

DentaQuest[®]

a Sun Life company

Office Reference Manual



PO Box 2906

Milwaukee, WI 53201-2906

855.225.1731

www.dentaquest.com

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DentaQuest Address and Telephone Numbers

Provider Services

PO BOX 2906

Milwaukee, WI 53201-2906

855.225.1731

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

Eligibility or Benefit Questions:

denelig.benefits@dentaquest.com

To reach IVR directly, dial 855.398.8411 and press 1 for eligibility

Electronic Claims Questions:

EDITeam@greatdentalplans.com

1.800.417.7140

Member Services

855.225.1729

Hearing Impaired/TTY:

TDD (Hearing Impaired)

Dial 711s

Fraud Hotline

800.237.9139

Authorizations should be sent to:

DENTAQUEST - CO

PO BOX 2906

Milwaukee, WI 53201-2906

Claims should be sent to:

DENTAQUEST- CO

PO BOX 2906

Milwaukee, WI 53201-2906

Electronic Claims should be sent:

Direct entry on the web – www.dentaquest.com

Or

Via Clearinghouse – Payer ID CX014

Include address on electronic claims –

DentaQuest

PO BOX 2906

Milwaukee, WI 53201-2906



DentaQuest USA Insurance Company, Inc. (DentaQuest) Overview

DentaQuest and The Department of Health Care Policy and Financing (“HCPF” or “the Department”) periodically modifies the dental benefits and services. Therefore, the information in this manual is subject to change, and the manual is updated on quarterly basis; January 1, April 1, July 1 and October 1.

Important: The scope of dental benefits and services are significantly different for members age 20 and under, members age 21 and older, and non-citizens. Please review each section of this document carefully before rendering any services.



Statement of Members' Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring that all members are treated in a manner that respects their rights and acknowledges its expectations of members' responsibilities. The following is a 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 providers and dental offices, as well as member's 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 members' rights and responsibilities policies.
8. All members have the right to ask that a specific provider be added to the participating network.
9. All members have the right to request and receive a copy of your medical /dental records and to request that they be changed or corrected.
10. All members have the right to exercise your rights without being treated differently.
11. All members have the right to be free from any form of restraint or seclusion used to convince you to do something you may not want to do, or as punishment.
12. Any other rights guaranteed by law, for example, the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA).
13. Be free from discrimination based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, disability or health status.
14. Ask your health plan for help if your provider does not offer a service, you need because of moral or religious reasons.
15. Get quality health care services in a timely and coordinated way.

Likewise:

1. All members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its providers need 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 conditions and

developing mutually agreed upon treatment goals to the degree possible.

4. All members have the responsibility to know their medication(s) and inform the provider of their medication(s).
5. All members have the responsibility to make sure to understand information and instructions given by your provider. Ask questions when you do not understand or want to learn more.
6. All members have the responsibility to be courteous to the provider and to other patients by arriving 10 minutes early for their appointment and to call the dental office at least 24 hours in advance if they cannot keep their appointment.
7. Treat other members, providers and their staff with respect.
8. Pay for services you get that are not covered by Health First Colorado.
9. Invite people who will be helpful and supportive to you to be included in your treatment.
10. Report suspected member or provider fraud or abuse to Member Fraud at **844-475-0444** or Provider Fraud at **855-375-2500** or go to [CO.gov/hcpf/how-report-suspected-fraud](https://www.co.gov/hcpf/how-report-suspected-fraud)



Statement of Provider Rights and Responsibilities

Providers shall have the right to:

- Communicate with patients regarding dental treatment options.
- Recommend a course of treatment to a member, even if the course of treatment is not a covered benefit or approved by Plan/DentaQuest. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the 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.
- File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.
- Supply accurate, relevant, information to a member in connection with an appeal or complaint filed by the member.
- Object to policies, procedures, or decisions made by Plan/DentaQuest.
- Maintain a current copy of the DentaQuest office reference manual (the manual is updated on a quarterly basis).
- Keep provider enrollment information current with the fiscal agent.
- Submit claims correctly to DentaQuest.
- Follow the procedures and guidelines for program participation established by the Department.

The Department of Health Care Policy and Financing (HCPF) manages the Health First Colorado and Child Health Plan *Plus* dental programs. HCPF creates dental policy using a number of factors including stakeholder engagement and rules adopted by the Medical Services Board. DentaQuest operationalizes these policies and manages the day-to-day operations of the dental benefit programs. To find out more about the Medical Service Board and stakeholder engagement, click here: <https://hcpf.colorado.gov/medical-services-board> [hcpf.colorado.gov]

DentaQuest makes every effort to maintain accurate information in this manual. This manual is updated on a quarterly basis by DentaQuest. We will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error at CODQ@dentaquest.com.so

DentaQuest's commitment To Culturally Competent care

DentaQuest is committed to ensuring that its staff and participating providers, as well as its policies and infrastructure meet the diverse needs of all members and follows National Standards on Culturally and Linguistically Appropriate Services (CLAS).

DentaQuest requires its providers to adopt all fifteen National Standards on Culturally and Linguistically Appropriate Services ("CLAS Standards") in health care to promote equity through clear plans and strategies, eliminate health disparities, and improve the quality of services and primary care outcomes for members.

Principal CLAS Standard

CLAS Standard One: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Cultural competence impacts every aspect of care and service throughout the organization including all dental plans and the provider network.

Theme one — Governance, Leadership, and Workforce

CLAS Standard Two: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

CLAS Standard Three: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

CLAS Standard Four: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

The cornerstone of the Cultural Competency Program is the commitment to establishing clinical, network, and operational policies to support ongoing assessment and improvement of health equity. DentaQuest believes that recruiting a workforce and provider network that reflect the communities in which it operates ensures that members feel welcome and that their values are respected.

Theme two — Communication and Language Assistance

CLAS Standard Five: Offer language assistance, at no cost, to individuals who have limited-English proficiency and/or other communication needs to facilitate timely access to health care and services.

CLAS Standard Six: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. Language assistance options are available in many different languages and dialects and are available at no cost to the member, including in provider offices.

CLAS Standard Seven: Ensure the competence of individuals providing language assistance and recognize that the use of untrained individuals and/or minors as interpreters should be avoided. DentaQuest contracts with Certified Languages International to accommodate enrollees that speak other languages. In addition, DentaQuest has dedicated TTY lines during to assist hearing impaired callers.

CLAS Standard Eight: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. To ensure materials are culturally appropriate and meet cultural competency requirements, an internal team reviews all materials available to members. The review is conducted by subject-matter experts in Compliance, Complaints & Grievances, Client Engagement, Legal and other departments as necessary.

Theme three — Engagement, Continuous Improvement, and Accountability

CLAS Standard Nine: Establish culturally and linguistically appropriate goals, policies and management accountability and infuse them throughout the organization's planning and operations.

CLAS Standard Ten: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

CLAS Standard Eleven: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and inform service delivery.

Providers are surveyed quarterly to determine their cultural capabilities and sensitivity to cultural awareness such as whether they can speak languages other than English, treat special needs enrollees, and accommodate handicapped enrollees. In developing the surveys, DentaQuest considers the cultural, ethnic, racial, and linguistic needs of the members and the providers that serve our members. This in-depth analysis allows DentaQuest to review and update service programs, processes, and resources to address the health care needs of members. In accordance with the federal law, protected health information is kept safe for our members, and we inform our members of what we do to keep it safe in writing or on the computer.

CLAS Standard Twelve: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

CLAS Standard Thirteen: Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

CLAS Standard Fourteen: Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

CLAS Standard Fifteen: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.



NONDISCRIMINATION NOTICE

DentaQuest complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DentaQuest does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DentaQuest:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call customer service 1-855-225-1729. If you believe that DentaQuest has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Compliance Department
96 Worcester Street, Wellesley, MA 024814
Fax: 617-886-1390 Phone: 800-417-7140
Email: FairTreatment@greatdentalplans.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ugonna Onyekwu is available to help. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can file a complaint electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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1.00 Patient Eligibility Verification Procedures

1.01 Plan Eligibility

Members who are enrolled in Health First Colorado (Colorado's Medicaid program) are eligible for dental benefits. The member's County Department of Human/Social Services establishes member eligibility for Health First Colorado benefits. Case managers advise potential members of proper application procedures and Health First Colorado benefits, and they also provide a brochure. To find a list of Colorado Human Services in your county, go to <https://www.colorado.gov/pacific/cdhs/contact-your-county>

1.02 State Plan Adult Benefit

Adult members may benefit from any approved covered dental benefit per state fiscal year (July 1 through June 30.) Frequency limitations, prior authorizations and pre-payment reviews apply.

Note: there is no limit for children's services (member 21 years old and under) that are medically necessary.

Please reference [Section 5.00](#) Adult State Plan Health First Colorado Dental Benefit (Non-Emergent) for additional information.

1.03 Home and Community Based Services (HCBS) Waiver Eligibility – IDD Programs

In addition to the State Plan adult benefit, adult waiver participant members age 21 and over may receive up to \$2,000 in basic/preventative dental benefits per individualized Service Plan year. IDD adult waiver participant members may also receive up to \$10,000 in major dental benefits over the 5-year lifespan of the Waivers (July 1, 2024- June 30, 2029). Please reference Appendix B, Exhibit C Health First Colorado IDD Program - 21 and Over Benefit Table for the listing of dental procedures that basic/preventative and major dental benefits.

The HCBS-DD and SLS waiver participant adult members have access to two dental benefit plans through Health First Colorado- the State Plan and the Waiver Plan. The State Plan benefit is the first payer and the waiver benefit is the secondary payer. The information below details the differences in the IDD plan dental benefit. All other sections of this ORM pertain to the management of the IDD members' benefit.

State Plan Limits for IDD Adult Waiver Participant Members

- Same benefit as general Health First Colorado population (please reference Appendix B, Exhibit B)

DD Waiver Program Limits for IDD Adult Waiver Participant Members

- \$2,000 basic/preventative benefit per service plan year (varies per individual Service Plan year)
- \$10,000 major benefit per lifetime of waiver (July 1, 2024- June 30, 2029)
- Additional covered procedures (please reference Appendix B, Exhibit C)

Not all adults with intellectual and developmental disabilities are in the IDD program. The adult must be enrolled with Health First Colorado and HCPF must determine and enroll them into the IDD program for the member to receive IDD benefits.

1.04 Member Identification Card

After member eligibility is established, the county issues a unique State Identification (State ID) number and members receive identification cards from DentaQuest. Participating Providers are responsible for verifying that members are eligible at the time services are rendered and to determine if members have other health insurance.

Always verify eligibility using the Health First Colorado provider portal **before** rendering services.

Please note that due to possible eligibility status changes, this card does not guarantee payment and eligibility status is subject to change without notice.

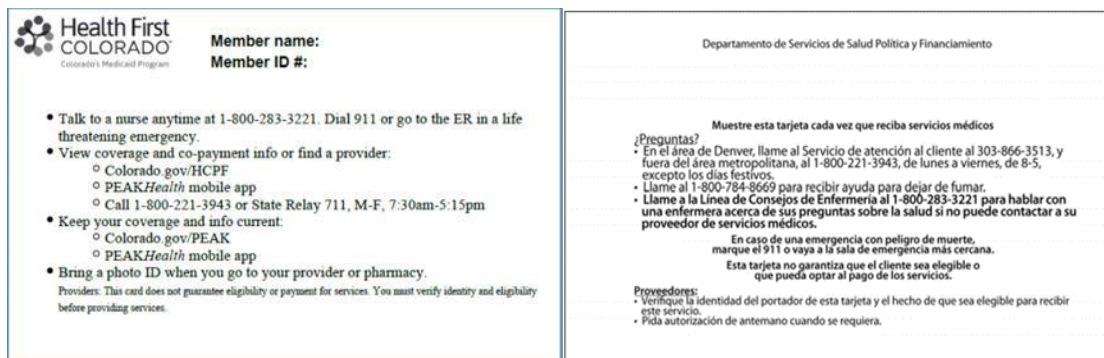
DentaQuest recommends that each dental office make a photocopy of the member's identification card each time treatment is provided. It is important to note that the DentaQuest identification card is not dated, and it does not need to be returned to DentaQuest should a member lose eligibility.

Sample of I.D. Card



office provided. need to lose

Health First Colorado ID Card:



In March of 2016, the Department began issuing Medical Identification Cards with a new look. A sample of the front and back of the new card is shown above. The new cards do not replace DentaQuest cards issued before March of 2016. Please accept both versions.

1.05 Verifying Member Eligibility

Always verify eligibility with the Health First Colorado provider portal before rendering services. Records of eligibility should be retained for billing purposes. It is critical for providers to always check the eligibility response on the day of each visit as eligibility may change. Eligibility verification is available electronically, 24 hours a day, 7 days a week. Eligibility information is updated daily, except for weekends and State holidays.

Providers may verify eligibility through one of the following means:

1. HIPPA 270/271 Health Care Eligibility Benefit Inquiry and Response

The HIPPA 270/271 Health Care Eligibility Benefit Inquiry and Response transaction is designed to allow providers to obtain member eligibility information using electronic data transfer. The HIPPA 270/271 eligibility verification system provides:

- Date span verification
- Eligibility Status
- Ability to print eligibility responses

Specific directions on how to submit a 270 eligibility inquiry and what to expect in the 271 eligibility response may be found in the 270/271 Companion Guide located in the Provider Services section <https://hcpf.colorado.gov/edi-support> [hcpf.colorado.gov]

2. Health First Colorado Provider Portal:

This portal is the system of record for member eligibility, not the DentaQuest Portal. To access the Provider Web Portal, go to [Colorado Provider Portal > Home](#)

Verifying Eligibility and Managed Care Assignment Details:

Providers must check the Managed Care Assignment Details box to determine member enrollment and eligibility.

The following language will appear for Medicaid:

Managed Care Plan: "Administrative Service Organization Dental

Provider Name: "DentaQuest USA Insurance Co Inc".

The following language will appear for CHP:

Managed Care Plan: "Child Health Plan Plus- Dental" Provider Name: "DentaQuest USA" (If "DentaQuest USA" does not appear in this box, then the member does not currently have dental coverage, and claims will not be processed.

When a member is enrolled in either program, dental coverage can take up to 30 days to be effective.

NOTE: On rare occasions, due to member eligibility requirements/qualifications, a member may initially show as enrolled in Medicaid and eligibility later updated to CHP+ enrollment by Health Care Policy and Financing (or vice versa).

See the examples below:

Example #1: This record shows the member is eligible for Medicaid but is still enrolled in CHP+. ("Medicaid" appears in the Benefit Details section, however, "CHP+" appears in the Managed Care

Assignment Details box. This claim will pay under CHP+ because the member is still enrolled in that program).




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Eligibility Verification

[Eligibility](#) > [Eligibility Verification](#) > Coverage Details Monday 02/08/2021 12:40 PM MST

Provider Name DENVER HEALTH MEDICAL PLAN **Provider ID** Managed Care - 99999908 **Location** 99999908 - DENVER HEALTH MEDICAL PLAN

[Print Preview](#)

Coverage Details

Coverage Details for Member ID [REDACTED]
Eligibility Verification Response Guarantee Number [REDACTED] [Expand All](#) | [Collapse All](#)

Demographic and Copay Details

Mailing Address [REDACTED] **City** [REDACTED] **State** Colorado **Zip Code** 80233-4617
Copay Status Exempt
Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
+	TXIX	Medicaid State Plan - HH	01/29/2021	01/29/2021
+	BHO+B	Behavioral Health Benefits - HH	01/29/2021	01/29/2021

Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 27474241	Child Health Plan Plus	COLORADO ACCESS	01/29/2021	01/29/2021
None/ 9000171765	Child Health Plan Plus - Dental	DENTAQUEST USA	01/29/2021	01/29/2021

 **R05.00.308** [Privacy Notice](#)

Example #2: This record shows the member is eligible for CHP+ but is still enrolled in Medicaid. (“CHP+” appears in the Benefit Details section, however, “Medicaid” is indicated in the Managed Care Assignment Details box. This claim will pay under Medicaid because the member is still enrolled in that program.)



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Eligibility Verification

[Eligibility](#) > [Eligibility Verification](#) > Coverage Details Friday 03/12/2021 01:58 PM MST

Provider Name DENVER HEALTH MEDICAL PLAN **Provider ID** Managed Care - 99999908 **Location** 99999908 - DENVER HEALTH MEDICAL PLAN

[Print Preview](#)

Coverage Details

Coverage Details for Member ID [REDACTED]
Eligibility Verification Response Guarantee Number [REDACTED] [Expand All](#) | [Collapse All](#)

Demographic and Copay Details

Mailing Address [REDACTED] **State** Colorado **Zip Code** 80010-3439
Copay Status Max Met

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.

Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details


	Coverage	Description	Effective Date	End Date
+	CHP+B	Child Health Plan Plus - N1	02/01/2021	02/01/2021

Managed Care Assignment Details


NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 23876239	Denver Health Medicaid Choice	DENVER HEALTH MEDICAID CHOICE	02/01/2021	02/01/2021
None/ 99999908	REGIONAL ACCOUNTABLE ENTITY	DENVER HEALTH MEDICAL PLAN	02/01/2021	02/01/2021
None/ 16374576	Administrative Service Organization - Dental	DENTAQUEST USA INSURANCE CO IN	02/01/2021	02/01/2021

 R05.00.311 [Privacy Notice](#)

Example #3: This example demonstrates eligibility and enrollment for Medicaid. (“Medicaid” appears in the Benefit Details section and “Medicaid” also appears in the Managed Care Assignment Details box):



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Eligibility Verification

[Eligibility](#) > [Eligibility Verification](#) > Coverage Details

Wednesday 02/10/2021 01:14 PM MST

Provider Name COLORADO ACCESS RAE 5 **Provider ID** Managed Care - 99999905 **Location** 99999905 - COLORADO ACCESS RAE 5

[Print Preview](#)

Coverage Details

Coverage Details for Member ID [REDACTED]

Eligibility Verification Response Guarantee Number [REDACTED]

[Expand All](#) | [Collapse All](#)

Demographic and Copay Details

Mailing Address [REDACTED]

City [REDACTED] **State** Colorado **Zip Code** 80601-2970

Copay Status Copay Due

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.


Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
+	TXIX	Medicaid State Plan - BJ	02/10/2021	02/10/2021
+	BHO+B	Behavioral Health Benefits - BJ	02/10/2021	02/10/2021

Managed Care Assignment Details


NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 99999908	REGIONAL ACCOUNTABLE ENTITY	DENVER HEALTH MEDICAL PLAN	02/10/2021	02/10/2021
None/ 23876239	Denver Health Medicaid Choice	DENVER HEALTH MEDICAID CHOICE	02/10/2021	02/10/2021
None/ 16374576	Administrative Service Organization - Dental	DENTAQUEST USA INSURANCE CO IN	02/10/2021	02/10/2021



R05.00.308

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Example #4: This record is valid proof of eligibility and enrollment for CHP+. (“CHP+” appears in the Benefit Details section and “CHP+” also appears in the Managed Care Assignment Details box):



COLORADO
Department of Health Care
Policy & Financing



Health First
COLORADO
Colorado's Medicaid Program
[Contact Us](#) | [Logout](#)

[Home](#) | [Eligibility](#) | [Resources](#)

Eligibility Verification

[Eligibility](#) > [Eligibility Verification](#) > Coverage Details Friday 03/12/2021 02:19 PM MST

Provider Name CCHA, LLC RAE 6
Provider ID Managed Care - 99999906
Location 99999906 - CCHA, LLC RAE 6

Print Preview

Coverage Details

Coverage Details for Member ID
 Eligibility Verification Response Guarantee Number

[Expand All](#) | [Collapse All](#)

Demographic and Copay Details

Mailing Address **City** **State** Colorado **Zip Code** 80229-4647

Copay Status Copay Due

Due to the timing of when claims are submitted and paid, it is possible that the member's Copay Status may change. This eligibility verification is NOT a guarantee of the copay status or copay due.


Click '+' to expand and view copay amounts. Click '-' to collapse.

Benefit Details

	Coverage	Description	Effective Date	End Date
+	CHP+B	Child Health Plan Plus - N1	02/01/2021	02/01/2021

Managed Care Assignment Details

NPI/MCD	Managed Care Plan	Provider Name	Effective Date	End Date
None/ 27474241	Child Health Plan Plus	COLORADO ACCESS	02/01/2021	02/01/2021
None/ 9000171765	Child Health Plan Plus - Dental	DENTAQUEST USA	02/01/2021	02/01/2021


R05.00.311
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Verifying Third-Party Liability Coverage

For Commercial Insurance, Health First Colorado is always the payer of last resort. Providers must be enrolled with and bill the commercial insurance as the primary payer before submitting claims to DentaQuest.

To see Third Party Liability (TPL) coverage (including Medicare), return to the Eligibility Verification page.

[Home](#) | [Eligibility](#) | [Claims](#) | [Care Management](#) | [Resources](#) | [Switch Provider](#)

Eligibility Verification

[Eligibility](#) > Eligibility Verification > Coverage Details Tuesday 06/04/2019 12:04 PM MST

Scroll to the bottom of the page and click "Other Insurance Detail Information."

Eligibility Verification Information for		from 06/28/2024 to 06/28/2024	
Member ID	Birth Date 01/01/1980	Gender Female	
Coverage	Effective Date	End Date	
Medicaid State Plan	01/01/2014	12/31/2299	
Medicaid Behavioral Health Benefits	01/01/2014	12/31/2299	
Alternative Benefit Plan	01/01/2014	12/31/2299	
Other Insurance Detail Information			

This is where other insurance coverage (including Medicare coverage) is displayed:

Other Insurance Information for Member ID						Back to Eligibility Verification		
* Indicates a required field.								
Click '+' to view details in a row. Click '-' to collapse the row.								
Carrier Name (Carrier ID)	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Effective From	Effective To	
Medicare A (1)						10/01/2010	12/31/2299	
Medicare B (2)						10/01/2010	12/31/2299	
Other Insurance Carrier Information								
Carrier 2 - Medicare B								
Policy ID			Group ID					
Policy Type								
Coverage Type								
Effective From 10/01/2010			Effective To 12/31/2299					
Other Policy Holder Information								
Relationship Self								
Save		Reset						

For more information on how to verify member eligibility in the Provider Web Portal, refer to the **Verifying Member Eligibility and Co-Pay Provider Web Portal Quick Guide** by going to this link: [Quick Guides | Department of Health Care Policy and Financing](#)

Providers may visit the Department's website for recorded webinars and training on the Health First Colorado Portal [Provider Training | Department of Health Care Policy and Financing](#)

3. Health First Colorado Eligibility Response System (CMERS)/ Interactive Voice Response System (IVRS)

IVRS is an automated voice response system that furnishes dental providers with:

- Unlimited Health First Colorado eligibility verification inquiries
- Eligibility for service by type
- Eligibility date spans
- Co-payment status
- Third party liability

- Managed care enrollment

To access the **CMERS/IVRS**, providers may call toll free:844-235-2387.

4. DentaQuest Provider Portal

Note: The DentaQuest Provider Portal is not the system of record. Any eligibility information obtained through this portal may not align with the HCPF provider portal.

Access the DentaQuest provider portal by visiting <https://provideraccess.dentaquest.com>. Providers will then be able to log in using their password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. Providers who have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Service Department at 855.225.1731.

Eligibility information is updated daily from files sent by Health First Colorado, except for weekends and State holidays. The eligibility information received from the DentaQuest Provider Portal will be the same information received by calling DentaQuest's Customer Service department. Providers may use the provider portal to obtain information 24 hours a day, 7 days a week, without having to wait for an available Customer Service Representative.

Providers can view the member's eligibility by entering the member's date of birth, the expected date of service and the member's identification number or last name and first initial.

5. DentaQuest Interactive Voice Response (IVR) System

To access the IVR, providers may call DentaQuest's Customer Service Department at 855.398.8411. At the prompt, enter your NPI number the last 4 digits of your Tax ID Numbers. The remainder of the IVR system is activated by voice prompts.

DentaQuest IVR system can provide the following information:

- Eligibility (prompt 1)
- Benefits or history (prompt 2)
- Claims (prompt 3)
- Authorizations (prompt 4)
- Help (prompt 5)
- Web portal Other (prompt 6)

Please note that due to possible eligibility status changes, verification of eligibility information by either system is not a guarantee of payment.

If you are having difficulty accessing either the DentaQuest IVR or website, please contact the DentaQuest Provider Service Department at 855.225.1731. They will be able to assist you in utilizing either system.

For further questions regarding member coverage verification please contact your DentaQuest Provider Relations Representative:

Northeastern Colorado and Denver Metro

Davis Edge 720.985.1167

Davis.Edge@DentaQuest.com

Northwestern Colorado

Natalie Archuleta 303.241.5183

Natalie.Archuleta@Dentaquest.com

Southwestern Colorado and FQHC

Cristal Chavez 970.210.6250

Cristal.Chavez@dentaquest.com

Southeastern Colorado

Abe Chavez 719.828.8897

Abe.Chavez@dentaquest.com

Network Manager Supervisor

Jennifer Labishak 719.313.0481

Jennifer.Labishak@DentaQuest.com

Network Managers can be reached Monday-Friday 8:00am-5pm MST

Delayed/Retroactive Eligibility

In some instances, a member's eligibility is determined to commence prior to the date the member submitted an application – this is delayed/retroactive eligibility. Charges for services are the member's responsibility until eligibility is established. (Example: A member is "pending" Health First Colorado eligibility. The member receives services prior to the determination of eligibility. The member is responsible for payment for services until the eligibility determination is final. If the client is subsequently determined to have been eligible on the date of service, the provider may submit claims for the date of service to Health First Colorado/DentaQuest). Claims are denied if the member's eligibility status is not available through eligibility verification methods. See Timely Filing in section 4.11 for more information.

Special Eligibility Programs

Qualified Medicare Beneficiaries

Elderly and disabled Medicare beneficiaries with incomes below the Federal poverty level and resources at twice the Supplemental Security Income (SSI) level are eligible for Health First Colorado payment of Medicare deductibles and coinsurance. These individuals are called Qualified Medicare Beneficiaries (QMBs). If QMBs are not also eligible for Medicaid, benefits are limited to the coverage of the Medicare coinsurance and deductibles for all Medicare-covered services. These members do not qualify for dental program benefits. For QMBs who are also eligible for Medicaid, ("QMB dually eligible"), Health First Colorado benefits include all Health First Colorado covered services, including dental benefits, as well as the coinsurance and deductibles for all Medicare-covered services.

Non-Citizens

Non-citizens are individuals who are in the United States for educational or visitation purposes, for employment purposes permitted with a visa, or for unknown reasons and without status verification documents.

Application Procedures for non-citizens

Non-citizens must apply for assistance through the county where they live and must meet Health First Colorado Program eligibility requirements. Because non-citizens may be reluctant to apply for government assistance, Providers are encouraged to contact the appropriate County Department of Social/Human Services office when a potentially eligible non-citizen receives emergency care services (please reference Appendix A-4 for Colorado County Departments listings for Human/Social services).

Benefits for non-citizens

Dental services for adult non-citizens are limited to emergency treatment of the oral cavity (reference section [5.01](#) – Emergency Treatment for Oral Cavity Conditions Adults). No other dental services are a benefit for adult non-citizens under any circumstances. Coverage does not include follow-up care. An unsupervised dental hygienist may not provide or receive reimbursement for dental services for a Health First Colorado non-citizen member of any age.

For more information regarding Special Eligibility Programs, please reference the Health First Colorado General Provider Information manual [General Provider Information Manual | Department of Health Care Policy and Financing](#) or on the [Department's website https://www.colorado.gov/hcpf](https://www.colorado.gov/hcpf)

1.06 Appealing Claim Denials for Eligibility

Records of eligibility should be retained for billing purposes. It is critical for providers to always check the eligibility response **on the day of each visit** as eligibility may change. If a claim is denied for eligibility by DentaQuest, the provider should first contact their provider relations representative as soon as possible for assistance. Your provider relations representative may work with the Department to address discrepancies. A provider may still appeal by submitting proof of eligibility obtained from the Health First Colorado provider portal (screenshot must be taken on the DOS). Using the appeal process detailed in ORM section 7.0. Timely filing requirements apply to claims denied due to eligibility. Please see section 4.11 for timely filing requirements.

1.07 Specialist Referral Process

A member requiring a referral to a dental specialist may be referred directly to any specialist contracted with the Department without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to the Covered Services Benefit Tables, Appendix B, Exhibits A, B and C of this manual. Providers who are unfamiliar with the contracted specialty network or need assistance locating a certain specialty may contact the Provider Service Department of DentaQuest

2.00 Authorization for Treatment

Providers can request medically necessary treatment for enrollees under 21 years of age through the EPSDT benefit. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E.

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 (please reference Clinical Criteria section). Please review these criteria as well as the Covered Services Benefit Tables, Appendix B, Exhibits A, B, and C to understand the decision-making process used to determine payment for services rendered.

Services that require prior authorization are clearly designated within the Covered Services Benefit Tables, found in Appendix B, Exhibits A, B, and C of this document. A column marked prior authorization required can be found in each benefit table. A "Yes" in this column indicates that the service listed requires prior authorization to be considered for reimbursement. Please reference these tables for a specific list of codes requiring prior authorization. Services that require prior authorization (non-emergent) should not be started prior to the determination of coverage (approval or denial of the Prior Authorization Request (PAR)). Non emergent treatment started prior to the determination of coverage will be performed at the financial risk of the dental office and the office may not balance bill the member, the Plan and/or DentaQuest.

An approved PAR is not a guarantee of payment.

Some reasons why claims may be denied even with an approved PAR are:

- Member eligibility changes.
- Member turns 21 years of age after PAR approval and moves from Child Benefits to Adult benefits.
- Program coverage differences between Medicaid and CHP+.
- Treatment changes from what was approved in the PAR.

2.02 Submitting Authorization Requests (non-emergent)

Prior Authorization requests (PAR) should include:

1. Radiographs, narrative, or other information where requested (please reference Covered Services Benefit Tables, Appendix B, Exhibits A, B, and C for specifics by code).
2. CDT codes on the current ADA claim form [here](#).

X-Ray Requirements for paper submissions of X-rays can be found [here](#).

Submitting Authorization Requests

Requests may be submitted one of the following ways:

- Electronic submission using the Provider Web Portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Mail to: DentaQuest, PO Box 2906, Milwaukee, WI 53201
 - It is recommended to send duplicates of radiographs, as they will not be returned.
 - If you would like DentaQuest to return radiographs, please include a self-addressed stamped (SASE) envelope. Note that determinations will be sent separately from the radiographs.

When a PAR is approved, the provider determination letter will include the authorization number and clearly state when the PAR expires. This is usually 180 days, and 1080 days for Orthodontia services. Services must be rendered while the PAR is active. The authorization number must be submitted along with the other required claim information after the treatment is rendered.

2.03 Expired Prior Authorizations

If services are rendered after a PAR expires, payment will be denied. It is the Providers responsibility to

make sure the PAR is in effect on the date of service (DOS). Providers may use the Provider Portal to look up the active span of a PAR. Providers may search for Prior Authorizations by the member's ID, member's name, or PAR number.

If a Provider wishes to extend the expiration date of a PAR (with the exception of Ortho PAR's which do not qualify for an extension), please request a PAR extension before the current PAR expires. Call Provider Customer Service at 855 -225-1731 to make your request or use the Provider Portal. You will receive a letter by mail or fax with the approval or denial of the extension, along with the new expiration date. The length of time a provider may extend a PAR varies depending on the specific service.

2.04 Authorization and Emergency Treatment

DentaQuest recognizes that emergency treatment may not permit prior authorization to be obtained prior to treatment. In these situations when services that normally require prior authorization is rendered under emergency conditions; the **claim** submission must contain the same documentation that would be included with the prior authorization request. It is essential that the Participating Provider understand that claims for emergency treatment sent without this "documentation" and the word "Emergency" in box 35 will be denied. Please reference the adult emergency code table in Section 5.01 for a list of codes. Authorization and documentation submitted with claim, after non-emergency services are rendered - **Pre-Payment Review (PPR)**

2.05 Pre-Payment Review (PPR)

In an effort to allow greater freedom for Participating Providers to appropriately treat a member in a timely manner, DentaQuest performs pre-payment review (PPR) on many types of covered services in lieu of requiring a Prior Authorization Request (PAR). The Department determines which covered services can utilize PPR so that Participating Providers can treat the member and submit the required documentation with the claim for reimbursement after the services have been rendered. DentaQuest will complete medical necessity review using the same clinical criteria as PARs. By utilizing the PPR process, the Department and DentaQuest aim to eliminate any delay in treating the member, as well as eliminating the need for a two-step process for payment. Participating Providers must consult the Covered Services Benefit Tables in Appendix B, Exhibits A, B, and C to determine which services are available for PPR and those services which a PAR is required before services are rendered. The required documentation necessary to support the medical necessity review under the PPR process can also be found in the benefit tables in Exhibits A, B, and C. When submitting for PPR, the same required documentation must be attached as if submitting for PAR.

2.06 Electronic Attachments

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, periodontics charts, intraoral pictures, narratives, and Explanations of Benefits (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 or call NEA at: 800.782.5150.

3.00 Participating Hospitals

Providers are required to administer outpatient services at the Department's participating hospitals and ambulatory surgery centers. The provider should submit planned services to DentaQuest via the prior authorization request (PAR) process to obtain medical necessity authorization for use of a hospital facility or Ambulatory Surgical Center (ASC). Services cannot be rendered until after the PAR is approved. Please reference the Provider Determination Letter for specific dates. The facility's name and address

should be included in Box 35 of the PAR submission form. Upon receipt of approval from DentaQuest, the provider should contact the hospital, ASC, etc. at which he/she has the appropriate staff privileges for facility authorization. For more information, please reference Section 15.14 Clinical Criteria for PAR of Hospital or Outpatient Facility. Participating Hospitals may change. Please visit the [Department's website](#) for a current listing and select hospital under the "Find Providers by Type" drop down.

