	Step 2 Once Step 1 is approved, Anesthesiologist submits:
Treating Dentist providing the anesthesia themselves	D9222/D9223 or D9239/D9243	N/A (Anesthesiologist not being utilized)
Treating Dentist utilizing a DDS Anesthesiologist	D9999	D9222/D9223 or D9239/D9243
Treating Dentist utilizing a MD Anesthesiologist	D9500*	MD Anesthesiologist will submit Prior Auth to their respective MCO with appropriate CPT codes

*D9500 is a Plan specific code for Medical Anesthesia, not an ADA code. This code is being utilized only to allow for coordination of Prior Authorization of General Anesthesia via a Medical Anesthesiologist. D9500 is not a billable code.

For detailed instructions on submission requirements, please see below.

In-office treatment

1. Prior authorization process when the treating dentist is providing the anesthesia

- If the provider administering level 4 sedation or general anesthesia is the treating dentist, separate PA from UnitedHealthcare Dental for level 4 sedation or general anesthesia is not required.
- Prior authorization request for general anesthesia or level 4 sedation should be submitted along with the requested therapeutic dental services.
- The treating dentist submits for prior authorization:
  - One unit of D9222, and appropriate units of D9223 (for general anesthesia) or one unit of D9239 and appropriate units of D9243 (moderate IV sedation).
  - All CDT code(s) that will be performed under general anesthesia or IV sedation.
  - A treatment plan and any additional required documentation.
  - The *Criteria for Dental Therapy Under General Anesthesia Score Sheet*. See Appendix I for this scoring form which includes instructions on how to fill out and calculate (required only for general anesthesia/deep IV sedation).
- UnitedHealthcare Dental will determine medical necessity of the general anesthesia or IV sedation.
- UnitedHealthcare Dental will notify the treating dentist of the determination.

Claim submission:

Upon completion of the approved services, the treating dentist will submit therapeutic services rendered along with the full anesthesia report with the administering provider's name, date of the anesthesia service, and start and stop times to UnitedHealthcare Dental.

2. Prior authorization process when the treating dentist uses a dental anesthesiologist

UnitedHealthcare Dental
Texas Medicaid Criteria for Dental Therapy Under General Anesthesia

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *UnitedHealthcare Dental Texas Medicaid Provider Manual*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from UnitedHeathcare Dental Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant UnitedHealthcare Dental Texas Medicaid Provider Manual and they agree and consent to the Certification above.

☐ We Agree

United Healthcare Dental

UnitedHealthcare Dental
Texas Medicaid Criteria for Dental Therapy Under General Anesthesia

Total points needed to justify treatment under general anesthesia=22

Age of client at time of examination	Points
Less than four years of age	8
Four and five years of age	6
Six and seven years of age	4
Eight years of age and older	2

Treatment Requirements (Carious and/or Abscessed Teeth)	Points
1-2 teeth or one sextant	3
3-4 teeth or 2-3 sextants	6
5-8 teeth or 4 sextants	9
9 or more teeth or 5-6 sextants	12

Behavior of Client**	Points
Definitely negative– unable to complete exam, client unable to cooperate due to lack of physical or emotional maturity, and/or disability	10
Somewhat negative– defiant; reluctant to accept treatment; disobeys instruction; reaches to grab or deflect operator's hand, refusal to take radiographs	4
Other behaviors such as moderate levels of fear, nervousness, and cautious acceptance of treatment should be considered as normal responses and are not indications for treatment under general	0
** Requires that narrative fully describing circumstances be present in the client's chart	

Additional Factors**	Points
Presence of oral/perioral pathology (other than caries), anomaly, or trauma requiring surgical intervention**	15
Failed conscious sedation**	15
Medically compromising of handicapping condition**	15
** Requires that narrative fully describing circumstances be present in the client's chart	

I understand and agree with the dentist's assessment of my child's behavior.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

To proceed with the dental care and general anesthesia, this form, the appropriate narrative, and all supporting documentation, as detailed in Attachment 1, must be included in the client's chart. The client's chart must be available for review by representatives of UnitedHealthcare Dental.

