



## **DentaQuest of Illinois, LLC**

### **Office Reference Manual**

Please Refer to Your Participation Agreement for  
Plans You are Contracted For

Aetna Better Health of Illinois  
Blue Cross Blue Shield of Illinois  
Humana Health Plan  
Molina Healthcare

PO Box 2906  
Milwaukee, WI 53201-2906  
800.508.6780  
[www.dentaquest.com](http://www.dentaquest.com)

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**DentaQuest of Illinois, LLC  
Address and Telephone Numbers**

**Provider Services:**

PO Box 2906  
Milwaukee, WI 53201-2906  
**800.508.6780**

**Fax numbers:**

Claims/payment issues: 262.241.7379  
Claims to be processed: 262.834.3589  
All other: 262.834.3450

**Claims questions:**

[denclaims@dentaquest.com](mailto:denclaims@dentaquest.com)

**Eligibility or Benefit Questions:**

[denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com)

**Customer Service/Member Services Dental:**

800.416.9185 – Aetna Better Health & MMAI  
888.291.3763 – Blue Cross Community Health  
855.343.7398 – Blue Cross Community MMAI  
855.225.1733 – Blue Cross Community Health  
844.583.5037 – Molina Healthcare  
844.284.8822 – Molina Healthcare MMAI  
855.398.8412 – Humana Health Plan Gold Plus

**Customer Service/Member Services  
Medical:**

866.329.4701 – Aetna Better Health Plan  
888.657.1211 – Blue Cross Community Health  
877.723.7702 – Blue Cross Community MMAI  
877.901.8181 – Molina Healthcare  
800.787.3311 – Humana Health Plan

**TDD (Hearing Impaired):**

800.466.7566

**DentaQuest Fraud Hotline:**

800.237.9139

**Credentialing:**

PO Box 2906  
Milwaukee, WI 53201-2906  
Phone: 800.233.1468  
Fax: 262.241.4077

**Authorizations should be sent to:**

PO Box 2906  
Milwaukee, WI 53201-2906  
Fax: 262.241.7150

**Electronic Claims should be sent to:**

Direct entry on the web – [www.dentaquest.com](http://www.dentaquest.com)

Or,

Via Clearinghouse – Payer ID CX014  
Include address on electronic claims –  
DentaQuest, LLC  
PO Box 2906  
Milwaukee, WI 53201-2906

**Claims should be sent to:**

PO Box 2906  
Milwaukee, WI 53201-2906



## DentaQuest of Illinois, LLC

### Statement of Members Rights and Responsibilities

1. All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.
2. All Members have a right to privacy and to be treated with respect and recognition of their dignity when receiving dental care.
3. All Members have the right to fully participate with caregivers in the decision-making process surrounding their health care.
4. All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
5. All Members have the right to voice a complaint against DentaQuest, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the Member's expectations.
6. All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.
7. All Members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.

Likewise:

1. All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.
2. All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners.
3. All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.



## DentaQuest of Illinois, LLC

### Statement of Provider Rights and Responsibilities

Providers shall have the right to:

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest.
3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by Plan/DentaQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.
7. To be informed of the status of their credentialing or recredentialing application, upon request.
8. Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross cultural situations. Cultural Competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of the health care and outcomes.

Group and its Represented Physicians shall use best efforts to incorporate Cultural Competence in the delivery of Covered Services to Medicaid Program Participants.

\* \* \*

DentaQuest makes every effort to maintain accurate information in this manual; however, will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

## Abuse, Neglect and Exploitation Reporting Requirements for Illinois Citizens

### *Children (Under the age of 18)*

As mandated by the Abused and Neglected Child Reporting Act (325 ILCS 5/4), persons required to report abuse and neglect of children and youth under the age of 18 include:

- **Medical Personnel:** Physicians, physician assistants, psychiatrists, surgeons, residents, interns, dentists, dentist hygienists, pathologists, osteopaths, coroners, medical examiners, Christian Science practitioners, respiratory care practitioners, chiropractors, podiatrists, acupuncturists, registered and licensed practical nurses, advanced practice nurses, emergency medical technicians, hospital administrators and other personnel involved in the examination, care or treatment of patients.
- **School and Child Care Personnel:** Teachers, school personnel, educational advocates assigned to a child pursuant to the School Code, truant officers, directors and staff assistants of day care centers and nursery schools, and childcare workers.
- **Law Enforcement:** Truant officers, probation officers, law enforcement officers, and field personnel of the Department of Corrections.
- **State Agencies:** Field personnel from the Departments of Children and Family Services, Healthcare and Family Services, Juvenile Justice, Public Health, Human Services (acting as successor to the Department of Mental Health and Developmental Disabilities, Rehabilitation Services, or Public Aid), Corrections, Human Rights, or Children and Family Services, supervisor and administrator of general assistance under the Illinois Public Aid Code, probation officers, animal control officers or Illinois Department of Agriculture Bureau of Animal Health and Welfare field investigators.
- **Others:** Social workers, social service administrators, substance abuse treatment personnel, domestic violence program personnel, crisis line or hotline personnel, foster parents, homemakers, home health aides, funeral home director or employee, licensed professional counselors, licensed clinical professional counselors, genetic counselors, recreational program or facility personnel, registered psychologists and assistants working under the direct supervision of a psychologist, members of the clergy.

A full version of the Abused and Neglected Child Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: [325 ILCS 5/](http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapAct=325%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=32&ChapterName=CHILDREN&ActName=Abused+and+Neglected+Child+Reporting+Act%2E) or at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1460&ChapAct=325%26nbsp%3BILCS%26nbsp%3B5%2F&ChapterID=32&ChapterName=CHILDREN&ActName=Abused+and+Neglected+Child+Reporting+Act%2E>

### **Reporting Procedures**

The types of critical incidents that must be reported include any specific incident of Abuse or Neglect or a specific set of circumstances involving suspected Abuse or Neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged Abuse or Neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to Abuse and Neglect.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an Abused or Neglected child. This is done by calling the Department of Children and Family Services 24-hour Child Abuse Hotline 1-800-25-ABUSE or 1-800-358-5117 (TTY). Reports must be confirmed in writing to the local investigation unit within 48 hours after the hotline call.

### ***Persons Age 18 through 59***

For participants aged 18 and older, mandated reporters under 59 Illinois Administrative Code 50 includes Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors). More details on the Administrative Code may be found at the following hyperlink: **[59 IL Adm. Code 50](http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html)** or at <http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html>.

### ***Reporting Procedures, 18 through 59***

At the time when the Division of Rehabilitation Services (DRS) central office is made aware of an incident, a Home Services Program (HSP) Counselor is assigned to the case. HSP counselors assist with reporting and remain involved in the case to help protect the customer from harm and to see that an adequate plan of care is in place. DRS also works with each case until there is satisfactory resolution. The Department of Human Services (DHS) Office of the Inspector General, which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged abuse, neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHS-funded community agencies. To make a report of abuse, neglect, or exploitation, call the DHS OIG Hotline at 1-800-368-1463 (voice and TTY). The DHS Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to Adults with Disabilities between the ages of 18 and 59 who reside in domestic situations. DHS OIG has the authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

### ***Elderly (Age 60 and over)***

Under the Elder Abuse and Neglect Act (*320 ILCS 202/f-5*), persons required as mandated reporters while carrying out their professional duties in working with the elderly population include:

- A professional or professional's delegate while engaged in:
- Social services
- Law enforcement
- Education
- The care of an eligible adult or eligible adults
- Any of the occupations required to be licensed under the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Dental Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Licensing Act, the Medical Practice Act of 1987, the Naprapathic Practice Act, the Nurse Practice Act, the Nursing Home Administrators Licensing and Disciplinary Act, the Illinois Occupational Therapy Practice Act, the Illinois Optometric Practice Act of 1987, the Pharmacy Practice Act, the Illinois Physical Therapy Act, the Physician Assistant Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor

Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, the Veterinary Medicine and Surgery Practice Act of 2004, and the Illinois Public Accounting Act

- An employee of a vocational rehabilitation facility prescribed or supervised by the Department of Human Services
- An administrator, employee, or person providing services in or through an unlicensed community-based facility
- Any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in any confession or sacred communication enjoined by the discipline of the religious denomination to be held confidential
- Field personnel of the Department of Healthcare and Family Services, Department of Public Health, and Department of Human Services, and any county or municipal health department
- Personnel of the Department of Human Services, the Guardianship and Advocacy Commission, the State Fire Marshal, local fire departments, the Department on Aging and its subsidiary Area Agencies on Aging and provider agencies, and the Office of State Long Term Care Ombudsman
- Any employee of the State of Illinois not otherwise specified herein who is involved in providing services to eligible adults, including professionals providing medical or rehabilitation services and other persons having direct contact with eligible adults
- A person who performs the duties of a coroner or medical examiner
- A person who performs the duties of a paramedic or an emergency medical technician

A full version of the Elder Abuse and Neglect Act can be found on the Illinois General Assembly website at the following hyperlink: **320 ILCS 20/** or at

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452&ChapAct=320%26nbsp%3BILCS%26nbsp%3B20%2F&ChapterID=31&ChapterName=AGING&ActName=Elder+Abuse+and+Neglect+Act%2E>.

### ***Reporting Procedures***

Persons can report suspected Abuse, Neglect or exploitation to the Department of Aging (DoA) by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. Reports may also be made directly to the local Elder Abuse Provider Agency in the service area. DoA policy specifically states that if direct service workers witness or identify a case of possible Abuse or Neglect, they are mandated to personally report the allegations to the designated Elder Abuse Provider Agency or to DoA's Hotlinenumbers. DoA's Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

### ***Persons with Developmental Disabilities in Residential Facilities***

#### ***For participants aged 18 and older***

For participants aged 18 and older, mandated reporters under *59 Illinois Administrative Code 50* include Medicaid Agency and Operating Agency staff and community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors).

More details on the Administrative Code may be found at the following hyperlink: **59 IL Adm. Code 50** or at <http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html>.

### **Reporting Procedures**

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer, or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered, or the reporter was informed of the death (four hours if Abuse or Neglect is suspected).

Anyone may make a report under either rule by calling the DHS Office of the Inspector General 24-hour hotline at 1-800-368-1463 (voice and TTY).

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it.

### **Long Term Care Facility Residents**

Persons required to make reports or cause reports to be made as defined by the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30) include:

- Any long-term care facility administrator, agent or employee
- Any physician, hospital, surgeon, registered nurse, dentist, osteopath, chiropractor, podiatrist, coroner, social worker, social services administrator, or law enforcement officer
- Any accredited religious practitioner who provides treatment by spiritual means alone through prayer in accordance with the tenets and practices of the accrediting church
- Field personnel of the Department of Healthcare and Family Services and the Illinois Department of Public Health and County or Municipal Health Departments
- Personnel of the Department of Human Services (acting as the successor to the Department of Mental Health and Developmental Disabilities or the Department of Healthcare and Family Services), the Guardianship and Advocacy Commission, the State Fire Marshal, local fire department inspectors or other personnel, the Illinois Department on Aging or its subsidiary Agencies on Aging, or employee of a facility licensed under the Assisted Living and Shared Housing Act
- Employees of the State of Illinois who are involved in providing services to residents, including professionals providing medical or rehabilitation services and other persons having direct contact with residents
- Employees of community service agencies who provide services to a resident of a public or private long term care facility outside of that facility
- Any long-term care surveyor of the Illinois Department of Public Health who has reasonable cause to believe in the course of a survey that a resident has been Abused or Neglected and initiates an investigation while on site at the facility shall be exempt from making a report under this Section but the results of any such investigation shall be forwarded to the central register in a manner and form described by the Department



In addition to the above persons required to report suspected resident Abuse and Neglect, any other person may make a report to the Department, or to any law enforcement officer, if such person has reasonable cause to suspect a resident has been Abused or Neglected.

A full version of the Abused and Neglected Long Term Care Facility Residents Reporting Act can be found on the Illinois General Assembly website at the following hyperlink: [210 ILCS 30/](http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapAct=210%26nbsp%3BILCS%26nbsp%3B30%2F&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Abused+and+Neglected+Long+Term+Care+Facility+Residents+Reporting+Act%2E) or at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapAct=210%26nbsp%3BILCS%26nbsp%3B30%2F&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Abused+and+Neglected+Long+Term+Care+Facility+Residents+Reporting+Act%2E>.

### **Reporting Procedures**

The types of critical incidents that must be reported include any allegation of physical or mental Abuse, Neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered Abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where Abuse or Neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Mandated reporters must report the allegation within four hours after the time it was first discovered by the staff. Mandated reporters must also report allegations if they are told about Abuse or Neglect, if they witness it, or if they suspect it. Reports are to be made to the Department of Public Health (DPH) Long Term Care/Nursing Home Hotline at 1-800-252-4343.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days after discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered, or the reporter was informed of the death (only four hours if Abuse or Neglect is suspected).

## ADA Requirement

Providers are required to comply with all Americans with Disabilities Act (ADA) requirements. These include:

- Utilization of waiting room and exam room furniture that meets the needs of all members, including those with physical and nonphysical disabilities
- Providing interpretation services and auxiliary aids for hearing and visually impaired and members with limited English proficiency
- Use of clear signage throughout provider offices
- Providing adequate parking

## ACA, Section 1557 Requirements

Providers that operate a health program or activity and receive federal financial assistance from the Department of Health and Human Services (HHS) for any part of that program or activity are required to comply with Section 1557 of the Affordable Care Act. Requirements include:

- Posting of a nondiscrimination statement in their offices
- Posting of a notice about nondiscrimination and accessibility requirements
- Helpful links:
- Model Notice of Nondiscrimination in English and Translated Versions:  
<https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html>
- Training Materials for Section 1557:  
<https://www.hhs.gov/civilrights/forproviders/training/index.html>

## Provider Training Requirements

- DentaQuest requires the following training by every credentialed provider. The SurveyMonkey attestation must be completed to confirm the completion of the trainings.
  - Annual CMS Fraud, Waste, and Abuse and Cultural Competency Training
  - Annual DentaQuest Provider Training
  - New Provider Orientation (required within the first 90 days of credentialing)



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**1.00 Patient Eligibility Verification Procedures**


**1.01 Plan Eligibility**

Any person who is enrolled in a Plan’s program is eligible for benefits under the member handbook.

**1.02 Member Identification Card**

**Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered.** Participating Providers should make a photocopy of the beneficiary’s card each time treatment is provided. However, Participating Providers should note that the **card in itself does not indicate that a person is currently enrolled in the health plan.** Many of the identification cards are not dated and are not required to be returned to the health plan after a Member is no longer eligible.




**Aetna Better Health Plan of Illinois, Inc I.D. Card:**

 <p>Member ID# 00000000-00      Date of Birth 00/00/0000                  Member Name Last Name, First Name      Sex X                  PCP Last Name, First Name                  PCP Phone 000-000-0000      Effective Date 00/00/0000</p> <hr/> <p>RxBIN 003858    RxPCN A4    RxGRP KC2A                  Pharmacist Use Only 1-800-824-0898</p> <p><small>THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.                  www.aetnabetterhealth.com</small></p>	<p>To verify member eligibility please call 1-866-212-2851.</p> <p>Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-866-212-2851.</p> <p><b>Member Services</b> (24 hours a day, 7 days a week) 1-866-212-2851  <b>Transportation Services</b> 1-000-000-0000  <b>Behavioral Health Services</b> 1-000-000-0000  <b>Dental Services</b> 1-000-000-0000  <b>Vision Services</b> 1-000-000-0000                  Hearing Impaired Illinois Relay 7-1-1</p> <p>Send Medical Claims To      Aetna Better Health                  Aetna Better Health      Payer ID 00000                  PO Box 62198      Provider Claims Questions                  Phoenix, AZ 85082-2198      1-866-716-3356</p>
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**Blue Cross Blue Shield ICP (MEDICAID) I.D. Card:**

 <p><b>Blue Cross Community ICP<sup>SM</sup></b></p> <p>Member Name:                  &lt;John A Doe&gt;</p> <hr/> <p>Group Number: &lt;XXXX&gt;                  Enrollment Effective Date: &lt;MM DD, YYYY&gt;                  PCP: &lt;PCP NAME&gt;                  &lt;PCP PHONE NUMBER&gt;</p>	<p>Medicaid ID: &lt;123456789&gt;                  Member ID: &lt;ABC123456789&gt;</p> <hr/> <p>RxBIN: &lt;011552&gt;                  RxPCN: &lt;XXXX&gt;</p>	<p>www.bcsilcommunityicp.com</p>  <p><b>MEMBERS:</b>                  Member Services: &lt;888-657-1211&gt;                  TDD/TTY: 711                  24/7 Nurse Line: &lt;888-343-2697&gt;  <b>PROVIDERS:</b>                  &lt;888-657-1211&gt;  <b>PHARMACISTS ONLY:</b>                  &lt;888-274-5218&gt;</p> <p>Medical &amp; Behavioral Health Claims:                  Blue Cross Community ICP                  Attn: Claims                  PO Box 805107                  Chicago, IL 60680-4112</p> <p>For all other claims (including dental, vision, and transportation) call &lt;888-657-1211&gt; for paper claim address.</p> <p>Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an independent licensee of the Blue Cross and Blue Shield Association.</p>
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**Blue Cross Blue Shield MMAI (MEDICARE/MEDICAID) I.D. Card:**

 <p><b>Member name:</b> &lt;John A Doe&gt;  <b>Member ID:</b> XOG&lt;123456789&gt;  <b>Health Plan (80840):</b> &lt;9101000237&gt;  <b>Medicaid ID</b> &lt;XXXXXXXXXX&gt;</p> <hr/> <p><b>PCP Name:</b> &lt;PCP Name&gt;  <b>PCP Phone:</b> &lt;PCP Phone&gt;</p>	 <p><b>RxBin:</b> &lt;011552&gt;  <b>RxPCN:</b> &lt;ILDEMD&gt;  <b>RxGRP:</b> &lt;XXXX/XXXXX&gt;  <b>RxID:</b> &lt;999999999&gt;</p>	 <p><b>Member Services:</b> &lt;1-877-723-7702&gt;  <b>TDD/TTY:</b> &lt;711&gt;  <b>Provider Services:</b> &lt;1-877-723-7702&gt;  <b>24/7 Nurse Line:</b> &lt;1-888-343-2697&gt;  <b>Website:</b> &lt;bcsilcommunitymmai.com&gt;  <b>Send claims to:</b> Blue Cross Community MMAI                  Attn: Claims                  &lt;PO Box 805107, Chicago, IL 60680-4112&gt;</p>
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**Humana Coordinated Care Plan I.D. Card:**

**Humana.**  
 <Humana Coordinated Care Plan>  
 Medicaid Managed Care Plan

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**


HFS ID#: XXXXXXXX      Effective Date: XX/XX/XX  
 Group #: XXXXX      Date of Birth: XX/XX/XX  
 ANSI BIN: XXXXXX

**Member/Provider Service: 1-800-764-7561**  
 Primary Physician: XXXXXXXXXXXXXXXX  
 Telephone: (XXX)-XXX-XXXX  
 HumanaFirst Nurse Advice Line: 1-800-622-9529

**Humana Medical Claims**      **Behavioral Health Claims**  
 PO Box 14601      500 Unicorn Park Drive  
 Lexington, KY 40512-4601      Woburn, MA 01801

**LTSS Claims**      **Dental Claims**  
 Smart Data Solutions      DentaQuest, LLC  
 PO Box 21596      12121 N Corporate Pkwy  
 Eagan, MN 55121      Mequon, WI 53092

**Molina Coordinated Care Plan I.D. Card:**

  
**HealthChoice Illinois**

Member: <Member\_Name\_1>  
 Member ID: <Member\_ID\_1>  
 DOB: <Data\_of\_Birth\_1>  
 PCP: <PCP\_Name\_1>      | RxBIN: <Bin\_Number\_1>  
 PCP Address: <PCP\_Address\_1>      | RxPCN: <RXPCN\_1>  
 PCP Phone: <PCP\_Phone\_Number\_1>      | RxGRP: <RXGroup\_1>  
 Effective Date: <Member\_Effective\_Date\_1>

[MyMolina.com](http://MyMolina.com)

**Members:** To verify eligibility or change your Primary Care Provider (PCP) visit [www.MyMolina.com](http://www.MyMolina.com) or call Member Services (855) 687-7861. For those who are hearing impaired, call the Illinois Relay at 7-1-1.