4.00 Claim Submission Procedures

Effective May 3, 2024, place of service 03 is an allowed place of service for all fee-for-service benefits. For community providers to bill fee-for-service to children in a school setting, the provider must follow school district policy. Please reference the Community Providers in a School Setting Policy memo.

DentaQuest accepts dental claims in four formats.

Providers may submit claims in the following ways:

4.01 Electronic Claim Submission Utilizing DentaQuest's Provider Web Portal

To submit claims via the portal, simply log on to [Provider Web Portal](#). 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. Your DentaQuest [network manager](#) should have contacted your office and provided instructions on how to register for the portal. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry ". The provider 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 portal, please contact your DentaQuest [network manager](#); or our Systems Operations at 1.800.417.7140; or via email at EDITeam@greatdentalplans.com.

4.02 Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Claim Remedi/Waystar at 800-763-8484; TriZetto at 800-969-3666; Vyne Dental at 866-712-9584; EDS at (651)480-8090; AthenaHealth at (360) 317-9677; and DentalXChange at 877-932-2567 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 Payer ID is CX014.

4.03 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 to inquire about this option for electronic claim submission.

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 provider web portal.

4.04 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards:

- Providers must register for the appropriate NPI classification at the following website <https://npiregistry.cms.hhs.gov/search> 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 enter all NPI numbers accurately for claims to be accepted. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPIs. These numbers are not interchangeable and could cause your claims to be denied.

4.05 Paper Claim Submission

Claims must be submitted on a [current claim form](#) filled out accurately and in its entirety per ADA claim form instructions. If you have questions about filling out the paper claim form, contact your [network manager](#).

Claims should be **mailed** to the following address:

DentaQuest - CO
P.O. BOX 2906
Milwaukee, WI 53201-2906

Or **Fax** to 262.834.3589

4.06 Submitting Claims with Attachments

Attachments such as x-rays, photos, charts, and reports can be submitted electronically with claims.

Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the “Learn More” button. Attachments can also be included with claims submitted through the DentaQuest provider web portal.

Requirements for paper submission can be found [here](#).

4.07 Coordination of Benefits

Health First Colorado is always the payer of last resort. Providers are responsible for checking eligibility in the HCPF portal (the system of record) which includes third party liability (TPL) information. Please reference section 1.05 of the ORM for checking TPL.

When members have other insurance, any other carrier’s Explanation of Benefits (EOB) must be submitted with the claim. The primary carrier’s EOB must include the member’s information, name of the primary insurance carrier, submitted codes, and denial reason, if applicable. For claim submissions, the payment made by the primary carrier must be indicated in the appropriate Coordination of Benefits (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 Receipt and Audit of Claims

To ensure timely, accurate remittances to each provider, DentaQuest performs an audit of all claims upon receipt. This audit validates member eligibility, procedure codes and provider identifying information. A DentaQuest benefit analyst analyzes any claim condition(s) 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 your network manager or 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 (EOB) report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered. For questions about information contained in EOB's please contact your [network manager](#).

4.09 Payment for Non-Covered Services

Participating providers agree to accept DentaQuest payment as payment in full for covered services. Colorado law prohibits providers from billing Health First Colorado members for covered services. Please see the [Health First Colorado policy statement](#) regarding billing members for more information.

Member billing is prohibited for the following:

- Covered services. A covered service is defined as:
 - Services listed in the benefit tables of the DentaQuest Health First Colorado Office Reference Manual (ORM) Appendix B, Exhibits A, B, and C.
- Personal Protective Equipment (PPE). Providers are prohibited from charging members for PPE costs through copayments, visit surcharges, lab fees, or any other means.
- Orthodontics. Accepting DentaQuest payment for orthodontia is considered payment in full and you may not balance bill members for additional services, supplies, or materials that are not medically necessary or requested by the member for cosmetic reasons.
- Participating providers may not bill members for missed appointments, telephone calls, completion of claim forms or medication refill approvals.
- Members may not be billed if the failure to obtain claim payment from DentaQuest is caused by the participating provider's failure to comply with the DentaQuest program billing procedures.
- Collection agencies cannot collect payment from a member.

Constraints against billing members for covered services apply whether DentaQuest makes or has made payment and whether the provider participates in the DentaQuest provider network.

Participating providers may bill a member for non-covered services. A non-covered service is: Any dental procedure code that is not listed as a covered benefit in the ORM

OR

Any dental procedure code listed as a covered benefit in the ORM that has been denied by DentaQuest through a prior authorization request (PAR) or a claim.

OR

Services rendered beyond the frequency limits listed in the ORM.

The following information must be included in the member written acknowledgment of financial responsibility:

- The service the member is responsible for,
- The amount owed
- The positive confirmation that the services are not covered.

A "Health First Colorado Dental Non-Covered Services Disclosure Form" template is in Appendix A, under "Forms" as a resource for providers. The participating provider may only bill the member if this form is completed and signed by the member **prior** to rendering services. (Any provider created agreement must include all the data elements listed on the Health First Colorado Dental Noncovered Services Disclosure form). DentaQuest and Health First Colorado encourage providers to bill members at or near the current Health First Colorado fee schedule amount.

- Members who obtain care outside of the contracted network may be charged for non-covered services.
- Health First Colorado is the payer of last resort. Members who have commercial insurance must obtain services from an in-network provider.

Co-Pays

Members eligible for dental services may not be billed for co-pays or deductibles when seen by a Health First Colorado participating provider. Dental Services are co-pay and deductible exempt.

4.10 Timely Filing

Original Timely Filing (365 days from DOS).

Timely filing for Health First Colorado claim submission is 365 days from the date of service or from the date of the member's primary dental insurance EOB. A claim is filed when DentaQuest documents the receipt of the claim. We encourage providers to submit claims soon after services are rendered as claims are subject to benefit limitations and payment based on the date received, not the date of service.

Electronic claims can be submitted 24 hours a day, 7 days a week on the Provider portal. When an electronic clearinghouse claim is submitted, the electronic system automatically notifies the submitting party either that the system has accepted the claim for processing, or that the system has rejected the claim due to some deficiency. These electronic acceptance and rejection messages include the transaction date, which is the date DentaQuest documents receipt of the claim.

DentaQuest documents receipt of a paper claim by assigning a Claim Number. This is captured in the "Received Data" field, viewable on the Provider Web Portal (PWP). State holidays, weekends, and dates of business closure do not extend the timely filing period. Dated claim signatures, computerized or clerically prepared claim listings, and/or postmarks and certified mail receipts do not constitute proof of receipt for timely filing purposes.

The provider is responsible for assuring that each claim is received within the timely filing period. With the exceptions of paper claims that are returned to the provider because of missing information and rejected electronic claims, all claims filed with DentaQuest appear on the Explanation of Benefits (EOB) as paid or denied within 60 days of receipt. If claim information does not appear on the EOB within 60 days of an electronic transmission or paper claim mailing, the provider is responsible for contacting DentaQuest to determine the status of the claim and resubmitting the claim if necessary.

Issues resulting in failure to transmit accurate and acceptable claims or failure to identify transmission errors in a timely manner must be addressed. Issues between the provider and the software venter, DentaQuest or clearinghouse, do not constitute an acceptable reason for late filing extension requests.

New provider enrollments, affiliations or updates are not acceptable reasons for late filing extension requests.

Eligibility Discrepancies

It is the provider's responsibility to address eligibility discrepancies within timely filing requirements. Claims denied due to a member not being covered or covered under a different plan can be resolved by contacting your DentaQuest network manager. Providers may also file an appeal. See section 4.13.

Failure to address this discrepancy within timely filing does not constitute circumstances beyond the providers control and the member cannot be billed.

Timely Filing Extensions for Circumstances Beyond the Provider's Control

Timely Filing Exceptions are granted only when the provider can document that appropriate action to meet filing requirements was taken and that the provider was prevented from filing as the result of exceptional circumstances that could not have been foreseen or controlled:

- Delayed processing by third party resources
- Delayed/retroactive member eligibility
- Delayed notification of eligibility
- Other circumstances beyond the provider's control

Employee negligence, employer failure to provide sufficient, well-trained employees, or failure to properly monitor the activities of employees and agents (e.g., billing services) are not considered extenuating circumstances beyond the provider's control. Timely filing exceptions will not be considered if the provider has not been actively trying to seek resolution of a claim within the original timely filing period.

Making false statements about timely filing compliance constitutes false claims and may subject the individual who prepares the claim and the provider to fines and imprisonment under state and/or federal law.

For extension of timely filing due to corrections of errors on claims, see section 4.12 Corrected Claims.

Delayed Processing by Other Insurers

Providers must complete third party information in the electronic claim format and retain a copy of the third-party payment or denial notice in their files. If a paper claim is required, the provider must either complete the third-party payment/denial fields, write "TPL Paid" or "TPL Denied" on the face of the claim, and retain a copy of the third-party payment or denial notice, or attach a copy of the third-party payment or denial notice to the claim. The provider is responsible for pursuing available third-party resources in a timely manner.

Delayed/Retroactive Member Eligibility

If the timely filing period expires because eligibility determination is delayed or back-dated, DentaQuest is authorized to consider the claim to be filed timely if it is received within 365 days of the date that the member's eligibility is approved. Providers will need to submit an initial claim, which will deny for timely filing. Providers must then submit the claim for appeal, via the DentaQuest appeal process. Each claim must have an attached Department-authorized form or letter from the County Department of Human/Social Services that verifies the delayed eligibility determination or backdated eligibility, and meet the following requirements:

- The document is identifiable as a county document (e.g., correspondence printed on county letterhead or an imprinted or typeset form).
- The appeal narrative states specifically that eligibility was delayed and/or backdated and indicates the dates of eligibility.

- The appeal states the date that such action was entered into the State's eligibility system

4.11 Corrected Claims

Providers may make corrections to claims during the timely filing period. For a claim to be treated as a corrected claim, it must be submitted within 365 days from the date of service, or within 60 days from the last adverse action/denial. (Please see 4.14 DentaQuest Provider appeals for an explanation of adverse actions.)

- The corrected claim must clearly state the word "Corrected" in box 35 along with the claim number of the claim you are correcting. This can be done through the provider portal under resubmit claim option, or a paper claim.
- The corrected claim must contain clear and accurate corrections to the erroneous information. (A resubmission of identical claims data is not considered a corrected claim. The corrected claim must include additional or different information.)
- If a claim is resubmitted for correction more than once, each must be submitted within 60 days of the adverse action on the previous submission.

DentaQuest will research the resubmission and adjudicate the corrected claim according to the resubmitted information. Once adjudicated, the corrected claim will appear on the provider's Explanation of Benefits (EOB) with a corresponding processing policy outlining the reason for payment or denial. Providers must maintain proof of claim submission history in their files for six years

Providers may make corrections to claims during the timely filing period. For a claim to be treated as a corrected claim, it must be submitted within 365 days from the date of service, or within 60 days from the last adverse action/denial. (Please see 4.14 DentaQuest Provider appeals for an explanation of adverse actions.)

4.12 DentaQuest Provider Appeals (60 days from original determination)

A provider who disagrees with DentaQuest's decision on a Prior Authorization Request (PAR) or with a claim determination may submit a written request for an appeal to DentaQuest that specifies the nature and rationale of the disagreement. This request *and* additional supporting information must be sent to DentaQuest within 60 days from the date of the original determination. NOTE: Overpayment recoupments listed on your EOBs will not be made for 30 days to allow for an appeal.

A Provider may request an appeal for the following adverse actions:

- A claim (EOB) or PAR rejection
- A claim (EOB) or PAR denial
- A dispute regarding the payment amount
- In accordance with 10 C.C.R. 2505-10, at Section 8.050.3, Provider Appeals Rights or in accordance with CMS in accordance with 42 C.F.R. § 447.31

The clinical appeal process is a second review by a DentaQuest Dental Director who was not involved in the original determination. This process may also be utilized for any medically necessary procedural changes that may occur mid treatment and were not included on the original PAR. These requests must be submitted by the provider within sixty (60) calendar days of the denial decision, which then goes through the following process:

- Review is completed by a dental director of the same profession and specialty as the ordering dental provider.
- Review will include all information submitted and any additional information the dental provider wishes to submit.
- Dental director may overturn or uphold the original denial decision.

Providers may submit their appeal request in one of the following ways:

Mail:

DQ Complaints and Grievances
P.O. BOX 2906
Milwaukee, WI 53201-2906

[Provider Web Portal](#)

Peer-to-Peer Process to Discuss Denial Determination

Providers may request a peer-to-peer call for any clinical denial within ten (10) calendar days from a denial decision. The peer-to-peer call will be a verbal discussion with a DentaQuest dental director (who was not involved in the original determination) to discuss denial determination. Any additional clinical information to be discussed in the peer-to-peer call should be submitted within the first ten (10) calendar days from a denial decision. The peer-to-peer process does not have to be utilized prior to requesting an appeal. A Peer to Peer can be requested through the provider portal. If you have questions or need help with the peer-to-peer process, please contact your network manager.

State Fair Hearing

Providers may appeal a denial by requesting a State Fair Hearing with a state administrative law judge and are not required to request an informal appeal with DentaQuest.

Provider State Fair Hearing appeals must be received by the court within 30 days of the denial.

To file an appeal, submit a written request which includes:

- Provider name, address, phone number and Health First Colorado provider number
- A statement explaining the reason for the appeal
- Attach the front page of the notice you are appealing

Submit the written request by:

Mail:

Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203

Fax: 303.866.5909 (10 pages or fewer; otherwise, mail your request)

Email: OAC-GS@state.co.us

The Office of Administrative Courts will contact you by mail with the date, time, and place for your hearing with the Administrative Law Judge. You may request that the hearing be conducted by phone.

Member Appeals Rights

Members have the right to request a member appeal hearing directly with an administrative law judge with the State of Colorado. Members do not need to request reconsideration with DentaQuest before

requesting an appeal hearing with an administrative law judge. For more information on member appeals please see the [Health First Colorado Member Handbook](#).

4.13 Direct Deposit

DentaQuest offers Electronic Funds Transfer (EFT) 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 that can be found on the [Provider Web Portal](#).

Allow up to 6 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. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2-3 weeks.

Providers enrolled in the direct deposit program are required to access their remittance statements online. Providers may access their remittance statements using these steps:

- Log into the [Provider Web Portal](#)
- Click on "Claims/Claims Search" or "Authorization & Estimate Search"
- Search for claim or authorization in question (must be listed as FINALIZED)

5.00 Adult State Plan Health First Colorado Dental Benefit (Non-Emergent)

Adult dental care is a benefit for Health First Colorado recipients. Adult dental services consist of diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment, removable prosthetic (denture) services and oral surgery. See the Covered Services Benefit Table in Appendix B, Exhibit B for adult non-emergent covered services. See [Section 4.10](#) on "Payment for Non-covered Services."

5.01 Emergency Treatment for Oral Cavity Conditions Adults

A submission is considered an emergency procedure when the word "Emergency" is written in Box 35 (the comments section of the claim form). Emergency must be the first word in Box 35 followed by the required narrative. Emergency claims will be reviewed by Utilization Management using the criteria and table below:

Emergency treatment provided to an adult member includes:

- Immediate treatment or surgery to repair trauma to the jaw
- Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose
- Extraction of tooth or tooth structures associated with the emergency treatment of a condition of the oral cavity
- Repair of traumatic oral cavity wounds

For Emergency hospital cases where a CT scan is the only available form of x-ray available, DQ will use the medical necessity narrative to review codes that require an x-ray. Please submit claims as follows:

include the CDT code D9420, narrative of medical necessity for codes that require an x-ray need to indicate that a CT scan is the only x-ray available at the facility, and Emergency written in box 35.

Code Table for Adult Emergency Treatment of Oral Cavity Conditions	
D0140	limited oral evaluation-problem focused
D0220	intraoral - periapical first radiographic image
D0230	intraoral - periapical each additional radiographic image
D0270	bitewing - single radiographic image
D0272	bitewing - two radiographic images
D0274	bitewing - four radiographic images
D0277	vertical bitewings - 7 to 8 films
D0330	panoramic radiographic image
D0460	pulp vitality tests
D3221	pulpal debridement, primary and permanent teeth
D7140	extraction, erupted tooth or
D7210	exposed root (elevation and/or forceps removal)
D7220	removal of impacted tooth-soft tissue
D7230	removal of impacted tooth-primary bony
D7240	removal of impacted tooth-completely bony
D7241	removal of impacted tooth-completely bony, with unusual surgical complications
D7250	surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.
D7261	primary closure of a sinus perforation
D7285	incisional biopsy of oral tissue-hard (bone, tooth)
D7286	incisional biopsy of oral tissue-soft
D7410	radical excision - lesion diameter up to 1.25cm
D7411	excision of benign lesion greater than 1.25 cm
D7412	excision of benign lesion, complicated
D7413	excision of malignant lesion up to 1.25 cm
D7414	excision of malignant lesion greater than 1.25 cm
D7415	excision of malignant lesion, complicated
D7440	excision of malignant tumor -lesion diameter up to 1.25cm
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm

Code Table for Adult Emergency Treatment of Oral Cavity Conditions	
D7461	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm
D7510	incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess-intraoral soft tissue-complicated
D7520	incision and drainage of abscess - extra oral soft tissue
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	removal of reaction-producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	maxilla - open reduction
D7620	maxilla - closed reduction
D7630	mandible-open reduction
D7640	mandible - closed reduction
D7650	malar and/or zygomatic arch-open reduction
D7660	malar and/or zygomatic arch-open reduction
D7670	alveolus stabilization of teeth, closed reduction splinting
D7671	alveolus - open reduction, may include stabilization of teeth
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	maxilla - open reduction
D7720	maxilla - closed reduction
D7730	mandible - open reduction
D7740	mandible - closed reduction
D7750	malar and/or zygomatic arch-open reduction
D7760	malar and/or zygomatic arch-closed reduction
D7770	alveolus-stabilization of teeth, open reduction splinting
D7771	alveolus, closed reduction stabilization of teeth
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	open reduction of dislocation
D7820	closed reduction dislocation
D7830	manipulation under anesthesia

Code Table for Adult Emergency Treatment of Oral Cavity Conditions	
D7840	Condylectomy
D7850	Surgical Discectomy with/without Implant
D7852	Disc Repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint Reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-Arthroscopic Lysis and Lavage
D7872	Arthroscopy Diagnosis with/wo Biopsy
D7873	Arthroscopy Surgical Lavage & Lysis Adh
D7874	Arthroscopy Surgical Disc Reposit & Stab
D7875	Arthroscopy Surgical Synovectomy
D7876	Arthroscopy Surgical Discectomy
D7877	Arthroscopy Surgical Debridement
D7880	Occlusal Orthotic Device
D7881	Occlusal orthotic device adjustment
D7899	Unspecified TMD Therapy
D7910	suture small wounds up to 5 cm
D7911	complicated suture-up to 5 cm
D7912	complex suture - greater than 5cm
D7990	emergency tracheotomy
D7997	appliance removal (not by dentist who placed appliance), includes removal of arch bar
D7999	unspecified oral surgery procedure, by report
D9110	palliative (emergency) treatment of dental pain - minor procedure
D9222	deep sedation/general anesthesia – first 15 minutes
D9223	deep sedation/general anesthesia – each 15-minute increment
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes

Code Table for Adult Emergency Treatment of Oral Cavity Conditions	
D9243	intravenous moderate (conscious) sedation/analgesia – each 15-minute increment
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9420	hospital or ambulatory surgical center call

5.02 Removable Prosthetics for Adult Members (age 21 years and older)

Removable prosthetics are not covered if eight (8) or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided, however, for anterior teeth, irrespective of the number of teeth in occlusion.

Description	Frequency
D5110 Complete Denture, Maxillary	One time every 7 years. Includes initial 6 months of relines. Prior authorization required.
D5120 Complete Denture, Mandibular	One time every 7 years. Includes initial 6 months of relines. Prior authorization required.
D5211 Maxillary Partial Denture/Resin Based	One time every 7 years. Prior authorization required.
D5212 Mandibular Partial Denture/Resin Based	One time every 7 years. Prior authorization required.
D5213 Maxillary Partial Denture/Cast Metal Framework	One time every 7 years. Prior authorization required.
D5214 Mandibular Partial Denture/Case Metal Framework	One time every 7 years. Prior authorization required.
D5225 Maxillary Partial Denture/Flexible Base	One time every 7 years. Prior authorization required.
D5226 Mandibular Partial Denture/Flexible Base	One time every 7 years. Prior authorization required.

Prior Authorization Requirements

Complete, Immediate, and partial dentures require prior authorization (PAR). Services must be rendered after the PAR is approved. Please reference the Provider Determination Letter for specific dates.

Limitations on Prosthetic Services for State Plan Members

Complete, immediate, and partial dentures shall only be provided once every 84 months (7 years) for adult members.

6.00 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 Participating Providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its Participating Provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following regarding record handling and HIPAA requirements:

DentaQuest, LLC October 2, 2025

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- 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 (e.g., American Dental Association Current Dental Terminology, as recognized by the ADA. Effective the date of this manual, DentaQuest will require Participating Providers to submit all claims with the current ADA/CDT codes listed in this manual. In addition, all paper claims must be submitted on the current ADA claim form. **Dental Providers cannot bill Health First Colorado for Current Procedural Terminology (CPT) medical and surgical codes.**

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 855.398.8411 or via e-mail at: privacy@greatdentalplans.com

To view a copy of the most recent HIPAA Companion Guide please login to the [provider web portal](#). Once you have logged in, click on the link named "Related Documents".

7.00 Grievances

DentaQuest adheres to State, Federal, and Plan requirements related to processing grievances. Grievance means a written or oral expression of dissatisfaction about any matter other than adverse action.

Providers may submit a grievance using **one** of the following ways:

Provider Web Portal:

- Log into the [Provider Portal](#)
- Click on the "Request Appeal" button

By Phone:

- DentaQuest Provider services at 1-855-225-1731 (7:30 – 5:00 MT, M-F)

The Complaints and Grievances representative is responsible for documenting the grievance. The representative investigates the issue(s), compiles the findings, requests patient records (if applicable). The appropriate individuals are notified of the results (i.e. plan, member, and provider as applicable).

8.00 Utilization Review Program

DentaQuest recognizes that there exists a relationship between the provider's treatment planning, treatment costs and treatment outcomes. DentaQuest's Utilization Review Programs are designed to

ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local providers and their peers. All utilization review analysis, evaluations and outcomes are related to these patterns. DentaQuest considers individual provider variance along with specialty care. Specialty providers are evaluated as a separate group.

DentaQuest's Utilization Review 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.

DentaQuest's Utilization Review Programs will help identify providers whose patterns show deviation from the normal practice patterns of the community of their peers (typically less than 5% of all providers). Once identified, DentaQuest will educate providers about practice patterns and work with them to modify their diagnosis and treatment processes, bringing their practices back within the normal range. However, in some instances, it may be necessary to recover reimbursement.

Fraud and Abuse

DentaQuest is committed to detecting, reporting, and preventing potential fraud, waste, and abuse.

Fraud is defined as an intentional act of deception, misrepresentation, or concealment in order to gain something of value.

Examples of actions by Health First Colorado providers which may be fraud include:

- Billing Health First Colorado/DentaQuest for office visits, dental or medical procedures, drugs, or supplies that are not provided to a member.
- Billing for the same services twice.

Provider Self-Disclosure

The provider has an obligation to ensure that claims are submitted accurately. Section 1128J(d) of the Social Security Act requires providers to report and return overpayments to the Department within 60 days from the date the overpayment is identified. Examples of appropriate self-disclosure may include, but are not limited to:

- Billing errors.
- Systemic errors; and
- Violations of state and federal laws and regulations relating to the Medical Assistance programs

To report a self-disclosure, please complete the form on the Department's website:

<https://www.colorado.gov/pacific/hcpf/Provider-Self-Disclosure>

Examples of actions by Health First Colorado members which may be fraud include:

- Providing false information on applications to receive benefits.
- Loaning Health First Colorado/DentaQuest ID card to others.
- Selling or buying a Health First Colorado/DentaQuest card.
- Giving or selling medication or medical/dental supplies to someone else.
- Forging prescriptions.

Waste is defined as over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

Abuse is defined as excessive or improper use of services or actions that are inconsistent with acceptable business or medical / dental practice.

If you suspect fraud, waste, or abuse, please report it to DentaQuest immediately

- Call DentaQuest toll free at 800.237.9139
- Call DentaQuest Anonymous Hotline at 866.737-3559
- Send a fax to 262.241.7366

Mail information to:

DentaQuest
P.O. Box 2906
Milwaukee, WI 53201-2906
Attn: Utilization Review Department

More information on Fraud, Waste and Abuse can be found on the Department's website
<https://www.colorado.gov/pacific/hcpf/fraud-waste-and-abuse>

8.06 Early and Periodic Screening Diagnostic and Treatment Exceptions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits cover medically necessary screenings, treatments, and care for children under 21 years of age to stay as healthy as possible as they grow and develop. For EPSDT rules, see 10 C.C.R. 2505-10, Section 8.280.4.E. Services available pursuant to EPSDT criteria at 42 U.S.C. § 1396d(r) are more robust than those covered by the Child Medicaid benefit package and may be eligible for reimbursement even if they are not regularly covered dental benefits.

For Health First Colorado clients ages 20 years and younger, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) regulations allow for exceptions to listed frequency limitations for covered benefits and/or coverage of services that do not appear as covered benefits in Exhibit A of this Provider Office Reference Manual (ORM).

EPSDT coverage is available to IDD waiver participant members ages 18 through 20 years of age. (Please reference Appendix B, Exhibit A – Health First Colorado Child – Under 21 Benefit Table).

To receive reimbursement for services delivered pursuant to EPSDT criteria:

- When authorization is requested for services that would exceed benefit limits, Providers must submit *prior* to treatment a detailed narrative along with supporting documentation, as appropriate, describing medical necessity.
- Services provided pursuant to EPSDT criteria are subject to review for medical necessity.
- Prior authorization may be required for some services as shown in Appendix B, Exhibit A “Health First Colorado Child – Under 21 Benefit Table.”
- Both Providers and enrolled Health First Colorado members (or their parents/guardians) will be notified promptly of a PAR determination by a notice of action which is sent to the member and the provider.
- Providers are prohibited from seeking payment from a member for any service that Health First Colorado has determined meets EPSDT criteria, regardless of whether the provider's claim for that service is ultimately paid. C.R.S. § 25-5-4-301(1).

- Approval of a PAR is not a guarantee of payment. The member and provider must meet eligibility requirements at the time of services. Providers must fulfill all requirements according to EPSDT criteria.

Services furnished to members under 21 years of age will be approved/covered only if all criteria specified below are met:

1. The services must be within the scope of those listed at 42 U.S.C. § 1396d(a) even if the service is not listed in Health First Colorado state plan. For example, “maintenance” and “rehabilitative services” are covered by EPSDT, even if the particular maintenance or rehabilitative services in not included in clinical policies or service definitions.
2. The services must be medically necessary to prevent, diagnose, evaluate, correct, ameliorate, or treat a defect, physical or mental illness, or a condition diagnosed by the member’s physician, therapist, or other licensed practitioner.
3. The requested service must be determined to be medical or behavioral health services.
4. The service must be safe and effective.
5. The service must be generally recognized as an accepted method of medical practice or treatment.
6. The service must not be experimental/investigational.

Health First Colorado may not deny medically necessary treatment to a member based on cost alone but may consider the relative cost effectiveness of equally effective, alternative treatment options as part of the prior authorization process. 10 C.C.R. 2505-10, Section 8.076.1.8.g.

Additionally, pursuant to federal and state law, Health First Colorado will cover services only if they are provided by an enrolled or contracted Health First Colorado provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available to deliver medically necessary services.

Transportation and EPSDT:

The non-emergency medical transportation (NEMT) benefit is available to transport Members who do not have private transportation available to their dental appointment. A family member or caretaker may accompany a member during transport to the appointment.

For NEMT services in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, Larimer, or Weld County:

Call Transdev/IntelliRide at **855-489-4999** (toll free) (State Relay 711). Or go to transdevhealthsolutions.com/colorado/.

For NEMT services in other Colorado counties:

Contact a local NEMT provider. Contact information for NEMT providers is available at hcpf.colorado.gov/nemtlist

For more information regarding EPSDT coverage, please reference the Health First Colorado EPSDT web page: <https://hcpf.colorado.gov/epsdt>

For more information regarding EPSDT benefits, please reference the Health First Colorado EPSDT Program web page at <https://hcpf.colorado.gov/epsdt>

8.07 High Risk Criteria

Members who are “High Risk” qualify for increased frequency of specific services (codes). A Provider should use these guidelines to determine if the member meets the requirements.

High Risk of Caries is indicated if a member has one or more of the following four criteria:

- presents with demonstrable caries, has a history of restorative treatment, has a history of dental plaque, **AND** has a history of enamel demineralization,

OR

- is a child member (age 0 through 20 years old) of mothers with a high caries rate, especially with untreated caries,

OR

- is a child member (age 0 through 20 years old) who sleeps with a bottle containing anything other than water, or who breastfeed throughout the night (at-will nursing),

OR

- is a child member ((age 0 through 20 years old) who has special health needs

High Risk for Periodontal Disease is indicated if a member:

- has a history of periodontal scaling
- has a history of root planing
- has a history of periodontal surgery
- has diabetes
- is pregnant

Topical Fluoride Treatment High Risk Criteria for Adult Members” includes:

- a history dry mouth
- a history of head or neck radiation
- indication of High Risk for Caries (please reference above criteria for adult members)
 - If, at the time of the adult member’s next oral examination he or she no longer has active decay, that adult member is no longer considered high risk.

To submit a claim to be considered for a “High Risk” member, the word HIGH RISK must be written in box 35 (the comments section of the current ADA Claim form).

Providers should mark “High Risk” in box 35 on the current ADA claim form ONLY when the service is beyond the standard benefit limitations and meets the High-Risk criteria. All claims marked “High Risk” require the additional step of Utilization Management review before they are processed for payment.

In addition, the criteria qualifying this member as “High Risk” needs to be documented in the Remarks section of the Claims form. Alternatively, the “Pediatric Oral Health Screening” form can be submitted in place of the narrative in the Remarks section.

HIGH RISK TABLE FOR CHILDREN- Health First Colorado members age 0 through 20 years old that qualify for High Risk:	
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver

HIGH RISK TABLE FOR CHILDREN- Health First Colorado members age 0 through 20 years old that qualify for High Risk:	
D0190	Screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.
D0270	Bitewing – single (1) film
D0272	Bitewings – two (2) films
D0273	Bitewings – three (3) films
D0274	Bitewings – four (4) films
D1110	Prophylaxis – adult, ages twelve (12) years and older
D1120	Prophylaxis – child
D1206	Topical application of fluoride varnish
D4346	Scaling in presence of generalized moderate or severe gingival inflammation
D4910	Periodontal Maintenance

HIGH RISK TABLE FOR ADULTS- Health First Colorado members age 21 years and over that qualify for High Risk.	
D1110	Prophylaxis – adult, ages twelve (12) years and older
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride (e.g., gel)
D4346	Scaling in presence of generalized moderate or severe gingival inflammation
D4910	Periodontal Maintenance

For more information on Preventative Services that High Risk members may qualify for is located in Sections [15.01](#), [15.02](#), [15.03](#), and [15.09](#).

9.00 Quality Improvement Program

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 administratively managed care. The Quality Improvement Program includes, but is not limited to:

- 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.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Service Department at 855.225.1731 or via e-mail at: denelig.benefits@dentaquest.com

10.00 Provider Credentialing and Enrollment

The Department will continue to credential all new Providers. To perform Health First Colorado dental benefit services and to receive payment from DentaQuest, providers must enroll with Health First Colorado. Enrolled providers must have and maintain licensure and certification required by Health First Colorado regulations. Providers seeking to enroll can find information regarding enrollment on the Department's website <https://www.colorado.gov/hcpf/provider-enrollment>

11.00 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. Gender.
 - 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 Provider.
 - m. History of alcohol and/or 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 Provider.
 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 (ADA) Current Dental Terminology (CDT) 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 Participating Provider who rendered the service.
14. Adequate documentation of the specialty care performed by another Provider that includes:
 - a. Patient examination.
 - b. Treatment plan.
 - c. Treatment status.
15. Tobacco cessation education should be noted in the record. Support is available for Health First Colorado members. Refer members 18 years and older with a desire to quit to their primary care provider to get a prescription for tobacco cessation products. Health First Colorado pays for any federal Food and Drug Administration (FDA) approved medications or products for two 90-day sessions each year to assist a member in quitting. Refer members 15 years and older to the Quitline for free telephone-based tobacco treatment (coaching), online, email, and text support at 1-800-QUIT-NOW or <https://www.coquitline.org/en-US/>. For more information on how to discuss tobacco use with members, visit <https://www.tobaccofreeco.org/>.

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.

12.00 Patient Recall System Requirements

A. Recall System Requirement

Each participating Health First Colorado/DentaQuest dental 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 enrollee that has sought dental treatment.

Dental offices indicate that Health First Colorado 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.

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 schedule 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.”

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.

Health First Colorado/DentaQuest Participating Providers are expected to meet minimum standards with regards to appointment availability.

- Urgent care must be available within 48 hours
- Emergency care must be available within 24 hours
- Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

13.00 Radiology Requirements

Note: Please reference the Covered Services Benefit Tables in Appendix B, Exhibits A and B for radiograph benefit limitations. DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health (i.e., “The Panel”). These guidelines were developed in conjunction with the Food and Drug Administration Revised 2004, American Dental Association, Council on Dental Benefit Program, Council on Dental Practice, Council of Scientific Affairs

A. Radiographic Examination of the New Patient

Child – Primary Dentition: Prior to eruption of first permanent molar.

The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts, individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.

Child – Transitional Dentition: After eruption of first permanent molar

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.

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 and panoramic exam for a new adolescent patient. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.

Adult – Dentulous: or Partially Edentulous

The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings with panoramic exam for a new dentulous adult patient. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.