PERFORMING DENTIST'S SIGNATURE: _____

DATE:_____ License No.: _____

United Healthcare Dental

UnitedHeathcare Dental

Texas MedicaidCriteriaforDental TherapyUnderGeneralAnesthesia –Attachment 1

To justify Intravenous Moderate Sedation or General Anesthesia for Dental Therapy, the following documentation is required in the Child's Dental Record (Note those required* and those as appropriate)**

1) The medical evaluation justifying the need for anesthesia
2) Description of relevant behavior and reference scale
3) Other relevant narrative justifying the need for general anesthesia.
4) Client's demographics, including date of birth.
5) Relevant dental and medical history.
6) Dental radiographs, intraoral\perioral photography and/or diagram of dental pathology.
7) Proposed Dental Plan ofCare.
8) Consent signed by parent\guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
9) Completed Criteria for Dental Therapy Under General Anesthesia form.
10) The parent/guardian dated signature on the Criteria for Dental Therapy Under General Anesthesia form attesting that they understand and agree with the dentist's assessment of their child's behavior.
11) Dentist's attestation statement and signature, which may be put on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand-alone form.

"I attest that the client's condition and the proposed treatment plan warrant the use of general anesthesia. Appropriate documentation of medical necessity is contained in the client's record and is available in my office."

REQUESTING DENTIST'S SIGNATURE:_____ DATE: _____

Revised Date: 05/11/2020 | Effective Date: 9/1/2020

- If utilizing a dental anesthesiologist, the treating dentist must select a dental anesthesia provider who is contracted with the member's dental plan and must have a current level 4 permit.
- The treating dentist is responsible for obtaining prior authorization from UnitedHealthcare Dental and is responsible for providing a copy of the anesthesia prior authorization approval to the dental anesthesiologist.
- The treating dentist submits for prior authorization:
  - One unit of D9999.
  - A narrative stating **"D9999 is for anesthesia administered by a dental anesthesiologist"** in Box 35 of the claims form.
  - Place of service must also be indicated in Box 38 of the 2012 or newer ADA approved claim form.
  - All CDT code(s) that will be performed under general anesthesia or IV sedation.
  - A treatment plan and any additional required documentation.
  - The *Criteria for Dental Therapy Under General Anesthesia Score Sheet*. See Appendix I for this scoring form which includes instructions on how to fill out and calculate.
- UnitedHealthcare Dental will determine medical necessity of the general anesthesia or IV sedation.
- UnitedHealthcare Dental will notify the treating dentist of the determination.
- For anesthesia that is approved, the treating dentist must provide a copy of the approved prior authorization of D9999 to the dental anesthesiologist.

Claim submission:

Dental Anesthesiologist

- The dental anesthesiologist must submit to UnitedHealthcare Dental:
  - 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 (moderate IV sedation)
  - Complete anesthesia report with start and stop times (aligning with the requested units of anesthesia)

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to UnitedHealthcare Dental.

3. Prior authorization process for treating dentist uses a medical anesthesiologist

- If utilizing a medical anesthesiologist, the treating dentist must select an anesthesia provider who is contracted with the member's MCO.
- The treating dentist is responsible for obtaining prior authorization from UnitedHealthcare Dental and is responsible for providing the anesthesia prior authorization information to the medical anesthesiologist.
- The treating dentist submits for prior authorization:
  - One unit of **D9500** (a Plan-specific code for Medical Anesthesia, not an ADA code)
  - A narrative stating **"D9500 is for anesthesia administered by a medical anesthesiologist"** in Box 35 of the claims form.
  - Place of service must also be indicated in Box 38 of the 2012 or newer ADA approved claim form

  - All CDT code(s) that will be performed under general anesthesia or IV sedation for prior authorization.
  - A treatment plan and any additional required documentation.
  - The *Criteria for Dental Therapy Under General Anesthesia Score Sheet*. See Appendix I for this scoring form which includes instructions on how to fill out and calculate.
- UnitedHealthcare Dental will determine medical necessity of the general anesthesia or IV sedation.
- UnitedHealthcare Dental will notify the treating dentist of the determination.
- For anesthesia that is approved, the treating dentist would then provide a copy of the approved prior authorization of D9500 (a Plan specific code for Medical Anesthesia, not an ADA code) to the medical anesthesiologist.
- The medical anesthesiologist is responsible for submitting a separate prior authorization request to the member's MCO.
- The medical anesthesiologist must attain prior authorization approval of general anesthesia or IV sedation from the member's MCO prior to rendering treatment.