**Emergency Services:** Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your PCP or call our 24-Hour Nurse Advice Line at (888) 275-8750 for English or (866) 648-3537 for Spanish. For those who are hearing impaired, call the Illinois Relay at 7-1-1.

**Behavioral Health:** 24-Hour Crisis Hotline (888) 275-8750. For Spanish dial (866) 648-3537.

**Transportation:** To schedule a ride or for day-of ride assist, call (844) 644-6354.

**Providers:** To verify eligibility, claims status or prior authorization, call (855) 866-5462.

**Prior Authorization:** Required for all inpatient admissions and selected outpatient services. Call (855) 687-7861 to notify us of an admission.

**Pharmacists:** For pharmacy questions, call (855) 866-5462.

**Dental and Vision:** Dental (844) 583-5037, Vision (866) 857-8124

**Claim Submission:** P.O. Box 540, Long Beach, CA 90801

**EDI Submissions:** Payor ID 20934

[MolinaHealthcare.com/Medicaid](http://MolinaHealthcare.com/Medicaid)

### 1.03 DentaQuest Eligibility Systems

#### **DentaQuest Eligibility Systems**

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed via [www.dentaquest.com](http://www.dentaquest.com). The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

#### **Access to eligibility information via the Internet**

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or the Member's full last name and first initial. To access the eligibility information via DentaQuest's website, simply go to our website at [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at (800) 341-8478. Once logged in, select "Patient" and then "Member Eligibility Search" and from there enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

#### **Access to eligibility information via the IVR line**

To access the IVR, simply call DentaQuest's Customer Service department at (800) 341-8478 and press 1 for eligibility. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6 digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative



**Directions for using DentaQuest's IVR to verify eligibility:**

Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at (800) 341-8478.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have numbers and letters in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have only numbers in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

**Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.**

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 800.508.6780. They will be able to assist you in utilizing either system.

**Use of MEDI to verify eligibility**

For information on MEDI see: <http://www.myhfs.illinois.gov/> or call the MEDI help desk at 217-524-3814. There are on-line videos on how to get your user name and password and how to register.

**1.04 Health Plan Facility Authorization Phone Number**

The Provider should submit a request for authorization for the outpatient facility to the respective health plan. DentaQuest does not coordinate the facility authorization with the individual health plans.

**1.05 Transportation Benefits for Certain Beneficiaries**

Transportation for dental appointments may be available to beneficiaries. Beneficiaries who need assistance with transportation, should contact their plan directly for assistance. Arrangements must be made prior to the appointment. Most plans require 48 to 72 hours advance notice of an appointment for scheduling. Please contact the plans directly for specifics on their transportation policies.

***Non-Emergency Customer Service/Member Services Medical:***

866.212.2851 – Aetna Better Health Plan

888.657.1211 – Blue Cross Community Health Plan

877.723.7702 – Blue Cross Community MMAI

877.860.2837 – Blue Cross Community Health Plan

877.901.8181 – Molina Healthcare

*Non-emergency* transportation for Humana, please outreach to MTM: 855.253.6867

**1.06 Aetna Better Health Plan of IL – Authorizations for Non-Covered Services**

The provider should contact Aetna Better Health Plan of IL directly for requests to authorize medically necessary non-covered services.

Aetna Better Health: 866.212.2851

**1.07 Specialist Referral Process**

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Member Services Department.

## 2.00 Authorization for Treatment

### 2.01 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit “documentation” associated with certain dental services for a Member. Participating Providers will not be paid if this “documentation” is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest’s operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see section 12). Please review these criteria as well as the Benefits covered to understand the decision-making process used to determine payment for services rendered.

#### A. Authorization and documentation submitted before treatment begins (Non-emergency) treatment.

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan and/or DentaQuest.

Your submission of “documentation” should include:

1. Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
2. CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits) contain a column marked Authorization Required. A “Yes” in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

#### B. Authorization and documentation submitted with claim (Emergency treatment)

DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations, services that require authorization, but are rendered under emergency conditions, will require the same “documentation” be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this “documentation” will be denied.

## 2.02 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. 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;
- Include the charge for the non-covered service;
- DentaQuest, Plan and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.

### ***Co-payment Limits and Member Charges For Non-covered Services:***

No deductibles or copayments are permitted for Medicaid covered services. A provider shall be permitted to charge an eligible Member for goods or services which are not covered only if the Member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them. For purposes of this section non-covered services are services not covered under the Medicaid state plan, services which are provided in the absence of appropriate authorization and services which are provided out-of-network unless otherwise specified in the contract, policy or regulation (e.g., family planning, mental health or emergency room services).

### ***Medicare-Medicaid-eligible deductible/coinsurance:***

Providers cannot collect coinsurance, copayments, deductibles, financial penalties or any other amount in full or part, for any service provided under this contract.

## 2.03 Electronic Attachments

**A. FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

**FastAttach™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to [www.nea-fast.com](http://www.nea-fast.com) or call NEA at:

800.782.5150

## 2.04 Dispute Resolution /Provider Appeals Procedure

Participating Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to DentaQuest that specifies the nature and rationale of the disagreement. This notice *and* additional support information must be sent to DentaQuest within 60 days (90 days for the Molina plans) from the date of the original determination to be reconsidered by DentaQuest's Peer Review Committee.

DentaQuest of IL  
Attention: Utilization Management/Provider Appeals  
PO Box 2906  
Milwaukee, WI 53201-2906

All notices received shall be submitted to DentaQuest's Peer Review Committee for review and reconsideration. The Committee will respond in writing with its decision to the Provider.

### 3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals. Participating Hospitals may change.

#### **Aetna Better Health Plan Participating Hospitals**

Please use the following link to access the most up to date listing of facilities:

[www.aetnabetterhealth.com](http://www.aetnabetterhealth.com)

#### **Blue Cross Blue Shield of Illinois Health Plan Participating Hospitals**

Please use the following link to access the most up to date listing of facilities:

[www.bcbsil.com](http://www.bcbsil.com)

#### **Humana Health Plan Participating Hospitals**

Please use the following link to access the most up to date listing of facilities:

[www.humana.com](http://www.humana.com)

#### **Molina Healthcare Plan Participating Hospitals**

Please use the following link to access the most up to date listing of facilities:

[www.molinahealthcare.com](http://www.molinahealthcare.com)

DentaQuest will review the treatment plan for the appropriateness of performing the services in a hospital or outpatient facility. You will receive a determination letter from DentaQuest notifying you of our determination. If your request is approved, DentaQuest will forward this notice of approval to appropriate plan (Family Health Network or Community Care Alliance of Illinois) based on the member's eligibility. The appropriate plan (Family Health Network or Community Care Alliance of Illinois) will then enter a medical services approval for the facility and general anesthesia and will send the determination to the facility. If you need to change the date of service, please notify DentaQuest and the facility as soon as possible.

### 4.00 Claim Submission Procedures (claim filing options)

DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website ([www.Dentaquest.com](http://www.Dentaquest.com)).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

#### **4.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website**

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at (800) 341-8478. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations at (800) 417-7140 or via e-mail at: [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com)

#### **4.02 Electronic Authorization Submission Utilizing DentaQuest's Internet Website**

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Pre-Authorizations via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit pre-authorizations via the website, simply log on to [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at (800) 341-8478. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.

#### **4.03 Electronic Claim Submission via ClearingHouse**

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

#### **4.04 HIPAA Compliant 837D File**

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email [EDITeam@greatdentalplans.com](mailto:EDITeam@greatdentalplans.com) to inquire about this option for electronic claim submission.

#### 4.05 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Dentist Portal.

#### 4.06 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
  - The paper claim must contain an acceptable provider signature.
  - The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
  - The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
  - The date of service must be provided on the claim form for each service line submitted.
  - Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
  - List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
  - Affix the proper postage when mailing bulk documentation. DentaQuest

does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

DentaQuest IL  
PO Box 2906  
Milwaukee, WI 53201-2906

#### 4.07 Coordination of Benefits (COB)

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

#### 4.08 Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

#### 4.09 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an "explanation of benefit" report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

#### 4.10 Direct Deposit

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form found on the website.
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.
  - Via Fax - 262.241.4077 **or**
  - Via Mail –

DentaQuest of IL  
PO Box 2906  
Milwaukee, WI 53201-2906



ATTN: PEC Department

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Dentist Portal. Providers may access their remittance statements by following these steps:

1. Go to [www.dentaquest.com](http://www.dentaquest.com)
2. Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

## 5.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 800.508.6780 or via e-mail at [denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com).

### 5.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at [www.dentaquest.com](http://www.dentaquest.com). Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and ID. Once you have logged in, click on the link named "Related Documents" (located under the picture on the right-hand side of the screen).

## 6.00 Complaints and Grievances (Policies 200 Series)

- A. **Grievances:** Members may file a grievance verbally or in writing directly with each plan in regard to policies, procedures or any aspect of administrative functions, including proposed actions. Members may contact their health plan provider by contacting them directly or in writing:

**Aetna Better Health**

Aetna Better Health  
Attn: Grievance and Appeals Dept.  
One South Wacker Dr.  
Chicago, IL 60606  
Telephone: 866-212-2851

**Blue Cross Blue Shield of Illinois**

Blue Cross Blue Shield of Illinois  
Attn: Grievance and Appeals Department  
300 E. Randolph  
Chicago, IL 60601  
Fax: 1-877-788-2830

**Molina HealthCare of Illinois**

Molina HealthCare of Illinois  
Attn: Grievance and Appeals Department  
1520 Kensington Rd. Ste 212  
Oak Brook, IL 60523  
Fax: 1-562-499-0610

**Humana Health Plan**

*MMAI Contact:* Telephone:  
1-900-867-6601 Fax:  
1-800-949-2961

- B. **Appeals:** Members may file an appeal verbally or in writing directly with each plan if the member is not happy with an authorization decision. Members may contact their health plan directly or in writing no later than 60 days after the date of the notice.

After review of the appeal, the member will receive a decision in writing within 30 days of the date the request is received.

- C. **Fast Appeals:** If the member or provider feels that a faster decision is necessary due to health or ability to function, the member or provider may request an expedited appeal. If the health plan agrees, the health plan will make a decision within 72 hours. If the health plan does not agree a fast review is needed, the health plan will write to you within 2 days and also try to call. Then, the appeal will be responded to within 30 days.
- D. **Fair Hearing:** A State Fair Hearing may be requested during the appeal process. The request must be made within 30 days from receipt of the notice. If the member wants services continued, the request must be made within 10 days of receiving the notice. The member does not have to wait for a decision from their health plan before filing the State Fair Hearing. The member may request a State Fair Hearing in two ways:

- By calling 1-800-435-0774 (TTY 1-877-734-7429)
- By writing to the IL Department of Healthcare and Family Services (HFS) at the following address:

Illinois Department of Human Services  
Bureau of Assistance Hearings  
401 S. Clinton, 6th Floor  
Chicago, Illinois 60607  
Fax: 312-793-3387  
Email: [DHS.BAH@illinois.gov](mailto:DHS.BAH@illinois.gov)

DentaQuest's Complaints/Grievance Coordinator receives Member and Provider inquiries and complaints. The Coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified of the resolution (i.e. Plan, Member, and Provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

The Complaints/Grievances Coordinator receives Member and Provider grievances. The Coordinator requests appropriate documentation, forwards the documentation to the dental consultant for review and determination, and the decision to uphold or overturn the initial decision is communicated to the appropriate individuals.

Note: Copies of DentaQuest policies and procedures can be requested by contacting Customer Service at 800.508.6780. (Policies 200.010, 200.011, 200.012, 200.012A, 200.012B, 200.013, 200.022, 200.023)

## 6.01 Provider Complaint and Claim Resolution Process

**A. Administrative Complaints:** Complaints in reference to administrative functions, policies and procedures of the Company and do not include claim denial issues.

- Administrative complaints may be made verbally by calling DentaQuest at 800.436.5286.

**B. Claim Resolution Process:** Appeals in reference to a denial issued by Claims for any reason. Providers are offered 90 calendar days to file written appeals in reference to claim denials. DentaQuest will process provider claim appeals within 30 business days of receipt.

- **Claim Resolution Requests may be sent to DentaQuest in writing:**

DentaQuest, LLC  
RE: Provider Claim Resolution  
PO Box 2906  
Milwaukee, WI 53201-2906

## **7.00 Utilization Management Program (Policies 500 Series)**

### **7.01 Introduction**

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or “budgets” the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

### **7.02 Community Practice Patterns**

To do this, DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist’s treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the “community practice patterns” of local dentists and their peers. With this in mind, DentaQuest’s Utilization Management Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest’s Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group, and not with general dentists, since the types and nature of treatment may differ.

### **7.03 Evaluation**

DentaQuest’s Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

### **7.04 Results**

Therefore, with the objective of ensuring the fair and appropriate distribution of these “budgeted” Medicaid Assistance Dental Program dollars to dentists, DentaQuest’s Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

## 7.05 Fraud and Abuse (Policies 700 series)

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.

The Illinois Office of Inspector General audits and investigates providers suspected of overbilling or defrauding Illinois' Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

To report suspected Medicaid fraud, contact our hotline at: 1.800.252.8903 or the Illinois Office of Inspector General at 1.888.814.4646. Providers are to cooperate fully in any investigation by the Agency, Office of Inspector General (OIG), or any subsequent legal action that may result from such an investigation.

## 7.06 Deficit Reduction Act of 2005: The False Claims Act

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. The DRA is a bill designed to reduce federal spending on entitlement programs over five years. The DRA requires that any entity that receives or makes annual Medicaid payments of a least \$5 million establish written policies for its employees, management, contractors and agents regarding the False Claims Act (the "FCA").

The FCA allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the FCA, the person bringing suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may seek to exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

**For more information about the False Claims Act go to the Tax Payers Against Fraud, The False Claims Web site.**

DentaQuest is contractually obligated to report suspected fraud, waste or abuse by Beneficiaries and Participating Dental Providers of the Illinois Medicaid dental programs. To report suspected fraud, waste or abuse call:

**The Illinois Office of Inspector General at  
1.888.814.4646**

## 8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes, but is not limited to:

- Provider credentialing and recredentialing.
- Member satisfaction surveys.
- Provider satisfaction surveys.
- Random Chart Audits.
- Complaint Monitoring and Trending.
- Peer Review Process.
- Utilization Management and practice patterns.
- Initial Site Reviews and Dental Record Reviews.
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

**Members should be triaged and provided appointments for care within the following time frames:**

Emergency care – A member must be provided an appointment within 24 hours.

Urgent care – A member shall be seen within three weeks from the date of the request.

Routine care – A member shall be seen within five weeks from the date of the request.

Therapeutic Restorative care - A member shall be seen within 14 days of the request.

In office wait time - A member shall be seen within 30 minutes of appointment time.

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 800.508.6780 or via e-mail at:

[denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com)

## 9.00 FQHC Denture Billing

A Federally Qualified Health Center (FQHC) may bill up to three (3) additional encounters per plate for a Beneficiary receiving a complete or partial denture. Partial dentures are limited to children age 2 through 20 only. The HFS Dental Program has established Procedure Code D5899 – Unspecified Removable Prosthodontic Procedure – as a covered service for HFS Dental Program Beneficiaries receiving dentures in a FQHC facility. Including the first visit (exam and X-rays) and placement, this allows an FQHC to receive reimbursement for a total of six (6) encounters per full denture placement per patient. (See Exhibit D).

To receive consideration for additional reimbursement, a FQHC must submit prior authorization for a maximum of three (3) procedure codes D5899 along with authorization for the complete or partial denture. If the authorization is approved, the FQHC will also receive approval for the additional visits.

Appropriate Visits for Procedure Code D5899

1. Initial denture impressions
2. Final denture impressions
3. Vertical dimension of occlusion visits
4. Wax try in visits
5. Necessary adjustments post insertion
6. Repairs or relines during the six (6) month period following the insertion of the new prosthesis

In each case, a narrative of the service performed must be provided at the time procedure code

D5899 is billed.

Providers should submit for payment for the complete denture (D5110, D5120, D5211, D5212) at the time prosthesis is delivered.

Exam and X-rays are considered the same encounter, as radiographic interpretation is included in the initial examination.

### Example #1 – Beneficiary Receives Mandibular and Maxillary Complete Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-Rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214
Fourth	Denture Adjustment	D5899
Fifth	Denture Adjustment	D5899
Sixth	Denture Reline	D5899
Seventh	Denture Reline	D5899
Eight	Denture Adjustment	D5899

### Example #2 – Beneficiary Receives Mandibular or Maxillary Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-Rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	VDO	D5899
Fourth	Wax try in	D5899
Fifth	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214

### Example #3 – Beneficiary Receives Mandibular or Maxillary Dentures

Appointment	Services Provided	Possible Procedure Codes Billed
First	Initial Exam and X-rays	D0120/D0150, D0210/D0330
Second	Denture Impressions	D5899
Third	Wax try in	D5899
Fourth	Denture Placement	D5110, D5120, D5211, D5212, D5213, D5214
Fifth	Denture Adjustment	D5899



## 10.00 School-Based Dental Program

The HFS Dental Program allows out-of-office delivery of preventive dental services in a school setting to children. Managed Care plans are required to allow school-based benefits in accordance with the guidelines adopted by the HFS All-Kids School Based Dental Program.

Recognizing the unique qualities of a school-based dental program, specific protocols have been developed to assist school based dental program providers.

### 10.01 Participation Guidelines and Forms

Providers who wish to participate as a school-based dental program provider must meet the following requirements. Providers who do not adhere to the requirements for participation are not eligible for reimbursement.

1. **Providers must be enrolled as a participating Provider in the HFS Dental Program and the All Kids School-Based Dental Program. They must be a provider in good-standing and adhere to all annual registration and record keeping requirements of that program.** Program participation requirements may be found in the HFS Dental Office Reference Manual, which can be found on the HFS website at [www.illinois.gov](http://www.illinois.gov).
2. **School-based dental program providers must be able to render the full scope of preventive school-based services for an out-of-office setting:**
  - D0120 - Periodic Oral Examination
  - D1120 - Prophylaxis – Child
  - D1208 - Topical Application of Fluoride (excluding prophylaxis)
  - D1206 - Topical Application of Fluoride Varnish
  - D1351 - Sealant – Per Tooth
  - D0601 – Caries Risk Assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
  - D0602 – Caries Risk Assessment and documentation, with a finding of medium risk (Equates to Oral Health Score 2)
  - D0603 – Caries Risk Assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)
3. **Effective August 1, 2014, school-based dental providers must submit a Caries Risk Assessment (CRA) code with each school-based dental service claim in order for the services on the claim to pay. The CRA codes are as follows:**
  - D0601 – Caries Risk Assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
  - D0602 – Caries Risk Assessment and documentation, with a finding of medium risk (Equates to Oral Health Score 2)
  - D0603 – Caries Risk Assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

### 10.02 Place of Service (POS) Definition

School-Based services coded as a POS of school are limited to the eight (8) preventive codes.

- D0120- Periodic Oral Examination
- D1120- Prophylaxis – Child

- D1208- Topical Application of Fluoride (excluding prophylaxis)
- D1206- Topical Application of Fluoride Varnish
- D1351- Sealant – Per Tooth
- D0601 – Caries risk assessment and documentation, with a finding of low risk (Equates to Oral Health Score 1)
- D0602 – Caries risk assessment and documentation, with a finding of moderate risk (Equates to Oral Health Score 2)
- D0603 – Caries risk assessment and documentation, with a finding of high risk (Equates to Oral Health Score 3)

### **11.00 Credentialing (Policies 300 Series)**

DentaQuest, in conjunction with the Plan, has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry.

Nothing in this Credentialing Plan limits DentaQuest's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

The Plan has the final decision-making power regarding network participation. DentaQuest will notify the Plan of all disciplinary actions enacted upon Participating Providers.

#### **Appeal of Credentialing Committee Recommendations. (Policy 300.017)**

If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by DentaQuest within 30 days of the date the Committee gave notice of its decision to the applicant.