Adult – Edentulous:

The Panel recommends individualized radiographic exam, based on clinical signs and symptoms.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or at increased risk for caries.
 - a. Child – Primary and Transitional Dentition:
 - b. 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 if proximal surfaces cannot be examined visually or with a probe.
 - c. Adolescent with Permanent Dentition
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 if proximal surfaces cannot be examined visually or with a probe.
 - d. Adult – Dentulous:
The Panel recommends that posterior bitewings be performed at a 6-18-month interval for adults with clinical caries or who are at increased risk for the development of caries.
 - e. 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 not at increased risk for caries.
 - a. Child – Primary Dentition:
The Panel recommends that posterior bitewings be performed at an interval of 12-24 months if proximal surfaces cannot be examined visually or with a probe 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 if proximal surfaces cannot be examined visually or with a probe for patients with a transitional dentition. Adolescents with permanent dentition posterior bitewing exam at 18-36-month intervals 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. Recall Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult.
 - a. Clinical judgement as to the need for and the type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, specific bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.
 4. Growth and Development Assessment.
 - a. Child – Primary Dentition:
 - b. 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. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.
 - c. 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. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.
 - d. Adolescent: Permanent Dentition
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. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development.
 - e. Adult:
The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.
 5. Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization. Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances for all patients.

14.00 Health Guidelines – Ages 0-18 Years

NOTE: Please reference Covered Services Benefit Tables in Appendix B, Exhibit A for benefits and limitations for Child members.

Recommendations for Preventive Pediatric Dental Care (AAPD Reference Manual- Published 2022)

Periodicity and Anticipatory Guidance Recommendations (AAPD/ADA/AAP guidelines) [AAPD | Recommended Dental Periodicity Schedule - Chart](#)

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this best practice for supporting information and references.

	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination ¹	•	•	•	•	•
Assess oral growth and development ²	•	•	•	•	•
Caries-risk assessment ³	•	•	•	•	•
Radiographic assessment ⁴	•	•	•	•	•
Prophylaxis and topical fluoride ^{3,4}	•	•	•	•	•
Fluoride supplementation ⁵	•	•	•	•	•
Anticipatory guidance/counseling ⁶	•	•	•	•	•
Oral hygiene counseling ^{3,7}	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling ^{3,8}	•	•	•	•	•
Counseling for nonnutritive habits ⁹	•	•	•	•	•
Injury prevention and safety counseling ¹⁰	•	•	•	•	•
Assess speech/language development ¹¹	•	•	•		
Assessment developing occlusion ¹²			•	•	•
Assessment for pit and fissure sealants ¹³			•	•	•
Periodontal-risk assessment ^{3,14}			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/vaccine				•	•
Counseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

- 1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
- 2 By clinical examination.
- 3 Must be repeated regularly and frequently to maximize effectiveness.
- 4 Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
- 5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
- 6 Appropriate discussion and counseling should be an integral part of each visit for care.
- 7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
- 8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.
- 9 At first, discuss the need for nonnutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
- 10 Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.
- 11 Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.
- 12 Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.
- 13 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
- 14 Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

*Please refer to Health First Colorado Dental Fee Schedule(s) regarding reimbursement. Not all recommended services will be reimbursed.

15.00 Clinical Criteria for Health First Colorado Child and Adult Benefits

The criteria outlined in DentaQuest's Provider Office Reference Manual (ORM) are based around procedure codes as defined in the American Dental Association's Dental Procedure Codes Manual. 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 Providers, 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. Participating Provider 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 Covered Services Benefit Tables, Appendix B, Exhibits A and B before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorization requests (PARs), 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 Covered Services Benefit Tables, Appendix B, Exhibits A and B in the "Review Required" column.

For all procedures, every Participating Provider in the DentaQuest program is subject to random chart audits. Participating Providers are required to comply with any request for records. These audits may occur in the Participating Provider's office as well as in the office of DentaQuest.

Health First Colorado network Participating Providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please reference 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 Participating Provider from the DentaQuest Provider Panel.

Criteria for Preventive Dental Services

15.01 Criteria for Dental Prophylaxis – Adult and Child Members

Dental prophylaxis (i.e., teeth cleanings) is recommended every 6 months, and may be reimbursed twice per 12 months per member. Prophylaxis is not a benefit when billed on the same date of service as any periodontal procedure code.

To be covered by Health First Colorado, dental prophylaxis must be performed and submitted in accordance with the ADA CDT manual description for D1110 (Adult Prophylaxis) or D1120 (Child Prophylaxis). These procedure codes are described as “removal of plaque, calculus, and stains from the tooth structure.” Claims for “toothbrush prophylaxis” should not be coded as D1110 or D1120, nor submitted for payment. Health First Colorado does not reimburse for toothbrush prophylaxis.

Members determined to be at high risk for periodontal disease or high risk for caries (decay) is eligible for additional services. These services include up to four (4) prophylaxis procedures without a history of periodontal disease or up to four (4) periodontal maintenance procedures once a history of periodontal disease is established, per year. Any services exceeding these guidelines will be subject to utilization management (UM) review.

High Risk of Caries is indicated if a member meets one of the following four criteria:

- presents with demonstrable caries, has a history of restorative treatment, has a history of dental plaque **AND** has a history of enamel demineralization,
OR
- is a child member (age 0 through 20 years old) of mothers with a high caries rate, especially with untreated caries,
OR
- is a child member (age 0 through 20 years old) who sleeps with a bottle containing anything other than water, or who breastfeed throughout the night (at-will nursing),
OR
- is a child member (age 0 through 20 years old) who has special health needs

Members who are determined to fit into the High Risk category for periodontal disease or high risk for caries (decay) are eligible for any combination of up to four (4) prophylaxes or up to four (4) periodontal maintenance visits per year.

Please reference “High Risk for Caries” under Definitions in [Appendix A](#).

Billing guidance regarding High Risk services is also located in [Section 8.07](#).

15.02 Criteria for Topical Fluoride and Fluoride Varnish for Child Members (ages 0 through 20 years old)

Topical fluoride is a covered benefit for child members through age 20 and topical fluoride treatments are allowed twice (2) per year for child members. Child members ages 0 through 4 years at high risk for caries may receive an additional two (2) fluoride topical applications per year for a total of up to four (4) per year. Child members ages 5 through 20 years may receive an additional one (1) per year with no adjustment for risk for a total of three (3) per year. Topical fluoride and fluoride varnish may be administered only after the risk assessment is completed. The approved risk assessment forms are the Pediatric Oral Health Screening forms. A form for use in dental offices and a form for use in medical offices can be found in Appendix A, under “Forms” of this ORM, on the Department’s website under the Provider Services Dental Forms section <https://www.colorado.gov/pacific/hcpf/provider-forms> or the forms can be downloaded for Medical or Dental under the resource tab @ <https://coloradooralhealth.org/initiatives/cavity-free-at-three/> [coloradooralhealth.org]

Documentation of risk using a Pediatric Oral Health Screening form must be part of the child member’s medical and/or dental record.

Fluoride varnish is considered the standard of care and is the only acceptable topical fluoride treatment for child member’s ages 0 through 5 years (up to the day before their sixth birthday). However, either topical fluoride or fluoride varnish may be used for child members after the child’s sixth birthday. Fluoride rinse is not an acceptable treatment for any child member and will not be reimbursed.

Please reference “High Risk for Caries” under Definitions in Appendix A.

Billing guidance regarding High Risk services is located in [section 8.07](#).

15.03 Criteria for Topical Fluoride and Fluoride Varnish for High Risk Adult Members (ages 21 years and older)

Topical fluoride and fluoride varnish is only a covered benefit for High Risk adult members age 21 and older. Topical fluoride treatments are allowed twice (2) per year for adult members considered high risk. Fluoride rinse is not an acceptable treatment for any member and will not be reimbursed.

For topical fluoride treatments (gel or varnish), high risk for adult’s members age 21 and over is indicated by:

- a history of dry mouth; or
- a history of head or neck radiation; or
- indication of high risk for caries (please reference definition in section 15.01).
 - If, at the time of the adult member’s next oral examination he or she no longer has active decay, that adult member is no longer considered high risk.

Please reference “Topical Fluoride Treatment High Risk Criteria for Adult members” under Definitions, Appendix A.

Prior authorization (PAR) is not necessary for adult members to receive topical fluoride treatments. Billing guidance regarding High Risk services is located in [section 8.07](#).

15.04 Criteria for Sealants for Child Members

Sealants may be applied twice per lifetime per tooth to the unrestored occlusal surface of any permanent first or second molar at risk for occlusal pit and fissure decay. A separate benefit will not be paid for sealant placed in the facial (buccal) pit and/or lingual groove of a permanent molar tooth. Sealants may be applied to all unrestored permanent molars without a capitated lesion in child member’s ages 5 through 15 years old.

15.05 Criteria for Space Maintainers

- Removable and fixed space maintainers are performed to prevent tooth movement and maintain the space for eruption of a first or second premolar or permanent first molar when a primary tooth has been lost prematurely or for a congenitally missing permanent tooth for members up to the age of 14.
- The procedure is reimbursable twice per quadrant per lifetime and includes any follow-up care and/or re-cementing, if necessary. Fixed space maintainers must be cemented prior to submitting a claim for reimbursement.
- Recommendation of space maintainers is allowed once per year and is not payable within 6 months of original placement by the same Provider/dental office.
- Space maintainers are not reimbursable when the eruption of the permanent tooth is imminent.
- Removal of fixed space maintainers is allowed once per lifetime and is not payable within 6 months of original placement by the same Provider/dental office who delivered the appliance.

15.06 Criteria for Stainless Steel Crowns

Prefabricated stainless steel crowns, prefabricated resin crowns, and prefabricated stainless-steel crowns with a resin window are a benefit for both primary and permanent teeth for child and adult members.

Prefabricated esthetic coated stainless-steel crowns are a benefit only for anterior primary teeth.

When treating children under the age of 21, a maximum of five (5) crowns may be prepared and inserted on the same day of service in a non-hospital setting unless in-office sedation is provided.

Documentation needed for pre-payment review of stainless-steel crown procedures:

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

Crowns 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 Provider'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 arches or is 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.
- An existing crown is present with an open margin without decay.
- An existing crown is present with chipped or fractured porcelain without decay.

15.07 Criteria for Cast Crowns

Documentation needed for post-treatment, pre-payment review (PPR) of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panoramic radiographic images.
- Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed prosthetics shall be based on the cementation/delivery date.

Criteria

- Criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- The tooth is in occlusion; and
- Only when the cause of the problem is either decay or fracture; and
- For adult members (age 21 and older): the tooth is not a second or third molar; the second molar may be covered if it meets all the above criteria, and it is necessary to support a partial denture or to maintain at least eight (8) posterior teeth (artificial or natural) in occlusion.
- For child members (age 20 and younger): the tooth is not a third molar.
- If a crown is requested for cracked tooth syndrome, then the tooth must be symptomatic and appropriate testing and documentation must be provided.
- 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.

Post-treatment, pre-payment review (PPR) 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 arches or is an abutment for a partial denture. 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. Crowns on permanent teeth are limited to one crown every seven years (84months).

Crowns will not meet criteria if:

- A lesser means of restoration is possible; or
- Tooth has subosseous and/or furcation caries; or
- Tooth has advanced periodontal disease; or
- Tooth is a primary tooth; or
- Crowns are being planned to alter vertical dimension.
- An existing crown is present with an open margin without decay
- An existing crown is present with chipped or fractured porcelain without decay

Lab Fees for Undelivered Crowns

If a provider incurs lab fees but cannot place the crown, please contact your Provider Representative about possible reimbursement for fees incurred.

15.08 Criteria for Endodontics

Covered Endodontic Services

- Therapeutic pulpotomy with the aim of maintaining the tooth vitality is a benefit for primary teeth and permanent teeth. It is not intended to be the first stage of conventional root canal therapy.
- Pulpal therapy, including pulpectomy, cleaning and filling of canals with resorbable material is a benefit for all primary teeth that are succedaneous teeth.
- Pulpal debridement is covered for child and adult members in emergency situations only and is not payable when the root canal is completed on the same day by the same Provider/dental office. Refer to section 5.00 for Emergency Treatment criteria.
- Direct and indirect pulp caps are a benefit when clearly documented in the dental records. All adhesives (including amalgam bonding agents), liners and bases are included as part of a restoration; they will not be reimbursed if billed separately.
- Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.
- For child members only, A root canal requested by the Provider for cracked tooth syndrome requires prior authorization, documentation and appropriate testing must be provided demonstrating the tooth is symptomatic.

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 Provider's ability to fill the canal to the apex.
- Fill must be properly condensed/obtured. Filling material does not extend excessively beyond the apex.

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.
- For adult members (age 21 and older): the tooth is a second or third molar; the second molar may be covered if it meets all the above criteria, and it is necessary to support a partial denture or to maintain at least eight (8) posterior teeth (artificial or natural) in occlusion.

- For child members (age 20 and younger): the tooth is not a third molar.
- 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 obturation of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet best practice or clinically accepted guidelines by the American Association of Endodontists. 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.
- Partial Pulpotomy for Apexogenesis is not considered the first part of Root Canal Therapy; and is only allowed on permanent teeth. Partial Pulpotomy for Apexogenesis requires removal of pulp and placement of medicament with the goal of maintaining vitality of the remaining portion to encourage continued physiological development and formation of the root.
- Retreatment of Previous Root Canal Therapy requires radiographic evidence of incomplete endodontic obturation, radiographic evidence of apical pathology and a narrative of symptomology consistent with failing root canal therapy.
- Apexification/Recalcification procedures includes opening of tooth, canal preparation and initial medication and closure. Interim appointments include medication change and closure. Final appointment includes completion of root canal therapy and closure and does not include final restoration. Includes all radiographs necessary at each step noted in this paragraph.
- Pulpal Regeneration includes opening of tooth, canal preparation and initial medication and closure. Interim appointments include medication change and closure. Does not include final restoration. Includes all radiographs necessary at each step noted in this paragraph.

15.09 Criteria for Periodontal Treatment

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

Members with a history of periodontal treatment, including scaling and root planing and osseous surgery or members who are high risk for periodontal disease will be eligible for up to four (4) periodontal maintenance or prophylaxis visits per year.

Any services exceeding these guidelines will be subject to utilization management (UM) review.

High risk indicators:

- history of periodontal scaling and of root planing
- history of periodontal surgery
- has diabetes
- is pregnant

Please reference “High Risk for Periodontal Disease” under Definitions, Appendix A.

Billing guidance regarding High Risk services is located in section [8.07](#).

Documentation needed for prior authorization (PAR) of periodontal procedure(s):

- Radiographs – periapicals or bitewings preferred.

- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Covered Procedures (child and adult members)

- Periodontal scaling and root planing – four (4) or more teeth affected in the quadrant (D4341)
- Periodontal scaling and root planing – one (1) to three (3) teeth affected in the quadrant (D4342).

Criteria

- Complete periodontal charting indicating abnormal pocket depths in multiple sites, PSR is not acceptable.
- AAP Case Type should be included in the charting.
- Radiographs – Periapicals or Bitewings preferred.
- Additionally, at least one of the following must be present:
 - Radiographic evidence of root surface calculus.
 - Radiographic evidence of noticeable loss of bone support (2.5 mm or greater from the CEJ).
- Periodontal scaling and root planing (D4341 and/or D4342) is allowed once per quadrant every three (3) years (children and adults).
- Maximum of two (2) quadrants per date of service is allowed except in a hospital/ASC setting.
- Not allowed if there is a history of gingivectomy (D4211 and/or D4212) provided in the past 12 months in the same quadrant.
- Prophylaxis (D1110 and/or D1120) is not paid on the same day as periodontal scaling and root planing (D4341 and/or D4342).

15.10 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Removable prosthetics are not covered if eight (8) or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided for anterior teeth irrespective of the number of teeth in occlusion. Full and partial dentures require prior authorization.

Billing and reimbursement removable prosthetics shall be based on the delivery date. Member must be active on the delivery date (date of service).

Documentation needed for prior authorization (PAR) of removable prosthetics procedure(s):

- Treatment plan
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panoramic images

Criteria for Partial Dentures:

- 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.
- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- 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, Providers are expected to instruct the patient in the proper care of the prosthesis.
- Any adjustment necessary to achieve a proper fit during the six months immediately following the delivery of the prosthesis is included as part of the service.
- For adult members (age 21 and older), if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 7 years old to qualify for replacement.
- For child members (age 20 and younger), if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old to qualify for replacement.

Partial dentures will not meet criteria:

- For adult members (age 21 and older), if there is a pre-existing prosthesis which is not at least 7 years old.
- For child members (age 20 and younger), if there is a pre-existing prosthesis which is not at least 5 years old.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- 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.

Complete Denture Criteria

- For adult members (age 21 and older), if there is a pre-existing prosthesis, it must be at least 7 years old to qualify for replacement.
- For child members (age 20 and younger), if there is a pre-existing prosthesis, it must be at least 5 years old 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 once per calendar year per denture.
- For adult members (age 21 and older), repairs will be reimbursed once per denture per year, with 7 total denture repairs per 7 years.
- For child members (age 20 and younger), repairs will be reimbursed twice per denture per year, with 10 total denture repairs per 5 years.
- Relines will be reimbursed once per denture every 4 years.
- A new prosthesis will not be reimbursed within 2 years 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 Dentures (Complete and Partial) Replacement of lost, stolen, or broken (non-repairable) complete or partial dentures is allowed once per member lifetime per member, provided that: The loss or damage occurred due to circumstances beyond the member's control (i.e., not the member's fault). Providers must submit a Prior Authorization Request (PAR) for all once-in-a-lifetime denture replacements.
 - Submission requirements:
 - Fill out the PAR Request
 - In box 35, clearly indicate "Denture Replacement"
- The use of Prefomed 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.

Complete dentures will not meet criteria:

- For adult members (age 21 and older), if there is a pre-existing prosthesis which is not at least 7 years old.
- For child members (age 20 and younger), if there is a pre-existing prosthesis which is not at least 5 years old.

Lab Fees for Undelivered Dentures

If a provider incurs lab fees but cannot seat the denture, please contact your Provider Representative about possible reimbursement for fees incurred.

15.11 Criteria for Oral Surgery

Covered Oral Surgery Services

Extractions of teeth that are involved with acute infection, acute pain, cyst, tumor or other neoplasm, radiographically demonstrable pathology that may fail to elicit symptoms and the extractions that are required to complete an approved orthodontic treatment plan.

Removal of third molars is only covered in instances of acute pain and overt symptomatology.

For orthodontics, the prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology may be covered subject to consultant review and must be prior authorized as part of the orthodontic treatment plan.

The removal of primary teeth whose exfoliation is imminent does not meet criteria.

For Child Clients who present with overt symptomatology or ectopic eruption because of an inability to extract the exfoliating teeth themselves, extraction of primary teeth may be prior authorized under EPSDT utilization management guidelines (please reference section 8.06).

Alveoplasty for surgical preparation of ridge for dentures and vestibuloplasties.

Removal of maxillary or mandibular lateral exostosis, torus palatinus or mandibularis and surgical reduction of osseous tuberosities, tumors, cyst, neoplasms and reactive inflammatory lesions are a covered benefit.

Surgical access to an un-erupted tooth and/or placement of a device to facilitate eruption of an impacted tooth may be covered in conjunction of a prior authorized orthodontic treatment plan.

Incision and drainage of an abscess concurrent with an extraction may be covered by report when narrative of medical necessity is documented and submitted with the claim for pre-payment review (D7511, D7520, and D7521). Incision and drainage of an abscess will not be reimbursed in same surgical area and on same visit as any other definitive treatment codes (D7510); except for covered services necessary for diagnosis.

Orthognathic surgery may be covered in conjunction with a prior authorized orthodontic treatment plan, trauma or congenital defects.

Frenulectomy and frenuloplasty are covered.

Tooth re-implantation is covered in the event of tooth evulsion.

Treatment of simple and compound fractures repair of traumatic wounds and miscellaneous repair procedures are covered.

Minor surgical procedures are allowed once per lifetime per quadrant to prepare the mouth for removable prostheses.

Criteria

- Alveoloplasty and Incision & Drainage will not be reimbursed in the same quadrant as surgical extraction on the same date.
- Alveoloplasty is limited to pre-prosthetic cases.
- Alveoloplasty is limited to one full quadrant or one partial quadrant.
- Incision and Drainage will not be routinely covered in conjunction with an extraction in the same area on the same date.
- Drainage is considered to occur with extraction in most cases, and can be evaluated with proper documentation, post-treatment, pre-payment review.

Assistant Surgeons

An Assistant Surgeon is allowed to bill for the ADA procedure codes listed in the table located in Section [19.00](#). Please reference this section for covered procedure codes and billing guidance.

15.12 Criteria for Deep Sedation/General Anesthesia in the Dental Office Setting

DentaQuest encourages providers to review the [Code of Colorado Regulations 3 709-1 Section 1.14](#) in addition to the [Colorado Dental Board: Laws, Rules and Policies | Division of Professions and Occupations](#).

Anesthesia for dental services may be performed either in the dental office or a facility setting (i.e., Operating Room [OR], Short Procedure Unit, Ambulatory Surgical Center [ASC], and/or Outpatient Facility). **The coverage requirements differ for facility setting and dental office setting.**

Dental Office Setting

- D9222 (Deep sedation/general anesthesia – first 15 minutes) and D9223 (Deep sedation/general anesthesia – each subsequent 15-minute increment) will not be subject to prior auth or pre-payment review.

DentaQuest will screen and audit providers who bill in-office deep sedation and general anesthesia (D9222, D9223). When anesthesia services are provided by a dental anesthesiologist, the anesthesiologist and general dentist, pediatric dentist, or oral surgeon shall coordinate the submission of documentation to DentaQuest to ensure all required documentation is submitted within 45 days from the date of the notice.

Providers must include the following information in each member's chart:

- if applicable the member's cognitive or behavioral health diagnosis which can be fulfilled by a physician's letter or record from another state agency that services the member (responsibility of the general dentist, pediatric dentist, or oral surgeon);
- documentation proof of medical necessity (general dentist, pediatric dentist or oral surgeon);
- condition of the tooth/teeth via treatment plan (general dentist, pediatric dentist, or oral surgeon);
- the type of anesthesia agent used, and any other drug administered including the dose(s), time given and route of administration (dental anesthesiologist or oral surgeon);
- the induction time of the anesthetic agent administered and the stop time of the anesthetic agent (dental anesthesiologist or oral surgeon);
- the staff members present and the party responsible for monitoring and recording the vital signs (dental anesthesiologist or oral surgeon);
- the member's vital signs pre, during and post anesthesia administration (dental anesthesiologist or oral surgeon); and
- the condition of patient at discharge (dental anesthesiologist or oral surgeon).

If a provider fails to submit any of the required documentation to DentaQuest within 45 days from the date of notice, fails to adequately document medical necessity, or the chart does not contain all the required elements, payments for claims from both the rendering dentist and the dental anesthesiologist shall be subject to recovery.

Medical Necessity Criteria

Claims for general anesthesia (D9222, D9223) must meet Health First Colorado medical necessity requirements:

- Adult members: In most instances, Health First Colorado covered services furnished in an office setting will be authorized for adult patients when the medical necessity criteria at [10 C.C.R 2505-10, Section 8.076.1.8.a-g](#) are met.
- Child members: In most instances, Health First Colorado covered services furnished in an office setting will be authorized for child patients when EPSDT medical necessity criteria at [10 C.C.R 2505-10, Section 8.280.4.E.2](#) are met.

15.13 Criteria for Deep Sedation/General Anesthesia in a Facility Setting

Dental treatment is authorized in a facility setting (i.e. Operating room [OR], Short Procedure Unit, Ambulatory Surgical Center [ASC], and/or Outpatient Facility) with general anesthesia only when such services are determined to be medically necessary. All facility cases must be authorized.

Prior authorization (PAR) is required for general anesthesia services (CDT codes D9222 and D9223) performed in a facility setting for both child (age 20 and younger) and adult members (age 21 and older). The following documentation is required for prior authorization:

The Participating Provider should submit their request with the following documentation:

- The treatment plan (even if the complete treatment plan is not available) on a current ADA claim form
- Narrative of medical necessity for general anesthesia specific to each patient.
- X-rays (if applicable)
- In box 35-Remarks of the current ADA claim form, the provider shall insert the word "HOSPITAL" and the name and address of the facility setting (i.e., Operating Room (OR), Short Procedure Unit, Ambulatory Surgical Center (ASC), and/or Outpatient Facility)
- In box 38-Place of Treatment of the current ADA claim form, the proper place of service code must be inserted
- Planned date of service

For treatment rendered under emergency conditions when review is not possible, the treatment plan and narrative of medical necessity shall be submitted with the claim for prepayment review.

Criteria

Adult members: In most instances, Health First Colorado covered services furnished in a facility setting will be authorized for adult patients when the medical necessity criteria at [10 C.C.R 2505-10, Section 8.201.2.A.10](#) are met.

Child members: In most instances, Health First Colorado covered services furnished in a facility setting will be authorized for child patients when EPSDT medical necessity criteria at [10 C.C.R 2505-10, Section 8.202.2.A.11.b](#) are met.

If a dental provider determines that a client who meets one or more of the medical necessity criteria requires hospitalization with or without associated general anesthesia, the provider shall:

1. Contact the client's HMO or medical management department for prior authorization to use the hospital. The HMO may require documentation of medical necessity; or
2. If the client is not enrolled in an HMO, the dentist should make prior arrangements with a hospital or ambulatory surgery center that is a participating Health First Colorado provider.
3. Check box number 38 (other) as the place of treatment on the current ADA paper claim form, or bill electronically via your Clearing House selecting either outpatient hospital or ambulatory surgery center as the place of treatment.
4. Bill for any X-rays taken in the facility setting (i.e., Operating Room (OR), Short Procedure Unit, Ambulatory Surgical Center (ASC), and/or Outpatient Facility) on the current ADA claim form or electronically via the provider's Clearing House itemizing X-ray procedures with other dental procedures. Facilities shall not bill additional CPT codes for dental X-rays performed during outpatient dental procedures.
5. If billing on the DentaQuest Provider Web Portal (PWP):
 - a. Providers with hospital privileges only (not under contract with the Facility location), bill services with the provider's primary office location, noting in box 35-Remarks field the facility name and address.
 - b. Providers who are under contract with the Facility location bill services using the facility name and location.

PAR Submission

The PAR shall be submitted:

- Online via the Colorado Provider Web Portal (PWP) at www.dentaquest.com/colorado, or
- By mail to:
 - DentaQuest – OR Authorizations
P.O. BOX 2906
Milwaukee, WI 53201-2906, or
- By fax: 262.834.3575

When a prior authorization request for anesthesia in a facility setting is reviewed for medical necessity, DentaQuest will automatically add the CDT code D9500 to your claim. D9500 is not a covered code, and no fee is attached to this code. Providers should refer to the determination status of the D9500 which will indicate the approval or denial of anesthesia in a facility setting. If DentaQuest approves a PAR, the provider shall schedule the member for services at a Health First Colorado participating facility in which the provider possesses the appropriate staff privileges.

Services must be rendered after the PAR is approved, during the authorization period. This is 180 days. Please reference the Provider Determination Letter for specific dates.

Payment for Medical Anesthesia

If the administration of anesthesia/deep sedation is provided by a medical health professional (instead of a dental professional) these services are billed to the Medical portion of Health First Colorado Program through the Department's [Colorado Medical Assistance Program Web Portal](#); these claims are not processed by DentaQuest. Any prior authorization request (PAR) required for anesthesia/deep sedation would occur with the Department and its medical utilization vendor.

15.14 Criteria for Prior Authorization of Hospital or Outpatient Facility

Documentation needed for prior authorization of procedure:

- Treatment Plan
- Narrative describing medical necessity for Operating Room (OR).
- The word “HOSPITAL” written in box 35 Remarks on the current ADA claim form and **include the name and address of the participating hospital, ASC or facility.**

Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when such services are determined to be medically necessary. All Hospital or Outpatient Facility Cases Must be Authorized, all operating room cases must be prior-authorized, even if the complete treatment plan is not available.

When a prior authorization is reviewed for medical necessity for rendering services in a hospital setting or outpatient facility, DentaQuest will automatically add the CDT code D9500 to your claim. D9500 is not a covered code, and no fee is attached to this code. Offices should refer to the determination status of the D9500 for indication of approval or denial of a hospital setting or outpatient facility. DentaQuest will review the necessity to perform the services in an outpatient setting and will approve or deny the request. Once authorization is obtained, the provider can schedule the eligible Health First Colorado member for the dental services in a facility which accepts Health First Colorado and in which he /she possesses the appropriate staff privileges. Services must be rendered after the PAR is approved, during the authorization period. This is usually 180 days. Please reference the Provider Determination Letter for specific dates.

Criteria

In most instances, Operating Room (OR) cases will be authorized (for procedures covered by Health First Colorado) 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.
- 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.
- Individuals with intellectual and/or developmental disabilities requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

If a dentist determines that a client needs hospitalization with or without associated general anesthesia, and meets one or more of the listed criteria, the dentist must:

1. Contact the client’s HMO or medical management department for prior authorization to use the hospital. The HMO may require documentation of medical necessity; or
2. If the client is not enrolled in an HMO, the dentist should make prior arrangements with a hospital or ambulatory surgery center that is a participating Health First Colorado provider.

3. Check box number 38 (other) as the place of treatment on the current ADA paper claim form, or bill electronically via your Clearing House selecting either outpatient hospital or ambulatory surgery center as the place of treatment.
4. Bill any X-rays taken in either an outpatient hospital or ambulatory surgery center on the current ADA claim for or electronically via your Clearing House line itemizing X-ray procedures with other dental procedures. Hospital outpatient departments and ambulatory surgery centers are not allowed to bill for additional CPT codes for dental X-rays performed during outpatient dental procedures.
5. If billing on the DentaQuest Provider Web Portal (PWP):
 - a. Providers with hospital privileges only (not contracted at OR/ Outpatient Facility location), bill services with the provider's primary office location, noting in remarks field the OR/facility name and address.
 - b. Providers who are contracted to the OR/Outpatient Facility location, bill services using the OR/facility name and location.

15.15 Criteria for Orthodontics (Child Members age 20 and younger)

Orthodontic treatment is available only to Health First Colorado child members age 20 and younger who qualify through the prior authorization process as having a severe handicapping malocclusion. The qualifying criteria for severe handicapping malocclusion are listed in Appendix A - Colorado Criteria Index Forms.

Please note:

- Orthodontists may use a wide range of services in the diagnosis, evaluation and treatment of orthodontic cases. Claims payment from Health First Colorado is considered payment in full and providers may not balance bill members for additional services or supplies, including cosmetic service, supply, or material upgrades.

- Cosmetic service upgrades include but are not limited to clear bracket/aligner systems such as Invisalign.

- Orthodontic treatment is not a benefit to treat dental conditions that are primarily cosmetic in nature [10 C.C.R. 2505-10, Vol. 8.280.5.F].

- Orthodontic treatment is not a benefit when there is no severe handicapping malocclusion, and self-esteem is the primary reason for treatment [10 C.C.R. 2505-10, Vol. 8.280.5.F].

- The current ADA claim form is required for prior authorization requests (PARs) and claims.

- Health First Colorado does not pay for all types of services that can possibly be used.

Only dental providers enrolled with an orthodontic specialty designation are allowed to provide orthodontic treatment. Enrollment with this specialty designation requires an evaluation of provider credentials. Providers will not be reimbursed for any orthodontic services rendered until they are enrolled by the Department as an Orthodontic specialist. See section 10.00 of this ORM for more information on provider credentialing and enrollment.

Orthodontic Services that Are Not Covered:

- Orthodontic treatment codes D8030, D8040.

Initial Orthodontic Examination (D8660) and Prior Authorization Requirements

Orthodontists may examine an eligible member that they believe is likely to qualify through the prior authorization process as having a severe handicapping malocclusion. A provider may not bill D8660 in conjunction with allowed oral evaluation codes for orthodontics (D0120, D0140, D0150, D0160, and/or D0170).

DentaQuest strongly discourages submission of PARs for mild and moderate malocclusions, unless there is a concurrent medical condition, (e.g., cleft palate, fetal alcohol syndrome, etc.) that should be evaluated under EPSDT utilization management guidelines.

Please reference the most current CDT ADA publication for accepted descriptions of primary, transitional, adolescent, and adult dentitions. Providers are required to submit the appropriate Colorado Orthodontic Criteria Index Form(s). The Colorado Orthodontic Criteria Index Form (A)- Orthodontic Treatment (D8070, D8080 and D8090) and the Colorado Orthodontic Index Form (B) (D8010/D8020) will be used to determine medical necessity.

The following documentation is required to show medical necessity:

- Colorado Orthodontic Criteria Index Form(s)
- Lateral cephalometric radiograph
- Panoramic radiograph
- Study models or OrthoCad equivalent or appropriate photographs

Appropriate photographic requirements include:

- 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, or in lieu of, the above photographic requirement, DentaQuest will accept quality photographs of study models with the following parameters:

- Occlusal view of the maxillary arch
- Occlusal view of the mandibular arch
- Right buccal view, in occlusion
- Left buccal view, in occlusion
- Facial views, straight on and low angle, in occlusion
- Posterior view of models in occlusion

DentaQuest will make a determination for orthodontic treatment upon receipt of all the work-up materials as outlined above for the prior authorization process following a review for medical necessity per 42 CFR § 438 and by the Department as in Rule 8.076.1.8, and Early Periodic Screening, Diagnostic and Treatment (EPSDT) Medical Necessity as in Rule 8.280. as well as 42 C.F.R. § 440.167.

Information on CMS efforts working with states to improve access to oral health services for children enrolled in Medicaid and CHIP can be found in CMS, Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy (April 11, 2011).