Claim submission:

Medical Anesthesiologist

- Upon completion of the approved services, the medical anesthesiologist will submit claim s to the member's MCO using the appropriate CPT code(s).

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to UnitedHealthcare Dental.

Outpatient treatment

Prior authorization process when treating dentist uses a medical anesthesiologist and/or facility

- If utilizing a medical anesthesiologist, the treating dentist must select an anesthesia provider who is contracted with the member's MCO.
- The treating dentist is responsible for obtaining prior authorization from UnitedHealthcare Dental and is responsible for providing the anesthesia prior authorization information to the medical anesthesiologist and / or facility.
- The treating dentist submits for prior authorization:
  - One unit of **D9500** (a Plan specific code for Medical Anesthesia, not an ADA code)
  - A narrative stating **"D9500 is for anesthesia administered by a medical anesthesiologist"** in Box 35 of the claims form.
  - All CDT code(s) that will be performed under general anesthesia or IV sedation.
  - A treatment plan and any additional required documentation.
  - The *Criteria for Dental Therapy Under General Anesthesia Score Sheet*. See Appendix I for this scoring form which includes instructions on how to fill out and calculate.
  - The prior authorization request must indicate tentative procedure date(s) of service and facility name in Box 35 (remarks) of the 2012 or newer ADA approved claim form.
  - Place of service must also be indicated in Box 38 of the 2012 or newer ADA approved claim form.

- UnitedHealthcare Dental will determine medical necessity of the general anesthesia or IV sedation.
- UnitedHealthcare Dental will notify the treating dentist of the determination.
- For anesthesia that is approved, the treating dentist would then provide a copy of the approved prior authorization of D9500 (a Plan specific code for Medical Anesthesia, not an ADA code) to the medical anesthesiologist and / or facility.
- The medical anesthesiologist is responsible for submitting a separate prior authorization request to the member's MCO.
- The medical anesthesiologist must attain prior authorization approval of general anesthesia or IV sedation from the member's MCO prior to rendering treatment.

Claim submission:

Medical Anesthesiologist and/or Facility

- Upon completion of the approved services, the medical anesthesiologist and / or facility will submit claims to the member's MCO using the appropriate CPT code(s).

Treating Dentist

- Upon completion of the approved services, the treating dentist will submit therapeutic services rendered to UnitedHealthcare Dental.

The provider who submits the authorization for the dental therapeutic services must be the provider that performs the services. If the authorized provider does not perform the service, claims will deny. In the event the authorized provider is unable to perform the services, UnitedHealthcare Dental must be notified to update the authorization prior to the services being performed.

Appendix J: UnitedHealthcare Dental Texas orthodontic continuation of care form

UnitedHealthcare Dental Texas
Orthodontic Continuation of Care Form

Date: _____

Patient Information

Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information (Provider continuing the orthodontic treatment)

Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:

Name and Plan Type of Previous Vendor that issued original approval _____

Banding Date _____

Number of Approved Adjustments Completed _____

Number of Approved Adjustments Remaining _____

Expected Number of Adjustments still needed to complete treatment _____

**Be sure to submit all the other required documentation, along with this form, listed in the UHC Dental TX Provider Manual for Continuation of Orthodontic Care at the same time that this form is submitted.*

Appendix K: Orthodontic private pay arrangement: Client Acknowledgment Statement

This form is to be utilized in the event that the Orthodontic provider's evaluation determines that the member would not meet the medical necessity criteria for Orthodontic services under the Texas Medicaid Program, however the member wishes to still receive these services and has agreed to a private pay arrangement with the provider.

Texas Medicaid Provide Procedures Manual (TMPPM)

1.7.11.1 Client Acknowledgment Statement

Texas Medicaid only reimburses services that are medically necessary or benefits of special preventive and screening programs such as family planning and THSteps. Hospital admissions denied by the Texas Medical Review Program (TMRP) also apply under this policy. The provider may bill the client only if:

- A specific service or item is provided at the client's request.
- The provider has obtained and kept a written Client Acknowledgment Statement signed by the client that states:

"I understand that, in the opinion of my Provider (_____), the services or items that I have requested to be provided to me on Dates of Service (_____) may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

ADA code and description of service _____

Fee: $ _____

Member name _____

Member signature _____

Provider signature _____

Date _____