#### **Discipline of Providers (Policy 300.019)**

#### **Procedures for Discipline and Termination (Policies 300.017-300.021)**

#### **Recredentialing (Policy 300.016)**

Network Providers are recredentialled at least every 24 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 800.508.6780 or via e-mail at:

[denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com).

## 12.00 The Patient Record

### A. Organization

1. The record must have areas for documentation of the following information:
  - a. Registration data including a complete health history.
  - b. Medical alert predominantly displayed inside chart jacket.
  - c. Initial examination data.
  - d. Radiographs.
  - e. Periodontal and Occlusal status.
  - f. Treatment plan/Alternative treatment plan.
  - g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
  - h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).
2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:
  - a. Health history.
  - b. Medical alert.
  - c. Examination/Recall data.
  - d. Periodontal status.
  - e. Treatment plan.
3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.
4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).
5. The organization of the record system must require that individual records be assigned to each patient.

### B. Content-The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:
  - a. Patient's first and last name.
  - b. Date of birth.
  - c. Sex.
  - d. Address.
  - e. Telephone number.
  - f. Name and telephone number of the person to contact in case of emergency.
2. An adequate health history that requires documentation of these items:
  - a. Current medical treatment.
  - b. Significant past illnesses.
  - c. Current medications.
  - d. Drug allergies.
  - e. Hematologic disorders.
  - f. Cardiovascular disorders.

- g. Respiratory disorders.
  - h. Endocrine disorders.
  - i. Communicable diseases.
  - j. Neurologic disorders.
  - k. Signature and date by patient.
  - l. Signature and date by reviewing dentist.
  - m. History of alcohol and tobacco usage including smokeless tobacco.
3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:
- a. Significant changes in health status.
  - b. Current medical treatment.
  - c. Current medications.
  - d. Dental problems/concerns.
  - e. Signature and date by reviewing dentist.
4. A conspicuously placed medical alert inside the chart jacket that documents highly significant terms from health history. These items are:
- a. Health problems which contraindicate certain types of dental treatment.
  - b. Health problems that require precautions or pre-medication prior to dental treatment.
  - c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
  - d. Drug sensitivities.
  - e. Infectious diseases that may endanger personnel or other patients.
5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:
- a. Blood pressure. (Recommended)
  - b. Head/neck examination.
  - c. Soft tissue examination.
  - d. Periodontal assessment.
  - e. Occlusal classification.
  - f. Dentition charting.
6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:
- a. Blood pressure. (Recommended)
  - b. Head/neck examination.
  - c. Soft tissue examination.
  - d. Periodontal assessment.
  - e. Dentition charting.
7. Radiographs which are:
- a. Identified by patient name.
  - b. Dated.
  - c. Designated by patient's left and right side.

- d. Mounted (if intraoral films).
8. An indication of the patient's clinical problems/diagnosis.
9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:
  - a. Procedure.
  - b. Localization (area of mouth, tooth number, surface).
10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:
  - a. Periodontal pocket depth.
  - b. Furcation involvement.
  - c. Mobility.
  - d. Recession.
  - e. Adequacy of attached gingiva.
  - f. Missing teeth.
11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
  - a. Gingival status.
  - b. Amount of plaque.
  - c. Amount of calculus.
  - d. Education provided to the patient.
  - e. Patient receptiveness/compliance.
  - f. Recall interval.
  - g. Date.
12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
  - a. Provider to whom consultation is directed.
  - b. Information/services requested.
  - c. Consultant's response.
13. Adequate documentation of treatment rendered which requires entry of these items:
  - a. Date of service/procedure.
  - b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
  - c. Type and dosage of anesthetics and medications given or prescribed.
  - d. Localization of procedure/observation. (tooth #, quadrant etc.)
  - e. Signature of the Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another dentist that includes:

- a. Patient examination.
- b. Treatment plan.
- c. Treatment status.

### **C. Compliance**

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

## **13.00 Patient Recall System Requirements**

### **A. Recall System Requirement**

Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Health Plan enrollee that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

### **B. Office Compliance Verification Procedures**

- In conjunction with its office claim audits described in section 4.09, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability from a member-initiated telephone call.
- Routine symptomatic care within 14 days.
- Urgent care must be available within 24 hours.
- Routine asymptomatic- within 60 days

**Follow-up appointments shall be scheduled consistent with the clinical need.**

## 14.00 Radiology Requirements

**Note:** Please refer to benefit tables for radiograph benefit limitations.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

### A. Radiographic Examination of the New Patient

1. Child – primary dentition

The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – transitional dentition

The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – permanent dentition prior to the eruption of the third molars

The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

4. Adult – dentulous

The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

5. Adult – edentulous

The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

### B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

a. Child – primary and transitional dentition

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

b. Adolescent

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

d. Adult – edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high risk factors for caries

a. Child – primary dentition

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult

The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a panoramic radiograph.



d. Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

**15.00 Health Guidelines – Ages 0-18 Years****NOTE: Please refer to benefit tables for benefits and limitations.****Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual 2002-2003)  
Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines)**

<b>Periodicity Recommendations</b>					
Age (1)	<b>Infancy 6 – 12 Months</b>	<b>Late Infancy 12 – 24 Months</b>	<b>Preschool 2 – 6 Years</b>	<b>School Aged 6 – 12 Years</b>	<b>Adolescence 12 – 18 Years</b>
Oral Hygiene Counseling (2)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient/ parents/ caregivers	Patient
Injury, Prevention Counseling (3)	X	X	X	X	X
Dietary Counseling (4)	X	X	X	X	X
Counseling for non-nutritive habits (5)	X	X	X	X	X
Fluoride Supplementation (6,7)	X	X	X	X	X
Assess oral growth and development (8)	X	X	X	X	X
Clinical oral exam	X	X	X	X	X
Prophylaxis and topical fluoride treatment (9)		X	X	X	X
Radiographic assessment (10)			X	X	X
Pit and Fissure Sealants			If indicated on primary molars	First permanent molars as soon as possible after eruption	Second permanent molars and appropriate premolars as soon as possible after eruption
Treatment of dental disease	X	X	X	X	X
Assessment and treatment of developing malocclusion			X	X	X
Substance abuse counseling				X	X
Assessment and/or removal of third molars					X
Referral for regular periodic dental care					X
Anticipatory guidance (11)	X	X	X	X	X
<ol style="list-style-type: none"> <li>1. First examination at the eruption of the first tooth and no later than 12 months.</li> <li>2. Initially, responsibility of parent; as child develops jointly with parents, then when indicated, only by child.</li> <li>3. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing.</li> <li>4. At every appointment discuss role of refined carbohydrates; frequency of snacking.</li> <li>5. At first discuss need for additional sucking; digits vs. pacifiers; then the need to wean from habit before eruption of a permanent incisor.</li> <li>6. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.</li> <li>7. Up to at least 16 years.</li> <li>8. By clinical examination.</li> <li>9. Especially for children at high risk for caries and periodontal disease.</li> <li>10. As per AAPD Guideline on Prescribing Dental Radiographs.</li> <li>11. Appropriate discussion and counseling should be an integral part of each visit for care.</li> </ol>					

## 16.00 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore, it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

Early and periodic screening, diagnostic and treatment (EPSDT) are required services under the Medicaid program for most individuals under age 21. EPSDT services include periodic screening, vision, dental and hearing services. Per Section 1905(r)(3)(A) of the Social Security Act, children's dental services are to be provided at intervals which meet reasonable standards of practice, or at such intervals indicated as medically necessary. Additionally, the statute requires that dental services shall, at a minimum, include relief of pain and infections. Also, for other necessary healthcare diagnostic services, treatment, and other measures to correct or ameliorate defects, illness and conditions discovered by the screening services shall be covered under EPSDT. For dental services that are deemed medically necessary above and beyond what is published in the benefit tables and the dental periodicity schedule, the dental provider should submit for prior authorization of the requested EPSDT services on the ADA Claim Form. On the ADA claim form check EPSDT/Title XIX in type of Transaction (Box#1), list the recommended procedure code(s) (Box #29), and provide a description of the services (Box #30). A narrative/justification should be included in the "remarks field" (Box #35).

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the “Patient Record” section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

#### **16.01 Criteria for Dental Extractions**

Not all procedures require authorization.

##### **Documentation needed for authorization procedure:**

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

##### **Criteria**

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.

#### **16.02 Criteria for Cast Crowns**

##### **Documentation needed for authorization of procedure:**

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

### Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface 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 or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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 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.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation involvement.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

### 16.03 Criteria for Endodontics

Not all procedures require authorization.

#### Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

### **Criteria**

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

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal 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.

### **Other Considerations**

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

#### 16.04 Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

##### **Documentation needed for authorization of procedure:**

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

##### **Criteria**

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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 permanent tooth must be at least 50% supported in bone.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.

#### **16.05 Criteria for Authorization of Operating Room (OR) Cases**

**Documentation needed for authorization of procedure:**

- Treatment Plan (prior-authorized, if necessary).
- Narrative describing medical necessity for OR.

#### **All Operating Room (OR) Cases Must be Authorized.**

The Provider should submit a request for authorization for the dental services and facility to DentaQuest. DentaQuest will coordinate the facility authorization with the plan and notify the provider, in writing, of the determination of the dental services and facility.

DentaQuest Authorization Fax Number: 262.241.7150

#### **Criteria**

In most cases, OR will be authorized (for procedures covered by Health Plan) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.



- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

#### **16.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)**

##### **Documentation needed for authorization of procedure:**

- Treatment plan.
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

##### **Criteria**

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with 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.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- 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.

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 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.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

### Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
  - Adjustments will be reimbursed at one per calendar year per denture.
  - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
  - Relines will be reimbursed once per denture every 36 months.
  - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
  - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

### 16.07 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT-4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

**Documentation needed for authorization of procedure:**

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed

**16.08 Criteria for the Determination of a Non-Restorable Tooth**

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

**16.09 Criteria for General Anesthesia and Intravenous (IV) Sedation****Documentation needed for authorization of procedure:**

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

**Criteria**

Requests for general anesthesia or IV sedation will be authorized (for procedures Covered by Health Plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.

- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

#### **16.10 Criteria for Periodontal Treatment**

**Not all procedures require authorization.**

**Documentation needed for authorization of procedure:**

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

“Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic.”

#### **Criteria**

- A minimum of four (4) teeth affected in the quadrant.

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
  - 1) Radiographic evidence of root surface calculus.
  - 2) Radiographic evidence of noticeable loss of bone support.

#### **16.11 Criteria for Orthodontia Treatment**

Effective January 1, 2017, medically necessary orthodontic treatment is approved only for patients under the age of 21 and is defined as:

- Treatment necessary to correct a condition that scores 28 points or more on the Handicapping Labio-Lingual Deviation Index (HLD); or
- Treatment necessary to correct the following conditions:
  - Cleft Palate
  - Deep impinging bite with signs of tissue damage (not just touching palate)
  - Anterior crossbite with gingival recession
  - Severe traumatic deviation (i.e., accidents, tumors, etc.)

#### **Criteria for Orthodontic Services**

When a participant is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the participant to a qualified enrolled dentist or orthodontist for a preliminary examination. After the initial exam, if the provider believes the participant requires such treatment, the following is required:

- The participant must have good oral hygiene and have all dental work up to date. Both should be noted in narrative.
- The participant must have permanent dentition, presenting a fully erupted set of permanent teeth. At least  $\frac{1}{2}$  to  $\frac{3}{4}$  of the clinical crown should be exposed.
- Prior approval must be requested and documentation must be submitted with the completed HLD scoring tool. In order to request prior approval, the participant must obtain a score of 28 on the HLD or automatically qualify. When received, dental consultants will review and make determination.
- The participant must be eligible in the MEDI system to qualify for orthodontia treatment.

Provider must always check to ensure eligibility of the participant throughout treatment as eligibility may change. Participants must be eligible for services at the time treatment is performed.

#### **Handicapping Labio-Lingual Deviation (HLD) Index**

Effective January 1, 2017, the Handicapping Labio-Lingual Deviation (HLD) Index is the new Orthodontia Scoring Tool. To determine whether or not a participant will be approved for orthodontic services, the participant must be initially screened using the HLD Index.

The HLD Index must be fully completed in accordance with the instructions. The HLD scoring tool and instructions can be found on page A-15 through A-18.

### **Prior Authorization for Orthodontics**

Orthodontia treatment is an example of a procedure that always requires prior authorization. Claims will not be reimbursed unless prior authorization was obtained before the date of service.

Requests for prior authorization should be sent with the appropriate documentation:

- Standard ADA approved claim form, marking the box in the top left corner noting it as a prior authorization request and listing requested services
- Completed Handicapping Labio-Lingual Deviation Index (HLD)
- X-rays, photographs, plaster or digital models
- A written narrative of medical necessity

### **Diagnostic Records**

Orthodontic records consist of a cephalometric x-ray; panoramic x-ray or full-mouth survey; external facial photographs (both frontal and profile); intraoral photographs (both sides of the dental arches in occlusion and a frontal view in occlusion); and dental study models (if submitting plaster or plastic molds they must be properly occluded and trimmed so that the models simulate centric occlusion of the patient when the models are placed on their heels).

If the x-rays are unusable they are rejected, and new records must be submitted prior to authorization of treatment.

The orthodontic examination and preparation of orthodontic records are not separately reimbursable. They are considered to be a part of the comprehensive treatment fee.

Providers are required to retain copies of the participant history, cephalometric x-rays, panoramic x-rays, facial photographs and study models for a minimum of ten (10) years.

### **Submission**

Prior approval requests may be submitted by the enrolled evaluating provider through OrthoCAD or mailed to:

DentaQuest of Illinois, LLC  
Prior Authorizations  
P. O. Box 2906  
Milwaukee, WI 53201-2906

A decision will be based upon the information provided. It is of utmost importance that prior approval requests contain adequate information upon which to make an informed decision. Regardless of the mode of transmission, submitting a complete and accurate prior approval request as well as any other pertinent information, at the time of request will prevent delays in reviewing the prior approval request.

Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request.

Authorizations are valid for three years. If additional of time is needed to complete an orthodontic case, an extension must be requested. Patients must not be charged for the continuation of services as long as the patient remains eligible.

### **Participant Eligibility for Orthodontic Treatment**

Upon receipt of an approved Prior Authorization Request, the enrolled provider must verify the participant's eligibility prior to beginning orthodontic treatment and on each date a service is provided. Providers must verify a participant's eligibility during the entire course of treatment as eligibility may change.

### **Comprehensive Orthodontic Treatment**

Comprehensive orthodontic treatment includes, but is not limited to:

- Initial exam
- Complete diagnostic records and written narrative
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances)
- Broken brackets
- Removal of appliances at the completion of the active phase of treatment
- Placement of retainers or necessary retention techniques

## **17.00 Cultural Competency Program**

DentaQuest incorporates measures to promote cultural sensitivity/awareness in the delivery of Member services as well as healthcare services. Services to Members are delivered in a manner sensitive to the Member's cultural background and his/her religious beliefs, values and traditions. It is the policy of DentaQuest to provide Medicare, Medicaid, Commercial and DentaQuest employee information in a culturally competent manner that assists all individuals, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds or physical or mental disabilities issues in obtaining health care services. DentaQuest incorporates measures to track bias/discrimination issues that hinder or prevent to be administered in accordance with the American with Disabilities Act, and other applicable Federal and State laws, to its Members and DentaQuest employees and report appropriate occurrences to the Complaint and Grievance Department or the Human Resources Department.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of Members.

DentaQuest ensures that its staff is trained in cultural awareness to provide a competent system of service, which acknowledges and incorporates the importance of culture, language, and the values and traditions of all DentaQuest's employees.

DentaQuest supports Providers in efforts to work in a cross-cultural environment and to ensure the adaptation of services to meet Members cultural and linguistic needs.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Provider Services Department at 1.800.508.6780 or via e-mail at [denelig.benefits@dentaquest.com](mailto:denelig.benefits@dentaquest.com)

### **Community Outreach/Provider Compliance**

Providers may participate/co-sponsor in community events (health fairs, advertisements, etc.). Providers need to be aware of and comply with the following requirements:

- Health care providers may display health-plan-specific materials in their own offices.
- Health care providers cannot orally or in writing compare benefits or provider networks among health plans, other than to confirm whether they participate in a health plan's network.
- Health care providers may announce a new affiliation with a health plan and give their patients a list of health plans with which they contract.
- Health care providers may co-sponsor events such as health fairs and advertise with the health plan in indirect ways, such as television, radio, posters, fliers and print advertisement. Any use of a Plan logo in advertising or print materials requires Plan approval.
- Health care providers shall not furnish lists of their patients to the health plan with which they contract, or any other entity; nor can providers furnish other health plans' membership lists to the health plan; nor can providers assist with health plan enrollment unless they have been contracted directly with the health plan to do so.
- If you have additional questions community outreach and use of plan logos, please outreach to your DentaQuest Provider Relations Representative at 888.875.7482



## **APPENDIX A**

### **Attachments**

#### **General Definitions**

The following definitions apply to this Office Reference Manual:

- A. "Contract" means the document specifying the services provided by DentaQuest to:
- an employer, directly or on behalf of the State of Illinois, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
  - a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of Illinois or its regulatory agencies or Plan and DentaQuest (a "Medicaid Contract");
  - a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Centers for Medicare and Medicaid Services ("CMS"- formerly HCFA) or Plan and DentaQuest (a "Medicare Contract").
- B. "Covered Services" is a dental service or supply that satisfies all of the following criteria:
- provided or arranged by a Participating Provider to a Member;
  - authorized by DentaQuest in accordance with the Plan Certificate; and
  - submitted to DentaQuest according to DentaQuest's filing requirements.
- C. "DentaQuest" shall refer to DentaQuest, LLC
- D. "Medically Necessary" means those Covered Services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to prevent disease, disability and other adverse health conditions or their progression, or prolong life. In order to be Medically Necessary, the service or supply for medical illness or injury must be determined by Plan or its designee in its judgement to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical practice in the community.
- E. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."
- F. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.
- G. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.
- H. "Plan Certificate" means the document that outlines the benefits available to Members.