Approaches states can use to improve the delivery of dental and oral health services to children in Medicaid and CHIP can be found in Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents and in Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States. All of these documents are available at [Oral Health Care & Dental Insurance \(dentquest.com\)](http://dentquest.com) CMS, State Medicaid Manual §5124.B.2.b. CMS, State Medicaid Manual § 5124.B.2.b. 21 42 C.F.R. § 441.56(b)(vi). 22 CMS, State Medicaid Manual § 5123.2.G.

Prior Authorization Request (PAR) Effective Dates

PARs include span dates, which are the dates for which the PAR is effective. Providers will receive written notification of the approval or denial of a PAR. Included in this notification will be the effective date and end date of the PAR (span date). In order to be reimbursed for approved orthodontic

services, the date of service on your claim must be within approved span dates on the PAR. Should the start of orthodontic treatment be delayed for any reason past the end date of the approved PAR, the Provider must submit a new PAR before starting treatment.

General Billing Information for Orthodontics:

Once a PAR has been approved for orthodontic treatment services may be rendered. Payment for orthodontic treatment for eligible members will be made per the following schedule:

Code	PAR Required?	Payment Structure	Additional Benefit Details
D8010/D8020	Yes	<p>Providers will be reimbursed full fee at time of banding</p> <p>COC not eligible</p>	<p>Approved PAR is valid for 1080 days.</p> <p>Approved PAR not valid if member is no longer eligible for Health First Child plan.</p> <p>PAR must be consumed prior to member reaching 21yrs of age.</p>
D8070/D8080/ D8090	Yes	<p>Providers will be reimbursed for one of approved banding code at time of banding</p> <p>Providers will be reimbursed no more than three D8670's during the 24 months</p> <p>Providers will be reimbursed one of D8680 at de-banding and retention</p> <p>COC eligible</p> <p>If it has been more than 24 months since banding and member meets criteria and is approved for severe handicapping malocclusion, provider will receive full case rate.</p> <p>If it has been less than 24 months since and the member still has a severe handicapping malocclusion,</p>	<p>Approved PAR is valid for 1080 days.</p> <p>Approved PAR not valid if member is no longer eligible for Health First Child plan.</p> <p>If the eligible child member's orthodontic treatment extends beyond the recipients 21st birthday, it is the members responsibility to pay for continued treatment if the member desires to go forward with treatment and pay out of pocket. Member is not obligated to continue treatment; reference Section 4.10 Payment for Noncovered Services for more information.</p>

		provider will receive payment based off chart below.	
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Providers must submit a claim for D8010, D8020, D8070, D8080, or D8090 on the date of banding. This payment includes all orthodontic care necessary to complete treatment. Once the PAR has been approved, all care is considered inclusive in the case rate, and no services will be reimbursed separately.

Orthodontic treatment for codes D8070/D8080/D8090:

- The first submission for D8670 must be at least five months (or more) after banding and correspond with a date of service.
- Maximum of three D8670's in total.

Submission of D8680 must correspond to the date of de-banding. D8670 may be billed on the same day as D8680.

During orthodontia treatment, Providers will ONLY be paid for one D8070, D8080, or D8090; three D8670's, and one D8680. Members must be eligible for services on the date of service. If the child member loses eligibility during orthodontic treatment, and chooses to continue treatment, it is the member's responsibility to pay for the continued treatment, unless the treatment has already been paid in full. Acknowledgment of the member's understanding of this responsibility is required; please reference Section 4.10 Payment for Non-Covered Services for more information.

If the child member does not return for the completion of services, or for any other reason that orthodontic care needs to be terminated or is not completed, the orthodontic provider must submit the Orthodontic Termination of Care Submission Form to DentaQuest (Appendix A.). Recoupment of pre-paid fees will be determined by DentaQuest. Using the 24-month chart below.

Continuation of Care (COC) to another Health First Colorado Orthodontic Provider

Current Orthodontic Provider

The orthodontic provider should maintain the orthodontic member as a patient of record until DentaQuest confirms in writing that PAR approval has been received for continuation of care from the new orthodontic provider.

Transfer of a Health First Colorado orthodontic case to any orthodontist who is not a Health First Colorado provider is considered by Health First Colorado to be termination of care and an Orthodontic Termination of Care (TOC) Submission Form is required.

Newly enrolled Health First Colorado child members who have an approved PAR for severe handicapping malocclusion from another state Medicaid agency and were actively receiving treatment in the previous state may apply for COC. The following is required for consideration.

- Copy of the approved PAR dated within the last 24 months of COC request. Approved PAR's for D8070, D8080, D8090 will only be considered.
- CO Orthodontic Continuation of Care Submission Form.
- Submit PAR request using D8999

New Orthodontic Provider

The new orthodontic provider must submit a request for prior authorization (PAR) using code D8999 for the remaining orthodontic services to be rendered and include the Continuation of Care Submission Form (Appendix A). Please reference the Continuation of Care Submission Form for a list of required supporting documentation. The new orthodontist must receive notification from DentaQuest of orthodontic PAR approval before accepting responsibility for care. DentaQuest will determine and pay the accepting orthodontic provider the appropriate balance remaining up to the amount of the current case rate using the chart below.

Health First Colorado Orthodontic Payment for TOC/COC is based off of total case rate divided by 24 months for cases completed within 24 months. For cases past 24 months from banding, when the member meets the orthodontic medical necessity criteria, a full case rate will be approved. See table below.

Provider A is the original provider, Provider B is the provider submitting D8999 for COC.

Comprehensive Ortho TOC and COC calculation table (7.1.222 Standard Fee Schedule)						
CODES	1	2	3	4	5	6
D8070/80/90 A	\$ 140.56	\$ 281.12	\$ 421.69	\$ 562.25	\$ 702.81	\$ 843.37
D8070/80/90 B	\$ 3,232.92	\$ 3,092.36	\$ 2,951.80	\$ 2,811.23	\$ 2,670.67	\$ 2,530.11
	7	8	9	10	11	12
D8070/80/90 A	\$ 983.93	\$ 1,124.49	\$ 1,265.06	\$ 1,405.62	\$ 1,546.18	\$ 1,686.74
D8070/80/90 B	\$ 2,389.55	\$ 2,248.99	\$ 2,108.43	\$ 1,967.86	\$ 1,827.30	\$ 1,686.74
	13	14	15	16	17	18
D8070/80/90 A	\$ 1,827.30	\$ 1,967.86	\$ 2,108.43	\$ 2,248.99	\$ 2,389.55	\$ 2,530.11
D8070/80/90 B	\$ 1,546.18	\$ 1,405.62	\$ 1,265.06	\$ 1,124.49	\$ 983.93	\$ 843.37
	19	20	21	22	23	Total Case Rate
D8070/80/90 A	\$ 2,670.67	\$ 2,811.23	\$ 2,951.80	\$ 3,092.36	\$ 3,232.92	\$ 3,373.48
D8070/80/90 B	\$ 702.81	\$ 562.25	\$ 421.69	\$ 281.12	\$ 140.56	\$ 3,373.48

DentaQuest will use the current case rate for transfer cases, rather than determining the case rate when the service was originally approved.

Removal of Braces/De-banding or Fixed Retainers (D8695/D8680)

For the removal of braces or fixed retainers that were placed by another orthodontist outside of Health First CO, use code D8695. For the removal of braces that were part of an approved PAR by DentaQuest, use code D8680.

Lost Retainer

The loss or breakage of a retainer is an inevitable part of orthodontic care. Health First Colorado will reimburse providers separately for significant repairs or replacements. Generally, repairs that can be made at chair side or within the office laboratory during the scheduled appointment cannot be separately billed from the global orthodontic fee paid at the start of treatment. D8696 & D8697 require a PAR and D8703 & D8704 are pre-payment review;. Please reference Exhibit A for more information.

Lost or Damaged Bands, Brackets, Wires, Headgear

DentaQuest does not separately reimburse orthodontic providers to repair or replace bands, brackets, wires, headgear nor any other device normally associated with routine orthodontic care.

Corrective Jaw Surgery

Orthodontic care in preparation for corrective jaw surgery is a Colorado Medical Assistance Program benefit. Health First Colorado oral surgery providers are required to obtain prior authorization for orthognathic surgery procedures before rendering services.

Informed Consent when Corrective Jaw Surgery may be Needed

The Colorado Medical Assistance Program strongly recommends that you obtain a written informed consent prior to the initiation of orthodontic care when future corrective jaw surgery is a possibility. The consent should remain a part of the client's dental records, be signed, dated, and updated when needed. The nature, content, and extent of the consent are the total responsibility of the treating orthodontist and should cover all planned orthodontic and dental treatment(s) and clearly address the following areas:

<p>Colorado Medical Assistance Program has not approved corrective jaw surgery</p> <p>Health First Colorado requires separate prior authorization approval for all corrective jaw surgery procedures</p> <p>Health First Colorado requires that corrective jaw surgery be provided before the member turns age 21</p> <p>Health First Colorado requires that corrective jaw surgery not be done primarily for cosmetic reasons</p> <p>Health First Colorado requires that medical necessity be reviewed in advance of corrective jaw surgery</p> <p>Future Health First Colorado prior authorization review of the medical necessity for corrective jaw surgery has not been completed at this time</p> <p>Future Health First Colorado prior authorization for corrective surgery requires a separate PAR submission by Health First Colorado provider Oral Surgeon</p> <p>Future Health First Colorado client eligibility has not been determined</p> <p>Future Health First Colorado program benefits for corrective jaw surgery have not been determined</p>	
Date	Health First Colorado Orthodontic Provider
Member Name	Member's Parent/Guardian Name(s)

15.16 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental providers 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

Dental dam is a part of the root canal procedure wherein a tooth is isolated by clamping around it and placing a flexible, tight, rubber-like sheet that will keep the equipment and irrigates on the dentist's side and a patient's saliva on the other side, away from the pulp chamber that is being kept sterile. Dams are considered standard operating procedure per the American Association of Endodontist's Position Statement entitled.

- There are some root canal treatments where extraordinary measures have to be taken to fit a dental dam over a tooth. In these cases, dam placement is documented using CDT code D3910 surgical procedure for isolation of tooth with rubber dam." Proper documentation, X-rays, photos and narrative of medical necessity must be included in the chart whenever D3910 is submitted with a claim.

16.00 Clinical Criteria for Colorado IDD Waiver Program Adult Member-Only Benefits

16.01 Criteria for Interim Prosthesis and Other Removable Prosthetic Services (IDD benefits)

Coverage is provided for anterior teeth if 1 or more are missing. Full and partial dentures require prior authorization.

Documentation needed for pre-payment review of procedure:

- Treatment plan
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panoramic images
- Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) and inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

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 prosthesis

- Partial dentures are 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, Providers are expected to instruct the patient in the proper care of the prosthesis.
- Any adjustment necessary to achieve a proper fit during the six months immediately following the delivery of the prosthesis is included as part of the service.
- Denture adjustments are covered only when performed by a Provider who did not provide the denture.
- In general, if there is a pre-existing removable prosthesis (includes partials full dentures), it must be at least 5 years old to qualify for replacement.
- The replacement teeth should be anatomically full-sized teeth.

Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old
- 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 5 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 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 nine total denture repairs per 5 years
- Relines will be reimbursed once per denture every 4 years.
- A new prosthesis will not be reimbursed within 2 years 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.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for 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, Providers 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.
- **Replacement Denture Process**

- **Submit a prior authorization for replacement (use original code previously used) denture/partial**
 - Include the key words "denture replacement" in box #35
 - The prior authorization will be directed to a dedicated review queue
- **Key Changes**
 - Prior Authorization will no longer automatically deny, requiring appeal
 - The Denture form is no longer required to be completed and attached

16.02 Criteria for Endosteal Dental Implants (IDD-only benefits)

Dental implants are not covered if there are two adjacent anterior teeth missing. Coverage is provided for one anterior tooth per arch irrespective of the number of teeth in occlusion. Endosteal dental implants require prior authorization.

Implants are not a covered service for participants who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users. Subsequent implants are not a covered service when prior implants fail. Full mouth implants are not covered.

Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

Documentation needed for prior authorization review of implant procedure:

- Treatment plan
- Appropriate radiographs clearly showing the 2 contiguous adjacent and opposing teeth must be submitted. Periapicals or panoramic images must be of diagnostic quality.
- Narrative indicating patient cannot tolerate a removable appliance.

Fabrication of an implant abutment and prosthetic includes multiple stages and steps (appointments) these steps (healing cover placement and exposure, tissue former, transfer impressions, analog, try-in appointments, delivery etc.) are inclusive in the fee. A stock or custom abutment, the prosthesis should either be cemented, or screw retained, and as such, is not eligible for additional compensation

Criteria for placement of Endosteal Dental Implant

- Prosthetic services are intended to restore oral form and function due to premature loss of a single permanent anterior tooth that would result in significant occlusal dysfunction.
- Endosteal dental implants 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. Limited to Class I and Class 2 bone structure.
- Radiographs must show no untreated cavities or active periodontal disease in the adjacent teeth and must be at least 50% supported in bone, and do not require crowns.
- As part of any prosthetic service, Providers are expected to instruct the patient in the proper care of the prosthesis, including instructions on sub gingival oral hygiene.
- Any adjustment necessary to achieve a proper fit during the six months immediately following the delivery of the prosthesis is included as part of the service.
- Crown adjustments for occlusion, abutment adjustments, capture screw tightening including access exposure if necessary are covered only when performed by a Provider who did not provide the prosthesis.
- In general, for adult members (age 21 and older), if there is a pre-existing implant, it must be at least 5 years old to qualify for replacement.

When billing for implant placement, abutment and final crown, Providers must list the date that the separate procedures were inserted as the date of service. Recipients must be eligible on the date of service in order for the Endosteal dental implant and restoration service to be covered.

17.00 Billing Procedures for Medical Personnel

The D0999 (Unspecified Diagnostic Procedure) code has been closed for reimbursement as of July 1, 2014. Dental providers, including Direct Access/Independent Dental Hygienists, MDs, DOs, nurse practitioners and physician assistants previously billing this code for dental screening services provided to children ages 3 and 4 years old should now begin to bill using the D0190 (Screening of a Patient) code for those dental screening services rendered on or after July 1, 2014 using the billing guidelines below. The pricing on D0190 has been updated to reflect the same reimbursement amount for all providers as was paid using the D0999 code for dental screening services.

Qualified Medical Personnel should continue using the Department's Web Portal to submit claims for dental services reimbursement using the CMS 1500 paper claim form that was implemented by the Department on December 1, 2014 or electronically as an 837P transaction.

Dental professionals, including Direct Access/Independent Dental Hygienists, are also able to provide these services. While encouraged, no additional training is required for dental professionals to provide these services. All dental providers, including Direct Access/Independent Dental Hygienists and those providing services at a FQHC, must now send all claims for reimbursement for all dental services rendered on or after July 1, 2014, to DentaQuest for processing using the electronic current ADA claim form found in the DentaQuest Provider Portal. For further assistance with billing, please call DentaQuest Provider Services at 855.225.1730.

Billing Procedures for Qualified Medical Personnel regarding children ages birth through 2 years old:

- Private Practices (MDs, DOs, nurse practitioners and physician assistants): D1206 (fluoride varnish) and D0145 (oral evaluation for a patient under 3 years of age and counseling with primary caregiver) must be billed on the CMS 1500 paper claim form that was implemented by the Department on December 1, 2014 or electronically as an 837P transaction in conjunction with a well-child visit using the Department's Web Portal.
- FQHCs and RHCs Medical Personnel: D1206 (fluoride varnish) and D0145 (oral evaluation for a patient under 3 years of age and counseling with primary caregiver) must be itemized on the claim with a well-child visit but reimbursement will be at the current encounter rate. Billing is on the UB-04 paper claim form or electronically as an 837I transaction using the Department's Web Portal.

Billing Procedures for Qualified Medical Personnel for children ages 3 through 4 years old:

- Private Practices (MDs, DOs, nurse practitioners and physician assistants): D1206 (fluoride varnish) and D0190 (dental screening) must be billed on the CMS 1500 paper claim form that was implemented by the Department on December 1, 2014 or electronically as an 837P transaction in conjunction with a well-child visit using the Department's Web Portal.
- FQHCs and RHCs Medical Personnel: D1206 (fluoride varnish) and D0190 (dental screening) must be itemized on the claim with a well-child visit but reimbursement will be at the current encounter rate. Billing is on the UB-04 paper claim form or electronically as an 837I transaction using the Department's Web Portal.

Billing Procedures for Qualified Medical Personnel for children ages 5 years and older:

- Private Practices (MDs, DOs, nurse practitioners and physician assistants): D1206 (fluoride varnish) or D1208* (topical fluoride gel) and D0190 (dental screening) must be billed on the CMS

1500 paper claim form that was implemented by the Department on December 1, 2014 or electronically as an 837P transaction using the Department's Web Portal.

- FQHCs and RHCs Medical Personnel: D1206 (fluoride varnish) or D1208* (topical fluoride gel) and D0190 (dental screening) must be itemized on the claim at the current encounter rate. Billing is on the UB-04 paper claim form or electronically as an 837I transaction using the Department's Web Portal.
- Please note: Fluoride varnish is considered the standard of care and is the only acceptable topical fluoride treatment for child member's ages 0 through 5 years (up to the day before their sixth birthday). However, either topical fluoride or fluoride varnish may be used for child Members after the child's sixth birthday. Fluoride rinse is not an acceptable treatment for any child member and will not be reimbursed.

Topical fluoride is a covered benefit for child members through age 20. For all child members, topical fluoride treatments are allowed twice (2) per year. Child members ages 0 through 4 years old may receive an additional two (2) fluoride topical applications per year for a total of up to four (4) per year. Child members ages 5 through 20 at high risk for caries may receive an additional one (1) fluoride topical application per year for a total of up to three (3) per year. Topical fluoride and fluoride varnish may be administered only after a risk assessment is completed. The approved risk assessment forms are the Pediatric Oral Health Screening forms. A form for use in dental offices and a form for use in medical offices can be found in Appendix A, under "Forms" of this ORM, on the Department's website under the Provider Services <https://www.colorado.gov/pacific/hcpf/provider-forms> or download the forms under the

[Medical Form \[coloradooralhealth.org\]](https://www.colorado.gov/pacific/hcpf/provider-forms)

[Dental Office \[coloradooralhealth.org\]](https://www.colorado.gov/pacific/hcpf/provider-forms)

Documentation of risk using a Pediatric Oral Health Screening form must be part of the child member's medical and/or dental record.

The maximum allowable benefit per eligible and High Risk child member age 0 through 4 years will be four (4) times per year. The maximum allowable benefit per eligible child member age 5 through 20 years will be three (3) times per year. Dental offices and medical offices are encouraged to communicate with one another to avoid duplication of services and/or nonpayment of services.

Charges for supplies used in self or home application of topical fluorides are not a benefit.

Billing Procedure for Oral Maxillofacial Surgeons

A D.D.S., D.M.D. that is dually credentialed (D.D.S.,D.M.D./M.D.) and or that has successfully completed a residency in Oral Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA) or holds privileges either issued by a credentialing committee of a hospital accredited by the Joint commission on Accreditation of Healthcare Organizations (JCAHO) or the Accreditation for Ambulatory Health Care (AAAHC) may be allowed to bill for medical (CPT) surgical codes covered by Medical portion of Health First Colorado Program through the Department's Colorado Medical Assistance Program Web Portal.

- Provider must be enrolled as provider type 04/061
- Provider will submit CPT code(s) when a CDT code(s) is not available or is not appropriate. CPT codes are a benefit for medically necessary treatment as based upon medical diagnosis.
 - Bill on professional claim form:
 - Procedures that are result of medical condition (trauma/orthognathic)
 - Services requiring hospital dentistry that are the result of a medical condition

- Professional must submit PAR from eQ Health for prior authorized codes to bill (CPT/CMS-1500 Claim) *NOTE- the main source for identifying which codes require a PAR and which do not can be found on the Health First Colorado Fee Schedule.
<https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule>
- The hospital must submit a PAR for the Inpatient Admission (UB-04 Claim)

When a CDT code is not available, covered or appropriate, dually enrolled providers may bill medical CPT codes. For more information on medical billing visit the Healthcare Policy and Finance website
<https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule>

18.00 Direct Access/Independent Dental Hygiene Providers

Dental procedures may be billed by an independent dental hygienist within their scope of practice, as defined by the Colorado Department of Regulatory Agencies (DORA).

The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and enforces standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act under Licensure of Dentists and Dental Hygienists. The Dental Practice Act and Board rules are available on DORA's website → Professions→ Dentists or Dental Hygienist. It is the provider's responsibility to ensure they are practicing, and subsequently billing, within their scope.

In order to provide continuity of care, dental hygienists who are directly reimbursed must identify and document in the member's treatment record Health First Colorado-participating dentist to which they refer members.

Limitations for Direct Access/Independent Dental Hygienists

Dental hygienists employed by a dentist, clinic or institution cannot submit claims directly to DentaQuest. Claims must be submitted using the enrolled employers National Provider Identification and Health First Colorado Provider number.

An unsupervised dental hygienist cannot provide and bill dental services for a Health First Colorado non-citizen member of any age.

Dental Hygienists may apply D1354- Silver Diamine Fluoride under the direct or indirect supervision of a dentist. RDH's must:

- hold a license in good standing to practice dental hygiene
- completes an interactive training course offered by a dental board-approved CE entity that addresses the use and limitations of silver diamine fluoride; is covered by professional liability insurance; and
- has a collaborative agreement with a dentist that outlines the protocol, any restrictions/limitations, follow-up and referral procedures for the use of silver diamine fluoride
- maintain a copy of collaboration agreement with a licensed dentist on file for auditing purposes or possible investigation related to a complaint.

RDH TABLE- Health First Colorado enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0120	Periodic oral evaluation-established patient
D0140	Limited oral evaluation - problem focused, established patient

RDH TABLE- Health First Colorado enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D0145	Oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
D0170	Re-evaluation, limited problem focused (established patient; not post-operative visit)
D0180	Comprehensive periodontal evaluation– new or established patient
D0190	Screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.
D0210	Intraoral - complete film series
D0220	Intraoral - periapical first film
D0230	Intraoral - periapical each additional film
D0240	Intraoral - occlusal film
D0251	Extra-oral posterior dental radiographic image
D0270	Bitewing – single (1) film
D0272	Bitewings – two (2) films
D0273	Bitewings – three (3) films
D0274	Bitewings – four (4) films
D0277	Vertical Bitewings – seven (7) to eight (8) radiographic images
D0330	Panoramic radiographic image
D0350*	2D oral/facial photographic image obtained intra-orally or extra-orally
D1110	Prophylaxis – adult, ages twelve (12) years and older
D1120	Prophylaxis – child
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride (e.g., gel)
D1351	Sealant (per tooth)
D1353	Sealant repair
D1354	Interim caries arresting medicament application- per tooth
D2940*	Protective restoration
D4341	Periodontal Scaling and root planing – four or more teeth per quadrant
D4342	Periodontal Scaling and root planing – one to three teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation

RDH TABLE- Health First Colorado enrolled unsupervised or direct access dental hygienists (as defined by DORA) may provide and be reimbursed for the following dental procedures for all clients:	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal Maintenance
D6081	Scaling and debridement of single implant
D6180	Implant maintenance
D9110	Palliative (emergency) treatment of dental pain- minor procedure
D9410	House/extended care facility call

* Only billable by dental hygienist with the applicable ITR permit from DORA

18.50 Dental Therapist

Dental procedures may be billed by a dental therapist within their scope of practice, as defined by the Colorado Department of Regulatory Agencies (DORA).

The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and enforces standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act under Dental Therapists. The Dental Practice Act and Board rules are available on DORA's website → Professions → Dentists, Dental Hygienists and Dental therapists. It is the provider's responsibility to ensure they are practicing, and subsequently billing, within their scope.

Health First Colorado enrolled Dental Therapists must submit claims using the enrolled employers National Provider Identification and Health First Colorado Provider number.

Dental therapist must comply with all Colorado Dental Board regulations for Dental Therapists

Supervising dentists and dental therapists must provide documentation of the DORA permit and a signed notification of a supervising dentist form to Ivy Beville (Ivy.Beville@state.co.us) or their DentaQuest Provider Relations Representative to be allowed this reimbursement.

Additional references:

- [DORA DT checklist](#)
- [DORA apply online](#)
- [DORA verify license](#)

Dental Therapists' Billable Codes (all benefit and frequency limitations apply)

D0120	periodic oral evaluation - established patient
D0140	limited oral evaluation-problem focused
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver
D0160	detailed and extensive oral eval-problem focused, by report
D0170	re-evaluation, limited problem focused
D0180	comprehensive periodontal evaluation - new or established patient

D0190	Screening of a patient
D0210	intraoral - comprehensive series of radiographic images
D0220	intraoral - periapical first radiographic image
D0230	intraoral - periapical each additional radiographic image
D0240	intraoral - occlusal radiographic image
D0251	extra-oral posterior dental radiographic image
D0270	bitewing - single radiographic image
D0272	bitewings - two radiographic images
D0273	bitewings - three radiographic images
D0274	bitewings - four radiographic images
D0277	vertical bitewings - 7 to 8 films
D0330	panorex
D0340	cephalometric radiographic image
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium
D0372	intraoral tomosynthesis – comprehensive series of radiographic images
D0373	intraoral tomosynthesis – bitewing radiographic image
D0374	intraoral tomosynthesis – periapical radiographic image
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium
D0384	Cone beam CT image capture for TMJ series including two or more exposures
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only

D0411	HbA1 in-office point of service testing
D0412	blood glucose level test
D0425	caries susceptibility tests
D0470	diagnostic casts
D1110	prophylaxis - adult
D1120	prophylaxis - child
D1206	topical application of fluoride varnish
D1208	topical application of fluoride - excluding varnish
D1351	sealant - per tooth
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.
D1353	Sealant repair - per tooth
D1354	application of caries arresting medicament- per tooth
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes
D1781	vaccine administration – human papillomavirus – Dose 1
D1782	vaccine administration – human papillomavirus – Dose 2
D1783	vaccine administration – human papillomavirus – Dose 3
D2140	Amalgam - one surface, primary or permanent
D2150	Amalgam - two surfaces, primary or permanent
D2160	amalgam - three surfaces, primary or permanent
D2161	amalgam - four or more surfaces, primary or permanent
D2330	resin-based composite - one surface, anterior
D2331	resin-based composite - two surfaces, anterior
D2332	resin-based composite - three surfaces, anterior

D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2390	resin-based composite crown, anterior
D2391	resin-based composite - one surface, posterior
D2392	resin-based composite - two surfaces, posterior
D2393	resin-based composite - three surfaces, posterior
D2394	resin-based composite - four or more surfaces, posterior
D2799	interim crown
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	re-cement or re-bond crown
D2928	prefabricated porcelain/ceramic crown – permanent tooth
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	prefabricated stainless steel crown - primary tooth
D2931	prefabricated stainless steel crown-permanent tooth
D2932	prefabricated resin crown
D2933	prefabricated stainless steel crown with resin window
D2934	prefabricated esthetic coated stainless-steel crown - primary tooth
D2940	protective restoration
D2980	crown repair, by report
D3470	intentional reimplantation
D4322	splint – intra-coronal; natural teeth or prosthetic crowns
D4323	splint – extra-coronal; natural teeth or prosthetic crowns
D4341	periodontal scaling and root planing - four or more teeth per quadrant
D4342	periodontal scaling and root planing - one to three teeth per quadrant
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4381	localized delivery of antimicrobial agents
D4910	periodontal maintenance procedures
D5511	repair broken complete denture base, mandibular
D5512	repair broken complete denture base, maxillary
D5520	replace missing or broken teeth - complete denture (each tooth)

D5611	repair resin partial denture base, mandibular
D5612	repair resin partial denture base, maxillary
D5621	repair cast partial framework, mandibular
D5622	repair cast partial framework, maxillary
D5630	repair or replace broken retentive/clasping materials per tooth
D5640	replace broken teeth-per tooth
D5986	fluoride gel carrier
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed.
D6980	fixed partial denture repair
D7111	extraction, coronal remnants - primary tooth
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7272	tooth transplantation (includes reimplantation from one site to another)
D9110	palliative treatment of dental pain - per visit
D9410	house/extended care facility call
D9911	application of desensitizing resin for cervical and/or root surface, per tooth

19.00 Billing Procedures for Assistant Surgeons

An Assistant Surgeon is allowed to bill for the ADA procedure codes listed in the table located below.

- A Prior Authorization Request (PAR) is NOT required for the use of an assistant surgeon. However, when the claim is submitted following the instructions below, it will deny due to no PAR on file triggering a manual review. This manual review allows DentaQuest to match up the primary surgeon and assistant surgeon claims for payment. The manual review process may take up to two weeks.
- Assistant surgeon claims must be submitted on a current or later ADA claim form.
- Bill one D7999 “unspecified oral surgery procedure, by report”, and enter the total charge for assisting with the surgery/surgeries.
- In the “Remarks” area (box 35), write “LARK.”
- Please do not send x-rays.
- Please submit the Assistant Surgeon Report form in the appendix.

- Please contact your network manager if you encounter any issues with your claim processing or if you have questions.

ASSISTANT SURGEON CODE TABLE: Table of Billable Codes for Health First Colorado Assistant Surgeons	
D7295	harvest of bone for use in autogenous grafting procedure
D7411	excision of benign lesion greater than 1.25cm
D7412	excision of benign lesion, complicated
D7413	excision of malignant lesion up to 1.25cm
D7414	excision of malignant lesion greater than 1.25cm
D7415	excision of malignant lesion, complicated
D7441	excision of malignant tumor-lesion diameter up to 1.25cm
D7451	removal of odontogenic cyst or tumor- lesion greater than 1.25cm
D7461	removal of nonodontogenic cyst or tumor- lesion greater than 1.25cm
D7511	incision and drainage of abscess -intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7521	incision and drainage of abscess -extra oral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7710	maxilla - open reduction
D7720	maxilla - closed reduction
D7730	mandible - open reduction
D7740	mandible - closed reduction
D7750	malar and/or zygomatic arch-open reduction
D7760	malar and/or zygomatic arch-closed reduction
D7770	alveolus-stabilization of teeth, open reduction splinting
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches
D7840	condylectomy
D7850	surgical discectomy, with/without implant
D7852	disc repair
D7854	synovectomy
D7856	myotomy
D7858	joint reconstruction

ASSISTANT SURGEON CODE TABLE: Table of Billable Codes for Health First Colorado Assistant Surgeons	
D7860	arthrotomy
D7865	arthroplasty
D7870	arthrocentesis
D7871	non-arthroscopic lysis and lavage
D7872	arthroscopy - diagnosis with or without biopsy
D7873	arthroscopy-surgical: lavage and lysis of adhesions
D7874	arthroscopy-surgical: disc repositioning and stabilization
D7875	arthroscopy-surgical synovectomy
D7876	arthroscopy-surgery discectomy
D7877	arthroscopy-surgical debridement
D7899	unspecified TMD therapy, by report
D7920	skin graft (identify defect covered, location and type of graft)
D7940	osteoplasty- for orthognathic deformities
D7941	osteotomy - mandibular rami
D7943	osteotomy - mandibular rami bone graft; includes obtaining the graft
D7944	osteotomy - segmented or subapical - per sextant or quadrant
D7945	osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7955	repair of maxillofacial soft and/or hard tissue defect
D7991	coronoidectomy
D7995	synthetic graft-mandible or facial bones, by report
D7996	implant-mandible for augmentation purposes, by report
D7999	unspecified oral surgery procedure, by report

20.00 Teledentistry and ITR Billing Procedures

Effective January 1st, 2017, Health First Colorado will reimburse DORA permitted RDH's for Protective Restorations and Interim Therapeutic Restorations (D2940). Permitted RDH's must designate a supervising dentist that is currently enrolled with Health First Colorado and within a reasonable proximity (30 miles - urban counties, 45 miles - rural counties, 60 Miles - frontier counties) of the location where the ITR is placed to ensure any follow-up care concerns can be addressed. Supervising dentists will be permitted to use code D0391 for their review of x-rays and photographs to make a diagnosis, treatment plan and order procedures such as an ITR. Please reference HB15-1309 for more information.

Supervising dentists and hygienists must provide documentation of the DORA permit and a signed notification of a supervising dentist form to Ivy Beville (Ivy.Beville@state.co.us) or their DentaQuest Provider Relations Representative to be allowed this reimbursement. **NOTE:** if a change in supervising dentist is made, the signed notification of the new supervising dentist form must be submitted to DORA so that the information can be added.

Code D9996 should be submitted whenever "store and forward" technology is used. This code enables HCPF to track and measure tele dentistry utilization.

Permitted RDH claims will trigger payment of the encounter rate, not the dentist claim for D0391. The RDH and the supervising dentist must work at the same FQHC.

Per HB15-1309 the RDH shall inform the member that appropriate follow up care with a Dentist is necessary.

21.00 Clinical Practice Guidelines

Clinical practice guidelines are recommendations for diagnosing and treating medical conditions that are written for healthcare professionals. They are developed by healthcare and professional organizations and are based on a systematic review of research evidence. The American Dental Association (ADA) defines clinical practice guidelines (CPGs) as statements that provide recommendations for patient care based on a systematic review of evidence. CPGs are considered the most rigorous examples of evidence-based dentistry (EBD) and are intended to help clinicians with diagnosis, treatment planning, and clinical decision-making. DentaQuest reviews and monitors any changes associated with CPGs annually. All Clinical Practice Guidelines, adopted by DentaQuest, can be located on the DentaQuest website for all providers/members to reference.