- I. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.
- J. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

### **Additional Resources**

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ [www.DentaQuest.com](http://www.DentaQuest.com). Once you have entered the website, click on the "Dentist" icon. From there choose your "State" and press go. You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- Acknowledgment of Disclosure and Acceptance Member Financial Responsibility for Non-Covered Services Consent Form

**If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service: (800) 341-8478.**

**The forms can also be found within this manual.**

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																				
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/ Title XIX																				
2. Predetermination/Preauthorization Number																				
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																				
3. Company/Plan Name, Address, City, State, Zip Code																				
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)																				
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																				
13. Date of Birth (MM/DD/CCYY)			14. Gender <input type="checkbox"/> M <input type="checkbox"/> F		15. Policyholder/Subscriber ID (SSN or ID#)															
16. Plan/Group Number				17. Employer Name																
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)																				
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)																				
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																				
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)																
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																		
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																				
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F		23. Patient ID/Account # (Assigned by Dentist)															
PATIENT INFORMATION																				
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other								19. Reserved For Future Use												
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																				
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.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)					31a. Other Fee(s)										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee		\$0.00
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	B _____ D _____				
35. Remarks																				
AUTHORIZATIONS						ANCILLARY CLAIM/TREATMENT INFORMATION														
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.  X Patient/Guardian Signature _____ Date _____						38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")			39. Enclosures (Y or N) <input type="checkbox"/>											
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.  X Subscriber Signature _____ Date _____						40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)												
						42. Months of Treatment		43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		44. Date of Prior Placement (MM/DD/CCYY)										
						45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident														
						46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State												
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)						TREATING DENTIST AND TREATMENT LOCATION INFORMATION														
48. Name, Address, City, State, Zip Code						53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  X Signed (Treating Dentist) _____ Date _____														
49. NPI		50. License Number		51. SSN or TIN		54. NPI		55. License Number												
52. Phone Number						52a. Additional Provider ID		56. Address, City, State, Zip Code		56a. Provider Specialty Code										
57. Phone Number						58. Additional Provider ID														

## ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

### GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

### COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

### DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

### PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "[www.cms.gov/PhysicianFeeSched/Downloads/Website\\_POS\\_database.pdf](http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf)"

### PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
<b>Dentist</b> A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
<b>General Practice</b>	1223G0001X
<b>Dental Specialty</b> (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "[www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy)"

ALLERGY	PRE MED	MEDICAL ALERT																																		
<b>INITIAL CLINICAL EXAM</b>																																				
PATIENT'S NAME _____ <table style="width: 100%; border: none; margin-top: 5px;"> <tr> <td style="width: 33%; border: none; text-align: center;">Last</td> <td style="width: 33%; border: none; text-align: center;">First</td> <td style="width: 33%; border: none; text-align: center;">Middle</td> </tr> </table>			Last	First	Middle																															
Last	First	Middle																																		
	GINGIVA MOBILITY PROTHESIS EVALUATION OCCLUSION    1    11    111 PATIENT'S CHIEF COMPLAINT																																			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px; text-align: center;">OK</td> <td rowspan="12" style="vertical-align: top; padding: 2px;"><b>CLINICAL FINDINGS/COMMENTS</b></td> </tr> <tr><td>LYMPH NODES</td><td></td></tr> <tr><td>PHARYNX</td><td></td></tr> <tr><td>TONSILS</td><td></td></tr> <tr><td>SOFT PALATE</td><td></td></tr> <tr><td>HARD PALATE</td><td></td></tr> <tr><td>FLOOR OF MOUTH</td><td></td></tr> <tr><td>TONGUE</td><td></td></tr> <tr><td>VESTIBULES</td><td></td></tr> <tr><td>BUCCAL MUCOSA</td><td></td></tr> <tr><td>LIPS</td><td></td></tr> <tr><td>SKIN</td><td></td></tr> <tr><td>TMJ</td><td></td></tr> <tr><td>ORAL HYGIENE</td><td></td></tr> <tr><td>PERIO EXAM</td><td></td></tr> </table>		OK	<b>CLINICAL FINDINGS/COMMENTS</b>	LYMPH NODES		PHARYNX		TONSILS		SOFT PALATE		HARD PALATE		FLOOR OF MOUTH		TONGUE		VESTIBULES		BUCCAL MUCOSA		LIPS		SKIN		TMJ		ORAL HYGIENE		PERIO EXAM		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 2px;">RADIOGRAPHS</td> <td style="width: 33%; padding: 2px;">B/P</td> <td style="width: 33%; padding: 2px;">RDH/DDS</td> </tr> </table>		RADIOGRAPHS	B/P	RDH/DDS
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RADIOGRAPHS	B/P	RDH/DDS																																		
<b>RECOMMENDED TREATMENT PLAN</b>																																				
TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B																																	
SIGNATURE OF DENTIST _____			DATE _____																																	

**Note:** The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

**RECALL EXAMINATION**

PATIENT'S NAME \_\_\_\_\_

CHANGES IN HEALTH STATUS/MEDICAL HISTORY \_\_\_\_\_

	OK		OK	CLINICAL FINDINGS/COMMENTS
<b>LYMPH NODES</b>		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS	B/P		RDH/DDS	

	R WORK NECESSARY L															
TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RECALL EXAMINATION**

PATIENT'S NAME \_\_\_\_\_

CHANGES IN HEALTH STATUS/MEDICAL HISTORY \_\_\_\_\_

	OK		OK	CLINICAL FINDINGS/COMMENTS
<b>LYMPH NODES</b>		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS	B/P		RDH/DDS	

	R WORK NECESSARY L															
TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**NOTE:** The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

### Authorization for Dental Treatment

I hereby authorize Dr. \_\_\_\_\_ and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): \_\_\_\_\_

Tooth Number(s): \_\_\_\_\_

Date: \_\_\_\_\_

Dentist: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Legal Guardian/  
Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS  
DISBURSED BY DENTAQUEST, LLC

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT:** Attach voided check from checking account.

MAINTENANCE TYPE:

\_\_\_\_\_ Add  
 \_\_\_\_\_ Change (Existing Set Up)  
 \_\_\_\_\_ Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: \_\_\_\_\_

Account Type: \_\_\_\_\_ Checking  
 \_\_\_\_\_ Personal \_\_\_\_\_ Business (choose one)

Bank Routing Number: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Account Holder Name: \_\_\_\_\_

Effective Start Date: \_\_\_\_\_

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest of Illinois, LLC** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

\_\_\_\_\_  
Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

\_\_\_\_\_  
Tax Id (As appears on W-9 submitted to DentaQuest)



**MEDICAL AND DENTAL HISTORY**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Why are you here today? \_\_\_\_\_

Are you having pain or discomfort at this time? Yes/No \_\_\_

If yes, what type and where? \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Yes/No \_\_\_

Medical Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Have you taken any medication or drugs during the past two years? Yes/No \_\_\_

Are you now taking any medication, drugs, or pills? Yes/No \_\_\_

If yes, please list medications: \_\_\_\_\_

Are you aware of being allergic to or have you ever reacted badly to any medication or substance?

Yes/No \_\_\_

If yes, please list: \_\_\_\_\_

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? Yes/No \_\_\_

Do your ankles swell during the day? Yes/No \_\_\_

Do you use more than two pillows to sleep? Yes/No \_\_\_

Have you lost or gained more than 10 pounds in the past year? Yes/No \_\_\_

Do you ever wake up from sleep and feel short of breath? Yes/No \_\_\_

Are you on a special diet? Yes/No \_\_\_

Has your medical doctor ever said you have cancer or a tumor? Yes/No \_\_\_

If yes, where? \_\_\_\_\_

Do you use tobacco products (smoke or chew tobacco)? Yes/No \_\_\_

If yes, how often and how much? \_\_\_\_\_

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? Yes/No \_\_\_

Do you have or have you had any disease, or condition not listed? Yes/No \_\_\_

If yes, please list: \_\_\_\_\_

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	Yes_	No_	Stroke	Yes_	No_	Hepatitis C	Yes_	No_
Heart Failure	Yes_	No_	Kidney Trouble	Yes_	No_	Arteriosclerosis (hardening of arteries)	Yes_	No_
Angina Pectoris	Yes_	No_	High Blood Pressure	Yes_	No_	Ulcers	Yes_	No_
Congenital Heart Disease	Yes_	No_	Venereal Disease	Yes_	No_	AIDS	Yes_	No_
Diabetes	Yes	No	Heart Murmur	Yes	No	Blood Transfusion	Yes	No
HIV Positive	Yes_	No_	Glaucoma	Yes_	No_	Cold sores/Fever blisters/ Herpes	Yes_	No_
High Blood Pressure	Yes_	No_	Cortisone Medication	Yes_	No_	Artificial Heart Valve	Yes_	No_
Mitral Valve Prolapse	Yes_	No_	Cosmetic Surgery	Yes_	No_	Heart Pacemaker	Yes_	No_
Emphysema	Yes	No	Anemia	Yes	No	Sickle Cell Disease	Yes	No
Chronic Cough	Yes	No	Heart Surgery	Yes	No	Asthma	Yes	No
Tuberculosis	Yes	No	Bruise Easily	Yes	No	Yellow Jaundice	Yes	No
Liver Disease	Yes	No	Rheumatic fever	Yes	No	Rheumatism	Yes	No
Arthritis	Yes_	No_	Epilepsy or Seizures	Yes_	No_	Fainting or Dizzy Spells	Yes_	No_
Allergies or Hives	Yes_	No_	Nervousness	Yes_	No_	Chemotherapy	Yes_	No_
Sinus Trouble	Yes_	No_	Radiation Therapy	Yes_	No_	Drug Addiction	Yes_	No_
Pain in Jaw Joints	Yes_	No_	Thyroid Problems	Yes_	No_	Psychiatric Treatment	Yes_	No_
Hay Fever	Yes_	No_	Hepatitis A (infectious)	Yes_	No_			
Artificial Joints (Hip, Knee, etc.)	Yes_	No_	Hepatitis B (serum)	Yes_	No_			

**For Women Only:**

Are you pregnant? Yes/No\_\_

If yes, what month? \_\_\_\_\_

Are you nursing? Yes/No\_\_

Are you taking birth control pills? Yes/No\_\_

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Review Date	Changes in Health Status	Patient's signature	Dentist's signature

**Note:** The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.



## Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077

**Section 1: Current Information - Complete for ALL Requests - Asterisk denotes required fields**

**Change Effective Date (Required) :** \_\_\_\_\_

\*Provider Last Name \_\_\_\_\_ \*Provider First Name \_\_\_\_\_

\*Individual National Provider Identifier (NPI) # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender \_\_\_\_\_

\*Specialty \_\_\_\_\_ \*Personal E-Mail \_\_\_\_\_

**Requestor Information**

\*Requestor Name \_\_\_\_\_ \*Title \_\_\_\_\_

\*Requestor Contact Information (Phone or E-mail) \_\_\_\_\_

**Section 2: Type of Update - Check all that Apply - Complete for ALL Requests - For Questions contact your Provider**

**Engagement Representative or Customer Service**

Business (Tax ID) - Add/ Term/ Update - **Complete Sections 1, 7 and 8**

Credentialing Correspondence Change/Update - **Complete Sections 1 and 5**

EFT/ Payment - **Complete Sections 1 and 8**

License Change - **Complete Sections 1 and 4**

Name Change - **Complete Sections 1 and 3**

Location - Add/ Term/ Update - **Complete Sections 1 and 6**

Termination Request - **Complete Sections 1 and 9**

**Section 3: Name Change - Attach supporting legal documentation**

New Last Name \_\_\_\_\_ New First Name \_\_\_\_\_

New Middle Name \_\_\_\_\_ New Suffix \_\_\_\_\_

**Please Note:** Before DentaQuest can change your name in our system, your license must reflect the name change.

**Section 4: License Change**

New Dental License Number \_\_\_\_\_ State \_\_\_\_\_

New DEA License Number \_\_\_\_\_ State \_\_\_\_\_

New State Drug License Number \_\_\_\_\_ State \_\_\_\_\_

New Medicaid License Number \_\_\_\_\_ State \_\_\_\_\_

Other License Name \_\_\_\_\_

Other License Number \_\_\_\_\_ State \_\_\_\_\_

**Section 5: Credentialing Correspondence Change**

Credentialing Contact Name \_\_\_\_\_

Correspondence Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Credentialing E-Mail \_\_\_\_\_

**Provider Update Form - Provider Operations**

**Section 6: Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.**

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update
Tax ID Number <input style="width:90%;" type="text"/>	Medicaid ID (if applicable) <input style="width:90%;" type="text"/>	
Location Name <input style="width:95%;" type="text"/>		
Location Address <input style="width:95%;" type="text"/>		
City <input style="width:30%;" type="text"/>	State <input style="width:15%;" type="text"/>	Zip Code <input style="width:20%;" type="text"/>
Is this location a Mobile Dental Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Telephone <input style="width:30%;" type="text"/>	Fax <input style="width:30%;" type="text"/>	
Can this fax number accept PHI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office E-Mail <input style="width:95%;" type="text"/>		
Office Hours	Monday - <input style="width:30%;" type="text"/>	Tuesday - <input style="width:30%;" type="text"/>
	Wednesday - <input style="width:30%;" type="text"/>	Thursday - <input style="width:30%;" type="text"/>
	Friday - <input style="width:30%;" type="text"/>	Saturday - <input style="width:30%;" type="text"/>
	Sunday - <input style="width:30%;" type="text"/>	
	Ages Minimum <input style="width:15%;" type="text"/>	Ages Maximum <input style="width:15%;" type="text"/>
<input type="checkbox"/> Primary Location	<input type="checkbox"/> Handicapped Accessible	
Office Languages <input style="width:95%;" type="text"/>		

**Section 7: Business - (Tax ID) Add/ Term/ Update - Updated Contract, W9 and Disclosure of Ownership required for all Adds and Updates - W9 and Disclosure of Ownership Attached**

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update
Old/ Current Tax ID Number <input style="width:90%;" type="text"/>	New Tax ID Number <input style="width:90%;" type="text"/>	
Business Name <input style="width:95%;" type="text"/>		
Business Address <input style="width:95%;" type="text"/>		
City <input style="width:30%;" type="text"/>	State <input style="width:15%;" type="text"/>	Zip Code <input style="width:20%;" type="text"/>
Telephone <input style="width:30%;" type="text"/>	Fax <input style="width:30%;" type="text"/>	
Office E-Mail <input style="width:95%;" type="text"/>		
Group NPI <input style="width:95%;" type="text"/>		

**Please Note:** DentaQuest requires a Group NPI for all business types except Sole Proprietors.  
 Will you have any outstanding claims to submit under the old/current Tax ID Number?  
 If yes, please provide a date of when all claims will be submitted by: \_\_\_\_\_  Yes  No

**Provider Update Form - Provider Operations**

**Section 9: Termination Request**

<input type="checkbox"/>	Term Provider at Location Listed Below	Tax ID Number	<input type="text"/>
<b>Please attach document with any additional locations to be termed.</b>			

<input type="checkbox"/>	Term Provider at ALL Locations - ALL Networks
<b>Please attach term letter, note or document from the provider that includes all locations to be termed as applicable.</b>	

<input type="checkbox"/>	Term Business	Tax ID Number	<input type="text"/>
<b>Please attach a list of providers and locations that need to be terminated.</b>			

Term Reason/ Comments	<input type="text"/>
Location Name	<input type="text"/>
Location Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>

**Section 10: Type of Update - Check all that Apply - Complete for ALL Requests - Internal Use ONLY**

- Product(s) Add/ Update/ Term- Complete Sections 1, 10 and Notes
- Claims Issue(s) - Complete Sections 1, 10 and Notes
- Dental Home - Complete Sections 1, 10 and Notes
- Fee Schedule Add - Complete Sections 1, 10 and Notes
- Fee Schedule Change - Complete Sections 1, 10 and Notes
- Provider Rule Add - Complete Sections 1, 10 and Notes
- Provider Rule Change - Complete Sections 1, 10 and Notes

**Notes**

**Provider Update Form - Provider Operations**

**Additional Location Add/ Term/ Update - In order to link this provider/location to an existing contract, include documentation for Adds and Changes that include the below information on Company Letterhead.**

<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> Update
Tax ID Number <input style="width:250px;" type="text"/>	Medicaid ID (if applicable) <input style="width:150px;" type="text"/>	
Location Name <input style="width:95%;" type="text"/>		
Location Address <input style="width:95%;" type="text"/>		
City <input style="width:150px;" type="text"/>	State <input style="width:80px;" type="text"/>	Zip Code <input style="width:100px;" type="text"/>
Is this location a Mobile Dental Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Telephone <input style="width:150px;" type="text"/>	Fax <input style="width:150px;" type="text"/>	
Can this fax number accept PHI?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Office E-Mail <input style="width:95%;" type="text"/>		
Office Hours	Monday - <input style="width:150px;" type="text"/>	Tuesday - <input style="width:150px;" type="text"/>
	Wednesday - <input style="width:150px;" type="text"/>	Thursday - <input style="width:150px;" type="text"/>
	Friday - <input style="width:150px;" type="text"/>	Saturday - <input style="width:150px;" type="text"/>
	Sunday - <input style="width:150px;" type="text"/>	
	Ages Minimum <input style="width:80px;" type="text"/>	Ages Maximum <input style="width:80px;" type="text"/>
<input type="checkbox"/> Primary Location	<input type="checkbox"/> Handicapped Accessible	
Office Languages <input style="width:95%;" type="text"/>		

## Request for Transfer of Records

I, \_\_\_\_\_, hereby request and give my permission to  
Dr. \_\_\_\_\_ to provide Dr. \_\_\_\_\_ any and all  
information regarding past dental care for \_\_\_\_\_.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Acknowledgment of Disclosure and Acceptance Member Financial  
Responsibility for Non-Covered Services  
CONSENT FORM**

Member Name: \_\_\_\_\_

Member ID: \_\_\_\_\_

Treating Provider Name: \_\_\_\_\_

Service Location Name and  
Address: \_\_\_\_\_

Not all dental services are covered by your health plan. Some services are covered, but only within specific time frames (twice per year, once per year, once every 5 years, etc.) Services requested or received more frequently than your benefit allows are considered to be non-covered. Some services also have criteria that must be met to be covered. This is called "medical necessity". If the service is not medically necessary, the service is not covered. The following service(s) are recommended for the above-named patient, but are not covered services:

**Non-Covered Services**

Code	Cost	Description	Reason service is not covered

I understand that the above services are not covered by my health plan, and that I am personally responsible for paying the dentist if I choose to receive these services. My signature shows that I understand this responsibility and will pay the dentist when I receive his/her billing statement.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature



Attachment H



First Review \_\_\_\_\_  
 Second Review \_\_\_\_\_

Models \_\_\_\_\_  
 Orthocad \_\_\_\_\_  
 Ceph Film \_\_\_\_\_  
 X-Rays \_\_\_\_\_  
 Photos \_\_\_\_\_  
 Narrative \_\_\_\_\_

**HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET**

Name (Last, First): \_\_\_\_\_ Medicaid ID: \_\_\_\_\_ DOB: \_\_\_\_\_

All necessary dental work completed? Yes \_\_\_ No \_\_\_ Patient oral hygiene: Excellent \_\_\_ Good \_\_\_ Poor \_\_\_  
 (all dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

**PROCEDURE** (use this score sheet and a Boley Gauge or disposable ruler):

- Indicate by checkmark next to A or B which criteria you are submitting for review
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE "0" IF CONDITION IS ABSENT

**A. \_\_\_\_\_ CONDITIONS 1-5 ARE AUTOMATIC QUALIFIERS** (indicate with an "X" if condition is present)

1. **Cleft palate** \_\_\_\_\_
2. Deep impinging bite **with** signs of tissue damage, not just touching palate \_\_\_\_\_
3. Anterior crossbite **with** gingival recession \_\_\_\_\_
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc. attach description) \_\_\_\_\_
5. **Impacted Maxillary Central Incisor** \_\_\_\_\_

Continue to scoring below if there are no qualifying conditions checked above

**B. \_\_\_\_\_ CONDITIONS 6-14 MUST SCORE 28 POINTS OR MORE TO QUALIFY**

6. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm \_\_\_\_\_ x 1 = \_\_\_\_\_
7. **Overbite** (maxillary central incisor relative to lower anteriors) mm \_\_\_\_\_ x 1 = \_\_\_\_\_
8. Mandibular protrusion (reverse overjet, "**underbite**") mm \_\_\_\_\_ x 5 = \_\_\_\_\_
9. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm \_\_\_\_\_ x 4 = \_\_\_\_\_
10. **Ectopic teeth** (excluding third molars) # teeth \_\_\_\_\_ x 3 = \_\_\_\_\_
11. **Anterior crowding of maxilla** (greater than 3.5 mm) if present score \_\_\_\_\_ 1 x 5 = \_\_\_\_\_
12. **Anterior crowding of mandible** (greater than 3.5 mm) if present score \_\_\_\_\_ 1 x 5 = \_\_\_\_\_
13. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm \_\_\_\_\_ x 1 = \_\_\_\_\_
14. Posterior **crossbite** (1 must be a molar), score only 1 time – if present score 1 x 4 = \_\_\_\_\_

**TOTAL SCORE** (must score 28 points or more to qualify) \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

NPI #: \_\_\_\_\_

Provider Name \_\_\_\_\_ Phone #: \_\_\_\_\_

### GUIDELINES AND RULES FOR APPLYING THE HLD INDEX

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment. Upon completion of the HLD Index score sheet, review all measurements and calculations for accuracy.

1. Indicate by checkmark next to A or B which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion.
3. Record all measurements in the order given and round off to the nearest millimeter.
4. Enter the score "0" if condition is absent.

#### A. CONDITIONS 1-5 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

1. **Cleft palate** --a cleft palate deformity *must* be demonstrated on the study model, if the deformity *cannot* be demonstrated on the study model, the condition *must* be diagnosed by properly credentialed experts and the diagnosis *must* be supported by documentation. If present, enter an "X".
2. **Deep impinging bite** --deep impinging overbite with signs of tissue damage of the palate, not just touching palate, including inflammation or damage of the gingiva palatal to the maxillary incisors. The condition *must* be clearly visible in the mouth and demonstrate on photos. On study models, the mandibular teeth *must* be clearly touching the palate and the tissue indentations or evidence of soft tissue damage or inflammation *must* be clearly visible. Tissue indentions without soft tissue damage do not meet the criteria. If present, enter an "X".
3. **Anterior Crossbite with gingival recession** - crossbite of individual anterior teeth. Damage of soft tissue *must* be clearly visible in the mouth and reproducible and visible on the study models. Gingival recession *must* be at least 1½ mm deeper than the adjacent teeth. If present, enter an "X". In the case of a canine, the amount of gingival recession should be compared to the opposite canine.
4. **Severe traumatic deviations** --these can include malocclusions caused by trauma, accidents, tumors, injury, disease process or craniofacial/developmental anomalies other than cleft palate that significantly impact the patient's occlusion and function. If present, enter an "X".
5. **Impacted Maxillary Central Incisor** - this includes maxillary central incisors that are at least one year beyond normal eruption age range and/or positioned in a manner that prevents eruption into the oral cavity. This does not include ectopic eruption. If present, enter an "X".

#### CONDITIONS 6 - 14 MUST SCORE 28 POINTS OR MORE TO QUALIFY

6. **Overjet** --this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do *not* use the upper lateral incisors or cuspids. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter the measurement in millimeters.
7. **Overbite** --a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge

of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter the measurement in millimeters.

8. **Mandibular (dental) protrusion or reverse overjet** --measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).
9. **Open bite** --measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).
10. **Ectopic eruption** --count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3).
11. **Anterior crowding of maxilla** --anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and one (1) point for a mandibular arch with anterior crowding and multiply by five (5).
12. **Anterior crowding of mandible** -- anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).
13. **Labio-lingual spread** --use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. The total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be measured for labiolingual spread but only the most severe individual measurement should be entered on the score sheet. Enter the measurement in mm.
14. **Posterior crossbite** --this condition involves one (1) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

**Illinois Department of Healthcare and Family Services (Orthodontia Scoring Tool):**

<https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn190115a.aspx>

# OrthoCAD Submission 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		
Dentist Name:	Provider NPI #	Location ID #
Address:	City, State, Zip	Area code & Phone number:
Treatment Requested		
Code:	Description of request:	

**IL Orthodontic Continuation of Care Submission Form** Date: \_\_\_\_\_

DENTIST Name:	Provider NPI #
Location ID #	Address:
City, State, Zip	Area code & Phone number:

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN or ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Months of Active Treatment Completed:	Months of Active Treatment Remaining:

**CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE BETWEEN MEDICAID PLANS**

Y Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different Medicaid program/vendor.

Required for submission:

Y Completed ADA form for number of adjustments (Code D8670) requested to complete case.

Y Copy of original Medicaid Prior Authorization for Comprehensive Orthodontic Treatment (Prior Authorization from Medicaid program/vendor for Comprehensive Orthodontic Treatment approved prior to initiation of orthodontic treatment).

\*If required information above is cannot be provided, the case will be reviewed as outlined below.

**CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE FROM NON-MEDICAID TO MEDICAID**

Y Member initiated treatment while covered by a NON-Medicaid program/vendor (FFS or Commercial Insurance plan) OR Self-Pay and Member is now covered by a Medicaid program/vendor with the same OR different Provider.

Required for submission:

Y Completed ADA form for number of adjustments (Code D8670) requested to complete case.

Y Diagnostic records (a copy of the original study models/OrthoCad equivalent and/or a complete set of diagnostic photographs and/or a panorex film). Progress records will be accepted if original records are not available. Documentation should demonstrate qualifying criteria for severe handicapping malocclusion.

**APPENDIX B****Covered Benefits (See Exhibits)**

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members under age 21. **Providers with benefit questions should contact DentaQuest's Customer Service Department directly at:**

**800.508.6780, press option 2**

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611  
800.947.4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT manual.

The benefit tables (Exhibits) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization,
6. any other applicable benefit limitations

**DentaQuest Authorization Process**

**IMPORTANT**

For procedures where “Authorization Required” fields indicate “**yes**”.

Please review the information below on when to submit documentation to DentaQuest. The information refers to the “Documentation Required” field in the Benefits Covered section (Exhibits). In this section, documentation may be requested to be sent prior to beginning treatment or “with claim” after completion of treatment.

When documentation is requested:

<b>“Authorization Required” Field</b>	<b>“Documentation Required” Field</b>	<b>Treatment Condition</b>	<b>When to Submit Documentation</b>
Yes	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation Requested	Emergency	Send documentation with claim after treatment

When documentation is requested “with claim:”

<b>“Authorization Required” Field</b>	<b>“Documentation Required” Field</b>	<b>Treatment Condition</b>	<b>When to Submit Documentation</b>
Yes	Documentation Requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

**Illinois Managed Care – HMO Comparison**  
*Medicaid vs. Medicare plans*

<b>Group Description</b>	<b>Subgroup Name</b>	<b>Category</b>	<b>Network Name</b>
IL Aetna Better Health	Aetna Premier MMAI	Dual	IL Aetna Premier MMAI
Blue Cross Blue Shield of Illinois - Medicaid	Blue Cross Community ICP 19 – 20 (BCCHP)	MA Spec Needs	IL BCBS ICP 19-20
	Blue Cross Community ICP 21 and Older 9 (BCCHP)	MA Spec Needs	IL BCBS ICP 21 and Older
	Blue Cross Community IL FHP Adult (BCCHP)	Medicaid- Adult	IL BCBS FHP Adult
	Blue Cross Community IL FHP Children (BCCHP)	Medicaid- Child	IL BCBS FHP Children
	Blue Cross Community MMAI	Dual	IL BCBS MMAI
Molina HealthCare of Illinois	IL Molina Dual Options MMP (HMO)	Dual	IL Molina Dual Options MMP
	IL Molina Child	Medicaid-Child	IL Molina Medicaid Child
	IL Molina Adult	Medicaid-Adult	IL Molina Medicaid Adult
	IL Molina ABD Child	Medicaid-Child	IL Molina Medicaid ABD Child
	IL Molina LTC Adult	Medicaid-Adult	IL Molina Medicaid LTC Adult
	IL Molina ACA Adult	Medicaid-Adult	IL Molina Medicaid ACA Adult
	IL Molina ACA Child	Medicaid-Child	IL Molina Medicaid ACA Child
Humana IL Medicaid	Humana IL Gold Plus 21 and older	Dual	IL Humana MMAI 21 and older



## Aetna MMAI & BCBS MMAI

### Value Added/Enhanced Benefits Listing

- Supplemental Dental Benefit of \$800 available each calendar year to use for comprehensive dental services.
- It will apply only to the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:
  - Diagnostics
  - Restorative Services
  - Endodontics
  - Periodontics
  - Extractions
  - Prosthodontics
  - Other Oral & Maxillofacial Surgery
  - Adjunctive
  - Other Services

## Molina MMAI

### Value Added/Enhanced Benefits Listing

- No Annual Maximums for fillings, scaling and root planing, denture adjustments.
- \$600 annual maximum applies to oral exams, x-rays, cleanings, fluoride.
- \$500 annual maximum for dentures.
  - Balance billing for denture services is not allowed. Denture claims will process under the members Medicare benefits of this dual program as primary and will be internally coordinated with the members Medicaid benefits of the duals program as secondary.

***\*Please see the applicable benefit tables for complete benefit information and provider agreement for appropriate fees. The IL Molina MMAI plan claims are paid at the current Medicaid Fee Schedule.***

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0150) per 12 Month(s) Per patient. Not covered on same date of service as D0140 or D0150.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with (D9110) on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0606	Molecular testing for a public health related pathogen, including coronavirus	21 and older		No	One of (D0606) per 1 Day(s) Per Provider OR Location.	

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4910) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	Zero of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient per tooth.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	21 and older		No	One of (D1705) per 1 Lifetime Per patient.	
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	21 and older		No	One of (D1706) per 1 Lifetime Per patient.	

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

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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.

BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)



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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or Provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

**Exhibit A Benefits Covered for  
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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient. Only covered after active therapy (D4341 or D4342) have been performed.	pre-op x-ray(s), perio charting

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		No	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		No	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		No		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		No		narrative of medical necessity
D5913	nasal prosthesis	21 and older		No		narrative of medical necessity
D5914	auricular prosthesis	21 and older		No		narrative of medical necessity
D5915	orbital prosthesis	21 and older		No		narrative of medical necessity
D5916	ocular prosthesis	21 and older		No		narrative of medical necessity
D5919	facial prosthesis	21 and older		No		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		No		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		No		narrative of medical necessity
D5924	cranial prosthesis	21 and older		No		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		No		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		No		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		No		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		No		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		No		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		No		narrative of medical necessity



**Exhibit A Benefits Covered for  
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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5932	obturator prosthesis, definitive	21 and older		No		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		No		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		No		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		No		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		No		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		No		narrative of medical necessity
D5951	feeding aid	21 and older		No		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		No		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		No		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		No		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		No		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		No		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		No		narrative of medical necessity
D5982	surgical stent	21 and older		No		narrative of medical necessity
D5983	radiation carrier	21 and older		No		narrative of medical necessity
D5984	radiation shield	21 and older		No		narrative of medical necessity
D5985	radiation cone locator	21 and older		No		narrative of medical necessity

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		No		narrative of medical necessity
D5987	commissure splint	21 and older		No		narrative of medical necessity
D5988	surgical splint	21 and older		No		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		No		narrative of medical necessity

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	No	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for  
Aetna Premier MMAI**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on same date of service as D7140 - D7250 (extractions)	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		No	One of (D7510, D7511) per 1 Day(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7620	maxilla - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		No		narrative of medical necessity

**Exhibit A Benefits Covered for  
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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

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**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		No	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9920	behavior management, by report	21 and older		No	One of (D9920) per 1 Day(s) Per Business. Practice visit fee for extremely apprehensive or developmentally disabled patients	



**Exhibit A Benefits Covered for  
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**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9999	unspecified adjunctive procedure, by report	21 and older		No	Description of service and narrative of medical necessity	narrative of medical necessity

## **Exhibit B Benefits Covered for Blue Cross Community FHP 0-20**

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health. For children entering or in kindergarten, second grade, and sixth grade, completion of a mandated IDPH Proof of School Dental Examination form is considered part of the oral examination. Providers must complete the exam form free of charge if requested by the parent or guardian within six (6) months of the oral examination.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment M of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

A comprehensive examination (D0150) is performed on a new or established patient. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic examination (D0120) is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

A complete Early Periodic Screening, Diagnosis and Treatment (EPSDT) examination (D0150 or D0120) is used when evaluating a child comprehensively. It is a thorough evaluation and a recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

Any dental service that is deemed medically necessary by the dentist should be submitted for prior authorization to be covered. It is strongly recommended that the Dental Periodicity Schedule (Attachment DD) be used as a guide for the provision of services with the understanding that services may be provided more frequently as medically indicated.

If a non-covered service or a service that has reached the stated benefit limitations is deemed medically necessary, a request for prior authorization due to medical necessity must be submitted marking "EPSDT" on Box 1 of the ADA claim form. Supporting documentation including narrative and diagnostic X-rays must be submitted for appropriate review. The service may not be rendered until after the request for prior authorization has been approved. Claims submitted for EPSDT coverage prior to authorization will be denied.

Out-of-office services: Providers who render preventive exams in an out-of-office setting must check the "Other" box (Box 38) on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the "Provider's Office" or "ECF" (Extended Care Facility) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for extended care facility

or 99 for other, as appropriate.

Dental Providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning s, and fluoride treatment. Each provider must provide any follow-up sealants in addition to the exam, cleaning and fluoride treatment when needed.

A Caries Risk Assessment Code (D0601 - D0603) is required on all claims with a place-of-service "School," effective August 1, 2014.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per patient. Participants are also eligible for one periodic oral evaluation (D0120) performed in a school setting per benefit period (08/01/XXXX - 07/31/XXXX). Completion of a mandated school exam form is considered part of the oral examination.	
D0140	limited oral evaluation-problem focused	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit B Benefits Covered for  
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Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0272	bitewings - two radiographic images	0-20		No	Two of (D0272, D0273, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	10 - 20		No	Two of (D0272, D0273, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0601	Caries risk assessment and documentation, with a finding of low risk	0-20		No		
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0-20		No		
D0603	Caries risk assessment and documentation, with a finding of high risk	0-20		No		

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Preventive services include routine and EPSDT prophylaxis (including scaling and polishing), topical fluoride treatments, dental sealants, and space maintenance therapy for Participants age 0 through 20. The goal of providing routine and periodic preventive dental services is to maintain oral health and prevent more extensive dental procedures.

Routine prophylaxis is covered for Participants age 0 through 20, once every 6 months in an office or school. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details.

Fluoride treatment (D1206 or D1208) is allowed once every 6 months in an office or school setting for Participants age 3 through 20.

For ages 0 through 2, three fluoride varnish treatments (D1206) are allowed per patient per 12 months in an office setting.

Sealants are covered for Participants age 5 through 17. Sealants should be applied to the occlusal surfaces of all erupted and appropriate first and second permanent molars. Priority should be given to applying sealants for all 7 and 12 year olds. Sealants will not be covered when they are placed over restorations.

Space maintainers are a covered service for Participants age 1 through 20 when determined by the dentist to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent. A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

Place of service must be indicated on all claims. Out-of-office services: Providers who render preventive services in an out-of-office setting must check the "Other" box (Box 38) on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the "Provider's Office" or "ECF" (Extended Care Facilities) box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate. Dental providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning and fluoride treatment. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed.

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. One of (D1120, D4355) per 6 Month(s) Per patient in school. in an office or school setting. Removal of plaque, calculus and stains from the tooth surfaces, intended to control local irrational factors.	

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. One of (D1206, D1208) per 6 Month(s) Per patient in school. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. One of (D1206, D1208) per 6 Month(s) Per patient in school. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 2 Year(s) Per patient per tooth. Regardless of place of service. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Tooth number must be identified for reimbursement.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Business per quadrant. Per appliance.	
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516) per 1 Lifetime Per Business.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517) per 1 Lifetime Per Business.	

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Business per quadrant. Per appliance.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1526) per 1 Lifetime Per Business.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1527) per 1 Lifetime Per Business.	
D1550	re-cement or re-bond space maintainer	0-20		No		
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-20		No	One of (D1551) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-20		No	One of (D1552) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1999	Unspecified preventive procedure, by report	0-20		No	To be billed on each claim when services are rendered by a Public Health Dental Hygienist. The name of the Public Health Dental Hygienist performing the dental services should be placed in the "Remarks" box 35, and the school place of service should be placed in box 38.	

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. 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.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately. 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.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date. Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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**.

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	



**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2542	onlay - metallic - two surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2544	onlay-metallic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

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 Dental Industry (or ADA) treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

- \* Root resorption has started and exfoliation is imminent
- \* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
- \* The general oral condition does not justify root canal therapy due to the loss of arch integrity
- \* Tooth does not demonstrate 50% bone support
- \* Tooth demonstrates active untreated periodontal disease

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3222, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3222 covered for trauma cases only	narr. of med. necessity, pre-op x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3351) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3353) per 1 Lifetime Per patient per tooth.	Pre and post-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Not payable concurrently with root canal treatment of tooth.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting



**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office setting.	
D4910	periodontal maintenance procedures	0-20		Yes	Only covered after active therapy has been performed.	pre-op x-ray(s), perio charting

**Exhibit B Benefits Covered for  
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Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. The date of placement must be used as the date of service when submitting for payment of dentures. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.

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.

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the denture that are anatomically correct (natural size, shape and color). Partial dentures must include one anterior tooth and/or 3 posterior teeth (including third molars).

Denture benefits for patients with the following medical conditions will not be considered for coverage:

- \* Patients on feeding tubes
- \* Post CVA patients with decreased facial muscle tone
- \* Patients in a coma
- \* Patients with diminished mental capacities that could not function with dentures
- \* Patients who do not desire dentures
- \* Advanced terminal patients

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5511	repair broken complete denture base, mandibular	0-20		No		

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5512	repair broken complete denture base, maxillary	0-20		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	0-20		No		
D5622	repair cast partial framework, maxillary	0-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0-20		Yes		narrative of medical necessity
D5912	facial moulage (complete)	0-20		Yes		narrative of medical necessity
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5914	auricular prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5919	facial prosthesis	0-20		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	0-20		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	0-20		Yes		narrative of medical necessity
D5924	cranial prosthesis	0-20		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	0-20		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	0-20		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	0-20		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	0-20		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	0-20		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	0-20		Yes		narrative of medical necessity
D5952	speech aid prosthesis, pediatric	0-12		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	13-20		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	0-20		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	0-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes		narrative of medical necessity
D5982	surgical stent	0-20		Yes		narrative of medical necessity
D5983	radiation carrier	0-20		Yes		narrative of medical necessity
D5984	radiation shield	0-20		Yes		narrative of medical necessity

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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5985	radiation cone locator	0-20		Yes		narrative of medical necessity
D5986	fluoride gel carrier	0-20		Yes		narrative of medical necessity
D5987	commissure splint	0-20		Yes		narrative of medical necessity
D5988	surgical splint	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

**Exhibit B Benefits Covered for  
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Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

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.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6211	pontic-cast base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6212	pontic - cast noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6240	pontic-porcelain fused-high noble	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6241	pontic-porcelain fused to base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)



**Exhibit B Benefits Covered for  
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Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6251	pontic-resin with base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6721	crown-resin with base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6750	crown-porcelain fused high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6751	crown-porcelain fused to base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6752	crown-porcelain fused noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6790	crown-full cast high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)

**Exhibit B Benefits Covered for  
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**Prosthodontics, fixed**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D6791	crown - full cast base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6792	crown - full cast noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6930	re-cement or re-bond fixed partial denture	0-20	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for  
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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review.	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons.	pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report

**Exhibit B Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes	Six of (D7961, D7963) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	One of (D7962) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7963	frenuloplasty	0-20		Yes	One of (D7961, D7963) per 1 Lifetime Per patient. One per arch per lifetime.	Narrative of medical necessity and photos

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7999	unspecified oral surgery procedure, by report	0-20		Yes		narrative of medical necessity

## **Exhibit B Benefits Covered for Blue Cross Community FHP 0-20**

Participants under the age of 21 may qualify for orthodontic care under the program. Participants are required to either score a minimum of 28 points on the HLD or automatically qualify to be eligible to receive medically necessary orthodontia services.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspid are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1.800.322.3722.

### **Documentation**

Previously DentaQuest required plaster models, in addition to other required documentation such as x-rays, to review the necessity of the request for orthodontic treatment. DentaQuest now accepts a complete series of intra-oral photos instead of the plaster models. All other required documentation, including panoramic and cephalometric films, score sheets, and narratives; must be submitted with the photos. This change was made to reduce postage costs for provider; increase the speed with which records are returned, and eliminate the possibility of models being damaged in shipment. If your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:

- Facial photographs (right and left profiles in addition to a straight-on facial view)
- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements. All other currently required documentation, including panoramic and cephalometric x-rays, narratives, and scoring forms will continue to be required for review. If your office currently submits digital models through OrthoCad these are still accepted and no change needs to be made regarding the submission of models.

In addition to the photographs, plaster models or digital models, authorization for orthodontia services requires a claim form listing the requested services, the Orthodontic Criteria Index Form ( Attachment G), and any other documentation that supports medical necessity.

### **Billing**

The charge for initial exam, radiographs and study models for approved cases should be submitted under procedure code D8660. The charges for these services for cases that do not meet the criteria should be submitted using code D8999.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service. In addition, the provider should verify eligibility of the Participant for the entire course of treatment. The Participant must be eligible on the dates each service is rendered, including banding, adjustments, debanding, and retainers. If a recipient's eligibility ends before the conclusion of treatment.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). In order to receive reimbursement for orthodontic adjustments, provider must bill for each date of service treatment was rendered.

Only one D8670 allowed per 45 days and 11 D8670's allowed per case per lifetime. If a Participant fails to keep an appointment for two consecutive appointments, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled as follows:

1. For cases that were started prior to the date the Participant was enrolled in the HFS Dental Program, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Dental Consultant. The Handicapping Labio-Lingual Deviation (HLD) will be performed and the original records reviewed using the criteria for all new cases. If approved, a continuation of benefits based on a proration of the remaining treatment will be

authorized.