Clinical Practice Guidelines (Adopted by DentaQuest) – Specialized Organizations Include:

- The American Academy of Pediatric Dentistry
- The Academy of General Dentistry
- The American Endodontic Society
- The American Orthodontic Society
- The American Association of Oral and Maxillofacial Surgery
- The American Academy of Ophthalmology
- The American Optometric Association

ITR Billing Information

Code	Description	Billing Information	Notes
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Billed by RDH	
D0391	Interpretation of diagnostic image by a practitioner not associated with the capture of the image, including report	Billed by Supervising dentist	Reimbursed at \$0.00 for dentists working in a FQHC
D2940	protective restoration	Billed by RDH	
D9996	asynchronous; information stored and forwarded to dentist for subsequent review	Billed by RDH	This code is used to determine Teledentistry utilization Reimbursement is \$0.00

Appendix A - Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

- A. "The Department" means the Colorado Department of Health Care Policy and Financing, which serves as Health First Colorado Single State Agency, as defined by the Code of Federal Regulations (CFR) Title 45 Section 2015.100 (45 CFR §205.100).
- B. "Contract" means the document specifying the services provided by DentaQuest to:

- an employer, directly or on behalf of the State of Colorado, as agreed upon between The Department and DentaQuest (a “Government Contract”).
 - a Health First Colorado beneficiary, directly or on behalf of The Department, as agreed upon between the State of Colorado or its regulatory agencies and DentaQuest (a “Health First Colorado Contract”).
 - a Medicare beneficiary, directly or on behalf of The Department, as agreed upon between the Center for Medicare and Health First Colorado Services (“CMS”) or Plan and DentaQuest (a “Medicare Contract”).
- C. “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.
- D. “DentaQuest” shall reference DentaQuest, USA Insurance Company, Inc.
- E. “DentaQuest Service Area” shall be defined as the State of Colorado.
- F. “Dental Professional” is a Participating Provider who is enrolled dental professional with Health First Colorado. The types of dental professional providers who can render these services are dentists and dental hygienists who are licensed in Colorado.
- G. “High Risk for Caries” includes: members who present with demonstrable caries, a history of restorative treatment, dental plaque, and enamel demineralization; or child members of mothers with a high caries rate, especially with untreated caries; or child members who sleep with a bottle containing anything other than water, or who breastfeed throughout the night (at-will nursing); or child members with special health care needs.
- H. “High Risk for Periodontal Disease” includes history of periodontal scaling; or root planing; or periodontal surgery; or diabetes; or pregnancy.
- I. “Medically Necessary” means those Covered Services provided by a physician, dental professional, 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 The Department or its designee in its judgment to be a Covered Service which is required and appropriate in accordance with the law, regulations, guidelines and accepted standards of medical and dental practices in the community.
- J. “Member” means any individual who is eligible to receive Health First Colorado Covered Services pursuant to the Department’s benefit scope, frequencies and limitations as outlined in this ORM. “Child member” means an individual who is age 20 years or under. “Adult member” means an individual who is age 21 years and older.
- K. “Participating Provider” is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with the Colorado Department of Health Care Policy and Financing, directly or through another entity, to provide dental services to selected groups of members.
- L. “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.
- M. “Plan Certificate” means the document that outlines the benefits available to members.
- N. “Provider” means the undersigned health professional or any other entity that has entered into a written agreement with the Colorado Department of Health Care Policy and Financing to provide certain health services to members. Each Provider shall have its own distinct tax identification number.
- O. “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 an Agreement with the Colorado Department of Health Care Policy and Financing.
- P. “Qualified Medical Personnel” means physicians (MDs), osteopaths (DOs), nurse practitioners and physician assistants with a focus on primary care, general practice, internal medicine,

pediatrics and who have participated in on-site training by the “Cavity Free at Three” team or have completed Module 2 (child oral health) and Module 6 (fluoride varnish) in the Smiles for Life curriculum when treating Child Clients age 0 years through 12 years of age. The qualified medical personnel must have participated in Module 3 (adult oral health) and Module 6 (fluoride varnish) in the Smiles for Life curriculum when treating Child Clients ages 12 years and older. Qualified medical personnel who complete this training must provide the documentation of this training when requested. Note: Qualified medical personnel may administer certain services; limited to oral examinations, screenings and the topical application of fluoride varnish.

- Q. “Topical Fluoride Treatment High Risk Criteria for Adult members” includes: a history dry mouth; or a history of head or neck radiation; or indication of High Risk for Caries. If, at the time of the adult member’s next oral examination he or she no longer has active decay, that adult member is no longer considered high risk.

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 Provider Web Portal at 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:

- Listing of Community Centered Boards (CCB) and Map
- Current ADA Claim Form
- Health First Colorado Dental Non-Covered Services Disclosure Form
- Direct Deposit/ACH Authorization Form
- Medical/Dental History Form
- Authorization for Treatment Form
- Initial Clinical Exam Form
- Request for Transfer of Records Form
- Recall Examination Form
- Pediatric Oral Health Screening Form – for Dental Office settings (Cavity Free at Three)
- Pediatric Oral Health Screening Form – for Medical Office settings (Cavity Free at Three)
- Colorado Orthodontic Criteria Index Form – Comprehensive Treatment (D8070, D8080, D8090) Form
- Orthodontic Continuation of Care Submission Form
- Orthodontic Termination of Care Submission Form
- Assistant Surgeon Report

If you do not have internet access you may also contact DentaQuest Provider Services at 855.225.1731 in order to have copies of the “Related Documents” listed under Additional Resources mailed to you

American Dental Association Dental CLAIM FORM

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION									
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> EPSDT / Title XIX									
2. Predetermination/Preauthorization Number									
DENTAL BENEFIT PLAN INFORMATION									
3. Company/Plan Name, Address, City, State, Zip Code									
3a. Payer ID									
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 <input type="checkbox"/> U		8. Policyholder/Subscriber ID (Assigned by Plan)					
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					
11a. Other Payer ID									
POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 <input type="checkbox"/> U		15. Policyholder/Subscriber ID (Assigned by Plan)				
16. Plan/Group Number				17. Employer Name					
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									
21. Date of Birth (MM/DD/CCYY)			22. Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U		23. Patient ID/Account # (Assigned by Dentist)				
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	30a. Diag. Pointer	30b. City	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/Cat Qualifier <input type="checkbox"/> (ICD-10 = AB)			31a. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
32. 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17					34a. Diagnosis Code(s) (Primary diagnosis in "A")			32. Total Fee	
A _____					B _____			C _____	
D _____									
35. Remarks									
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)				
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.					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)	
Patient/Guardian Signature _____ Date _____					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)			39a. Date Last SRP	
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dental or dental entity.					42. Months of Treatment			41. Date Appliance Placed (MM/DD/CCYY)	
Subscriber Signature _____ Date _____					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. <input checked="" type="checkbox"/> Signed (Treating Dentist) _____ Date _____				
49. NPI					53a. Locum Tenens Treating Dentist? <input type="checkbox"/>			54. NPI	
50. License Number					55. License Number			56. Address, City, State, Zip Code	
51. SSN or TIN					56a. Provider Specialty Code				
52. Phone Number () -			52a. Additional Provider ID		57. Phone Number () -			58. Additional Provider ID	

American Dental Association Dental Claim Form Instructions

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"

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
Dentist 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
General Practice	1223G0001X
Dental Specialty (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"

Health First Colorado (Colorado’s Medicaid Program)Dental Non-Covered Service Disclosure Form

Health First Colorado (Medicaid) members may purchase additional dental services as non-covered procedure(s) or treatment(s) for an additional fee. Medicaid requires that the participating provider and the member complete the **Health First Colorado Dental Non-Covered Services Disclosure Form** prior to rendering these services. A copy of this completed and signed form **must** be kept in the member’s treatment record. If the member elects to receive the non-covered procedure(s) or treatment(s) the member will be charged a fee, not to exceed the maximum rate of the participating provider’s Usual and Customary Fees (UCF), as payment in full for the agreed procedure(s) or treatment(s).

The member is financially responsible for such non-covered service(s) or treatment(s) as defined by the Health First Colorado Dental Program in section 4.10 of the DentaQuest Office Reference Manual (ORM). The member may be subject to collection action upon failure to make the required payment. If the member is subject to collection action, the terms of the action must be kept in the member’s treatment record. Failure to comply with the Health First Colorado policy regarding non-covered services and member billing will subject the participating provider to sanctions up to and including termination as outlined in State statutes (CRS 25.5-4-301)

This section to be completed by the participating provider rendering dental care:

I have done my due diligence on behalf of the member and educated the member about their covered benefits and informed the member that these procedure(s) may not be paid by Health First Colorado.

I am recommending: *(Member Name and Medicaid Number)*

receive services that are **not** covered by the Health First Colorado Dental Program and Fee Schedule. The Health First Colorado dental program encourages participating providers to bill members at or near the current fee schedule amount (FEES ARE NOT TO EXCEED PROVIDER’S UCF.) The following procedure codes are recommended: NOTE: Any provider-created agreement must include all of the data elements listed on this form.

Procedure Code (If applicable)	Description	Fee	Date(s) of Service

The total amount for service to be rendered is \$_____.

Participating Provider’s Signature Date

NOTE: Any provider-created agreement must include all of the data elements listed on this form.

This section to be completed by the member:

I _____ have been told that I require, or I have
Print Member Name
 requested, dental services that are not covered by Health First Colorado.

Read the following statements and check Yes or No:

	<u>Yes</u>	<u>No</u>
1. My dental provider has assured me that there are no other covered benefits available to me as an alternative treatment option(s).	_____	_____
2. I am willing to receive services not covered by Health First Colorado Dental Program.	_____	_____
3. I am aware that I am financially responsible for paying for these services.	_____	_____
4. I am aware that Health First Colorado is not paying for these services.	_____	_____

I agree to pay \$ _____ per month towards the total amount due to my dental provider for the services rendered as outlined in this agreement. If I fail to make this payment, I may be subject to collection action by the participating provider.

 Member Signature Date

 Parent or Guardian Signature, if under 18. Date

Formulario de divulgación para los servicios odontológicos no incluidos en Health First Colorado (Programa de Medicaid de Colorado)

Los afiliados de Health First Colorado (Medicaid) pueden comprar servicios odontológicos adicionales, como procedimientos o tratamientos no incluidos, por un costo adicional. Medicaid exige que el proveedor participante y el afiliado completen el Formulario de divulgación para los servicios odontológicos no incluidos en Health First Colorado antes de que estos servicios se presten. Se debe conservar una copia de este formulario completado y firmado en el expediente de tratamientos del afiliado. Si el afiliado decide recibir los procedimientos o tratamientos no incluidos, se le cobrará un costo, que no deberá superar el costo máximo de las tarifas comunes y prevaletientes (*Usual and Customary Fees*, UCF) del proveedor participante, como pago total para los procedimientos o tratamientos acordados.

El afiliado es responsable económicamente de dichos servicios o tratamientos no incluidos, según lo que define el Programa Odontológico de Health First Colorado en la sección 4.10 del Manual de referencia del consultorio (*Office Reference Manual*, ORM) de DentaQuest. El afiliado puede ser objeto de medidas de cobro en caso de no realizar el pago obligatorio. Si el afiliado es objeto de medidas de cobro, los términos de las medidas deben conservarse en el expediente de tratamientos del afiliado.

Si no se cumplen las políticas de Health First Colorado con respecto a los servicios no incluidos y la facturación del afiliado, el proveedor participante será objeto de sanciones que pueden incluir hasta el cese, como se detalla en los estatutos estatales (CRS 25.5-4-301)

Esta sección debe ser completada por el proveedor participante que presta atención odontológica:

He hecho mis debidas diligencias en representación del afiliado e instruido al afiliado sobre sus beneficios incluidos, y le he informado que es posible que Health First Colorado no pague estos procedimientos.

Recomiendo que:

(Nombre del afiliado y número de Medicaid)

reciba servicios que no están incluidos en el Programa Odontológico ni en la tabla de tarifas de Health First Colorado. El programa odontológico de Health First Colorado alienta a los proveedores participantes a facturar a los afiliados un monto equivalente o cercano al de la tabla de tarifas actualizada (LAS TARIFAS NO DEBEN SUPERAR LAS UCF DEL PROVEEDOR). Se recomiendan los siguientes códigos de procedimientos:

Código del procedimiento (si corresponde) Descripción Tarifa Fecha(s) de los servicios En blanco

Código del procedimiento (si corresponde)	Descripción	Tarifa	Fecha(s) de los servicios

El monto total por el servicio a prestar es de \$_____

Firma del proveedor participante Fecha

NOTA: Cualquier acuerdo elaborado por el proveedor debe incluir todos los datos indicados en este formulario. El afiliado debe completar esta sección:

Me han informado a mí _____ que necesito, o he solicitado, servicios
Nombre del afiliado en letra de imprenta.
odontológicos que no están incluidos en Health First Colorado.

Lea las siguientes declaraciones y marque Sí o No:

Sí / No

- | | |
|---|-------|
| 1. Mi proveedor de servicios odontológicos me ha asegurado que no dispongo de otros beneficios incluidos como opciones alternativas de tratamiento. | _____ |
| 2. Estoy dispuesto a recibir servicios que no están incluidos en el Programa Odontológico de Health First Colorado. | _____ |
| 3. Soy consciente de que soy económicamente responsable de pagar estos servicios. | _____ |
| 4. Soy consciente de que Health First Colorado no pagará estos servicios. | _____ |

Acepto pagar \$_____ por mes de la cantidad total adeudada a mi proveedor de servicios odontológicos por los servicios prestados, como se detalla en este acuerdo. Si no realizo este pago, puedo ser objeto de medidas de cobro por parte del proveedor participante.

Firma del afiliado Fecha

Firma del padre, madre o tutor, si es menor de 18 años. Fecha



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

***Indicates Required Field. Please print legibly.**

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	
Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	
Provider Identifiers Information			
*Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits		*National Provider Identifier (NPI) Numeric 10 Digits	
Provider Contact Information			
*Provider Contact Name- (Name of contact in provider office authorized to handle EFT issues)		Title	
*Telephone Number		*Email Address	
Financial Institution Information			
*Financial Institution Name			
Financial Institution Address			
*Street		*City	
*State/Province		*Zip Code/Postal Code	
*ZIP Code/Postal Code		Financial Institution Telephone Number	
*Financial Institution Routing Number (Numeric 9 Digits)		*Type of Account at Financial Institution (e.g., Checking, Saving)	
*Provider's Account Number with Financial Institution		*Account Number Linkage to Provider Identifier – Select One	Provider TIN <input type="checkbox"/> Provider NPI <input type="checkbox"/>
Submission Information			
*Reason for Submission Select One	New Enrollment <input type="checkbox"/>	Change Enrollment <input type="checkbox"/>	Cancel Enrollment <input type="checkbox"/>
Include with Enrollment Submission	Voided Check A voided check is attached to provide confirmation of Identification/Account Numbers		

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 upstairs 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	Provider'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.

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 Provider 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 Provider.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Provider: _____

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 reference State statutes for specific State requirements and guidelines.

ALLERGY	PRE MED	MEDICAL ALERT
---------	---------	---------------

INITIAL CLINICAL EXAM

PATIENT'S NAME _____
Last
First
Middle

<p style="font-size: small; margin-top: 5px;"> 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 B L L B RIGHT A B C D E F G H I J LEFT T S R Q P O N M L K L B L B 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 </p>	<p>GINGIVA</p> <hr/> <p>MOBILITY</p> <hr/> <p>PROTHESIS EVALUATION</p> <hr/> <p>OCCLUSION 1 11 111</p> <hr/> <p>PATIENT'S CHIEF COMPLAINT</p>
--	--

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS
-------------	-----	---------

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST _____

DATE _____

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: _____

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		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 reference State statutes for specific State requirements and guidelines.

First Review _____
 Second Review _____

Models _____
 Orthocad _____
 Ceph Films _____
 X-Rays _____
 Photos _____
 Narrative _____

HEALTH FIRST COLORADO ORTHODONTIC CRITERIA INDEX FORM COMPREHENSIVE ORTHODONTIC TREATMENT (D8070, D8080, D8090)

8.280.5.F. Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist documents Medical Necessity that is confirmed by pre-treatment case review. Orthodontists shall submit requests for prior authorization of covered orthodontic services.” 10 Colo. Code Regs. § 2505-10-8.280.5

Patient Name: _____ DOB: _____ Medicaid Number: _____

Abbreviations	CRITERIA	YES	NO
DO	Deep impinging overbite with the palatal impingement of 1 (one) or more lower incisors. Photos or models must be shown at an angle to clearly demonstrate palatal impingement.		
AO	Skeletal anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)		
AP	Demonstrates a large anterior-posterior discrepancy. (Class II and Class III malocclusions that are) greater than a full-cusp (step) Class II or III, either side)		
AX	Anterior maxillary crossbite. (Involves three or more anterior teeth in full crossbite or in cases where gingival recession of 1.5mm or greater resulting from the crossbite is demonstrated). Partial crossbites or teeth occluding edge-to-edge do not qualify.		
PX	Posterior transverse discrepancies (involves 3 or more posterior teeth in crossbite in the arch, one of which must be a molar). Photos or models must clearly demonstrate maxillary buccal cusps positioned lingual to mandibular buccal cusps or maxillary lingual cusps positioned buccal to mandibular buccal cusps.		
PO	Significant posterior openbites. (Not involving unerupted teeth or one or two teeth slightly out of occlusion. Openbite must be amenable to orthodontic correction. i.e. not Primary Failure of Eruption)		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic and/or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
CR	Crowding of greater than 7mm in either the maxillary or mandibular arch. Photos or models must clearly demonstrate a tooth size-arch length discrepancy of greater than 7mm.		
OJ	Overjet in excess of 9mm. (measure from lingual of the maxillary incisor tip to the labial of the mandibular incisor tip). Measure most affected tooth. Photos or cephalogram must clearly demonstrate the presence of this condition.		
CDD	Congenital, developmental or traumatic deformity with a significant accompanying dental deformity. (Provide evidence and narrative of deformity below).		
FAS	Severe skeletal malocclusion requiring orthodontics and orthognathic surgery. (Medical prior approval required).		

Additional information demonstrating severe handicapping malocclusion: Note: Only one of the listed criteria is necessary for qualification/approval of the treatment plan

. APPROVED: _____ DENIED: _____ Reviewed by: _____

Date: _____

First Review _____

Models _____

Second Review _____

Orthocad _____
Ceph Films _____

X-Rays _____
Photos _____
Narrative _____



COLORADO ORTHODONTIC CRITERIA INDEX FORM B – ORTHODONTIC TREATMENT (D8010, D8020)

Patient Name: _____ DOB: _____ Medicaid Number: _____

CRITERIA	YES	NO
Two or more teeth 6-11 in crossbite with photograph documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth.		
Bilateral crossbite of teeth 3/30 and 14/19 with photographs documenting cusp overlap completely in fossa, or completely buccal / lingual of opposing teeth.		
Bilateral crossbite of teeth A/T and J/K with photographs documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth.		
Crowding with radiograph documenting current bony impaction of a tooth 6-11, 22-27 that requires either serial extractions or surgical exposure and guidance for the impacted tooth to erupt into the arch.		
Crowding with radiograph documenting resorption of 25% of the root of an adjacent permanent tooth.		
Unilateral crossbite with a functional shift.		

Additional factors for consideration:

Note: Only one of the listed criteria is necessary for qualification/approval of the treatment plan.

APPROVED:

DENIED:

Reviewed by: _____ Date: _____



CO Orthodontic Continuation of Care Submission Form

Date: _____

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN of ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Last Date of Treatment from Previous Provider:	

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

Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different **Medicaid** program/vendor. Required for submission:

- Completed ADA form for preauthorization of CDT Code **D8999**.
- 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) **UNLESS PRIOR AUTHORIZATION WAS APPROVED BY DENTAQUEST.**

****If required information above 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

- 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:

- Completed ADA form for preauthorization of CDT Code **D8999**.
- 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.

CHANGES THAT DO NOT HAVE TO BE SUBMITTED FOR CONTINUATION OF CARE PREAUTHORIZATION

- *Changes between treating providers that are affiliated with the same group practice. To ensure timely payment, please make sure that any claim is submitted with the correct Group (Billing) and Provider NPI information.*
- *Initiation of Comprehensive Orthodontic Treatment after completion of or Limited Orthodontic Treatment (Phased treatment). Please submit a prior-authorization (with any required documentation per plan) with the correct ADA Code for Comprehensive Ortho (D8070-D8090)*
- *De-banding/Retention (D8680) following completion of Comprehensive Orthodontic Treatment by the same provider that initiated care. Please submit a claim with the ADA Code D8680 with date of service of de-banding.*



Orthodontic Termination of Care Submission Form

Date: _____

Member Information (Required)

Name (First & Last)	Date of Birth:	SS or ID#
Address:	City, State, Zip	Area code & Phone number:
Group Name:	Plan Type:	

Provider Information (Required)

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

Claim Information (Required)

Date of Original Approval:	Original PAR Number:	Procedure Code:
Banding Date:	Case Rate (Amount) Approved on Original PAR:	Last Seen Date:
Reason Given for Termination of Treatment:		

Mail to: DentaQuest-CO Attn: Continuation P.O. BOX 2906 Milwaukee, WI 53201-290



Assistant Surgeon Report

Report Date: _____

Assistant Surgeon Name: _____

Provider Health First Colorado Program Number: _____

Provider NPI: _____

Primary Surgeon Name: _____

Provider Health First Colorado Program Number: _____

Provider NPI: _____

Health First Colorado Program Client Name: _____

Client Health First Colorado ID Number: _____

Claim Date of Service: _____

If enrolled in Health First Colorado as a dentist rather than physician, CPT medical and surgical codes cannot be used. Please reference the table in Section 19.00 for allowable CDT codes for dental assistant surgeons and additional billing guidance.



Denture Request Form for Once-In-A-Lifetime Replacement (This form must be filled out in its entirety to be considered for a replacement denture)

Member ID: _____ Date of Request _____

Member Name: _____

Provider Name: _____

Denture Code(s) being requested: _____

Date of original denture: _____ Code of original code _____

Date of original denture: _____ Code of original code _____

Did you provide the original denture? Yes ___ No ___ Has a repair been attempted? Yes ___ No ___

Is this the same code that is being requested to be replaced? Yes ___ No ___

(Immediate dentures will not be considered)

Provider Signature Required: _____ Date: _____

Replacement of lost, stolen, or broken dentures will be considered once per member's lifetime if the replacement is necessary due to circumstances beyond the member's control. Complete descriptive and detailed narrative for the requested replacement must be submitted with the claim.

Date of Incident: _____ Address of Incident: _____

Complete description of incident and why the incident/damage was beyond the member's control:

Member Signature Required: _____ Date: _____

Keep a copy of this form in the member's record. This form may be used for auditing purposes.

Dentaquest, LLC 2024



APPENDIX B

Covered Services Benefit Tables (See Exhibits A, B, and C)

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations for members under the various Health First Colorado plans (children, adults, IDD waivers). Providers with benefit questions should contact DentaQuest's Provider Service department directly at:

855.225.1731

Dental offices are not allowed to charge members for missed appointments. Health First Colorado 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, Providers should bill only per unique surface regardless of location. For example, when a Provider places separate filling 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 (ADA) Current Dental Terminology (CDT) code manual 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, current version of the CDT manual 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 American Dental Association (ADA) Current Dental Terminology (CDT) code manual.

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

1. The ADA approved CDT procedure code to submit when billing.
2. A brief description of the covered service.
3. Any age limits imposed on coverage.
4. A description of documentation, in addition to a completed current 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 (PAR) and any other applicable benefit limitations.

ORM CHANGE LOG This includes changes to ALL subgroups				
Revision Date	Effective Date	Section	CDT Code	Detail
9.15.25	10.1.2025	16.01		Updated once-in-a-lifetime replacement denture request process
8.1.2025	10.1.2025	Adult Exhibit B	D2931	Removed UM review
8.1.2025	10.1.2025	Child Exhibit A	D3221 D7280 D7283	Removed UM review
8.1.2025	10.1.2025	Child. Adult and IDD exhibits	All partial denture codes	Refer to Prosthodontic benefit tables for updates
2.12.25	3.1.2025	Child. Adult and IDD exhibits	D0251, D0310 D0320, D0321 D0411, D2955 D2980, D3310 D3320, D3330 D3351, D3353 D3470, D4212 D4245, D4249 D4261, D4263 D4264, D4266 D4267, D4273 D4274, D4283 D4285, D5710	Removed UM review- refer to benefit tables for affected subgroup per code.

ORM CHANGE LOG This includes changes to ALL subgroups				
Revision Date	Effective Date	Section	CDT Code	Detail
			D5711, D5720 D5721, D5730 D5731, D5740 D5741, D5750 D5751, D5760 D5761, D5765 D5850, D5851 D5862, D5867 D5875, D5982 D5986, D6980	
1.30.2025	1.1.2025	18.00	D2941	Removing code from RDH and Dental Therapy Tables
		18.5	D6180	Adding code to the RDH and Dental Therapy Tables
1.30.2025	1.1.2025	IDD Exhibit	D3110 D6180 D6193 D7252 D7259 D9986 D9987	Adding codes- D9986 and D9987 pay \$0
1.30.2025	1.1.2025	Adult Exhibit	D7259 D3110 D3120 D9986 D9987	Adding codes- D9986 and D9987 pay \$0

ORM CHANGE LOG

This includes changes to ALL subgroups

Revision Date	Effective Date	Section	CDT Code	Detail
1.30.2025	1.1.2025	Child Exhibit	D7259 D9986 D9987	Adding codes- D9986 and D9987 pay \$0
1.1.2025	7.1.2024	15.18		Updated COC Chart
11.1.2024		1.04		Updated Network Management contact information.
11.1.2024		21.00		Added Clinical Practice Guidelines
11.5.2024	1.1.2025	Child. Adult and IDD exhibits	D7055 D7471 D7472 D7473	Updated codes for consistency
11.4.2024	1.1.2025	Child Exhibit A	Remove codes D6055- D6199	HCPF removed implant codes from Child Benefits. All codes can be accessed through EPSDT if medical necessity is met.
10.15.24		Child Exhibit A	8.06	HCPF updated EPSDT section
6.1.2024	4.1.2024	15.12		Updated information
6.1.2024	7.1.2024	Child Exhibit A Adult Exhibit B	D9222 D9223	Updated codes
5.1.2024	5.31.24	15.14		Updated COC qualifiers
5.1.2024	5.31.24	Appendex A	D8670, D8680, D8695, D8701, D8702, D8703, D8704,	Updated codes
4.25.23		14.00		Updated the Periodicity Schedule

ORM CHANGE LOG

This includes changes to ALL subgroups

Revision Date	Effective Date	Section	CDT Code	Detail
2.1.2024		Appendex A		Updated 2024 ADA claim form
1.4.2024	1.1.2024	Child Exhibit A	D2991, D6089, D7284, D9939.	Adding new 2024 ADA CDT codes
1.4.2024	1.1.2024	Adult Exhibit B	D2991, D7284.	Adding new 20242 ADA CDT codes
1.4.2024	1.1.2024	IDD Exhibit C	D2991, D6089, D7284, D9939.	Adding new 2024 ADA CDT codes
11.6.2023	11.27.23	Child. Adult and IDD exhibits	D0350	Frequency: 6 of (D0350) per 12 months. Removed teeth numbers.
10.24.2023	11.10.23	7.00		Clarification added to member appeals process
9.25.23			D8070, D8080, D8090	Limitation: removed per 1 lifetime per patient
9.25.23		15.14		Updated the "Criteria for Orthodontics" section per HCPF – no changes to orthodontic medical necessity criteria
9.6.23				HCPF has changed the word reconsideration to read appeal. No changes to the process
7.12.23	5.1.23	18.50		Added informational section for Dental Therapists
7.1.2023	7.1.2023	15.14		Updated COC Ortho chart with new fees effective 7.1.2023
6.16.2023	7.1.2023			Adult members will no longer have an annual \$1500 maximum. All current benefit limitations and frequencies will still apply.
6.1.2023		Appendix A		Clarified the Orthodontic Criteria form D8070, D8080 and D8090. No changes to the criteria.

ORM CHANGE LOG

This includes changes to ALL subgroups

Revision Date	Effective Date	Section	CDT Code	Detail
6.1.23	6.1.23	Child Exhibit A	D0372, D0373, D0374, D0380. D0381, D0382, D0383, D0384, D0385, D0386, D0387, D0388, D0389, D1781, D1782, D1783, D7509	Added Codes
6.1.23	6.1.23	Adult Exhibit B	D0372, D0373, D0374, D0380. D0381, D0382, D0383, D0384, D0385, D0386, D0387, D0388, D0389, D1781, D1782, D1783, D7509	Added Codes
6.1.2323	6.1.2023	IDD Exhibit C	D0372, D0373, D0374, D0380. D0381, D0382, D0383, D0384,	Added Codes

ORM CHANGE LOG This includes changes to ALL subgroups				
Revision Date	Effective Date	Section	CDT Code	Detail
			D0385, D0386, D0387, D0388, D0389, D4286, D6105, D6106, D6107, D6197, D7509, D7956, D7957	

2015, 2016, 2017, 2018, 2019, Change log is archived on the Provider portal.

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Diagnostic series include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the member's oral health. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for the individual radiographs taken on the same day will be limited to the allowance for a full mouth series. A minimum of 10 films is required for an intraoral complete series (full mouth series). A panoramic film with or without bitewing radiographs is considered equivalent to an intraoral complete series and cannot be billed on the same date of service as a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitation. All radiographs and oral/facial photographic images must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	0-20		No	No	Two of (D0120, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location.	
D0140	limited oral evaluation-problem focused	0-20		No	No	Two of (D0140) per 1 Year(s) Per Provider OR Location. Not reimbursable on the same day as D0120, D0150, D0160, or D0170. Dental Hygienists may only provide for an established client of record.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	Two of (D0120, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location. Not payable on the same date as D0120. Patients at High Risk for Caries, four of (D0145) per year. May be performed by dental professional or qualified medical personnel. See ORM Section 8.07. A formal caries risk assessment shall be performed and documented as part of the patient record.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	No	One of (D0150) per 3 Year(s) Per Provider OR Location. Two of (D0120, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location.	

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Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0160	detailed and extensive oral eval-problem focused, by report	0-20		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location.	
D0170	re-evaluation, limited problem focused	0-20		No	No	Two of (D0120, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location. Must be an established patient, not a post op visit.	
D0180	comprehensive periodontal evaluation - new or established patient	15 - 20		No	No	One of (D0180) per 1 Year(s) Per Provider OR Location. Two of (D0120, D0145, D0150, D0160, D0170, D0180) per 1 Year(s) Per Provider OR Location. Billable by dental professional only.	
D0190	Screening of a patient	3 - 20		No	No	Two of (D0190) per 1 Year(s) Per patient ages 3 to 4. Three of (D0190) per 1 Year(s) Per patient ages 5 to 20. Patients ages 3 and 4 at High Risk for Caries, up to four per year are allowed. Shall be performed by dental professional or qualified medical personnel. See ORM Section 8.07. Not payable on same date of service as (D0120, D0140, D0145, D0150, D0160, D0170, D0180).	
D0210	intraoral - comprehensive series of radiographic images	6 - 20		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 5 Year(s) Per Provider OR Location. Minimum of 10 (periapical or posterior) bitewing images required. Radiographic survey counts as one set of bitewings per year.	
D0220	intraoral - periapical first radiographic image	0-20		No	No	Six of (D0220, D0374) per 1 Year(s) Per Provider OR Location. Not reimbursed on the same date of service as (D0210).	
D0230	intraoral - periapical each additional radiographic image	0-20		No	No	Working and final endodontic treatment films are included in the endo codes . Not covered if billed with D3310, D3320, D3330, D3331, D3332, D3333, D3346. D3347, D3348. Not reimbursed on the same date of services as (D0210)	

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Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0240	intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240, D0374) per 2 Year(s) Per Provider OR Location. Patients ages 20 and under with trauma or pulpal treatment, additional occlusal films may be approved subject to EPSDT guidelines. See ORM Section 13.00 & 8.06.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No	No		
D0251	extra-oral posterior dental radiographic image	0-20		No	No		
D0270	bitewing - single radiographic image	2 - 20		No	No	One of (D0270, D0272, D0273, D0274) per 1 Year(s) Per Provider OR Location. One set is equal to 1 to 4 films. Patients ages 2 through 20 at High Risk of Caries, D0270, D0272, D0273 or D0274 may be taken once every 6 months. See ORM Section 8.07.	
D0272	bitewings - two radiographic images	2 - 20		No	No	One of (D0270, D0272, D0273, D0274) per 1 Year(s) Per Provider OR Location. One set is equal to 2 to 4 films. Patients ages 2 through 20 at High Risk of Caries, D0270, D0272, D0273 or D0274 may be taken once every 6 months. See ORM Section 8.07.	
D0273	bitewings - three radiographic images	10 - 20		No	No	One of (D0270, D0272, D0273, D0274) per 1 Year(s) Per Provider OR Location. One set is equal to 2 to 4 films. Patients ages 2 through 20 at High Risk of Caries, D0270, D0272, D0273 or D0274 may be taken once every 6 months. See ORM Section 8.07.	

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Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0274	bitewings - four radiographic images	10 - 20		No	No	One of (D0270, D0272, D0273, D0274) per 1 Year(s) Per Provider OR Location. One set is equal to 2 to 4 films. Patients ages 2 through 20 at High Risk of Caries, D0270, D0272, D0273 or D0274 may be taken once every 6 months. See ORM Section 8.07.	
D0277	vertical bitewings - 7 to 8 films	6 - 20		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 5 Year(s) Per Provider OR Location. Counts as a full mouth series.	
D0310	sialography	0-20		No	No		
D0320	temporomandibular joint arthogram, including injection	0-20		No	No		
D0321	other temporomandibular joint films, by report	0-20		No	No		
D0322	tomographic survey	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D0330	panoramic radiographic image	6 - 20		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 3 Year(s) Per Provider OR Location. With or without bitewing(s). Counts as a full mouth series. Patients age 6 or under with trauma or suspected pathology, additional panoramic films may be approved subject to EPSDT guidelines. See ORM Section 5.01 & 17.00.	
D0340	cephalometric radiographic image	0-20		No	No		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	No	Six of (D0350) per 12 Month(s) Per patient. RDH's will receive reimbursement when used for telehealth dentistry in partnership with a treating dentist.	
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity

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Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-20		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0372, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-20		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0373, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-20		No	No	One of (D0220, D0374) per 12 Month(s) Per patient.	
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	0-20		No	No	One of (D0372, D0373, D0380) per 12 Month(s) Per patient.	
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	0-20		No	Yes	One of (D0372, D0373, D0381) per 12 Month(s) Per patient. Subject to pre-payment review.	narrative of medical necessity
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	0-20		No	Yes	One of (D0372, D0373, D0382) per 12 Month(s) Per patient. Subject to pre-payment review.	narrative of medical necessity
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	0-20		No	No	One of (D0372, D0373, D0383) per 12 Month(s) Per patient.	
D0384	Cone beam CT image capture for TMJ series including two or more exposures	0-20		No	No	One of (D0372, D0373, D0384) per 12 Month(s) Per patient.	
D0385	Maxillofacial MRI image capture	0-20		No	No	One of (D0385) per 12 Month(s) Per patient.	

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Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0386	Maxillofacial ultrasound image capture	0-20		No	No	One of (D0386) per 12 Month(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-20		No	No	One of (D0381, D0382, D0383, D0387) per 12 Month(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-20		No	No	One of (D0381, D0382, D0383, D0388) per 12 Month(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-20		No	No	One of (D0381, D0382, D0383, D0389) per 12 Month(s) Per patient.	
D0411	HbA1 in-office point of service testing	0-20		No	No	One in-office screening via finger-stick HbA1c glucose test per provider. Referral documentation with test results to be kept in patient record.	
D0412	blood glucose level test	0-20		No	No	One of (D0411, D0412) per 1 Day(s) Per Provider.	
D0425	caries susceptibility tests	0-5		No	No	Not to be used for carious dentin staining; for in-office lab culture, provider must be CLIA certified.	
D0460	pulp vitality tests	0-20		No	No	One of (D0460) per 1 Day(s) Per patient. Includes multiple teeth and contralateral comparison(s).	
D0470	diagnostic casts	0-20		No	No	One of (D0470) per 12 Month(s) Per patient. Includes both maxillary and mandible casts.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

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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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	12 - 20		No	No	Two of (D1110, D1120, D4346, D4910) per 1 Year(s) Per patient. Not reimbursed when billed on the same date of service as any periodontal procedure code. Patients at High Risk for Caries or Periodontal Disease, up to four (D1110, D1120, D4910) per year. See ORM Section 8.07.	
D1120	prophylaxis - child	0-11		No	No	Two of (D1110, D1120, D4346, D4910) per 1 Year(s) Per patient. Not reimbursed when billed on the same date of service as any periodontal procedure code. Patients at High Risk for Caries or Periodontal Disease, up to four (D1110, D1120, D4910) per year. See ORM Section 8.07.	
D1206	topical application of fluoride varnish	0-20		No	No	Two of (D1206) per 1 Year(s) Per patient ages 0 to 4. Three of (D1206) per 1 Year(s) Per patient ages 5 to 72. Three of (D1206, D1208) per 1 Year(s) Per patient ages 6 and above. D1206 is only acceptable topical fluoride treatment for patients age 5 and under. Patients ages 0 through 4 at High Risk of Caries, up to four (D1206) per year. May be provided by dental professional or qualified medical personnel. See ORM Section 8.07	

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Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1208	topical application of fluoride - excluding varnish	6 - 20		No	No	Three of (D1206, D1208) per 1 Year(s) Per patient. Not available for patients ages 0 through 5. May be provided by dental professional or qualified medical personnel. See ORM Section 8.07.	
D1351	sealant - per tooth	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	Two of (D1351, D1352, D1353) per 1 Lifetime Per patient per tooth. Reimbursable sealants are limited to permanent molars and unrestored occlusal surfaces only.	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	5-15	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	Two of (D1351, D1352, D1353) per 1 Lifetime Per patient per tooth. Reimbursable sealants are limited to permanent molars and occlusal surfaces only. Teeth must be caries free and unrestored. (D1352) limited to tooth surfaces O, OL, OB, B, and L.	
D1353	Sealant repair - per tooth	5 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	Two of (D1351, D1352, D1353) per 1 Lifetime Per patient per tooth.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	No	Two of (D1354) per 12 Month(s) Per patient per tooth. not to exceed 4 times per lifetime. Cannot be billed on the same day as D3110 or D3120 or any D2000 series code (D2140-D2999)	
D1510	space maintainer-fixed, unilateral- per quadrant	0-14	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1510, D1520, D1575) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim. Includes maintenance & repair.	
D1516	space maintainer --fixed--bilateral, maxillary	0-14		No	No	Two of (D1516, D1526) per 1 Lifetime Per patient per arch. Indicate missing tooth numbers on claim. Includes maintenance and repair.	
D1517	space maintainer --fixed--bilateral, mandibular	0-14		No	No	Two of (D1517, D1527) per 1 Lifetime Per patient per arch. Indicate missing tooth numbers on claim. Includes maintenance and repair.	

**Exhibit A Benefits Covered for
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Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1520	space maintainer-removable-unilateral	0-14	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1510, D1520, D1575) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim. Includes maintenance & repair.	
D1526	space maintainer --removable--bilateral, maxillary	0-14		No	No	Two of (D1516, D1526) per 1 Lifetime Per patient per arch. Indicate missing tooth numbers on claim. Includes maintenance and repair.	
D1527	space maintainer --removable--bilateral, mandibular	0-14		No	No	Two of (D1517, D1527) per 1 Lifetime Per patient per arch. Indicate missing tooth numbers on claim. Includes maintenance and repair.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-14		No	No	One of (D1550, D1551) per 12 Month(s) Per patient. Not reimbursable within 6 months of original placement by same dentist or group.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-14		No	No	One of (D1550, D1552) per 12 Month(s) Per patient. Not reimbursable within 6 months of original placement by same dentist or group.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-14	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1553) per 12 Month(s) Per patient. Not reimbursable within 6 months of original placement by same dentist or group.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D1555, D1556) per 1 Lifetime Per patient. Not reimbursable within 6 months of original placement by same dentist or group. Subject to pre-payment review.	pre-operative x-ray(s)
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-20		No	Yes	One of (D1555, D1557) per 1 Lifetime Per patient. Not reimbursable within 6 months of original placement by same dentist or group. Subject to pre-payment review.	pre-operative x-ray(s)

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Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-20		No	Yes	One of (D1558) per 1 Lifetime Per patient. Not reimbursable within 6 months of original placement by same dentist or group. Subject to pre-payment review.	pre-operative x-ray(s)
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-14	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1510, D1520, D1575) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and quadrant on claim. Includes maintenance and repair.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	No	One of (D1701) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	No	One of (D1702) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	No	One of (D1703) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	No	One of (D1704) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP1.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	No	One of (D1707) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1781	vaccine administration – human papillomavirus – Dose 1	0-20		No	No	One of (D1781) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	

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Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1782	vaccine administration – human papillomavirus – Dose 2	0-20		No	No	One of (D1782) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1783	vaccine administration – human papillomavirus – Dose 3	0-20		No	No	One of (D1783) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	

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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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

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Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2390) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

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Health First Colorado Dental Program - 20 and under**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2710	crown - resin-based composite (indirect)	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2712	crown - 3/4 resin-based composite (indirect)	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2721	crown - resin with predominantly base metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2752	crown - porcelain fused to noble metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2781	crown - ¾ cast predominantly base metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2782	crown - ¾ cast noble metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2783	crown - ¾ porcelain/ceramic	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2790	crown - full cast high noble metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	16 - 20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2794	Crown- Titanium and Titanium Alloys	16-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2799	interim crown	16-20	Teeth 2 - 15, 18 - 31	Yes	No		narr. of med. necessity, pre-op x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No	No	Not allowed within 6 months of placement.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	No	Not allowed within 6 months of placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 6 - 11, 22 - 27	No	Yes	One of (D2928, D2931, D2932, D2933) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review when 6 or more crowns required on the same day of service. Must meet criteria for in-office sedation or hospitalization.	narr. of med. necessity, pre-op x-ray(s)
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth A - T	No	Yes	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth for Primary Teeth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Yes	One of (D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)

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Health First Colorado Dental Program - 20 and under**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	No	Yes	One of (D2928, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2932	prefabricated resin crown	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2928, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2932	prefabricated resin crown	0-20	Teeth A - T	No	Yes	One of (D2928, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	Yes	One of (D2928, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	Yes	One of (D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2940	Placement of interim direct restoration.	0-20	Teeth 1 - 32, A - T	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. primary and permanent teeth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with a treating dentist.	

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Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2941	Interim therapeutic restoration - primary dentition	0-20	Teeth A - T	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist.	
D2950	core buildup, including any pins when required	0-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2950, D2952, D2953, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	No	Four of (D2951) per 36 Month(s) Per patient per tooth.	
D2952	cast post and core in addition to crown	0-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2950, D2952, D2953, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.	pre-operative x-ray(s)
D2953	each additional cast post - same tooth	0-20	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2950, D2952, D2953, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2953, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review.	pre-operative x-ray(s)
D2955	post removal (not in conjunction with endodontic therapy)	0-20	Teeth 1 - 32	No	No		
D2957	each additional prefabricated post - same tooth	0-20	Teeth 2 - 15, 18 - 31	No	Yes	Must be billed with D2954. Subject to pre-payment review.	pre-operative x-ray(s)
D2980	crown repair, by report	0-20	Teeth 1 - 32	No	No		

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Health First Colorado Dental Program - 20 and under**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2991	application of hydroxyapatite regeneration medicament – per tooth	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	No	One of (D2991) per 1 Lifetime Per patient per tooth. Cannot be billed on the same day/same tooth as any other D2000's codes or D1351, D1352, D1353, D1354.	
D2999	unspecified restorative procedure, by report	0-20	Teeth 1 - 32, A - T	Yes	No		narrative of medical necessity

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EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Reimbursement includes local anesthesia. In cases where a root canal filling does not meet DentaQuest's general criteria 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. A pulpotomy, pulpal debridement or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra operative and final radiographs.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3110	pulp cap - direct (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	No		
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	No		
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. Not reimbursable as the first state of root canal or for apexogenesis. Not reimbursable if the original treatment was previously reimbursed to the same provider by the CO Medicaid Dental Program.	
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 2 - 15, 18 - 31	No	No	One of (D3221) per 1 Lifetime Per patient per tooth.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3222) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	

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Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	
D3331	treatment of root canal obstruction; non-surgical access	0-20	Teeth 2 - 15, 18 - 31	No	No	One of (D3331) per 1 Lifetime Per patient per tooth.	
D3332	incomplete endodontic therapy; inoperable or fractured tooth	0-20	Teeth 2 - 15, 18 - 31	No	No	One of (D3332) per 1 Lifetime Per patient per tooth.	
D3333	internal root repair of perforation defects	0-20	Teeth 2 - 15, 18 - 31	No	No	One of (D3333) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. Pre- and post-operative radiographs shall be maintained in patient records. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by CO Medicaid.	Pre and post-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3347) per 1 Lifetime Per patient per tooth. Pre- and post-operative radiographs shall be maintained in patient records. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by CO Medicaid.	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No	One of (D3348) per 1 Lifetime Per patient per tooth. Pre- and post-operative radiographs shall be maintained in patient records. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by CO Medicaid.	Pre and post-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	No	No	One of (D3351) per 1 Lifetime Per patient per tooth.	
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3352) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)

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Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	No	No	One of (D3353) per 1 Lifetime Per patient per tooth.	
D3355	Pulpal regeneration - initial visit	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D3356	Pulpal regeneration - interim medication replacement	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D3357	Pulpal regeneration - completion of treatment	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	Pre and post-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth.	
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth.	
D3425	apicoectomy - molar (first root)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3425) per 1 Lifetime Per patient per tooth.	
D3426	apicoectomy (each additional root)	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	No		
D3430	retrograde filling - per root	0-20	Teeth 2 - 15, 18 - 31	No	No		
D3450	root amputation - per root	0-20	Teeth 2 - 15, 18 - 31	No	No		
D3460	endodontic endosseous implant	0-20	Teeth 2 - 15, 18 - 31	Yes	No	Pre-operative radiographs of adjacent and opposing teeth.	pre-operative x-ray(s)
D3470	intentional reimplantation	0-20	Teeth 2 - 15, 18 - 31	No	No	One of (D3470) per 1 Lifetime Per patient per tooth.	
D3910	surgical procedure for isolation of tooth with rubber dam	0-20	Teeth 2 - 15, 18 - 31	No	Yes	One of (D3910) per 12 Month(s) Per patient. (Only payable when billed with D3310, D3320, D3330, D3346, D3347 or D3348) Refer to sections 15.08 and 15.15 in the ORM. Subject to pre-payment review.	Narr. of med. necessity, pre and post-op x-ray(s)

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Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3920	hemisection (including any root removal), not incl root canal therapy	0-20	Teeth 2 - 15, 18 - 31	No	No		
D3950	canal preparation and fitting of preformed dowel or post	0-20	Teeth 2 - 15, 18 - 31	No	No		
D3999	unspecified endodontic procedure, by report	0-20	Teeth 1 - 32, A - T	Yes	No	Pre-operative radiographs of adjacent and opposing teeth.	pre-operative x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Reimbursement includes local anesthetic. Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351 and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	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	No	One of (D4210, D4211) per 3 Year(s) Per patient per quadrant. Includes 6 months of routine post-operative care.	Perio Charting, pre-op radiographs and narr of med necessity
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	No	One of (D4210, D4211) per 3 Year(s) Per patient per quadrant. Includes 6 months of routine post-operative care.	Perio Charting, pre-op radiographs and narr of med necessity
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-20	Teeth 1 - 32, 51 - 82	No	No	One of (D4212) per 3 Year(s) Per patient per tooth. Includes 6 months of routine post-operative care.	
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	No	Four or more contiguous teeth or tooth bounded spaces per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4245	apically positioned flap	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D4245) per 36 Month(s) Per patient.	
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	No	No	One of (D4249) per 1 Lifetime Per patient per tooth.	
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	No	One of (D4260, D4261) per 12 Month(s) Per patient per quadrant. A maximum of two quadrants on one date of service is allowed except in a hospital setting.	Perio Charting, pre-op radiographs and narr of med necessity
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)	No	No	One of (D4260, D4261) per 12 Month(s) Per patient per quadrant.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	No	No	One of (D4263) per 1 Lifetime Per patient per tooth.	
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	No	No	One of (D4264) per 1 Lifetime Per patient per tooth.	
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	0-20	Teeth 1 - 32	No	No	One of (D4266) per 1 Lifetime Per patient per tooth.	
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	0-20	Teeth 1 - 32	No	No	One of (D4267) per 1 Lifetime Per patient per tooth.	
D4268	surgical revision procedure	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4268) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes	No	One of (D4270) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	No	No	One of (D4273) per 1 Lifetime Per patient per tooth.	
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	No	No	One of (D4274) per 1 Lifetime Per patient per tooth.	
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	No	No	One of (D4277) per 1 Lifetime Per patient per tooth.	
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	No	No	One of (D4278) per 1 Lifetime Per patient per tooth.	
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	No	No	One of (D4283) per 1 Lifetime Per patient per tooth.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	No	No	One of (D4285) per 1 Lifetime Per patient per tooth.	
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	0-20	Teeth 1 - 32	No	No	One of (D4322) per 1 Lifetime Per patient per tooth.	
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	0-20	Teeth 1 - 32	No	No	One of (D4323) per 1 Lifetime Per patient per tooth.	
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	No	One of (D4341, D4342) per 3 Year(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Prophylaxis (D1110 and D1120) are not benefits when provided on the same date of service as D4341.	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)	Yes	No	One of (D4341, D4342) per 3 Year(s) Per patient per quadrant. A maximum of three (3) teeth in the affected quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Not paid on the same date as (D1110).	pre-op x-ray(s), perio charting
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	0-20		No	No	Two of (D1110, D1120, D4346, D4910) per 12 Month(s) Per patient. Not reimbursed when billed on the same date of service as (D1110, D1120, D4341, D4342, D4355, D4910). Patients at High Risk for Caries or Periodontal disease, four of (D1110, D1120, D4910, D4346) per 12 months. See ORM Sections 8.07 and 15.01.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	13 - 20		No	No	One of (D4355) per 3 Year(s) Per patient. (D0150, D0160, D0180, D1110, D1120) are not reimbursable when provided on the same day of service as (D4355).(D4355)is not reimbursable if patient record indicates (D1110, D1120, D4910) have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as (D4355).	
D4381	localized delivery of antimicrobial agents	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D4381) per 36 Month(s) Per patient per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4910	periodontal maintenance procedures	0-20		No	Yes	Two of (D1110, D1120, D4346, D4910) per 1 Year(s) Per patient. Patients at High Risk for Caries or Periodontal Disease, up to four (D1110, D1120, D4910) per year. See ORM Section 8.07 Subject to pre-payment review.	Perio Charting, pre-op radiographs and narr of med necessity
D4999	unspecified periodontal procedure, by report	0-20		Yes	No		narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Removable prosthetics are not covered if eight or more posterior teeth (natural or artificial) are in occlusion.

Coverage is provided for anterior teeth

irrespective of the number of teeth in occlusion. Maxillofacial prostheses that serve to rehabilitate esthetics and function for member with acquired, congenital or developmental defects of the head and neck are covered. Necessary prostheses to restore both form and function is covered for members exposed to chemotherapy, radiation or cytotoxic drugs. Services for removable prostheses must include instruction in the use and care of the prosthesis and any adjustments necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	0-20		Yes	No	One of (D5110, D5130) per 5 Year(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	0-20		Yes	No	One of (D5120, D5140) per 5 Year(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only.	narr. of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	0-20		Yes	No	One of (D5130) per 1 Lifetime Per patient. Includes initial 6 months of relines.	narr. of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	0-20		Yes	No	One of (D5140) per 1 Lifetime Per patient. Includes initial 6 months of relines.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	No	One of (D5211, D5225) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	No	One of (D5212, D5226) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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)	0-20		Yes	No	One of (D5213, D5225) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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)	0-20		Yes	No	One of (D5214, D5224) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5221) per 1 Lifetime Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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	No	One of (D5222) per 1 Lifetime Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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	No	One of (D5223) per 1 Lifetime Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5224) per 1 Lifetime Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		Yes	No	One of (D5211, D5225) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture-flexible base	0-20		Yes	No	One of (D5212, D5226) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	0-20	Per Quadrant (UL, UR)	Yes	No	One of (D5282) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	0-20	Per Quadrant (LL, LR)	Yes	No	One of (D5283) per 5 Year(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D5284, D5286) per 1 Lifetime Per patient per quadrant. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D5284, D5286) per 1 Lifetime Per patient per quadrant. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	0-20		No	No	One of (D5410) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5411	adjust complete denture - mandibular	0-20		No	No	One of (D5411) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5421	adjust partial denture-maxillary	0-20		No	No	One of (D5421) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5422	adjust partial denture - mandibular	0-20		No	No	One of (D5422) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5511	repair broken complete denture base, mandibular	0-20		No	No	One of (D5511) per 12 Month(s) Per patient.	
D5512	repair broken complete denture base, maxillary	0-20		No	No	One of (D5512) per 12 Month(s) Per patient.	
D5520	replace missing or broken teeth - complete denture - per tooth	0-20	Teeth 1 - 32	No	No	One of (D5520) per 12 Month(s) Per patient per tooth.	
D5611	repair resin partial denture base, mandibular	0-20		No	No	One of (D5611) per 12 Month(s) Per patient.	
D5612	repair resin partial denture base, maxillary	0-20		No	No	One of (D5612) per 12 Month(s) Per patient.	
D5621	repair cast partial framework, mandibular	0-20		No	No	One of (D5621) per 12 Month(s) Per patient.	
D5622	repair cast partial framework, maxillary	0-20		No	No	One of (D5622) per 12 Month(s) Per patient.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No	No	One of (D5630) per 12 Month(s) Per patient per tooth.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5640	replace missing or broken teeth – partial denture – per tooth	0-20	Teeth 1 - 32	No	No	One of (D5640) per 12 Month(s) Per patient per tooth.	
D5650	add tooth to existing partial denture – per tooth	0-20	Teeth 1 - 32	No	No	One of (D5650) per 12 Month(s) Per patient per tooth.	
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No	No	One of (D5660) per 12 Month(s) Per patient per tooth.	
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	0-20		No	No	One of (D5670) per 12 Month(s) Per patient.	
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	0-20		No	No	One of (D5671) per 12 Month(s) Per patient.	
D5710	rebase complete maxillary denture	0-20		No	No	One of (D5710, D5730, D5750) per 4 Year(s) Per patient.	
D5711	rebase complete mandibular denture	0-20		No	No	One of (D5711, D5731, D5751) per 4 Year(s) Per patient.	
D5720	rebase maxillary partial denture	0-20		No	No	One of (D5720, D5740, D5760) per 4 Year(s) Per patient.	
D5721	rebase mandibular partial denture	0-20		No	No	One of (D5721, D5741, D5761) per 4 Year(s) Per patient.	
D5730	reline complete maxillary denture (chairside)	0-20		No	No	One of (D5710, D5730, D5750) per 4 Year(s) Per patient.	
D5731	reline complete mandibular denture (chairside)	0-20		No	No	One of (D5711, D5731, D5751) per 4 Year(s) Per patient.	
D5740	reline maxillary partial denture (chairside)	0-20		No	No	One of (D5720, D5740, D5760) per 4 Year(s) Per patient.	
D5741	reline mandibular partial denture (chairside)	0-20		No	No	One of (D5721, D5741, D5761) per 4 Year(s) Per patient.	
D5750	reline complete maxillary denture (laboratory)	0-20		No	No	One of (D5710, D5730, D5750) per 4 Year(s) Per patient.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	No	One of (D5711, D5731, D5751) per 4 Year(s) Per patient.	
D5760	reline maxillary partial denture (laboratory)	0-20		No	No	One of (D5720, D5740, D5760) per 4 Year(s) Per patient.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5761	reline mandibular partial denture (laboratory)	0-20		No	No	One of (D5721, D5741, D5761) per 4 Year(s) Per patient.	
D5765	soft liner for complete or partial removable denture – indirect	0-20	Per Arch (01, 02, LA, UA)	No	No	One of (D5765) per 4 Year(s) Per patient.	
D5810	interim complete denture-maxillary	0-20		No	Yes	One of (D5810, D5820) per 1 Lifetime Per patient. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D5811	interim complete denture-mandibular	0-20		No	Yes	One of (D5811, D5821) per 1 Lifetime Per patient. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D5820	interim partial denture (maxillary)	0-20		No	Yes	One of (D5810, D5820) per 1 Lifetime Per patient. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D5821	interim partial denture-mandibular	0-20		No	Yes	One of (D5811, D5821) per 1 Lifetime Per patient. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D5850	tissue conditioning, maxillary	0-20		No	No	One of (D5850) per 1 Lifetime Per patient.	
D5851	tissue conditioning,mandibular	0-20		No	No	One of (D5851) per 1 Lifetime Per patient.	
D5862	precision attachment, by report	0-20	Teeth 1 - 32	No	No		
D5863	Overdenture - complete maxillary	0-20		Yes	No	One of (D5863) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5864	Overdenture - partial maxillary	0-20		Yes	No	One of (D5864) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5865	Overdenture - complete mandibular	0-20		Yes	No	One of (D5865) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5866	Overdenture - partial mandibular	0-20		Yes	No	One of (D5866) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D5867	Replacement of replaceable part of semi-precision per attachment	0-20	Teeth 1 - 32	No	No	One of (D5867) per 84 Month(s) Per patient per tooth.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5875	modification of removable prosthesis following implant surgery	0-20	Per Arch (01, 02, LA, UA)	No	No		
D5899	unspecified removable prosthodontic procedure, by report	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5911	facial moulage (sectional)	0-20		Yes	No		narrative of medical necessity
D5912	facial moulage (complete)	0-20		Yes	No		narrative of medical necessity
D5913	nasal prosthesis	0-20		Yes	No		narrative of medical necessity
D5914	auricular prosthesis	0-20		Yes	No		narrative of medical necessity
D5915	orbital prosthesis	0-20		Yes	No		narrative of medical necessity
D5916	ocular prosthesis	0-20		Yes	No		narrative of medical necessity
D5919	facial prosthesis	0-20		Yes	No		narrative of medical necessity
D5922	nasal septal prosthesis	0-20		Yes	No		narrative of medical necessity
D5923	ocular prosthesis, interim	0-20		Yes	No		narrative of medical necessity
D5924	cranial prosthesis	0-20		Yes	No		narrative of medical necessity
D5925	facial augment implant prosthesis	0-20		Yes	No		narrative of medical necessity
D5926	nasal prosthesis, replacement	0-20		Yes	No		narrative of medical necessity
D5927	auricular prosthesis, replace	0-20		Yes	No		narrative of medical necessity
D5928	orbital prosthesis, replace	0-20		Yes	No		narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Maxillofacial Prosthetics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5929	facial prosthesis, replacement	0-20		Yes	No		narrative of medical necessity
D5931	obturator prosthesis, surgical	0-20		Yes	No		narrative of medical necessity
D5932	obturator prosthesis, definitive	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5933	obturator prosthesis, modification	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5934	mandibular resection prosthesis with guide flange	0-20		Yes	No		narrative of medical necessity
D5935	mandibular resection prosthesis without guide flange	0-20		Yes	No		narrative of medical necessity
D5936	obturator prosthesis, interim	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5937	trismus appliance (not for TMD treatment)	0-20		Yes	No		narrative of medical necessity
D5951	feeding aid	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5952	speech aid prosthesis, pediatric	0-20		Yes	No		narrative of medical necessity
D5954	palatal augment prosthesis	0-20		Yes	No		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-20		Yes	No		narrative of medical necessity
D5958	palatal lift prosthesis, interim	0-20		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5959	palatal lift prosthesis, modification	0-20		Yes	No		narrative of medical necessity
D5960	speech aid prosthesis, modification	0-20		Yes	No		narrative of medical necessity
D5982	surgical stent	0-20		No	No		
D5983	radiation carrier	0-20		Yes	No		narrative of medical necessity

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Health First Colorado Dental Program - 20 and under**

Maxillofacial Prosthetics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5984	radiation shield	0-20		Yes	No		narrative of medical necessity
D5985	radiation cone locator	0-20		Yes	No		narrative of medical necessity
D5986	fluoride gel carrier	0-20		No	No		
D5987	commissure splint	0-20		Yes	No		narrative of medical necessity
D5988	surgical splint	0-20		No	No		
D5991	vesiculobullous disease medicament carrier	0-20		No	No		
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20	Per Arch (01, 02, LA, UA)	No	No		
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-20	Per Arch (01, 02, LA, UA)	No	Yes	Subject to pre-payment review.	narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes	No		narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease). The space cannot be filled with a removable partial dentures. The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral and the opposing arch). Each abutment or each pontic constitutes a unit in a bridge. Porcelain is allowed on all teeth. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form. Periapical radiographs are required for each tooth. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6211	pontic-cast base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6211, D6241) per 84 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6241	pontic-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6211, D6241) per 84 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6545	retainer - cast metal fixed	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D6545) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6751	crown-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6751) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6791	crown - full cast base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6791) per 84 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6920	connector bar	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6920) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D6930	re-cement or re-bond fixed partial denture	0-20		No	No	One of (D6930) per 6 Month(s) Per patient. Not covered within 6 months of delivery.	
D6940	stress breaker	0-20	Teeth 1 - 32	Yes	No	One of (D6940) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)

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Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6950	precision attachment	0-20	Teeth 1 - 32	Yes	No	One of (D6950) per 60 Month(s) Per patient.	narr. of med. necessity, pre-op x-ray(s)
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No		
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Reimbursement includes local anesthesia and routine post-operative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Covered dental services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D7111) per 1 Lifetime Per patient per tooth.	
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	No	One of (D7140) per 1 Lifetime Per patient per tooth. Removal of asymptomatic teeth are not covered except when member has been approved for orthodontic treatment.	
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	No	One of (D7210) per 1 Lifetime Per patient per tooth. Includes cutting of soft tissue and bone, removal of tooth structure and closure. Removal of asymptomatic teeth are not covered except when member has been approved for orthodontic treatment.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82	No	No	Removal of asymptomatic teeth are not covered except when member has been approved for orthodontic treatment.	
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	No	No	Removal of asymptomatic teeth are not covered except when member has been approved for orthodontic treatment.	
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	No	No	Removal of asymptomatic teeth are not covered except when member has been approved for orthodontic treatment.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82	No	No	Unusual complications such as nerve dissection, separate closure of maxillary sinus, or aberrant tooth positions. Removal of asymptomatic tooth not covered.	
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	No	No	Will not be paid to the dentist or group that removed the tooth.	
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	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	Yes	Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7259	nerve dissection	0-20	Teeth 1 - 32, 51 - 82	No	No	One of (D7259) per 1 Lifetime Per patient per tooth.	
D7260	oroantral fistula closure	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	Yes	Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	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	Yes	Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	No	No	Includes splinting and/or stabilization.	
D7272	tooth transplantation (includes reimplantation from one site to another)	0-20	Teeth 1 - 32	No	No	One of (D7272) per 1 Lifetime Per patient per tooth.	
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	No	No	One of (D7280) per 1 Lifetime Per patient per tooth.	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	0-20	Teeth 1 - 32	Yes	No	One of (D7282) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)

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Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth.	
D7284	excisional biopsy of minor salivary glands	0-20		No	No	Not allowed to billed on the same day as D7286.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		No	Yes	Only covered if there is a suspicious lesion. Subject to pre-payment review.	Pathology report
D7286	incisional biopsy of oral tissue-soft	0-20		No	Yes	Only covered if there is a suspicious lesion. Subject to pre-payment review.	Pathology report
D7287	cytology sample collection	0-20		No	No		
D7290	surgical repositioning of teeth	0-20	Teeth 1 - 32	No	No		
D7291	transseptal fiberotomy, by report	0-20	Teeth 1 - 32	No	Yes	Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7295	Harvest of bone for use in autogenous grafting procedure	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7296) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op 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	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of 4 extractions in the affected quadrant. Not allowed with surgical extractions.	pre-operative x-ray(s)
D7311	alveoloplasty 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	No	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Maximum of three extractions in the affected quadrant. Not allowed with surgical extractions.	narr. of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty 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	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)

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Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7321	alveoloplasty 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	No	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Arch (01, 02, LA, UA)	No	No		
D7350	vestibuloplasty - ridge extension	0-20	Per Arch (01, 02, LA, UA)	No	No		
D7410	radical excision - lesion diameter up to 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7411	excision of benign lesion greater than 1.25 cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7412	excision of benign lesion, complicated	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7413	excision of malignant lesion up to 1.25 cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7414	excision of malignant lesion greater than 1.25 cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7415	excision of malignant lesion, complicated	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)

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Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7465	destruction of lesion(s) by physical or chemical method, by report	0-20		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7471	removal of exostosis - per site	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	0-20	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	0-20	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7485	surgical reduction of osseous tuberosity	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)

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Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7490	radical resection of maxilla or mandible	0-20	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7509	marsupialization of odontogenic cyst	0-20	Teeth 1 - 32, A - T	No	No	One of (D7509) per 1 Lifetime Per patient. Narrative of medical necessity to include treatment prognosis and plans for follow up. Will not be reimbursed on same surgical area on same date of services as any other definitive treatment codes.	narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, A - T	No	Yes	One of (D7510, D7511) per 1 Day(s) Per Location per tooth. Will not be reimbursed in same surgical area on same date of service as any other definitive treatment codes. Subject to pre-payment review.	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	Teeth 1 - 32, A - T	No	Yes	One of (D7510, D7511) per 1 Day(s) Per Location per tooth. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		No	Yes	One of (D7520, D7521) per 1 Day(s) Per Location. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-20		No	Yes	One of (D7520, D7521) per 1 Day(s) Per Location. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-20		No	No		

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Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		No	No		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7550) per 12 Month(s) Per patient per quadrant.	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	0-20		No	No		
D7610	maxilla - open reduction	0-20		No	No		
D7620	maxilla - closed reduction	0-20		No	No		
D7630	mandible-open reduction	0-20		No	No		
D7640	mandible - closed reduction	0-20		No	No		
D7650	malar and/or zygomatic arch-open reduction	0-20		No	No		
D7660	malar and/or zygomatic arch-closed	0-20		No	No		
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		No	No		
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		No	No		
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		No	No		
D7710	maxilla - open reduction	0-20		No	No		
D7720	maxilla - closed reduction	0-20		No	No		
D7730	mandible - open reduction	0-20		No	No		
D7740	mandible - closed reduction	0-20		No	No		
D7750	malar and/or zygomatic arch-open reduction	0-20		No	No		
D7760	malar and/or zygomatic arch-closed reduction	0-20		No	No		

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Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7770	alveolus-stabilization of teeth, open reduction splinting	0-20		No	No		
D7771	alveolus, closed reduction stabilization of teeth	0-20		No	No		
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		No	No		
D7910	suture small wounds up to 5 cm	0-20		No	No		
D7911	complicated suture-up to 5 cm	0-20		No	No		
D7912	complex suture - greater than 5cm	0-20		No	No		
D7920	skin graft (identify defect covered, location and type of graft)	0-20		No	No		
D7940	osteoplasty- for orthognathic deformities	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7941	osteotomy - madibular rami	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7943	osteotomy- mandibular rami with bone graft; includes obtaining the graft	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7944	osteotomy - segmented or subapical - per sextant or quadrant	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7945	osteotomy - body of mandible	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7946	LeFort I (maxilla - total)	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7947	LeFort I (maxilla - segmented)	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)

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Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7948	LeFort II or LeFort III - without bone graft	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7949	LeFort II or LeFort III - with bone graft	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7951	sinus augmentation	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	0-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	0-20		No	No	Three of (D7961, D7963) per 1 Lifetime Per patient.	
D7962	lingual frenectomy (frenulectomy)	0-20		No	No	One of (D7962) per 1 Lifetime Per patient.	
D7963	frenuloplasty	0-20		No	No	Three of (D7963) per 1 Lifetime Per patient.	
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	No	No	One of (D7970) per 1 Lifetime Per patient per arch.	
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	No	No	One of (D7971) per 1 Lifetime Per patient per tooth.	
D7972	surgical reduction of fibrous tuberosity	0-20		No	No		
D7979	non-surgical sialolithotomy	0-20		No	No		
D7980	surgical sialolithotomy	0-20		No	No		
D7981	excision of salivary gland, by report	0-20		No	No		
D7982	sialodochoplasty	0-20		No	No		
D7983	closure of salivary fistula	0-20		No	No		