2. For cases that were started under the HFS Dental Program, a Participant will be allowed to transfer treatment only under extreme situations. Usually this will be limited to when a Participant moves out of the immediate service area. In this instance, the dentist who will complete the treatment must submit a claim form indicating the treatment status of the case, his/her intention to continue care and a charge for the remaining treatment. DentaQuest will review the request on a case by case basis and issue a determination of benefits.

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

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	One of (D8660) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 45 Day(s) Per patient. Maximum of 1 per 45 days regardless of number of visits within 45 day period.	
D8680	orthodontic retention (removal of appliances)	0-20		Yes	One of (D8680) per 1 Lifetime Per patient.	Date of de-banding with claim form
D8999	unspecified orthodontic procedure, by report	0-20		Yes	One of (D8999) per 1 Lifetime Per patient. Only covered if case fails to qualify.	narrative of medical necessity



**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No		narrative of medical necessity
D9610	therapeutic drug injection, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	

**Exhibit B Benefits Covered for  
Blue Cross Community FHP 0-20**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	0-20		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment M of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

A comprehensive examination (D0150) is performed on a new or established patient. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

Place of service must be indicated on all claims.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0150) per 12 Month(s) Per patient. Not covered on same date of service as D0140 or D0150.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Routine prophylaxis is covered for Participants age 21 and over, once every 6 months. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4910) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. 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. Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately. 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.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date. Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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**.

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)



**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

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 Dental Industry (or ADA) treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

- \* Root resorption has started and exfoliation is imminent
- \* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
- \* The general oral condition does not justify root canal therapy due to the loss of arch integrity
- \* Tooth does not demonstrate 50% bone support
- \* Tooth demonstrates active untreated periodontal disease

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient. Only covered after active therapy (D4341 or D4342) have been performed.	pre-op x-ray(s), perio charting

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. The date of placement must be used as the date of service when submitting for payment of dentures. Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Billing and reimbursement for cast crowns and cast post and cores or any other fixed prosthetics shall be based on the cementation date.

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.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

- \* Patients on feeding tubes
- \* Post CVA patients with decreased facial muscle tone
- \* Patients in a coma
- \* Patients with diminished mental capacities that could not function with dentures
- \* Patients who do not desire dentures
- \* Advanced terminal patients

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5140	immediate denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement



**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		Yes		narrative of medical necessity
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5914	auricular prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5924	cranial prosthesis	21 and older		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	21 and older		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narrative of medical necessity
D5983	radiation carrier	21 and older		Yes		narrative of medical necessity
D5984	radiation shield	21 and older		Yes		narrative of medical necessity
D5985	radiation cone locator	21 and older		Yes		narrative of medical necessity

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		Yes		narrative of medical necessity
D5987	commissure splint	21 and older		Yes		narrative of medical necessity
D5988	surgical splint	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately. 'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity



**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9920	behavior management, by report	21 and older		No	Two of (D9920) per 12 Month(s) Per patient. One of (D9920) per 1 Lifetime Per Business. Allowed with at least one other covered service per 1 Day(s) Per Business.	

**Exhibit C Benefits Covered for  
Blue Cross Community FHP 21+**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology and develop an adequate treatment plan for the Participant's oral health.

Reimbursement for radiographs includes exposure of the radiograph, developing, mounting and radiographic interpretation. Reimbursement for multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal policies relating to radiation exposure. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration and are described in Attachment M of this manual.

If the total allowed amount for radiographs performed on a participant exceeds the allowed amount for procedure code D0210 (Complete Series), the submitted radiograph codes will be consolidated and paid as a Complete Series (D0210). The maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete service.

An initial examination is typically used when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This would include the evaluation and recording of the patient's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

A periodic examination is performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

OUT-OF-OFFICE SERVICES: Providers who render preventive exams in an out-of-office setting must check the

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	19-20		No	One of (D0120) per 6 Month(s) Per patient.	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0140	limited oral evaluation-problem focused	19-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with (D9110) on same date of service	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	19-20		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	19-20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	19-20		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0230	intraoral - periapical each additional radiographic image	19-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0270	bitewing - single radiographic image	19-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0272	bitewings - two radiographic images	19-20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0274	bitewings - four radiographic images	19-20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0277	vertical bitewings - 7 to 8 films	19-20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	
D0330	panoramic radiographic image	19-20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210)	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Routine prophylaxis is covered for Participants age 0 through 20, once every 6 months in an office or school. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details.

Fluoride treatment (D1206 or D1208) is allowed once every 6 months in an office or school setting for Participants age 3 through 20.

For ages 0 through 2, three fluoride varnish treatments (D1206) are allowed per patient per 12 months in an office setting.

D1206 topical fluoride varnish- prescription strength fluoride delivered to the dentition under the direct supervision of a dental professional.

Space maintainers are a covered service for Participants age 1 through 20 when determined by a DentaQuest Consultant to be indicated due to the premature loss of a posterior primary tooth. Space maintainers will not be covered if premolar eruption is imminent.

A lower lingual holding arch placed when there is not premature loss of a primary molar is considered a transitional orthodontic appliance and not a covered benefit.

PLACE OF SERVICE MUST BE INDICATED ON ALL CLAIMS.

OUT-OF-OFFICE SERVICES: Providers who render preventive services in an out-of-office setting must check the "Other" box on the ADA form or, if filing electronically, put code 03 for school or 99 for other, as appropriate. Providers who render comprehensive services in an out-of-office setting must check the "Provider's Office" or "ECF" box on the ADA form, or, if filing electronically, put code 15 for mobile unit, 32 for an extended care facility or 99 for other, as appropriate. Dental providers who are performing preventive out-of-office services must have the ability to provide all four preventive treatment services. Services cannot be limited to only exams, cleaning and fluoride treatment. Each provider must provide any follow up sealants in addition to the exam, cleaning, and fluoride treatment when needed.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	19-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office or school setting. Removal of plaque, calculus and stains from the tooth surfaces, intended to control local irrational factors.	
D1206	topical application of fluoride varnish	19-20		No	One of (D1206, D1208) per 6 Month(s) Per patient. in an office or school. Ages 3-20	
D1208	topical application of fluoride - excluding varnish	19-20		No	One of (D1206, D1208) per 6 Month(s) Per patient. in an office or school. Ages 3-20	
D1351	sealant - per tooth	19-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 1 Lifetime Per patient per tooth. Occlusal surfaces only. Sealant will not be covered when placed over restorations. Tooth number must be identified for reimbursement.	
D1354	application of caries arresting medicament- per tooth	19-20	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1510	space maintainer-fixed, unilateral-per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Business per quadrant. Per appliance	
D1516	space maintainer --fixed--bilateral, maxillary	19-20		No	One of (D1516) per 1 Lifetime Per Business.	
D1517	space maintainer --fixed--bilateral, mandibular	19-20		No	One of (D1517) per 1 Lifetime Per Business.	
D1520	space maintainer-removable-unilateral	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Business per quadrant. Per appliance	
D1526	space maintainer --removable--bilateral, maxillary	19-20		No	One of (D1526) per 1 Lifetime Per Business.	
D1527	space maintainer --removable--bilateral, mandibular	19-20		No	One of (D1527) per 1 Lifetime Per Business.	
D1550	re-cement or re-bond space maintainer	19-20		No		
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	19-20		No	One of (D1551) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	19-20		No	One of (D1552) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative services (amalgams and composites) are provided to remove decay and restore dental structures (teeth) to a reasonable condition. 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.

Bases, cements, liners, pulp caps, bonding agents and local anesthetic are included in the restorative service fees and are not reimbursed separately.

Restorations are expected to last a reasonable amount of time. Restorations replaced within 12 months of the date of the completion of the original restoration will not be allowed to the same provider or provider group. Repeated unexplained failures will result in review by Peer Review and may necessitate removal of the dentist from the panel.

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**.

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.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	19-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	19-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2160	amalgam - three surfaces, primary or permanent	19-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	19-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2330	resin-based composite - one surface, anterior	19-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	



**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2331	resin-based composite - two surfaces, anterior	19-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2332	resin-based composite - three surfaces, anterior	19-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-based composite - four or more surfaces (anterior)	19-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	19-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure	
D2392	resin-based composite - two surfaces, posterior	19-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2393	resin-based composite - three surfaces, posterior	19-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2394	resin-based composite - four or more surfaces, posterior	19-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth.	
D2542	onlay - metallic - two surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2543	onlay-metallic-3 surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2740	crown - porcelain/ceramic	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	19-20	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	19-20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 by the same provider or provider group	
D2920	re-cement or re-bond crown	19-20	Teeth 1 - 32, A - T	No		
D2930	prefabricated stainless steel crown - primary tooth	19-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2931	prefabricated stainless steel crown-permanent tooth	19-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	19-20	Teeth 1 - 32, A - T	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	19-20	Teeth 1 - 32, A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	19-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2940	protective restoration	19-20	Teeth 1 - 32, A - T	No	Not allowed with any 2000 or 3000 series code other than D3110 or D3120. (D3110 abd D3120 are not covered services)	
D2950	core buildup, including any pins when required	19-20	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	19-20	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	19-20	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Endodontic services are provided to retain teeth through root canal therapy made necessary due to trauma or carious exposure.

The following guidelines must be followed when providing endodontic services:

Pulpotomies will only be covered on primary teeth with no evidence of internal resorption, furcation or periapical pathologic involvement.

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 DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs. The fee does not include the final restoration.

Root canals and pulpotomies may not be covered in the following situations:

- \* Root resorption has started and exfoliation is imminent
- \* Gross periapical or periodontal pathosis is demonstrated radiographically (caries to the furcation, or subcrestal deeming the tooth non-restorable)
- \* The general oral condition does not justify root canal therapy due to the loss of arch integrity
- \* Tooth does not demonstrate 50% bone support
- \* Tooth demonstrates active untreated periodontal disease

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	19-20	Teeth 1 - 32, A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	19-20	Teeth 1 - 32	Yes	One of (D3222, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3222 covered for trauma cases only	narr. of med. necessity, pre-op x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	19-20	Teeth C - H, M - R	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	19-20	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	19-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3330	endodontic therapy, molar tooth (excluding final restoration)	19-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	19-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3351) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	19-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	19-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3353) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3410	apicoectomy - anterior	19-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Not payable concurrently with root canal treatment of tooth	pre-operative x-ray(s)

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Periodontal scaling and root planing, gingivectomy, and certain other procedures as required can be considered for coverage. The initial stages of therapy should include Oral Hygiene Instructions and treatment to remove deposits. Surgical intervention will not be considered until there is a sufficient amount of time for healing and re-evaluation.

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	19-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	19-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	19-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	19-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting



**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4273	subepithelial connective tissue graft procedure	19-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4274	distal or proximal wedge procedure	19-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	19-20	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	19-20	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	19-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office or school setting. One full mouth service is covered every 24 months.	
D4910	periodontal maintenance procedures	19-20		Yes	Only covered after active therapy has been performed	pre-op x-ray(s), perio charting

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Provisions for removable prosthesis include initial placement when masticatory function is impaired or when existing prosthesis is at least five years old and unserviceable. All necessary restorative work must be completed before fabrication of a partial denture. Abutments for partial dentures must be free of active periodontal disease, and have at least 50% bone support.

Payment for dentures includes any necessary adjustments, replacement of lost teeth (tooth) from the denture or relines necessary during the six - (6) month period following delivery of a new prosthesis. Relines are covered once every 24 months. The reimbursement for an incomplete denture service (non-delivery) will be limited to the out-of-pocket costs as documented by a copy of the lab bill. **THE DATE OF PLACEMENT MUST BE USED AS THE DATE OF SERVICE WHEN SUBMITTING FOR PAYMENT OF DENTURES.** Extractions and other procedures necessary prior to denture placement must be rendered and paid before dentures will be reimbursed. If immediate dentures, extractions must be rendered and billed with the same date of service as placement of the immediate dentures.

In situations where it is impractical to obtain pre-operative radiographs on a patient in a nursing home or long term care facility, a written narrative by the dentist stating that the patient is in a physical and mental state sufficient to function with full dentures is required for authorization.

Denture benefits for patients with the following medical conditions will not be considered for coverage:

- \* Patients on feeding tubes
- \* Post CVA patients with decreased facial muscle tone
- \* Patients in a coma
- \* Patients with diminished mental capacities that could not function with dentures
- \* Patients who do not desire dentures
- \* Advanced terminal patients

A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).

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.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	19-20		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	19-20		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit D Benefits Covered for  
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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5130	immediate denture - maxillary	19-20		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	19-20		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	19-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	19-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19-20		Yes	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19-20		Yes	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5511	repair broken complete denture base, mandibular	19-20		No		

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5512	repair broken complete denture base, maxillary	19-20		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	19-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	19-20		No		
D5612	repair resin partial denture base, maxillary	19-20		No		
D5621	repair cast partial framework, mandibular	19-20		No		
D5622	repair cast partial framework, maxillary	19-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	19-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	19-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	19-20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	19-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	19-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	19-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	19-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	19-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	19-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	19-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	19-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	19-20		Yes		narrative of medical necessity
D5912	facial moulage (complete)	19-20		Yes		narrative of medical necessity
D5913	nasal prosthesis	19-20		Yes		narrative of medical necessity
D5914	auricular prosthesis	19-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	19-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	19-20		Yes		narrative of medical necessity
D5919	facial prosthesis	19-20		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	19-20		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	19-20		Yes		narrative of medical necessity
D5924	cranial prosthesis	19-20		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	19-20		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	19-20		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	19-20		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	19-20		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	19-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	19-20		Yes		narrative of medical necessity

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5932	obturator prosthesis, definitive	19-20		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	19-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	19-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	19-20		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	19-20		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	19-20		Yes		narrative of medical necessity
D5951	feeding aid	19-20		Yes		narrative of medical necessity
D5952	speech aid prosthesis, pediatric	19-20		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	19-20		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	19-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	19-20		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	19-20		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	19-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	19-20		Yes		narrative of medical necessity
D5982	surgical stent	19-20		Yes		narrative of medical necessity
D5983	radiation carrier	19-20		Yes		narrative of medical necessity
D5984	radiation shield	19-20		Yes		narrative of medical necessity

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5985	radiation cone locator	19-20		Yes		narrative of medical necessity
D5986	fluoride gel carrier	19-20		Yes		narrative of medical necessity
D5987	commissure splint	19-20		Yes		narrative of medical necessity
D5988	surgical splint	19-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	19-20		Yes		narrative of medical necessity

**Exhibit D Benefits Covered for  
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Fixed bridgework will only be considered for the replacement of the permanent anterior teeth.

Fixed Prosthetic Services are covered for Participants with prior authorization. Services will not be authorized until it is documented that all necessary restorative, endodontic, periodontic and oral surgery has been completed.

Fixed bridgework will not be allowed in conjunction with the placement of a partial denture in the same arch.

Fixed prosthesis will not be covered when they replace a removable appliance that is less than 5 years old.

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.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6211	pontic-cast base metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6212	pontic - cast noble metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6240	pontic-porcelain fused-high noble	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6241	pontic-porcelain fused to base metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)



**Exhibit D Benefits Covered for  
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Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6242	pontic-porcelain fused-noble metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6251	pontic-resin with base metal	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6721	crown-resin with base metal	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6750	crown-porcelain fused high noble	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6751	crown-porcelain fused to base metal	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6752	crown-porcelain fused noble metal	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	19-20	Teeth 1 - 32	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D6790	crown-full cast high noble	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6791	crown - full cast base metal	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6792	crown - full cast noble metal	19-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6930	re-cement or re-bond fixed partial denture	19-20	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement	
D6999	fixed prosthodontic procedure	19-20	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity	narr. of med. necessity, pre-op x-ray(s)

**Exhibit D Benefits Covered for  
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Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	
D7220	removal of impacted tooth-soft tissue	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	pre-operative x-ray(s)

**Exhibit D Benefits Covered for  
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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7240	removal of impacted tooth-completely bony	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	19-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	19-20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons	pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	19-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. Allowed only on approved orthodontic cases per lifetime	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	19-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	19-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	19-20		Yes		Pathology report

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	19-20		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	19-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on same date of service as D7140 - D7250 (extractions)	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	19-20		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	19-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	19-20		Yes	Six of (D7961, D7963) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	19-20		Yes	One of (D7962) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7963	frenuloplasty	19-20		Yes	One of (D7961, D7963) per 1 Lifetime Per patient per arch.	Narrative of medical necessity and photos
D7999	unspecified oral surgery procedure, by report	19-20		Yes		narrative of medical necessity

## **Exhibit D Benefits Covered for Blue Cross Community ICP 19-20**

Participants under the age of 21 may qualify for orthodontic care under the program. Participants are required to either score a minimum of 28 points on the HLD or automatically qualify to be eligible to receive medically necessary orthodontia services.

Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspid are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered. If it is determined that the case will not qualify for comprehensive orthodontic treatment, the initial examination (consultation) can be billed using procedure code D8999.

For cleft palate cases, please contact the Division of Specialized Care for Children (DSCC) at 1.800.322.3722.

### **Documentation**

Previously DentaQuest required plaster models, in addition to other required documentation such as x-rays, to review the necessity of the request for orthodontic treatment. DentaQuest now accepts a complete series of intra-oral photos instead of the plaster models. All other required documentation, including panoramic and cephalometric films, score sheets, and narratives; must be submitted with the photos. This change was made to reduce postage costs for provider; increase the speed with which records are returned, and eliminate the possibility of models being damaged in shipment. If your office is unable to submit intra-oral photos, plaster models are still accepted.

The photos must be of good clinical quality and should include:

- Facial photographs (right and left profiles in addition to a straight-on facial view)
- Frontal view, in occlusion, straight-on view
- Frontal view, in occlusion, from a low angle
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Maxillary Occlusal view
- Mandibular Occlusal view

In addition to the photos, requests for orthodontic treatment must include overjet and any other pertinent measurements. All other currently required documentation, including panoramic and cephalometric x-rays, narratives, and scoring forms will continue to be required for review. If your office currently submits digital models through OrthoCad these are still accepted and no change needs to be made regarding the submission of models.

In addition to the photographs, plaster models or digital models, authorization for orthodontia services requires a claim form listing the requested services, the Orthodontic Criteria Index Form ( Attachment G), and any other documentation that supports medical necessity.

### **Billing**

The charge for initial exam, radiographs and study models for approved cases should be submitted under procedure code D8660. The charges for these services for cases that do not meet the criteria should be submitted using code D8999.

The date of service for orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the Participant's mouth. It is important to verify the Participant's eligibility, as the Participant must be eligible on this date of service. In addition, the provider should verify eligibility of the Participant for the entire course of treatment. The Participant must be eligible on the dates each service is rendered, including banding, adjustments, debanding, and retainers. If a recipient's eligibility ends before the conclusion of treatment.

Payment for orthodontics includes all appliances, retainers and all follow-up visits. Orthodontic appliance benefit limited to once per lifetime.

To initiate payment on an approved comprehensive orthodontic case, the dental office must submit a claim form indicating the date the appliances were placed (banding date). In order to receive reimbursement for orthodontic adjustments, provider must bill for each date of service treatment was rendered.

Only one D8670 allowed per 45 days and 11 D8670's allowed per case per lifetime. If a Participant fails to keep an appointment for two consecutive appointments, the dental office must notify DentaQuest.

Continuation of orthodontic care will be handled as follows:

1. For cases that were started prior to the date the Participant was enrolled in the HFS Dental Program, DentaQuest will attempt to secure the original pre-treatment records for review by a DentaQuest Dental Consultant. The Handicapping Labio-Lingual Deviation (HLD) will be performed and the original records reviewed using the criteria for all new cases. If approved, a continuation of benefits based on a proration of the remaining treatment will be

authorized.

2. For cases that were started under the HFS Dental Program, a Participant will be allowed to transfer treatment only under extreme situations. Usually this will be limited to when a Participant moves out of the immediate service area. In this instance, the dentist who will complete the treatment must submit a claim form indicating the treatment status of the case, his/her intention to continue care and a charge for the remaining treatment. DentaQuest will review the request on a case by case basis and issue a determination of benefits.