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7990	emergency tracheotomy	0-20		No	No		
D7991	coronoidectomy	0-20		Yes	No		narrative of medical necessity
D7995	synthetic graft-mandible or facial bones, by report	0-20		Yes	No		narrative of medical necessity
D7996	implant-mandible for augmentation purposes, by report	0-20		Yes	No		narrative of medical necessity
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-20		No	No		
D7999	unspecified oral surgery procedure, by report	0-20		Yes	No		narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. The maximum case payment for orthodontic treatment will be 1 initial payment for comprehensive orthodontic treatment and for the completion of the case. Member may not be billed for broken, repaired or replacement of brackets or wires. The member must be eligible in order for payments to be made. DentaQuest will reimburse for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records as DentaQuest cannot generate claims on the behalf of a provider. Claims for orthodontic records payment must be made in accordance with timely filing protocols, submitted on a HIPAA complaint ADA claim form, billed using the proper CDT code and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency and benefit limitations outlined.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D8010	limited orthodontic treatment of the primary dentition	0-20		Yes	No	One of (D8010, D8020) per 1 Lifetime Per patient. See ORM Section 15.14 for additional benefit limitations.	Photos /Narrative /Treatment Plan /Index Form
D8020	limited orthodontic treatment of the transitional dentition	0-20		Yes	No	One of (D8010, D8020) per 1 Lifetime Per patient. See ORM Section 15.14 for additional benefit limitations.	Photos /Narrative /Treatment Plan /Index Form
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		Yes	No		Photos, Narrative/treatment plan
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	No		Photos, Narrative/treatment plan
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		Yes	No		Photos, Narrative/treatment plan
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		No	No	One of (D8210, D8220) per 1 Lifetime Per patient. Clients do not need to have a handicapping malocclusion to receive this service.	
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		No	No	One of (D8210, D8220) per 1 Lifetime Per patient. Clients do not need to have a handicapping malocclusion to receive this service.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Orthodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		No	No	One of (D8660) per 6 Month(s) Per Provider OR Location. Not allowed on same day or after the date of service of D8070, D8080, or D8090.	
D8670	periodic orthodontic treatment visit	0-20		Yes	No	One of (D8670) per 5 Month(s) Per patient. Not allowed within 5 months of D8070, D8080 or D8090. The PAR approval for D8070, D8080, or D8090 will include the PARs for D8670. Three (D8670) per approved orthodontic case.	
D8680	orthodontic retention (removal of appliances)	0-20		No	No	An approved orthodontic PAR must be on file. Per approved Orthodontic case	
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-20		No	Yes	Subject to pre-payment review	narrative of medical necessity
D8696	Repair of orthodontic appliance-maxillary	0-20		Yes	No	Documentation Required. 2012 or later ADA claim form, narrative describing service, and a report that the client has previously been approved as having a handicapping malocclusion by Colorado Medicaid or Medicaid from another state.	narrative of medical necessity
D8697	Repair of orthodontic appliance-mandibular	0-20		Yes	No	Documentation Required. 2012 or later ADA claim form, narrative describing service, and a report that the client has previously been approved as having a handicapping malocclusion by Colorado Medicaid or Medicaid from another state.	narrative of medical necessity
D8698	Recement or rebond fixed retainer - maxillary	0-20		Yes	No	Documentation Required. 2012 or later ADA claim form, narrative describing service, and a report that the client has previously been approved as having a handicapping malocclusion by Colorado Medicaid or Medicaid from another state.	narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Orthodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D8699	Recement or rebond fixed retainer - mandibular	0-20		Yes	No	Documentation Required. 2012 or later ADA claim form, narrative describing service, and a report that the client has previously been approved as having a handicapping malocclusion by Colorado Medicaid or Medicaid from another state.	narrative of medical necessity
D8701	Repair of fixed retainer, includes reattachment - maxillary	0-20		Yes	No		narrative of medical necessity
D8702	Repair of fixed retainer, includes reattachment - mandibular	0-20		Yes	No		narrative of medical necessity
D8703	Replacement of lost or broken retainer - maxillary	0-20		No	Yes	Subject to pre-payment review	narrative of medical necessity
D8704	Replacement of lost or broken retainer - mandibular	0-20		No	Yes	Subject to pre-payment review	narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	0-20		Yes	No	DOCUMENTATION REQUIRED: 2012 or later ADA claim form, Colorado Orthodontics Criteria Index-Comprehensive D8080 Form, and a report describing the service/s to be rendered. See ORM Section 15.14 for additional benefit limitations.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

EPSDT benefits include medically necessary treatments and screenings for enrollees under 21 years of age. Provider documentation must demonstrate that the service is medically necessary. Services that meet medical necessity as determined by DentaQuest under the EPSDT process are eligible for reimbursement, including services not normally covered by the Child Medicaid benefit package and services beyond frequency limitations. Refer to section 10 C.C.R. 2505-10, Section 8.280.4.E. Local anesthesia is considered part of the treatment procedure and no additional payment will be made for it. General anesthesia and deep sedation is only covered when there is sufficient evidence to support medical necessity. Hospital or surgery center cases require prior authorization.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	0-20		No	No	Not reimbursable with any other services other than radiographs necessary for diagnosis. Not reimbursable when the only other service is writing a prescription.	
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	0-20		No	No	One of (D9219, D9310) per 12 Month(s) Per Provider OR Location.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		No	No	One of (D9222) per 1 Day(s) Per patient.	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		No	No	Not reimbursable with (D9223, D9230, D9243, D9248). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	No	Not reimbursable with (D9223, D9230, D9243, D9248). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.	
D9239	intravenous moderate (conscious) sedation/analgesia-first 15 minutes	0-20		No	Yes	One of (D9239) per 1 Day(s) Per patient. Subject to pre-payment review	narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		No	No	Thirteen of (D9243) per 1 Day(s) Per patient. Not reimbursable with (D9223, D9230, D9243, D9248). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-20		No	No	One of (D9248) per 1 Day(s) Per patient. Not reimbursable with (D9223, D9230, D9243, D9248). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.	
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No	No	One of (D9310) per 12 Month(s) Per Provider OR Location.	
D9311	consultation with medical health care professional	0-20		No	Yes	One of (D9311) per 12 Month(s) Per Provider OR Location. Subject to pre-payment review.	narrative of medical necessity
D9410	house/extended care facility call	0-20		No	No	One of (D9410) per 1 Day(s) Per patient.	
D9420	hospital or ambulatory surgical center call	0-20		No	No	One of (D9420) per 1 Day(s) Per patient.	
D9613	infiltration of sustained release therapeutic drug--per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D9613) per 1 Lifetime Per patient per quadrant.	
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	0-20	Teeth 1 - 32	No	No	One of (D9911) per 12 Month(s) Per patient.	
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	0-20	Per Arch (01, 02, LA, UA)	No	No	One of (D9939) per 1 Lifetime Per patient. Not to be billed on the same day as D1520, D1526, D1527, D5820, D5821.	
D9943	occlusal guard adjustment	0-20		Yes	No	One of (D9943) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement (D9944, D9945, D9946) Limit to 1 per year	narrative of medical necessity

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9944	occlusal guard--hard appliance, full arch	0-20	Per Arch (01, 02, LA, UA)	No	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Subject to pre-payment review.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	No	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Subject to pre-payment review.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	0-20	Per Arch (01, 02, LA, UA)	No	Yes	One of (D9944, D9945, D9946) per 24 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Subject to pre-payment review.	narrative of medical necessity
D9951	occlusal adjustment - limited	0-20		No	No	One of (D9951) per 24 Month(s) Per patient. Not to be reported with bite adjustment in post-delivery care of direct/indirect restorations or fixed/removable prosthodontics.	
D9952	occlusal adjustment - complete	0-20		No	No	One of (D9952) per 24 Month(s) Per patient.	
D9971	Odontoplasty- per tooth, removal reshaping of enamel surfaces or projections.	0-20	Teeth 1 - 32	No	No	One of (D9971) per 1 Lifetime Per patient per tooth.	
D9986	Missed Appointment	0-20		No	No		
D9987	Cancelled Appointment	0-20		No	No		
D9995	teledentistry – synchronous; real-time encounter	0-20		No	Yes	Two of (D9995) per 1 Month(s) Per patient. 6 visit maximum per member. Narrative must demonstrate visit is an emergency due to trauma, infection, or COVID-related. Cannot be used for COVID screening questions. Subject to pre-payment review.	narrative of medical necessity
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	No	One of (D9996) per 1 Day(s) Per patient.	

**Exhibit A Benefits Covered for
Health First Colorado Dental Program - 20 and under**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9999	unspecified adjunctive procedure, by report	0-20		Yes	No		narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Diagnostic series include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the member's oral health. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for the individual radiographs taken on the same day will be limited to the allowance for a full mouth series. A minimum of 10 films is required for an intraoral complete series (full mouth series). A panoramic film with or without bitewing radiographs is considered equivalent to an intraoral complete series and cannot be billed on the same date of serves as a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitation. All radiographs and oral/facial photographic images must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	No	Two of (D0120, D0150, D0180) per 12 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	No	Two of (D0140, D0160, D0170) per 12 Month(s) Per Location. Per patient. Not reimbursable on the same day as D0120, D0150, D0160, D0170 or D0180. Dental Hygienists may only provide for an established client or record.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	No	One of (D0150, D0160, D0170) per 36 Month(s) Per Location. Two of (D0120, D0150, D0180) per 12 Month(s) Per Provider OR Location.	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	No	Two of (D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per Provider OR Location.	
D0170	re-evaluation, limited problem focused	21 and older		No	No	Two of (D0140, D0160, D0170, D0180) per 12 Month(s) Per Provider OR Location. Must be an established patient, not a post op visit.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	No	One of (D0160, D0170, D0180) per 36 Month(s) Per patient. Two of (D0120, D0150, D0180) per 12 Month(s) Per patient.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 60 Month(s) Per patient. Cannot be billed on the same date of tx as Pano, a minimum of 10 films is required. Clients over the age of 12 require 12-20 films.	
D0220	intraoral - periapical first radiographic image	21 and older		No	No	Six of (D0220, D0374) per 12 Month(s) Per patient. Working and final endodontic treatment films are not covered. Not covered if rendered on the same day as D0210.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	No	Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, D3330, D3331, D3332, D3333, D3346. D3347, D3348. Not allowed on the same day as D0210.	
D0270	bitewing - single radiographic image	21 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0273	bitewings - three radiographic images	21 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	No	One of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 60 Month(s) Per Provider OR Location. Counts as a full mouth series. Counts as an intraoral complete series.	
D0330	panoramic radiographic image	21 and older		No	No	One of (D0210, D0277, D0330) per 60 Month(s) Per Provider OR Location. Counts as a full mouth series.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	21 and older		No	No	Six of (D0350) per 12 Month(s) Per patient. RDH's will receive reimbursement when used for telehealth dentistry in partnership with a treating dentist.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0372, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0373, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No	No	One of (D0220, D0374) per 12 Month(s) Per patient.	
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	21 and older		No	No	One of (D0372, D0373, D0380) per 12 Month(s) Per patient.	
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	21 and older		No	No	One of (D0372, D0373, D0381) per 12 Month(s) Per patient.	
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	21 and older		No	No	One of (D0372, D0373, D0382) per 12 Month(s) Per patient.	
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	21 and older		No	No	One of (D0372, D0373, D0383) per 12 Month(s) Per patient.	
D0384	Cone beam CT image capture for TMJ series including two or more exposures	21 and older		No	No	One of (D0372, D0373, D0384) per 12 Month(s) Per patient.	
D0385	Maxillofacial MRI image capture	21 and older		No	No	One of (D0385) per 12 Month(s) Per patient.	
D0386	Maxillofacial ultrasound image capture	21 and older		No	No	One of (D0386) per 12 Month(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0387) per 12 Month(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0388) per 12 Month(s) Per patient.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0389) per 12 Month(s) Per patient.	
D0411	HbA1c in-office point of service testing	21 and older		No	No	One in-office screening via finger-stick HbA1c glucose test per provider. Referral documentation with test results to be kept in patient record.	
D0412	blood glucose level test	21 and older		No	No	One of (D0411, D0412) per 1 Day(s) Per Provider.	
D0460	pulp vitality tests	21 and older		No	No	One of (D0460) per 1 Day(s) Per patient.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Sealants may be placed on the occlusal or occlusa-buccal surfaces of lower molars or occlusal or occlusal -lingual surfaces of upper molars. Space maintainers are a covered service when determined by a DentaQuest consultant to be medically indicated due to the premature loss of a posterior primary tooth, permanent first molar or congenitally missing permanent tooth. A lower lingual hold arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance. Fees for space maintainers include maintenance and repair.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient. For members who fall into a high risk category for caries, periodontal disease, diabetes or pregnant women with histories of periodontal disease are entitled to four(D1110 , D4910) per 12 months. Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355. See ORM Section 8.07.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	No	Two of (D1354) per 12 Month(s) Per patient per tooth for Primary and Permanent Teeth. not to exceed 4 times per lifetime. Cannot be billed on the same day as D3110 or D3120 or any D2000 series code (D2140-D2999)	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	No	One of (D1701) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	No	One of (D1702) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	No	One of (D1703) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	No	One of (D1704) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/1.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	No	One of (D1707) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1781	vaccine administration – human papillomavirus – Dose 1	21 and older		No	No	One of (D1781) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1782	vaccine administration – human papillomavirus – Dose 2	21 and older		No	No	One of (D1782) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	
D1783	vaccine administration – human papillomavirus – Dose 3	21 and older		No	No	One of (D1783) per 1 Lifetime Per patient. Please refer to the CDC for the most up to date and current guidelines and information.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Reimbursement includes local anesthesia. Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 months. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration. An amalgam or composite restoration and a crown on the same tooth and on the same date of service is not allowed. Prefabricated stainless steel crowns are a benefit for both primary and permanent teeth. Prefabricated resin crowns, prefabricated stainless steel crowns with resin window and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. Cast crown materials are limited to porcelain and noble metal or full porcelain on anterior teeth and premolars. Full noble metal crowns will be the material of choice for molars. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 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	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 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	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2390) per 36 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 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	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 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	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394) per 36 Month(s) Per patient per tooth, per surface.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2710	crown - resin-based composite (indirect)	21 and older	Teeth D - G	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight artificial or natural teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2712	crown - 3/4 resin-based composite (indirect)	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight artificial or natural teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2721	crown - resin with predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2740	crown - porcelain/ceramic	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2781	crown - ¾ cast predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2782	crown - ¾ cast noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2783	crown - ¾ porcelain/ceramic	21 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2794	Crown- Titanium and Titanium Alloys	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 Month(s) Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion. Subject to pre-payment review.	pre-operative x-ray(s)
D2799	interim crown	21 and older	Teeth 2 - 15, 18 - 31	Yes	No		pre-operative x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No	No	Not allowed within 6 months of placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	No	Not allowed within 6 months of placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	21 and older	Teeth 6 - 11, 22 - 27	No	Yes	One of (D2928, D2931, D2933) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review when 6 or more crowns required on the same day of service. Must meet criteria for in-office sedation or hospitalization.	narr. of med. necessity, pre-op x-ray(s)
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	No	One of (D2928, D2931, D2933) per 36 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	21 and older	Teeth 6 - 11, 22 - 27	No	Yes	One of (D2928, D2931, D2933) per 36 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D2940	Placement of interim direct restoration.	21 and older	Teeth 1 - 32	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist.	
D2941	Interim therapeutic restoration - primary dentition	21 and older	Teeth A - T	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist.	
D2950	core buildup, including any pins when required	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review.	pre-operative x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2952	cast post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review.	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 84 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review.	pre-operative x-ray(s)
D2991	application of hydroxyapatite regeneration medicament – per tooth	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	No	One of (D2991) per 1 Lifetime Per patient per tooth. Cannot be billed on the same day/same tooth as any other D2000's codes or D1351, D1352, D1353, D1354.	
D2999	unspecified restorative procedure, by report	21 and older	Teeth 1 - 32, A - T	Yes	No		narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Reimbursement includes local anesthesia. In cases where a root canal filling does not meet DentaQuest's general criteria 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. A pulpotomy, pulpal debridement or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra operative and final radiographs.

In all instances which the adult client is in acute pain or there exists acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to pre-payment review. Please see section 5.01

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3110	pulp cap - direct (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	No	One of (D3110) per 1 Lifetime Per patient per tooth. Cannot be billed on the same day as D3120 and D3221	
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	No	One of (D3120) per 1 Lifetime Per patient per tooth. Cannot be billed on the same day as D3110 and D3221	
D3221	pulpal debridement, primary and permanent teeth	21 and older	Teeth 1 - 32, A - T	No	Yes	One of (D3221) per 1 Lifetime Per patient per tooth. Permanent teeth only. Not to be used by the provider completing endodontic treatment unless emergency situation exists. Not reimbursable when root canal is completed on the same day by the same dentist or group. Subject to pre-payment review.	pre-operative x-ray(s)
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. Only reimbursable if original treatment not paid by CO Medicaid.	Pre and post-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3347) per 1 Lifetime Per patient per tooth. Only reimbursable if original treatment not paid by CO Medicaid.	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No	One of (D3348) per 1 Lifetime Per patient per tooth. Only reimbursable if original treatment not paid by CO Medicaid. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.	Pre and post-operative x-ray(s)
D3921	decoronation or submergence of an erupted tooth	21 and older	Teeth 1 - 32	No	Yes	One of (D3921) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	narrative of medical necessity
D3999	unspecified endodontic procedure, by report	21 and older	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Reimbursement includes local anesthetic. Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351 and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	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)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. Includes six months of routine postoperative care.	Perio Charting, pre-op radiographs and narr of med necessity
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)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. Includes six months of routine postoperative care.	Perio Charting, pre-op radiographs and narr of med necessity
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Teeth 1 - 32, 51 - 82	No	No	One of (D4212) per 36 Month(s) Per patient per tooth. Includes six months of routine postoperative care.	
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	No	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Not paid on the same date as (D1110).	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	No	One of (D4341, D4342) per 36 Month(s) Per patient per quadrant. A maximum of three (3) teeth in the affected quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Not paid on the same date as (D1110).	pre-op x-ray(s), perio charting
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	21 and older		No	No	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient. Not reimbursed when billed on the same date of service as (D1110, D4341, D4342, D4355, D4910). Patients at High Risk for Caries or Periodontal disease, four of (D1110, D4910, D4346) per 12 months. See ORM Sections 8.07 and 15.01.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	Yes	One of (D4355) per 3 Year(s) Per patient. (D0150, D0160, D0180,(D1110) are not reimbursable when provided on the same day of service as (D4355). (D4355) is not reimbursable if patient record indicates (D1110,D4910) have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as (D4355). Subject to pre-payment review.	pre-operative x-ray(s)
D4910	periodontal maintenance procedures	21 and older		No	Yes	Two of (D1110, D4346, D4910) per 12 Month(s) Per patient. unless patient falls into a high risk category for periodontal disease. Members with diabetes and pregnant women with histories of periodontal disease are entitled to four per 12 months. Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355. Subject to pre-payment review. See ORM Section 8.07.	Perio Charting, pre-op radiographs and narr of med necessity
D4999	unspecified periodontal procedure, by report	21 and older		Yes	No		narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Removable prosthetics are not covered if eight or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided for anterior teeth irrespective of the number of teeth in occlusion. Maxillofacial prostheses that serve to rehabilitate esthetics and function for member with acquired, congenital or developmental defects of the head and neck are covered. Necessary prostheses to restore both form and function is covered for members exposed to chemotherapy, radiation or cytotoxic drugs. Services for removable prostheses must include instruction in the use and care of the prosthesis and any adjustments necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	No	One of (D5110, D5130) per 84 Month(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only.	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	No	One of (D5120, D5140) per 84 Month(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only.	narr. of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	21 and older		Yes	No	One of (D5110, D5130) per 84 Month(s) Per patient. Includes initial 6 months of relines.	narr. of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	21 and older		Yes	No	One of (D5120, D5140) per 84 Month(s) Per patient. Includes initial 6 months of relines.	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5211, D5225) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5212, D5226) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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)	21 and older		Yes	No	One of (D5213, D5225) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	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)	21 and older		Yes	No	One of (D5214, D5226) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture-flexible base	21 and older		Yes	No	One of (D5211, D5225) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture-flexible base	21 and older		Yes	No	One of (D5212, D5226) per 84 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10.	narr. of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	21 and older		No	No	One of (D5410) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5411	adjust complete denture - mandibular	21 and older		No	No	One of (D5411) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5421	adjust partial denture-maxillary	21 and older		No	No	One of (D5421) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5422	adjust partial denture - mandibular	21 and older		No	No	One of (D5422) per 12 Month(s) Per patient. Not allowed within 6 months of delivery.	
D5511	repair broken complete denture base, mandibular	21 and older		No	No	One of (D5511) per 12 Month(s) Per patient.	
D5512	repair broken complete denture base, maxillary	21 and older		No	No	One of (D5512) per 12 Month(s) Per patient.	
D5520	replace missing or broken teeth - complete denture - per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5520) per 12 Month(s) Per patient per tooth.	
D5611	repair resin partial denture base, mandibular	21 and older		No	No	One of (D5611) per 12 Month(s) Per patient.	
D5612	repair resin partial denture base, maxillary	21 and older		No	No	One of (D5612) per 12 Month(s) Per patient.	
D5621	repair cast partial framework, mandibular	21 and older		No	No	One of (D5621) per 12 Month(s) Per patient.	
D5622	repair cast partial framework, maxillary	21 and older		No	No	One of (D5622) per 12 Month(s) Per patient.	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5630) per 12 Month(s) Per patient per tooth.	
D5640	replace missing or broken teeth – partial denture – per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5640) per 12 Month(s) Per patient per tooth.	
D5650	add tooth to existing partial denture – per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5650) per 12 Month(s) Per patient per tooth.	
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	No	One of (D5660) per 12 Month(s) Per patient per tooth.	
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	21 and older		No	Yes	One of (D5670) per 12 Month(s) Per patient. Subject to pre-payment review.	narrative of medical necessity
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	21 and older		No	Yes	One of (D5671) per 12 Month(s) Per patient. Subject to pre-payment review.	narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5710	rebase complete maxillary denture	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5711	rebase complete mandibular denture	21 and older		No	No	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5720	rebase maxillary partial denture	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5721	rebase mandibular partial denture	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5725	rebase hybrid prosthesis	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	One of (D5725) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Subject to pre-payment review.	narrative of medical necessity
D5730	reline complete maxillary denture (chairside)	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	No	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5740	reline maxillary partial denture (chairside)	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5741	reline mandibular partial denture (chairside)	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	No	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5761	reline mandibular partial denture (laboratory)	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5765	soft liner for complete or partial removable denture – indirect	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D5765) per 48 Month(s) Per patient. Not allowed for first six months after delivery.	
D5850	tissue conditioning, maxillary	21 and older		No	No	One of (D5850) per 1 Lifetime Per patient. Not allowed for first six months after delivery.	
D5851	tissue conditioning,mandibular	21 and older		No	No	One of (D5851) per 1 Lifetime Per patient. Not allowed for first six months after delivery.	
D5862	precision attachment, by report	21 and older	Teeth 1 - 32	No	No	One of (D5862) per 84 Month(s) Per patient. Not allowed for first six months after delivery.	
D5867	Replacement of replaceable part of semi-precision per attachment	21 and older	Teeth 1 - 32	No	No	One of (D5867) per 84 Month(s) Per patient per tooth. Not allowed for first six months after delivery.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes	No		narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Multiple units of crown and bridge is not a covered benefit for adults.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Reimbursement includes local anesthesia and routine post-operative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Covered dental services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	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	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
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	Yes	One of (D7210) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7220) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7230) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7240) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7241) per 1 Lifetime Per patient per tooth. Subject to pre-payment review.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	Will not be paid to the dentists or group that removed the tooth. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7259	nerve dissection	21 and older	Teeth 1 - 32, 51 - 82	No	No	One of (D7259) per 1 Lifetime Per patient per tooth.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7260	oroantral fistula closure	21 and older		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D7261	primary closure of a sinus perforation	21 and older		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D7284	excisional biopsy of minor salivary glands	21 and older		No	No	Not allowed to billed on the same day as D7286.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		No	Yes	Only covered if there is a suspicious lesion. Subject to pre-payment review.	Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		No	Yes	Only covered if there is a suspicious lesion. Subject to pre-payment review.	Pathology report
D7287	cytology sample collection	21 and older		No	Yes	Subject to pre-payment review.	narrative of medical necessity
D7310	alveoloplasty 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	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of 4 extractions in the affected quadrant. Not allowed with surgical extractions. Subject to Pre-payment review.	pre-operative x-ray(s)
D7311	alveoloplasty 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	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Maximum of 3 extractions in the affected quadrant. Not allowed with surgical extractions. Subject to Pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty 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	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty 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	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Subject to pre-payment review.	narrative of medical necessity
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7412	excision of benign lesion, complicated	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7413	excision of malignant lesion up to 1.25 cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7415	excision of malignant lesion, complicated	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	Yes	Subject to payment review. Pathology Report required.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7471	removal of exostosis - per site	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7485	surgical reduction of osseous tuberosity	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7490	radical resection of maxilla or mandible	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Subject to pre-payment review.	narr. of med. necessity, pre-op x-ray(s)
D7509	marsupialization of odontogenic cyst	21 and older	Teeth 1 - 32, A - T	No	No	One of (D7509) per 1 Lifetime Per patient per tooth. Narrative of medical necessity to include treatment prognosis and plans for follow up. Will not be reimbursed on same surgical area on same date of services as any other definitive treatment codes.	narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32	No	No	One of (D7510, D7511) per 1 Lifetime Per patient per tooth.	narrative of medical necessity
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older	Teeth 1 - 32	No	No	One of (D7510, D7511) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No	No	One of (D7520, D7521) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		No	No	One of (D7520, D7521) per 1 Lifetime Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	21 and older		No	No		
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		No	No		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7550) per 12 Month(s) Per patient per quadrant.	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	21 and older		No	No		
D7610	maxilla - open reduction	21 and older		No	No		
D7620	maxilla - closed reduction	21 and older		No	No		
D7630	mandible-open reduction	21 and older		No	No		
D7640	mandible - closed reduction	21 and older		No	No		
D7650	malar and/or zygomatic arch-open reduction	21 and older		No	No		
D7660	malar and/or zygomatic arch-closed	21 and older		No	No		
D7670	alveolus stabilization of teeth, closed reduction splinting	21 and older		No	No		

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7671	alveolus - open reduction, may include stabilization of teeth	21 and older		No	No		
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	21 and older		No	No		
D7710	maxilla - open reduction	21 and older		No	No		
D7720	maxilla - closed reduction	21 and older		No	No		
D7730	mandible - open reduction	21 and older		No	No	One of (D7730) per 1 Lifetime Per patient per arch.	
D7740	mandible - closed reduction	21 and older		No	No		
D7750	malar and/or zygomatic arch-open reduction	21 and older		No	No		
D7760	malar and/or zygomatic arch-closed reduction	21 and older		No	No		
D7770	alveolus-stabilization of teeth, open reduction splinting	21 and older		No	No		
D7771	alveolus, closed reduction stabilization of teeth	21 and older		No	No		
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	21 and older		No	No		
D7910	suture small wounds up to 5 cm	21 and older		No	No		
D7911	complicated suture-up to 5 cm	21 and older		No	No		
D7912	complex suture - greater than 5cm	21 and older		No	No		
D7920	skin graft (identify defect covered, location and type of graft)	21 and older		No	No		
D7947	LeFort I (maxilla - segmented)	21 and older		Yes	No		narr. of med. necessity, pre-op x-ray(s)

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	21 and older		No	No		
D7955	repair of maxillofacial soft and/or hard tissue defect	21 and older		No	No		
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D7970) per 1 Lifetime Per patient per arch.	
D7971	excision of pericoronal gingiva	21 and older	Teeth 1 - 32	No	No	One of (D7971) per 1 Lifetime Per patient per tooth.	
D7972	surgical reduction of fibrous tuberosity	21 and older		No	No		
D7979	non-surgical sialolithotomy	21 and older		No	No		
D7980	surgical sialolithotomy	21 and older		No	No		
D7981	excision of salivary gland, by report	21 and older		No	No		
D7982	sialodochoplasty	21 and older		No	No		
D7983	closure of salivary fistula	21 and older		No	No		
D7990	emergency tracheotomy	21 and older		No	No		
D7991	coronoidectomy	21 and older		No	No		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	21 and older		Yes	No		narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	21 and older		Yes	No		narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	21 and older		No	Yes	One of (D8695) per 1 Lifetime Per patient. Subject to pre-payment review	narrative of medical necessity

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Local anesthesia is considered part of the treatment procedure and no additional payment will be made for it. General anesthesia and deep sedation is only covered when there is sufficient evidence to support medical necessity. Hospital or surgery center cases require prior authorization.

Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia will be reimbursed.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	No	Not allowed with any other services other than radiographs. Cannot be billed when the only other service is writing a prescription.	
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	21 and older		No	No	One of (D9219, D9310) per 12 Month(s) Per Provider OR Location.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		No	No	One of (D9222) per 1 Day(s) Per patient.	
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		No	No	Not allowed with D9243.	
D9239	intravenous moderate (conscious) sedation/analgesia-first 15 minutes	21 and older		No	Yes	One of (D9239) per 1 Day(s) Per patient. Subject to pre-payment review	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		No	Yes	Thirteen of (D9243) per 1 Day(s) Per patient. Not allowed with D9223. Subject to pre-payment review.	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	No	One of (D9219, D9310) per 12 Month(s) Per Provider OR Location. Diagnostic service by dentist other than practitioner providing treatment.	
D9311	consultation with medical health care professional	21 and older		No	Yes	One of (D9311) per 12 Month(s) Per Provider OR Location. Subject to pre-payment review.	narrative of medical necessity
D9410	house/extended care facility call	21 and older		No	No	One of (D9410) per 1 Day(s) Per patient.	
D9420	hospital or ambulatory surgical center call	21 and older		No	No	Covered for emergency services only.	