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

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	19-20		Yes	One of (D8080) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	19-20		Yes	One of (D8660) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8670	periodic orthodontic treatment visit	19-20		Yes	One of (D8670) per 45 Day(s) Per patient. Maximum of 1 per 45 days regardless of number of visits within 45 day period	
D8680	orthodontic retention (removal of appliances)	19-20		Yes	One of (D8680) per 1 Lifetime Per patient.	Date of de-banding with claim form
D8999	unspecified orthodontic procedure, by report	19-20		Yes	One of (D8999) per 1 Lifetime Per patient. Only covered if case fails to qualify.	narrative of medical necessity



**Exhibit D Benefits Covered for  
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Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	19-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9222	deep sedation/general anesthesia first 15 minutes	19-20		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	19-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	19-20		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	19-20		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	19-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	19-20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19-20		No		
D9610	therapeutic drug injection, by report	19-20		Yes	Name of drug and amount administered	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	19-20		Yes	Name of drug and amount administered	narrative of medical necessity
D9920	behavior management, by report	19-20		No	One of (D9920) per 1 Day(s) Per Business. Practice visit fee for extremely apprehensive or developmentally disabled patients	

**Exhibit D Benefits Covered for  
Blue Cross Community ICP 19-20**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	19-20		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	19-20		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	19-20		Yes	Description of service and narrative of medical necessity	narrative of medical necessity

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0150) per 12 Month(s) Per patient. Not covered on same date of service as D0140 or D0150.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with (D9110) on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Routine prophylaxis is covered for Participants age 21 and over, once every 6 months. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4910) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)



**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or Provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient. Only covered after active therapy (D4341 or D4342) have been performed.	pre-op x-ray(s), perio charting

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		No	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		No	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		No		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		No		narrative of medical necessity
D5913	nasal prosthesis	21 and older		No		narrative of medical necessity
D5914	auricular prosthesis	21 and older		No		narrative of medical necessity
D5915	orbital prosthesis	21 and older		No		narrative of medical necessity
D5916	ocular prosthesis	21 and older		No		narrative of medical necessity
D5919	facial prosthesis	21 and older		No		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		No		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		No		narrative of medical necessity
D5924	cranial prosthesis	21 and older		No		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		No		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		No		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		No		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		No		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		No		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		No		narrative of medical necessity



**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5932	obturator prosthesis, definitive	21 and older		No		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		No		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		No		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		No		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		No		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		No		narrative of medical necessity
D5951	feeding aid	21 and older		No		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		No		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		No		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		No		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		No		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		No		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		No		narrative of medical necessity
D5982	surgical stent	21 and older		No		narrative of medical necessity
D5983	radiation carrier	21 and older		No		narrative of medical necessity
D5984	radiation shield	21 and older		No		narrative of medical necessity
D5985	radiation cone locator	21 and older		No		narrative of medical necessity

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		No		narrative of medical necessity
D5987	commissure splint	21 and older		No		narrative of medical necessity
D5988	surgical splint	21 and older		No		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		No		narrative of medical necessity

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	No	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately. 'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on same date of service as D7140 - D7250 (extractions)	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		No	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9920	behavior management, by report	21 and older		No	One of (D9920) per 1 Day(s) Per Business. Practice visit fee for extremely apprehensive or developmentally disabled patients	



**Exhibit E Benefits Covered for  
Blue Cross Community ICP 21 & Older**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	21 and older		No	Description of service and narrative of medical necessity	narrative of medical necessity

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

MMAI members have a supplemental dental benefit of \$800 available each calendar year to use for additional comprehensive dental services. It will apply only for the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:

- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0150) per 12 Month(s) Per patient. Not covered on same date of service as D0140 or D0150.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with (D9110) on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

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- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

Routine prophylaxis is covered for Participants age 21 and over, once every 6 months. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D4910) per 12 Month(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per 12 Month(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1206, D1208) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

MMAI members have a supplemental dental benefit of \$800 available each calendar year to use for additional comprehensive dental services. It will apply only for the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:

- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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.

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit F Benefits Covered for  
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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or Provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	



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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray

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Blue Cross Community MMAI**

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- Restorative Services
- Endodontics/Periodontics/Extractions
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Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

**Exhibit F Benefits Covered for  
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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient. Only covered after active therapy (D4341 or D4342) have been performed.	pre-op x-ray(s), perio charting

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- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		No	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		No	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

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- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		No		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		No		narrative of medical necessity
D5913	nasal prosthesis	21 and older		No		narrative of medical necessity
D5914	auricular prosthesis	21 and older		No		narrative of medical necessity
D5915	orbital prosthesis	21 and older		No		narrative of medical necessity
D5916	ocular prosthesis	21 and older		No		narrative of medical necessity
D5919	facial prosthesis	21 and older		No		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		No		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		No		narrative of medical necessity
D5924	cranial prosthesis	21 and older		No		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		No		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		No		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		No		narrative of medical necessity

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5928	orbital prosthesis, replace	21 and older		No		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		No		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		No		narrative of medical necessity
D5932	obturator prosthesis, definitive	21 and older		No		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		No		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		No		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		No		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		No		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		No		narrative of medical necessity
D5951	feeding aid	21 and older		No		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		No		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		No		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		No		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		No		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		No		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		No		narrative of medical necessity
D5982	surgical stent	21 and older		No		narrative of medical necessity



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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5983	radiation carrier	21 and older		No		narrative of medical necessity
D5984	radiation shield	21 and older		No		narrative of medical necessity
D5985	radiation cone locator	21 and older		No		narrative of medical necessity
D5986	fluoride gel carrier	21 and older		No		narrative of medical necessity
D5987	commissure splint	21 and older		No		narrative of medical necessity
D5988	surgical splint	21 and older		No		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		No		narrative of medical necessity

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

MMAI members have a supplemental dental benefit of \$800 available each calendar year to use for additional comprehensive dental services. It will apply only for the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:

- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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

**Prosthodontics, fixed**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	No	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit. Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately. Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

MMAI members have a supplemental dental benefit of \$800 available each calendar year to use for additional comprehensive dental services. It will apply only for the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:

- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, A - T	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on same date of service as D7140 - D7250 (extractions)	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		No	One of (D7510, D7511) per 1 Day(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7610	maxilla - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		No		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		No		narrative of medical necessity

## **Exhibit F Benefits Covered for Blue Cross Community MMAI**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

MMAI members have a supplemental dental benefit of \$800 available each calendar year to use for additional comprehensive dental services. It will apply only for the following areas (excludes cosmetic dentistry) and does not apply to benefit limitations:

- Diagnostics
- Restorative Services
- Endodontics/Periodontics/Extractions
- Prosthodontics/Other Oral/Maxillofacial Surgery, Other Services

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

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same date of service as D9222, D9223, D9239, D9243 or D9248.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, D9239 or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		No	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9920	behavior management, by report	21 and older		No	One of (D9920) per 1 Day(s) Per Business. Practice visit fee for extremely apprehensive or developmentally disabled patients	

**Exhibit F Benefits Covered for  
Blue Cross Community MMAI**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	21 and older		No	Description of service and narrative of medical necessity	narrative of medical necessity



**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0150) per 6 Month(s) Per patient. Not covered on same date of service as D0140 or D0150.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam will only be covered when performed in conjunction with treatment for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not allowed with (D9110) on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business. One of (D0120, D0150) per 12 Month(s) Per patient. Not covered on same date of service as D0120 or D0140.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Routine prophylaxis is covered for Participants age 21 and over, once every 6 months. Prophylaxis includes necessary scaling and polishing. Periodontal scaling and root planning (D4341 and D4342) is not covered on the same date of service as a routine prophylaxis. Please refer to the benefit tables for complete benefit details.

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	One of (D1110, D4910) per 6 Month(s) Per patient. Not covered within 6 Month(s) of D4355.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	21 and older		No	One of (D1705) per 1 Lifetime Per patient.	
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	21 and older		No	One of (D1706) per 1 Lifetime Per patient.	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventative procedure	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740, D2750, D2751, D2752, D2790, D2791, or D2972 by the same provider or Provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for two (2) or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth. For All Permanent Teeth.	Final fill periapical x-ray



**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-operative x-ray(s)
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4355, D4910) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older		Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		Yes		narrative of medical necessity
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5914	auricular prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5924	cranial prosthesis	21 and older		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes		narrative of medical necessity
D5951	feeding aid	21 and older		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narrative of medical necessity
D5983	radiation carrier	21 and older		Yes		narrative of medical necessity
D5984	radiation shield	21 and older		Yes		narrative of medical necessity
D5985	radiation cone locator	21 and older		Yes		narrative of medical necessity

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		Yes		narrative of medical necessity
D5987	commissure splint	21 and older		Yes		narrative of medical necessity
D5988	surgical splint	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity



**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately.

'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, A - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on same date of service as D7140 - D7250 (extractions)	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		Yes	Six of (D7961, D7963) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	21 and older		Yes	One of (D7962) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on the same date of service with D9222, D9223, D9230, or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9223, D9230, or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9920	behavior management, by report	21 and older		No	One of (D9920) per 1 Day(s) Per Business. Practice visit fee for extremely apprehensive or developmentally disabled patients	

**Exhibit G Benefits Covered for  
Humana Gold Plus - 21 and Older**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02.	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be billed with a D0140. Must be billed with a Place of Service of 02.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	Description of service and narrative of medical necessity	narrative of medical necessity

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Aetna Better Health of IL Child NDC, Aetna Better Health of IL Child DC, Aetna Better Health of IL Foster Care, Aetna Better Health of IL Pregnancy Under 21

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per patient. Participants are also eligible for one periodic oral evaluation (D0120) performed in a school setting per benefit period (08/01/XXXX - 07/31/XXXX). Completion of a mandated school exam form is considered part of the oral examination.	
D0140	limited oral evaluation-problem focused	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	



**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0601	Caries risk assessment and documentation, with a finding of low risk	0-20		No		
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0-20		No		
D0603	Caries risk assessment and documentation, with a finding of high risk	0-20		No		

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. One of (D1120, D4355) per 6 Month(s) Per patient in school. in an office and school setting. Removal of plaque, calculus and stains from the tooth surfaces, intended to control local irrational factors.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 2 Year(s) Per patient per tooth. Regardless of place of service. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Tooth number must be identified for reimbursement.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Business per quadrant. Per appliance.	

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516) per 1 Lifetime Per Business.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517) per 1 Lifetime Per Business.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Business per quadrant. Per appliance.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1526) per 1 Lifetime Per Business.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1527) per 1 Lifetime Per Business.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-20		No	One of (D1551) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-20		No	One of (D1552) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	One of (D1704) per 1 Lifetime Per patient.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	0-20		No	One of (D1705) per 1 Lifetime Per patient.	

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	0-20		No	One of (D1706) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	One of (D1707) per 1 Lifetime Per patient.	
D1999	Unspecified preventive procedure, by report	0-20		No	To be billed on each claim when services are rendered by a Public Health Dental Hygienist. The name of the Public Health Dental Hygienist performing the dental services should be placed in the "Remarks" box 35, and the school place of service should be placed in box 38.	

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2542	onlay - metallic - two surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2643	onlay-porcelain/ceramic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No		



**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth C - H, M - R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	Final fill periapical x-ray

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Aetna Better Health of IL - Medicaid Children**

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Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3222, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3222 covered for trauma cases only	narr. of med. necessity, pre-op x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3351) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3353) per 1 Lifetime Per patient per tooth.	Pre and post-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Not payable concurrently with root canal treatment of tooth.	pre-operative x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	Yes		
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office setting.	
D4910	periodontal maintenance procedures	0-20		Yes	Only covered after active therapy has been performed.	pre-op x-ray(s), perio charting

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	0-20		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	0-20		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	
D5511	repair broken complete denture base, mandibular	0-20		No		
D5512	repair broken complete denture base, maxillary	0-20		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	0-20		No		
D5622	repair cast partial framework, maxillary	0-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5741	reline mandibular partial denture (chairside)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0-20		Yes		narrative of medical necessity
D5912	facial moulage (complete)	0-20		Yes		narrative of medical necessity
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5914	auricular prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5919	facial prosthesis	0-20		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	0-20		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	0-20		Yes		narrative of medical necessity
D5924	cranial prosthesis	0-20		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	0-20		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	0-20		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	0-20		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity



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Aetna Better Health of IL - Medicaid Children**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	0-20		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	0-20		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	0-20		Yes		narrative of medical necessity
D5952	speech aid prosthesis, pediatric	0-12		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	13-20		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	0-20		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	0-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes		narrative of medical necessity
D5982	surgical stent	0-20		Yes		narrative of medical necessity
D5983	radiation carrier	0-20		Yes		narrative of medical necessity
D5984	radiation shield	0-20		Yes		narrative of medical necessity

**Exhibit H Benefits Covered for  
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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5985	radiation cone locator	0-20		Yes		narrative of medical necessity
D5986	fluoride gel carrier	0-20		Yes		narrative of medical necessity
D5987	commissure splint	0-20		Yes		narrative of medical necessity
D5988	surgical splint	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6211	pontic-cast base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6212	pontic - cast noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6240	pontic-porcelain fused-high noble	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6241	pontic-porcelain fused to base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6251	pontic-resin with base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6721	crown-resin with base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6750	crown-porcelain fused high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6751	crown-porcelain fused to base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6752	crown-porcelain fused noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6790	crown-full cast high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6791	crown - full cast base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6792	crown - full cast noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6930	re-cement or re-bond fixed partial denture	0-20	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review.	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons.	pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	pre-operative x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7720	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes	Six of (D7961, D7963) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	One of (D7962) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7963	frenuloplasty	0-20		Yes	One of (D7961, D7963) per 1 Lifetime Per patient. One per arch per lifetime.	Narrative of medical necessity and photos
D7999	unspecified oral surgery procedure, by report	0-20		Yes		narrative of medical necessity

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	One of (D8660) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 45 Day(s) Per patient. Maximum of 1 per 45 days regardless of number of visits within 45 day period.	
D8680	orthodontic retention (removal of appliances)	0-20		Yes	One of (D8680) per 1 Lifetime Per patient.	Date of de-banding with claim form
D8999	unspecified orthodontic procedure, by report	0-20		Yes	One of (D8999) per 1 Lifetime Per patient. Only covered if case fails to qualify.	narrative of medical necessity



**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No		narrative of medical necessity
D9610	therapeutic drug injection, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity

**Exhibit H Benefits Covered for  
Aetna Better Health of IL - Medicaid Children**

<b>Adjunctive General Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 10 or 02	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 10 or 02	
D9999	unspecified adjunctive procedure, by report	0-20		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

Aetna Better Health of IL Adults DS; Aetna Better Health of IL Adults NDA, Aetna Better Health of IL Pregnant Over 21

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0150) per 12 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business. One of (D0120, D0150) per 12 Month(s) Per patient.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

**Diagnostic**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

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Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	One of (D1110, D4355, D4910) per 12 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	21 and older		No	One of (D1705) per 1 Lifetime Per patient.	
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	21 and older		No	One of (D1706) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit I Benefits Covered for  
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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)



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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	Final fill periapical x-ray

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Aetna Better Health of IL - Medicaid Adults**

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Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		Yes		narrative of medical necessity
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5914	auricular prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5924	cranial prosthesis	21 and older		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity

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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	21 and older		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narrative of medical necessity
D5983	radiation carrier	21 and older		Yes		narrative of medical necessity
D5984	radiation shield	21 and older		Yes		narrative of medical necessity
D5985	radiation cone locator	21 and older		Yes		narrative of medical necessity



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<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		Yes		narrative of medical necessity
D5987	commissure splint	21 and older		Yes		narrative of medical necessity
D5988	surgical splint	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

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Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

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Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models

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**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity

**Exhibit I Benefits Covered for  
Aetna Better Health of IL - Medicaid Adults**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 10 or 02	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 10 or 02	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

**Exhibit J Benefits Covered for  
IL Molina MMAI**

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0140, D0150) per 1 Calendar year(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 3 Calendar year(s) Per Provider OR Location. Two of (D0120, D0140, D0150) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373) per 1 Calendar year(s) Per patient.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330, D0372) per 3 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	One of (D0270, D0272, D0273, D0274, D0373) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No	One of (D0374) per 1 Calendar year(s) Per patient.	



**Exhibit J Benefits Covered for  
IL Molina MMAI**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	One of (D1208) per 1 Calendar year(s) Per patient.	

**Exhibit J Benefits Covered for  
IL Molina MMAI**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	

**Exhibit J Benefits Covered for  
IL Molina MMAI**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	Three of (D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per patient.	

**Exhibit J Benefits Covered for  
IL Molina MMAI**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Radiographs and perio charting	
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Radiographs and perio charting	

**Exhibit J Benefits Covered for  
IL Molina MMAI**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	Full mouth x-rays.	
D5120	complete denture - mandibular	21 and older		Yes	Full mouth x-rays.	
D5225	maxillary partial denture-flexible base	21 and older		Yes	Full mouth x-rays.	
D5226	mandibular partial denture-flexible base	21 and older		Yes	Full mouth x-rays.	
D5410	adjust complete denture - maxillary	21 and older		No		
D5411	adjust complete denture - mandibular	21 and older		No		
D5421	adjust partial denture-maxillary	21 and older		No		
D5422	adjust partial denture - mandibular	21 and older		No		

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

IL Molina Child, IL Molina ABD Child, IL Molina ACA Child, IL Molina Pregnant Under 21

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120) per 6 Month(s) Per patient. Participants are also eligible for one periodic oral evaluation (D0120) performed in a school setting per benefit period (08/01/XXXX - 07/31/XXXX). Completion of a mandated school exam form is considered part of the oral examination.	
D0140	limited oral evaluation-problem focused	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 1 Lifetime Per Business.	
D0210	intraoral - comprehensive series of radiographic images	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	0-20		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	2 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	10 - 20		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0330	panoramic radiographic image	6 - 20		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0601	Caries risk assessment and documentation, with a finding of low risk	0-20		No		
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0-20		No		
D0603	Caries risk assessment and documentation, with a finding of high risk	0-20		No		

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1120	prophylaxis - child	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. One of (D1120, D4355) per 6 Month(s) Per patient in school. in an office or school setting. Removal of plaque, calculus and stains from the tooth surfaces, intended to control local irrational factors	
D1206	topical application of fluoride varnish	0-20		No	Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1208	topical application of fluoride - excluding varnish	0-20		No	Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office and school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 2 Year(s) Per patient per tooth. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Tooth number must be identified for reimbursement.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Business per quadrant. Per appliance.	



**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516) per 1 Lifetime Per Business.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517) per 1 Lifetime Per Business.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Business per quadrant. Per appliance.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1526) per 1 Lifetime Per Business.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1527) per 1 Lifetime Per Business.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-20		No	One of (D1551) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-20		No	One of (D1552) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient. Not allowed within 6 months of placement.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	One of (D1704) per 1 Lifetime Per patient.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	0-20		No	One of (D1705) per 1 Lifetime Per patient.	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	0-20		No	One of (D1706) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	One of (D1707) per 1 Lifetime Per patient.	
D1999	Unspecified preventive procedure, by report	0-20		No	To be billed on each claim when services are rendered by a Public Health Dental Hygienist. The name of the Public Health Dental Hygienist performing the dental services should be placed in the "Remarks" box 35, and the school place of service should be placed in box 38.	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2150	Amalgam - two surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-4	Teeth D - G, N - Q	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	0-9	Teeth A - C, H - M, R - T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2161	amalgam - four or more surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2330	resin-based composite - one surface, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth D - G, N - Q	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-4	Teeth D - G, N - Q	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-based composite - four or more surfaces (anterior)	0-9	Teeth C, H, M, R	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-based composite - four or more surfaces (anterior)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-based composite - four or more surfaces (anterior)	5 - 20	Teeth D - G, N - Q	Yes	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2335	resin-based composite - four or more surfaces (anterior)	10 - 20	Teeth C, H, M, R	Yes	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2391	resin-based composite - one surface, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	
D2394	resin-based composite - four or more surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2161, D2335, D2394) per 12 Month(s) Per patient per tooth.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2542	onlay - metallic - two surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2643	onlay-porcelain/ceramic-3 surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)



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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2644	onlay-porcelain/ceramic-4+ surfaces	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931, D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2930	prefabricated stainless steel crown - primary tooth	0-4	Teeth D - G, N - Q	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-9	Teeth A - C, H - M, R - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-4	Teeth D - G, N - Q	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2932	prefabricated resin crown	0-9	Teeth C, H, M, R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2932	prefabricated resin crown	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2932	prefabricated resin crown	5 - 20	Teeth D - G, N - Q	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	pre-operative x-ray(s)
D2932	prefabricated resin crown	10 - 20	Teeth C, H, M, R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	pre-operative x-ray(s)

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Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2933	prefabricated stainless steel crown with resin window	0-4	Teeth D - G, N - Q	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-9	Teeth C, H, M, R	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	5 - 20	Teeth D - G, N - Q	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	10 - 20	Teeth C, H, M, R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth D - G, N - Q	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-9	Teeth A - C, H - M, R - T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth A, B, I - L, S, T	No	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth.	
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	Final fill periapical x-ray

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A - T	No	Not reimbursable when performed in conjunction with a root canal - Primary Teeth Only.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3222, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth. D3222 covered for trauma cases only	narr. of med. necessity, pre-op x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	No		
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3351) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3352) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	One of (D3222, D3310, D3320, D3330, D3353) per 1 Lifetime Per patient per tooth.	Pre and post-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth. Not payable concurrently with root canal treatment of tooth.	pre-operative x-ray(s)

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	Yes		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32, 51 - 82	Yes		pre-op x-ray(s), perio charting
D4320	provision splinting - intracoronal	0-20	Per Arch (01, 02, LA, UA)	Yes		
D4321	provision splinting - extracoronal	0-20	Per Arch (01, 02, LA, UA)	Yes		
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One full mouth service is covered every 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-20		No	One of (D1120, D4355) per 6 Month(s) Per patient. in an office setting.	
D4910	periodontal maintenance procedures	0-20		Yes	Only covered after active therapy has been performed.	pre-op x-ray(s), perio charting

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	0-20		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	0-20		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5211, D5213) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	One of (D5212, D5214) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5222	immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date



**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	One of (D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) per 60 Month(s) Per patient.	
D5511	repair broken complete denture base, mandibular	0-20		No		
D5512	repair broken complete denture base, maxillary	0-20		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	0-20		No		
D5622	repair cast partial framework, maxillary	0-20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5731	reline complete mandibular denture (chairside)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement

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IL Molina - Medicaid Children**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5741	reline mandibular partial denture (chairside)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	0-20		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	0-20		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	0-20		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	0-20		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0-20		Yes		narrative of medical necessity
D5912	facial moulage (complete)	0-20		Yes		narrative of medical necessity
D5913	nasal prosthesis	0-20		Yes		narrative of medical necessity
D5914	auricular prosthesis	0-20		Yes		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes		narrative of medical necessity
D5919	facial prosthesis	0-20		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	0-20		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	0-20		Yes		narrative of medical necessity
D5924	cranial prosthesis	0-20		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	0-20		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	0-20		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	0-20		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	0-20		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes		narrative of medical necessity

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	0-20		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	0-20		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	0-20		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	0-20		Yes		narrative of medical necessity
D5952	speech aid prosthesis, pediatric	0-12		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	13-20		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	0-20		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	0-20		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	0-20		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes		narrative of medical necessity
D5982	surgical stent	0-20		Yes		narrative of medical necessity
D5983	radiation carrier	0-20		Yes		narrative of medical necessity
D5984	radiation shield	0-20		Yes		narrative of medical necessity

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5985	radiation cone locator	0-20		Yes		narrative of medical necessity
D5986	fluoride gel carrier	0-20		Yes		narrative of medical necessity
D5987	commissure splint	0-20		Yes		narrative of medical necessity
D5988	surgical splint	0-20		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		narrative of medical necessity

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6211	pontic-cast base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6212	pontic - cast noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6240	pontic-porcelain fused-high noble	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6241	pontic-porcelain fused to base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6251	pontic-resin with base metal	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6721	crown-resin with base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6750	crown-porcelain fused high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6751	crown-porcelain fused to base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6752	crown-porcelain fused noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6790	crown-full cast high noble	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6791	crown - full cast base metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6792	crown - full cast noble metal	0-20	Teeth 5 - 12, 21 - 28	Yes	One of (D6210, D6211, D6212, D6240, D6241, D6242, D6251, D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792, D6972) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s). Prior placement date (if applicable)
D6930	re-cement or re-bond fixed partial denture	0-20	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately. 'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-5	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	6-10	Teeth A - C, H - M, R - T	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	6 - 20	Teeth AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	6 - 20	Teeth D - G, N - Q	Yes		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	11 - 20	Teeth A - C, H - M, R - T	Yes		



**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-5	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6-10	Teeth A - C, H - M, R - T	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	6 - 20	Teeth D - G, N - Q	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	11 - 20	Teeth A - C, H - M, R - T	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylatic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	Narrative with claim for prepayment review.	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	To expose crown of an impacted tooth not intended to be extracted. For orthodontic reasons.	pre-operative x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. ALLOWED ONLY ON APPROVED ORTHODONTIC CASES PER LIFETIME.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		Pathology report

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes	Six of (D7961, D7963) per 1 Lifetime Per patient. Six of (D7961, D7963) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	One of (D7962) per 1 Lifetime Per patient. One of (D7962) per 1 Lifetime Per patient.	narr. of med. necessity, model or photo
D7963	frenuloplasty	0-20		Yes	One of (D7961, D7963) per 1 Lifetime Per patient. One per arch per lifetime.	Narrative of medical necessity and photos

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7999	unspecified oral surgery procedure, by report	0-20		Yes		narrative of medical necessity

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

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

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	One of (D8080) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	One of (D8660) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 45 Day(s) Per patient. Maximum of 1 per 45 days regardless of number of visits within 45 day period.	
D8680	orthodontic retention (removal of appliances)	0-20		Yes	One of (D8680) per 1 Lifetime Per patient.	Date of de-banding with claim form
D8999	unspecified orthodontic procedure, by report	0-20		Yes	One of (D8999) per 1 Lifetime Per patient. Only covered if case fails to qualify.	narrative of medical necessity

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	0-20		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-20		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No		narrative of medical necessity
D9610	therapeutic drug injection, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	0-20		Yes	Name of drug and amount administered.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	

**Exhibit K Benefits Covered for  
IL Molina - Medicaid Children**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	0-20		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity



**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

IL Molina Dual Options Medicaid, IL Molina Adult, IL Molina LTC Adult, IL Molina ACA Adult, IL Molina Pregnant Over 21

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Limited emergency exam for an emergency situation that is medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury. Not covered with D9110 on same date of service.	Description of emergency and services provided with claim
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 1 Lifetime Per Business. One of (D0120, D0150) per 12 Month(s) Per patient.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0270	bitewing - single radiographic image	21 and older		No	Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0272	bitewings - two radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0274	bitewings - four radiographic images	21 and older		No	One of (D0272, D0274) per 12 Month(s) Per Business. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

**Diagnostic**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0277, D0330) per 36 Month(s) Per patient. Maximum reimbursement for a single date of service for radiographs limited to fee for Complete Series (D0210).	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	One of (D1110, D4355, D4910) per 6 Month(s) Per patient.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	Four of (D1354) per 1 Day(s) Per patient. Two of (D1354) per 1 Year(s) Per patient per tooth. Six of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1705	AstraZeneca Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	21 and older		No	One of (D1705) per 1 Lifetime Per patient.	
D1706	AstraZeneca Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	21 and older		No	One of (D1706) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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.

**BILLING AND REIMBURSEMENT FOR CAST CROWNS, CAST POST & CORES AND LAMINATE VENEERS OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.**

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

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2642	onlay-porcelain/ceramic-2 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2643	onlay-porcelain/ceramic-3 surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2644	onlay-porcelain/ceramic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No		
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of D2954 (Prefabricated Post and Core in Addition to Crown) by the same provider or provider group.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	Not allowed within 6 months of D2740-D2792, by the same provider or provider group.	
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	Yes	One of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 Month(s) Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	Yes	One of (D2930, D2932, D2933, D2934) per 1 Lifetime Per patient per tooth. Authorization required for three or more crowns. Not compensated with construction of permanent crown.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	No	Not allowed within any 2000 or 3000 series code other than D3110 or D3120. (D3110 and D3120 are not covered services).	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	No	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Not allowed with (D2950, D2954) on the same date of service	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Restorative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2954) per 60 Month(s) Per patient per tooth for All Permanent Teeth.	Final fill periapical x-ray



**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310, D3320, D3330, D3351, D3352, D3353) per 1 Lifetime Per patient per tooth.	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 Month(s) Per Business per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No		pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	No		pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	No		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. Must show bone loss and pockets greater than 4 mm.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	One of (D1110, D4355) per 12 Month(s) Per patient.	
D4910	periodontal maintenance procedures	21 and older		Yes	One of (D4910) per 12 Month(s) Per patient.	pre-op x-ray(s), perio charting

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	Narr of med necessity, pre-op x-ray(s); Prior placement date
D5130	immediate denture - maxillary	21 and older		Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	Full mouth x-rays
D5140	immediate denture - mandibular	21 and older		Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	Full mouth x-rays
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5730	reline complete maxillary denture (chairside)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5731	reline complete mandibular denture (chairside)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5740	reline maxillary partial denture (chairside)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5741	reline mandibular partial denture (chairside)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement
D5750	reline complete maxillary denture (laboratory)	21 and older		Yes	One of (D5730, D5750) per 24 Month(s) Per patient.	Date of denture placement
D5751	reline complete mandibular denture (laboratory)	21 and older		Yes	One of (D5731, D5751) per 24 Month(s) Per patient.	Date of denture placement
D5760	reline maxillary partial denture (laboratory)	21 and older		Yes	One of (D5740, D5760) per 24 Month(s) Per patient.	Date of denture placement
D5761	reline mandibular partial denture (laboratory)	21 and older		Yes	One of (D5741, D5761) per 24 Month(s) Per patient.	Date of denture placement

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	21 and older		Yes		narrative of medical necessity
D5912	facial moulage (complete)	21 and older		Yes		narrative of medical necessity
D5913	nasal prosthesis	21 and older		Yes		narrative of medical necessity
D5914	auricular prosthesis	21 and older		Yes		narrative of medical necessity
D5915	orbital prosthesis	21 and older		Yes		narrative of medical necessity
D5916	ocular prosthesis	21 and older		Yes		narrative of medical necessity
D5919	facial prosthesis	21 and older		Yes		narrative of medical necessity
D5922	nasal septal prosthesis	21 and older		Yes		narrative of medical necessity
D5923	ocular prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5924	cranial prosthesis	21 and older		Yes		narrative of medical necessity
D5925	facial augment implant prosthesis	21 and older		Yes		narrative of medical necessity
D5926	nasal prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5927	auricular prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5928	orbital prosthesis, replace	21 and older		Yes		narrative of medical necessity
D5929	facial prosthesis, replacement	21 and older		Yes		narrative of medical necessity
D5931	obturator prosthesis, surgical	21 and older		Yes		narrative of medical necessity

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Maxillofacial Prosthetics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D5932	obturator prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5933	obturator prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	21 and older		Yes		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	21 and older		Yes		narrative of medical necessity
D5936	obturator prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	21 and older		Yes	Not for TMD Treatment.	narrative of medical necessity
D5951	feeding aid	21 and older		Yes		narrative of medical necessity
D5953	speech aid prosthesis, adult	21 and older		Yes		narrative of medical necessity
D5954	palatal augment prosthesis	21 and older		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	21 and older		Yes		narrative of medical necessity
D5958	palatal lift prosthesis, interim	21 and older		Yes		narrative of medical necessity
D5959	palatal lift prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5960	speech aid prosthesis, modification	21 and older		Yes		narrative of medical necessity
D5982	surgical stent	21 and older		Yes		narrative of medical necessity
D5983	radiation carrier	21 and older		Yes		narrative of medical necessity
D5984	radiation shield	21 and older		Yes		narrative of medical necessity
D5985	radiation cone locator	21 and older		Yes		narrative of medical necessity

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

<b>Maxillofacial Prosthetics</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5986	fluoride gel carrier	21 and older		Yes		narrative of medical necessity
D5987	commissure splint	21 and older		Yes		narrative of medical necessity
D5988	surgical splint	21 and older		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes		narrative of medical necessity



**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

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

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D6930	re-cement or re-bond fixed partial denture	21 and older	Teeth 5 - 12, 21 - 28	No	Not billable by same provider within 6 months of placement.	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	Description of service and narrative of medical necessity.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Prophylactic removal of multiple asymptomatic teeth, or teeth free from pathology is not a covered benefit.

Extraction of deciduous teeth that radiographically appear to be near imminent exfoliation is not a covered benefit.

Reimbursement includes local anesthesia and post-operative care.

Claims for all oral surgical procedures except simple, non-surgical extractions or for procedure code D7210 must include a pre-operative radiograph to be considered for reimbursement.

Simple and surgical extractions are covered. Local anesthesia and routine post-operative care are included in the fees and will not be reimbursed separately. 'Erupted surgical extractions' are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone, and/or section of the tooth and closure.

Tuberosity reductions are not payable in conjunction with extractions or alveolectomy in the same quadrant.

For oral surgery performed as part of emergency care, the requirement for prior authorization is waived. Service will still be subject to retrospective review.

Emergency care is defined as treatment of pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

Providers billing anesthesia services with oral surgery services must have the appropriate permits in order to be reimbursed for sedation. See anesthesia codes for further detail (D9222 - D9248).

Certain covered codes require the pertinent Quadrant or Arch be submitted on the claim. To identify the applicable Quadrant use either/or of the following; 10 or LL, 20 or LR, 30 or UL, 40 or UR. To identify the applicable Arch use either/or of the following; 01 or LA, 02 or UA.

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

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit.	pre-operative x-ray(s)
D7310	alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7311	alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D7320	alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7321	alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	Diagnostic models
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		Yes		Pathology report
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	One of (D7510, D7511) per 1 Day(s) Per patient per tooth. Not allowed on the same date of service as D7140-D7250 (extractions).	narr. of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes	One of (D7510, D7511) per 1 Day(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

**Oral and Maxillofacial Surgery**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D7620	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7630	mandible-open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7820	closed reduction dislocation	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	21 and older		Yes		narrative of medical necessity

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Adjunctive general services include general anesthesia, intravenous sedation, nitrous oxide analgesia, consultations and various drugs and medicaments, and emergency services provided for relief of dental pain.

Procedure code D9110 – palliative treatment is to be used to bill for minor palliative procedures when the only other procedure code billed for is a diagnostic radiograph. If any other services (filling, endodontics, oral surgery etc.) are billed for on the same day, the palliative treatment code will be denied. Sedation and general anesthesia will only be a covered service for participating dentists that hold the applicable permits required by the Illinois Dental Practice Act. Requests for sedation and general anesthesia will be reviewed on a case-by-case basis. A case will be covered for Participants with physical or mental health problems of such severity that treatment cannot be reasonably attempted without the use of sedation or general anesthesia. Sedation or general anesthesia may be allowed when a surgical procedure is being rendered. Claims for sedation and general anesthesia must include a narrative of medical necessity. Acceptable conditions include:

- \* Toxicity to local anesthesia supported by documentation;
- \* Severe mental retardation;
- \* Severe physical disability;
- \* Uncontrolled management problem;
- \* Extensive or complicated surgical procedures;
- \* Failure of local anesthesia;
- \* Documented medical complications; and
- \* Acute infection that would preclude the efficacy of local anesthesia.

For cases requiring sedation or general anesthesia, Providers must document the following in the Participant's chart for appropriate psychosomatic disorders: diagnosis, description of past evidence of situational anxiety or uncontrolled behaviors, and in the case of referral due to uncontrolled behavior, the name of the referring dentist or provider group. Apprehension alone is not typically considered medically necessary. DentaQuest or HFS may elect to perform chart audits on these services. Services not documented as required may be denied for payment. General anesthesia, intravenous sedation, conscious sedation and nitrous oxide are only covered in conjunction with a covered dental procedure. Payment for any one of these services precludes payment for the remaining procedure codes. Payment for general anesthesia, conscious sedation or intravenous sedation includes any other drugs administered on the same day.

Reimbursement for local anesthesia is included in the fee for the procedures.

Procedure code D9310 – consultation, will only be reimbursed to a dentist other than the one providing definitive treatment. A consultation includes an examination and evaluation of the patient, and a written report from the consultant to the treating dentist. When billing for a consultation, a copy of the written report must be attached. When the consulting dentist also performs services, reimbursement to that dentist will be limited to the actual services performed. There will not be a separate reimbursement for a consultation.

Procedure code D9999 is to be utilized to submit a request for reimbursement for a dental service not otherwise described herein. Request should include a description of the service, medical necessity, a proposed fee and any pertinent radiographs.

In accordance with the Illinois Dental Practice Act as defined in the Illinois Administrative Code 1220.500, procedure codes D9239, D9243 and D9248 require a dental sedation permit A or dental sedation permit B in order to perform service.

Procedure code D9222 and D9223 requires a dental sedation permit B in order to perform service.

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

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	One of (D0140, D9110) per 1 Day(s) Per Business. Not covered with D0140 on same date of service.	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per Business. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per Business. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	As Medically necessary. Permit B is required. Not allowed on the same date of service as D9230, D9239, D9243 or D9248. no limit (D9223) per Day(s) Per Business.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Limited to patients who are extremely apprehensive, mentally or physically handicapped, or those having extensive treatment in a single appointment. Permit A or B is required. Not allowed on same date of service as D9222, D9223, D9230, or D9243.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No		
D9610	therapeutic drug injection, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9630	other drugs and/or medicaments, by report	21 and older		Yes	Name of drug and amount administered.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	

**Exhibit L Benefits Covered for  
IL Molina - Medicaid Adult**

**Adjunctive General Services**

<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	Must be an emergency. Must be billed with a D0140. Must be billed with a Place of Service of 02 or 10.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	Description of service and narrative of medical necessity.	narrative of medical necessity

**Exhibit AB Benefits Covered for  
Pregnant Women - All Groups**

In addition to the codes covered for Adults - Age 21 and older, the following codes are covered for Pregnant Women. These services are available during the term of pregnancy until the date of delivery.

Claims for pregnant women must be submitted with the word "Pregnant" in the Remarks field (Box 35) of the ADA claim form. If the word "Pregnant" is not included on the claim form, these additional covered services will deny.

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

Diagnostic						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation	21 and older		No	One of (D0120) per 6 month(s) per patient.	

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1110	Prophylaxis - adult	21 and older		No	One of (D1110, D4355) per 6 month(s) per patient. Removal of plaque, calculus and stains from tooth surfaces. Intended to control irrational factors.	

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 months per patient per quadrant. One full mouth service is covered every 24 months.	Pre-op x-ray(s), perio charting
D4342	Periodontal scaling and root planing - 1 - 3 teeth, per quadrant	21 and older	Per quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 months per patient per quadrant. One full mouth service is covered every 24 months.	Pre-op x-ray(s), perio charting
D4355	Full mouth debridement to enable comprehensive periodontal evaluation	21 and older		No	One of (D1110, D4355) per 6 month(s) per patient.	



**Exhibit AC FQHC Denture Billing  
- IL Humana & Meridian**

Complete and Partial Dentures (FQHCs only)

For an approved complete or partial denture, a FQHC provider may be reimbursed for procedure code D5899 a maximum of three (3) times per plate. Partial dentures are limited to children age 2 through 20 only. Complete dentures are allowed for both children and adults. Procedure code D5899 will not reimburse separately when billed with another covered procedure.

Procedure code D5899 is to be used for visits for denture impressions and denture adjustments prior to the denture being placed and for necessary adjustments, repairs, or relines during the six (6) month period following the delivery of a new prosthesis. Providers must provide a narrative of the services performed at the time procedure code D5899 is billed.

Providers should submit payment for completed denture (Procedure Codes D5110, D5120, D5211, D5212, D5213, or D5214) at the time the prosthesis is delivered.

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

<b>Removable Prosthodontic Services</b>						
<b>Code</b>	<b>Description</b>	<b>Age Limitation</b>	<b>Teeth Covered</b>	<b>Authorization Required</b>	<b>Benefit Limitations</b>	<b>Documentation Required</b>
D5899	Unspecified removable Prosthodontic procedure	None		Yes	Maximum of three visits per approved denture.	Narrative of service performed