**Exhibit B Benefits Covered for
Health First Colorado Dental Program - 21 and over**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9986	Missed Appointment	21 and older		No	No		
D9987	Cancelled Appoinment	21 and older		No	No		
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	Yes	Two of (D9995) per 1 Month(s) Per patient. 6 visit maximum per member. Narrative must demonstrate visit is an emergency due to trauma, infection, or COVID-related. Cannot be used for COVID screening questions. Subject to pre-payment review.	narrative of medical necessity
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	No	One of (D9996) per 1 Day(s) Per patient.	
D9999	unspecified adjunctive procedure, by report	21 and older		Yes	No		narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Diagnostic series include the oral examinations, and selected radiographs needed to assess the oral health, diagnose oral pathology and develop an adequate treatment plan for the member's oral health. Reimbursement for some or multiple x-rays of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for the individual radiographs taken on the same day will be limited to the allowance for a full mouth series. A minimum of 10 films is required for an intraoral complete series (full mouth series). A panoramic film with or without bitewing radiographs is considered equivalent to an intraoral complete series and cannot be billed on the same date of serves as a full mouth series. Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis. DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitation. All radiographs and oral/facial photographic images must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	21 and older		No	No	Six of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per patient. Basic/Preventative Service	
D0140	limited oral evaluation-problem focused	21 and older		No	No	Six of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per patient. Not reimbursable on the same day as D0120, D0150, D0160 or D0170. Dental Hygienists may only provide for an established client or record. Basic/Preventative Service	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	No	One of (D0150) per 24 Month(s) Per patient. Two of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per Provider OR Location. Basic/Preventative Service	
D0160	detailed and extensive oral eval-problem focused, by report	21 and older		No	No	Four of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per Provider OR Location. Basic/Preventative Service	
D0170	re-evaluation, limited problem focused	21 and older		No	No	Four of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per Provider OR Location. Must be an established patient, not a post op visit. Basic/Preventative Service.	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0171	Re-evaluation post-operative office visit	21 and older		No	No	Not reimbursable on the same day as D0120, D0140, D0150, D0160, D0170, D0180, D0190, or D0191. Basic/Preventative Service	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	No	One of (D0180) per 12 Month(s) Per patient. Four of (D0120, D0140, D0150, D0160, D0170, D0180) per 12 Month(s) Per patient. Basic/Preventative Service	
D0190	Screening of a patient	21 and older		No	No	Four of (D0190, D0191) per 12 Month(s) Per patient. Basic/Preventative Service	
D0191	Assessment of a patient	21 and older		No	No	Four of (D0190, D0191) per 12 Month(s) Per patient. Basic/Preventative Service	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0277, D0330) per 12 Month(s) Per Location. Cannot be billed on the same date of tx as Pano, a minimum of 10 films is required, Clients over the age of 12 require 12-20 films. Basic/Preventative Service	
D0220	intraoral - periapical first radiographic image	21 and older		No	No	Six of (D0220) per 12 Month(s) Per patient. Not allowed on the same day as D0210. Working and final endodontic treatment films are not covered. Basic/Preventative Service	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	No	Not allowed on the same day as D0210. Working and final endodontic treatment films are not covered. Basic/Preventative Service	
D0240	intraoral - occlusal radiographic image	21 and older		No	No	Two of (D0240) per 12 Month(s) Per patient. Basic/Preventative Service	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No	No	One of (D0250) per 12 Month(s) Per patient. Basic/Preventative Service	
D0251	extra-oral posterior dental radiographic image	21 and older		No	No	Basic/Preventative Service.	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0270	bitewing - single radiographic image	21 and older		No	No	Two of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient. Basic/Preventative Service	
D0272	bitewings - two radiographic images	21 and older		No	No	Two of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient. Basic/Preventative Service	
D0273	bitewings - three radiographic images	21 and older		No	No	Two of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient. Basic/Preventative Service	
D0274	bitewings - four radiographic images	21 and older		No	No	Two of (D0270, D0272, D0273, D0274) per 12 Month(s) Per patient. Basic/Preventative Service	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	No	One of (D0210, D0277, D0330) per 60 Month(s) Per Provider OR Location. Counts as a full mouth series. Basic/Preventative Service	
D0310	sialography	21 and older		No	No	One of (D0310) per 12 Month(s) Per patient. Basic/Preventative Service	
D0320	temporomandibular joint arthogram, including injection	21 and older		No	No	One of (D0320) per 12 Month(s) Per patient. Basic/Preventative Service	
D0321	other temporomandibular joint films, by report	21 and older		No	No	One of (D0321) per 12 Month(s) Per patient. Basic/Preventative Service	
D0322	tomographic survey	21 and older		No	No	One of (D0322) per 12 Month(s) Per patient. Basic/Preventative Service	
D0330	panoramic radiographic image	21 and older		No	No	One of (D0210, D0277, D0330) per 60 Month(s) Per Location. One of (D0330) per 12 Month(s) Per patient. Counts as a full mouth series. Basic/Preventative Service	
D0340	cephalometric radiographic image	21 and older		No	No	One of (D0340) per 12 Month(s) Per patient. Basic/Preventative Service	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	21 and older		No	No	One of (D0350) per 12 Month(s) Per patient. (unlimited images) RDH's will receive reimbursement when used for telehealth dentistry in partnership with a treating dentist. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	21 and older		No	No	One of (D0365) per 12 Month(s) Per patient. Basic/Preventative Service	
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	21 and older		No	No	One of (D0366) per 12 Month(s) Per patient. Basic/Preventative Service	
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	21 and older		No	No	One of (D0367) per 12 Month(s) Per patient. Basic/Preventative Service	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0372, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	No	One of (D0210, D0277, D0330, D0365, D0366, D0367, D0373, D0380, D0381, D0382, D0383, D0384) per 12 Month(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No	No	One of (D0220, D0374) per 12 Month(s) Per patient.	
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	21 and older		No	No	One of (D0372, D0373, D0380) per 12 Month(s) Per patient.	
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	21 and older		No	No	One of (D0372, D0373, D0381) per 12 Month(s) Per patient.	
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	21 and older		No	No	One of (D0372, D0373, D0382) per 12 Month(s) Per patient.	
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	21 and older		No	No	One of (D0372, D0373, D0383) per 12 Month(s) Per patient.	
D0384	Cone beam CT image capture for TMJ series including two or more exposures	21 and older		No	No	One of (D0372, D0373, D0384) per 12 Month(s) Per patient.	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Diagnostic							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D0385	Maxillofacial MRI image capture	21 and older		No	No	One of (D0385) per 12 Month(s) Per patient.	
D0386	Maxillofacial ultrasound image capture	21 and older		No	No	One of (D0386) per 12 Month(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0387) per 12 Month(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0388) per 12 Month(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	21 and older		No	No	One of (D0381, D0382, D0383, D0389) per 12 Month(s) Per patient.	
D0411	HbA1 in-office point of service testing	21 and older		No	Yes	One in-office screening via finger-stick HbA1c glucose test per provider. Referral documentation with test results to be kept in patient record. Subject to pre-payment review.	
D0412	blood glucose level test	21 and older		No	No	One of (D0411, D0412) per 1 Day(s) Per Provider. Basic/Preventative Service	
D0425	caries susceptibility tests	21 and older		No	No	Basic/Preventative Service	
D0460	pulp vitality tests	21 and older		No	No	One of (D0460) per 1 Day(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Sealants may be placed on the occlusal or occlusa-buccal surfaces of lower molars or occlusal or occlusal -lingual surfaces of upper molars. Space maintainers are a covered service when determined by a DentaQuest consultant to be medically indicated due to the premature loss of a posterior primary tooth, permanent first molar or congenitally missing permanent tooth. A lower lingual hold arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance. Fees for space maintainers include maintenance and repair.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1110	prophylaxis - adult	21 and older		No	No	Six of (D1110, D4346, D4910) per 12 Month(s) Per patient. with a maximum of 2 x D4346. Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355. Basic/Preventative Service.	
D1206	topical application of fluoride varnish	21 and older		No	No	Six of (D1206, D1208) per 12 Month(s) Per patient. Basic/Preventative Service.	
D1208	topical application of fluoride - excluding varnish	21 and older		No	No	Six of (D1206, D1208) per 12 Month(s) Per patient. Basic/Preventative Service.	
D1351	sealant - per tooth	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	No	Four of (D1351) per 12 Month(s) Per patient. Basic/Preventative Service	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	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	No	Four of (D1352) per 12 Month(s) Per patient. Basic/Preventative Service	
D1353	Sealant repair - per tooth	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	No	Four of (D1353) per 12 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Preventative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	No	Four of (D1354) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	
D1510	space maintainer-fixed, unilateral- per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510) per 12 Month(s) Per patient. Basic/Preventative Service	
D1520	space maintainer-removable-unilateral	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1520) per 12 Month(s) Per patient. Basic/Preventative Service	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	21 and older		No	No	One of (D1550, D1551) per 12 Month(s) Per patient. Basic/Preventative Service. Not reimbursable within 6 months of original placement by same dentist or group.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	21 and older		No	No	One of (D1550, D1552) per 12 Month(s) Per patient. Basic/Preventative Service. Not reimbursable within 6 months of original placement by same dentist or group.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1555, D1556) per 1 Lifetime Per patient. Basic/Preventative Service. Not reimbursable within 6 months of original placement by same dentist or group.	
D1557	Removal of fixed bilateral space maintainer- Maxillary	21 and older		No	No	One of (D1555, D1557) per 1 Lifetime Per patient. Basic/Preventative Service. Not reimbursable within 6 months of original placement by same dentist or group.	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1510, D1520, D1575) per 1 Lifetime Per patient per quadrant. Indicate missing tooth numbers and quadrant on claim. Includes maintenance and repair. Basic/Preventive Service	
D1999	Unspecified preventive procedure, by report	21 and older		Yes	No	Basic/Preventative Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Reimbursement includes local anesthesia. Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 months. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration. An amalgam or composite restoration and a crown on the same tooth and on the same date of service is not allowed. Prefabricated stainless steel crowns are a benefit for both primary and permanent teeth. Prefabricated resin crowns, prefabricated stainless steel crowns with resin window and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. Cast crown materials are limited to porcelain and noble metal or full porcelain on anterior teeth and premolars. Full noble metal crowns will be the material of choice for molars. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation / delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	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. Basic/Preventative Service	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	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. Basic/Preventative Service	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	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. Basic/Preventative Service	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	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. Basic/Preventative Service	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	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. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	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. Basic/Preventative Service	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	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. Basic/Preventative Service	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27	No	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. Basic/Preventative Service	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2390) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	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. Basic/Preventative Service	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	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. Basic/Preventative Service	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	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. Basic/Preventative Service	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	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. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2710	crown - resin-based composite (indirect)	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2712	crown - 3/4 resin-based composite (indirect)	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2721	crown - resin with predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2722	crown - resin with noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2740	crown - porcelain/ceramic	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2753	Crown- Porcelain Fused to Titanium and Titanium Alloys	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2781	crown - ¾ cast predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2782	crown - ¾ cast noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2783	crown - ¾ porcelain/ceramic	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2790	crown - full cast high noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2794	Crown- Titanium and Titanium Alloys	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2799	interim crown	21 and older	Teeth 2 - 15, 18 - 31	Yes	No	One of (D2799) per 12 Month(s) Per patient. Major Service	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	No	Not allowed within 6 months of placement. Basic/Preventative Service	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	No	Not allowed within 6 months of placement. Basic/Preventative Service	
D2930	prefabricated stainless steel crown - primary tooth	21 and older	Teeth A - T	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2940) per 24 Month(s) Per patient per tooth. Subject to pre-payment review. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2940) per 24 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review . Major Service.	narr. of med. necessity, pre-op x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 1 - 32, A - T	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2940) per 24 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review . Major Service.	narr. of med. necessity, pre-op x-ray(s)
D2933	prefabricated stainless steel crown with resin window	21 and older	Teeth 6 - 12, 22 - 27	No	Yes	Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. Subject to pre-payment review. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	21 and older	Teeth A - T	No	Yes	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2930, D2931, D2932, D2940) per 24 Month(s) Per patient per tooth. Limit of 5 crowns per day in a non-hospital setting unless in-office sedation is being provided. When 6 or more crowns required on the same day of service, must meet criteria for in-office sedation or hospitalization. Subject to pre-payment review . Major Service.	pre-operative x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2940	Placement of interim direct restoration.	21 and older	Teeth 1 - 32, A - T	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist. Basic/Preventive Service	
D2941	Interim therapeutic restoration - primary dentition	21 and older	Teeth A - T	No	No	One of (D2940, D2941) per 1 Lifetime Per patient per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist. Basic/Preventive Service	
D2950	core buildup, including any pins when required	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review. Major Service	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	Yes	One of (D2951) per 12 Month(s) Per patient. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2952	cast post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review. Major Service	pre-operative x-ray(s)
D2953	each additional cast post - same tooth	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Major Service	pre-operative x-ray(s)
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	Yes	One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951. Subject to pre-payment review. Major Service	pre-operative x-ray(s)
D2955	post removal (not in conjunction with endodontic therapy)	21 and older	Teeth 1 - 32	No	No	One of (D2955) per 12 Month(s) Per patient. Major Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Restorative							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D2957	each additional prefabricated post - same tooth	21 and older	Teeth 1 - 32	No	Yes	One of (D2957) per 12 Month(s) Per patient. Must be billed with D2954. Subject to pre-payment review. Major Service.	pre-operative x-ray(s)
D2980	crown repair, by report	21 and older	Teeth 1 - 32	No	No	One of (D2980) per 12 Month(s) Per patient per tooth. Basic/Preventative Service.	
D2991	application of hydroxyapatite regeneration medicament – per tooth	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	No	One of (D2991) per 1 Lifetime Per patient per tooth. Cannot be billed on the same day/tooth as any other D2000's codes or D1351, D1352, D1353, D1354. Basic/Preventative Service.	
D2999	unspecified restorative procedure, by report	21 and older	Teeth 1 - 32, A - T	Yes	No	Major Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Reimbursement includes local anesthesia. In cases where a root canal filling does not meet DentaQuest's general criteria 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. A pulpotomy, pulpal debridement or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filing material) is not covered. Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra operative and final radiographs.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3110	pulp cap - direct (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	No	One of (D3110) per 12 Month(s) Per patient. Cannot be billed on the same day as D3120 or D3221) Basic/Preventative Service.	
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	No	One of (D3120) per 12 Month(s) Per patient. Cannot be billed on the same day at D3120 and D3221. Basic/Preventative Service.	
D3221	pulpal debridement, primary and permanent teeth	21 and older	Teeth 2 - 15, 18 - 31, A - T	No	No	One of (D3221) per 12 Month(s) Per patient. Permanent teeth only. Not to be used by the provider completing endodontic treatment unless emergency situation exists. Not reimbursable when root canal is completed on the same day by the same dentist or group. Subject to pre-payment review. This code is considered an emergency code. Basic/Preventative Service	pre-operative x-ray(s)
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	21 and older	Teeth C - H, M - R	No	Yes	One of (D3230) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	21 and older	Teeth A, B, I - L, S, T	No	Yes	One of (D3240) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. Basic/Preventative Service.	

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Health First Colorado IDD Dental Program - 21 and over**

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. Basic/Preventative Service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. Basic/Preventative Service.	
D3331	treatment of root canal obstruction; non-surgical access	21 and older	Teeth 1 - 32	No	Yes	One of (D3331) per 12 Month(s) Per patient. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D3332	incomplete endodontic therapy; inoperable or fractured tooth	21 and older	Teeth 1 - 32	No	Yes	One of (D3332) per 12 Month(s) Per patient. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D3333	internal root repair of perforation defects	21 and older	Teeth 1 - 32	No	Yes	One of (D3333) per 12 Month(s) Per patient. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. only if original treatment not paid by CO Medicaid. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3347) per 1 Lifetime Per patient per tooth. only if original treatment not paid by CO Medicaid. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No	One of (D3348) per 1 Lifetime Per patient per tooth. only if original treatment not paid by CO Medicaid. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	No	No	One of (D3351) per 12 Month(s) Per patient. Basic/Preventative Service	
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 1 - 32	Yes	No	One of (D3352) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)

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Health First Colorado IDD Dental Program - 21 and over**

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	No	No	One of (D3353) per 12 Month(s) Per patient. Basic/Preventative Service	
D3355	Pulpal regeneration - initial visit	21 and older	Teeth 1 - 32	Yes	No	One of (D3355) per 12 Month(s) Per patient. One of (D3355) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3356	Pulpal regeneration - interim medication replacement	21 and older	Teeth 1 - 32	Yes	No	One of (D3356) per 12 Month(s) Per patient. One of (D3356) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3357	Pulpal regeneration - completion of treatment	21 and older	Teeth 1 - 32	Yes	No	One of (D3357) per 12 Month(s) Per patient. One of (D3357) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3430	retrograde filling - per root	21 and older	Teeth 1 - 32	Yes	No	One of (D3430) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3450	root amputation - per root	21 and older	Teeth 1 - 32	Yes	No	One of (D3450) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3460	endodontic endosseous implant	21 and older	Teeth 1 - 32	Yes	No	One of (D3460) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3470	intentional reimplantation	21 and older	Teeth 1 - 32	No	No	One of (D3470) per 12 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Endodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D3910	surgical procedure for isolation of tooth with rubber dam	21 and older	Teeth 1 - 32	No	Yes	One of (D3910) per 12 Month(s) Per patient. (Only payable when billed with D3310, D3320, D3330, D3346, D3347 or D3348) Refer to sections 15.08 and 15.15 in the ORM. Basic/Preventative Service. Pre-payment review.	Narr. of med. necessity, pre and post-op x-ray(s)
D3920	hemisection (including any root removal), not incl root canal therapy	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3920) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3921	decoronation or submergence of an erupted tooth	21 and older	Teeth 1 - 32	No	No	One of (D3921) per 1 Lifetime Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D3950	canal preparation and fitting of preformed dowel or post	21 and older	Teeth 1 - 32	Yes	No	One of (D3950) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D3999	unspecified endodontic procedure, by report	21 and older	Teeth 1 - 32	Yes	No	One of (D3999) per 12 Month(s) Per patient. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Reimbursement includes local anesthetic. Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351 and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	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)	Yes	No	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Includes six months of routine postoperative care. Basic/Preventative Service	Perio Charting, pre-op radiographs and narr of med necessity
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)	Yes	No	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant. Includes six months of routine postoperative care. Basic/Preventative Service	Perio Charting, pre-op radiographs and narr of med necessity
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Teeth 1 - 32, 51 - 82	No	No	One of (D4212) per 12 Month(s) Per patient per tooth. Includes six months of routine postoperative care. Basic/Preventative Service	
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)	Yes	No	One of (D4240) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D4245	apically positioned flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D4245) per 12 Month(s) Per patient. Basic/Preventative Service	
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	No	No	One of (D4249) per 12 Month(s) Per patient. Basic/Preventative Service	
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)	Yes	No	One of (D4260) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
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	No	One of (D4261) per 12 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4263	bone replacement graft - first site in quadrant	21 and older	Teeth 1 - 32	No	No	One of (D4263) per 12 Month(s) Per patient. Basic/Preventative Service	
D4264	bone replacement graft - each additional site in quadrant	21 and older	Teeth 1 - 32	No	No	One of (D4264) per 12 Month(s) Per patient. Basic/Preventative Service	
D4265	biological materials to aid in soft and osseous tissue regeneration per site	21 and older	Teeth 1 - 32	Yes	No	One of (D4265) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	21 and older	Teeth 1 - 32	No	No	One of (D4266) per 12 Month(s) Per patient. Basic/Preventative Service	
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	21 and older	Teeth 1 - 32	No	No	One of (D4267) per 12 Month(s) Per patient. Basic/Preventative Service	
D4268	surgical revision procedure	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4268) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	Yes	No	One of (D4270) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	No	No	One of (D4273) per 12 Month(s) Per patient. Basic/Preventative Service	
D4274	distal or proximal wedge procedure	21 and older	Teeth 1 - 32	No	No	One of (D4274) per 12 Month(s) Per patient. Basic/Preventative Service	
D4275	soft tissue allograft	21 and older	Teeth 1 - 32	Yes	No	One of (D4275) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	narrative of medical necessity
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	Yes	No	One of (D4277) per 12 Month(s) Per patient. Basic/Preventative Service	Pre and post-operative x-ray(s)
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32	No	No	One of (D4283) per 12 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32	No	No	One of (D4285) per 12 Month(s) Per patient. Basic/Preventative Service	
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D4322) per 12 Month(s) Per patient. Basic/Preventative Service	Perio Charting, pre-op radiographs and narr of med necessity
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D4323) per 12 Month(s) Per patient. Basic/Preventative Service	Perio Charting, pre-op radiographs and narr of med necessity
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	Yes	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of four or more teeth in the affected quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Not paid on the same date as (D1110). Subject to pre-payment review. Basic/Preventative Service.	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	Yes	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A maximum of three (3) teeth in the affected quadrant. Maximum of two quadrants per date of service in a non-hospital setting. Not paid on the same date as (D1110). Subject to pre-payment review. Basic/Preventative Service.	
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	21 and older		No	No	Two of (D4346) per 12 Month(s) Per patient. Six of (D1110, D4346, D4910) per 12 Month(s) Per patient. Not reimbursed when billed on the same date of service as (D1110, D4341, D4342, D4355, D4910). Basic/Preventive Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Periodontics							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	Yes	One of (D4355) per 12 Month(s) Per patient. D0150, D0160, D0180, D1110) are not reimbursable when provided on the same day of service as (D4355). (D4355) is not reimbursable if patient record indicates (D1110, D4910) have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as (D4355). Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D4381	localized delivery of antimicrobial agents	21 and older	Teeth 1 - 32	No	No	Basic/Preventative Service	
D4910	periodontal maintenance procedures	21 and older		No	Yes	Six of (D1110, D4346, D4910) per 12 Month(s) Per patient. Subject to pre-payment review. Basic/Preventative Service	Perio Charting, pre-op radiographs and narr of med necessity
D4999	unspecified periodontal procedure, by report	21 and older		Yes	No	One of (D4999) per 12 Month(s) Per patient. Basic/Preventative Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Removable prosthetics are not covered if eight or more posterior teeth (natural or artificial) are in occlusion. Coverage is provided for anterior teeth irrespective of the number of teeth in occlusion. Maxillofacial prostheses that serve to rehabilitate esthetics and function for member with acquired, congenital or developmental defects of the head and neck are covered. Necessary prostheses to restore both form and function is covered for members exposed to chemotherapy, radiation or cytotoxic drugs. Services for removable prostheses must include instruction in the use and care of the prosthesis and any adjustments necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the Documentation Required column with the claim form. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5110	complete denture - maxillary	21 and older		Yes	No	One of (D5110) per 60 Month(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only. Major Service	narr. of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	21 and older		Yes	No	One of (D5120) per 60 Month(s) Per patient. Includes initial 6 months of relines. Replacement of a removable prosthesis is allowed one time only. Major Service	narr. of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	21 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes initial 6 months of relines. Major Service	narr. of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	21 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes initial 6 months of relines. Major Service	narr. of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5211, D5225) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5212, D5226) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	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)	21 and older		Yes	No	One of (D5213, D5225) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	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)	21 and older		Yes	No	One of (D5214, D5226) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture-flexible base	21 and older		Yes	No	One of (D5211, D5225) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture-flexible base	21 and older		Yes	No	One of (D5212, D5226) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	21 and older		Yes	No	One of (D5227) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	21 and older		Yes	No	One of (D5228) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member needs. Refer to section 16.01. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	21 and older	Per Quadrant (UL, UR)	No	No	One of (D5282) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10. Major Service.	
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	21 and older	Per Quadrant (LL, LR)	No	No	One of (D5283) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10. Major Service.	
D5284	Removeable Unilateral Partial Denture- One Piece Flexible Base- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D5284, D5286) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10. Major Service.	
D5286	Removeable Unilateral Partial Denture- One Piece Resin Base- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D5284, D5286) per 60 Month(s) Per patient. Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the patient's needs. Refer to section 15.10. Major Service.	
D5410	adjust complete denture - maxillary	21 and older		No	No	Not allowed within 6 months of delivery. Basic/Preventative Service	
D5411	adjust complete denture - mandibular	21 and older		No	No	One of (D5411) per 12 Month(s) Per patient. Not allowed within 6 months of delivery. Basic/Preventative Service	
D5421	adjust partial denture-maxillary	21 and older		No	No	One of (D5421) per 12 Month(s) Per patient. Not allowed within 6 months of delivery. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5422	adjust partial denture - mandibular	21 and older		No	No	One of (D5422) per 12 Month(s) Per patient. Not allowed within 6 months of delivery. Basic/Preventative Service	
D5511	repair broken complete denture base, mandibular	21 and older		No	No	One of (D5511) per 12 Month(s) Per patient. Basic/Preventative Service	
D5512	repair broken complete denture base, maxillary	21 and older		No	No	One of (D5512) per 12 Month(s) Per patient. Basic/Preventative Service	
D5520	replace missing or broken teeth - complete denture - per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5520) per 12 Month(s) Per patient per tooth. Major Service	
D5611	repair resin partial denture base, mandibular	21 and older		No	No	One of (D5611) per 12 Month(s) Per patient. Basic/Preventative Service	
D5612	repair resin partial denture base, maxillary	21 and older		No	No	One of (D5612) per 12 Month(s) Per patient. Basic/Preventative Service	
D5621	repair cast partial framework, mandibular	21 and older		No	No	One of (D5621) per 12 Month(s) Per patient. Basic/Preventative Service	
D5622	repair cast partial framework, maxillary	21 and older		No	No	One of (D5622) per 12 Month(s) Per patient. Basic/Preventative Service	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5630) per 12 Month(s) Per patient. Basic/Preventative Service	
D5640	replace missing or broken teeth – partial denture – per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5640) per 12 Month(s) Per patient. Major Service	
D5650	add tooth to existing partial denture – per tooth	21 and older	Teeth 1 - 32	No	No	One of (D5650) per 12 Month(s) Per patient. Major Service	
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	No	One of (D5660) per 12 Month(s) Per patient. Basic/Preventative Service	
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	21 and older		No	Yes	One of (D5670) per 12 Month(s) Per patient. Subject to pre-payment review. Major Service	narrative of medical necessity
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	21 and older		No	Yes	One of (D5671) per 12 Month(s) Per patient. Subject to pre-payment review. Major Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5710	rebase complete maxillary denture	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5711	rebase complete mandibular denture	21 and older		No	No	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5720	rebase maxillary partial denture	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5721	rebase mandibular partial denture	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5725	rebase hybrid prosthesis	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	One of (D5725) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Subject to pre-payment review. Major Service	narrative of medical necessity
D5730	reline complete maxillary denture (chairside)	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5731	reline complete mandibular denture (chairside)	21 and older		No	No	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5740	reline maxillary partial denture (chairside)	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5741	reline mandibular partial denture (chairside)	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	

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Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5750	reline complete maxillary denture (laboratory)	21 and older		No	No	One of (D5710, D5730, D5750) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	Yes	One of (D5711, D5731, D5751) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D5760	reline maxillary partial denture (laboratory)	21 and older		No	No	One of (D5720, D5740, D5760) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	No	One of (D5721, D5741, D5761) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Basic/Preventative Service	
D5765	soft liner for complete or partial removable denture – indirect	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D5765) per 48 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	
D5810	interim complete denture-maxillary	21 and older		Yes	No	One of (D5810, D5820) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5811	interim complete denture-mandibular	21 and older		Yes	No	One of (D5811, D5821) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5820	interim partial denture (maxillary)	21 and older		Yes	No	One of (D5810, D5820) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5821	interim partial denture-mandibular	21 and older		Yes	No	One of (D5811, D5821) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5850	tissue conditioning, maxillary	21 and older		No	No	One of (D5850) per 1 Lifetime Per patient. Not allowed for first six months after delivery. Major Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, removable							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5851	tissue conditioning,mandibular	21 and older		No	No	One of (D5851) per 1 Lifetime Per patient. Not allowed for first six months after delivery. Major Service	
D5862	precision attachment, by report	21 and older	Teeth 1 - 32	No	No	Major Service	
D5863	Overdenture - complete maxillary	21 and older		Yes	No	One of (D5863, D5864) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5864	Overdenture - partial maxillary	21 and older		Yes	No	One of (D5863, D5864) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5865	Overdenture - complete mandibular	21 and older		Yes	No	One of (D5865, D5866) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5866	Overdenture - partial mandibular	21 and older		Yes	No	One of (D5865, D5866) per 60 Month(s) Per patient. Not allowed for first six months after delivery. Major Service	narrative of medical necessity
D5867	Replacement of replaceable part of semi-precision per attachment	21 and older	Teeth 1 - 32	No	No	One of (D5867) per 60 Month(s) Per patient per tooth. Basic/Preventative Service	
D5875	modification of removable prosthesis following implant surgery	21 and older	Per Arch (01, 02, LA, UA)	No	No	Basic/Preventative Service	
D5899	unspecified removable prosthodontic procedure, by report	21 and older		Yes	No	Major Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D5999	unspecified maxillofacial prosthesis, by report	21 and older		Yes	No	One of (D5999) per 12 Month(s) Per patient. Major Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Endosteal Implants are appropriate when masticatory function is impaired with a removable prostheses or when existing prostheses is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of the member. Authorization for endosteal implants to replace posterior teeth will not be allowed if there are in each quadrant at least eight (8) sound posterior teeth in fairly good position and occlusion with opposing dentition. Authorization for endosteal dental implants for anterior teeth generally will not be given unless one or more anterior teeth in the same arch are missing. Dental Implants will not be authorized when dental history reveals that any or all fixed prosthesis made in recent years have been unsatisfactory for reasons that are not remediable because of physiological or psychological reasons; or when repair, relining or rebasing of the patient's present prosthesis will make them serviceable. BILLING AND REIMBURSEMENT FOR IMPLANTS, ABUTMENTS, CAST CROWNS AND POST & CORES OR REMOVABLE PROSTHETICS SHALL BE BASED ON THE CEMENTATION OR INSERTION DATE. Fabrication of Implants, Abutments, and Prosthesis includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the entire implant placement, abutment and prosthetic and as such not eligible for additional compensation.

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

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6010	surgical placement of implant body: endosteal implant	21 and older	Teeth 1 - 32	Yes	No	One of (D6010, D6012, D6013, D6210, D6211, D6214, D6240, D6241, D6242, D6245) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6011	second stage implant surgery	21 and older	Teeth 1 - 32	Yes	No	One of (D6010, D6012, D6013, D6210, D6211, D6214, D6240, D6241, D6242, D6245) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6012	surgical placement of interim implant body-endosteal implant	21 and older	Teeth 1 - 32	Yes	No	One of (D6010, D6012, D6013, D6210, D6211, D6214, D6240, D6241, D6242, D6245) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6055	connecting bar - implant supported or abutment supported	21 and older	Teeth 1 - 32	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6056	prefabricated abutment	21 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2953, D2954, D2957, D6056, D6057, D6970, D6972, D6976, D6977) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6057	custom abutment	21 and older	Teeth 1 - 32	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6058	abutment supported porcelain/ceramic crown	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6059	abutment supported porcelain fused to metal crown (high noble metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6061	abutment supported porcelain fused to metal crown (noble metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6062	abutment supported cast metal crown (high noble metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6063	abutment supported cast metal crown (predominantly base metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6064	abutment supported cast metal crown (noble metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments.	21 and older	Teeth 1 - 32	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6081	scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning on the implant surfaces, without flap entry and closure	21 and older	Teeth 1 - 32	No	No	Two of (D4341, D4342, D6081) per 12 Month(s) Per patient per tooth. Not reimbursed when billed on the same day as D1110, D4910. Basic/Preventive Service	
D6082	Implant supported crown-porcelain fused to predominantly base alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6086	Implant supported crown-predominately base alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6088	Implant supported crown-titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6089	accessing and retorquing loose implant screw – per screw	21 and older	Teeth 1 - 32	No	No	One of (D6089) per 12 Month(s) Per patient per tooth. Not allowed within 6 months of delivery. Major Service.	
D6090	repair of implant/abutment supported prosthesis	21 and older	Teeth 1 - 32	Yes	No	One of (D6090, D6095, D6100) per 12 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6092	re-cement or re-bond implant/abutment supported crown	21 and older		No	Yes	One of (D6092) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	21 and older		No	Yes	One of (D6093) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D6095	repair implant abutment	21 and older	Teeth 1 - 32	No	Yes	One of (D6090, D6095, D6100) per 12 Month(s) Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D6096	remove broken implant retaining screw	21 and older	Teeth 1 - 32	No	No	One of (D6096) per 60 Month(s) Per patient per tooth. Basic/Preventative Service	
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6098	Implant supported retainer-porcelain fused to predominately base alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6100	surgical removal of implant body	21 and older	Teeth 1 - 32	Yes	No	One of (D6090, D6095, D6100) per 12 Month(s) Per patient per tooth. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

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Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6105	removal of implant body not requiring bone removal nor flap elevation	21 and older	Teeth 1 - 32	No	No	One of (D6105) per 1 Lifetime Per patient per tooth.	narrative of medical necessity
D6106	guided tissue regeneration – resorbable barrier, per implant	21 and older	Teeth 1 - 32	No	No	One of (D6106) per 1 Lifetime Per patient per tooth. Does not include flap entry and closure or when indicated wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	
D6107	guided tissue regeneration – non-resorbable barrier, per implant	21 and older	Teeth 1 - 32	No	No	One of (D6107) per 1 Lifetime Per patient per tooth. Does not include flap entry and closure or when indicated wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	21 and older		Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6118	implant/abutment supported interim fixed denture for edentulous arch – mandibular	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6118) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6119	implant/abutment supported interim fixed denture for edentulous arch – maxillary	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6119) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6121	Implant supported retainer for metal FPD- predominately base alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6082, D6084, D6086, D6088, D6097, D6098, D6121, D6194, D6210) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	21 and older	Teeth 1 - 32	No	No	Two of (D6180) per 12 Month(s) Per patient per tooth. Basic/Preventive services	
D6193	replacement of an implant screw	21 and older	Teeth 1 - 32	No	No	One of (D6193) per 12 Month(s) Per patient per tooth. Not allowed within in 6 months of delivery. Not reimbursed when billed on the same day as D6089. Major Service.	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Implant Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6194	Abutment supported retainer crown for FPD- titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	21 and older	Teeth 1 - 32	No	No	One of (D6197) per 60 Month(s) Per patient per tooth. Screw retained implant supported crown or implant supported FPD retainer. Not to be used at time of initial implant restoration placement or in place of D6080, or D2330 or D2391	
D6198	remove interim implant component	21 and older	Teeth 1 - 32	No	No	One of (D6198) per 1 Lifetime Per patient per tooth. Major Service	narrative of medical necessity
D6199	unspecified implant procedure	21 and older	Teeth 1 - 32	Yes	No	Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
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At least one abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease). The space cannot be filled with a removable partial dentures. The purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral and the opposing arch). Each abutment or each pontic constitutes a unit in a bridge. Porcelain is allowed on all teeth. Covered services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form. Periapical radiographs are required for each tooth. Billing and reimbursement for cast crowns, cast post & cores and laminate veneers or any other fixed or removable prosthetics shall be based on the cementation/delivery 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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6210	pontic - cast high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6211	pontic-cast base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6240	pontic-porcelain fused-high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6241	pontic-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6242	pontic-porcelain fused-noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6245	prosthodontics fixed, pontic - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. May not be a covered benefits when part of an implant-supported fixed prosthesis. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6545	retainer - cast metal fixed	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	21 and older	Teeth 1 - 32	Yes	No	One of (D6548) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6549	Resin retainer-For resin bonded fixed prosthesis	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6740	retainer crown, porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6750	crown-porcelain fused high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6751	crown-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6752	crown-porcelain fused noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6752) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6781) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6782	prosthodontics fixed, crown ¾ cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6782) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D6783) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6790	crown-full cast high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D6790) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6791	crown - full cast base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6792) per 84 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6793	interim retainer crown	21 and older	Teeth 1 - 32	Yes	No	One of (D6793) per 84 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6794	Retainer crown - titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6794) per 84 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6920	connector bar	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6930	re-cement or re-bond fixed partial denture	21 and older		No	No	Basic/Preventative Service	

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Prosthodontics, fixed							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D6940	stress breaker	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6950	precision attachment	21 and older	Teeth 1 - 32	Yes	No	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D6057, D6059, D6060, D6061, D6062, D6063, D6064, D6070, D6073, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6245, D6250, D6251, D6252, D6253, D6545, D6549, D6740, D6750, D6751, D6791, D6920, D6940, D6950) per 60 Month(s) Per patient per tooth. Major Service	narr. of med. necessity, pre-op x-ray(s)
D6980	fixed partial denture repair	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Basic/Preventative Service	
D6999	fixed prosthodontic procedure	21 and older	Teeth 1 - 32	Yes	No	One of (D6999) per 12 Month(s) Per patient. Implants are a benefit only when the procedure is necessary to support a single crown, abutment supported or a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. Major Service.	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Reimbursement includes local anesthesia and routine post-operative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition. The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure. Covered dental services will be subject to retrospective pre-payment review and will require submission of proper documentation as indicated in the "Documentation Required" column with the claim form.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Yes	One of (D7111) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
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	No	One of (D7140) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	
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	No	One of (D7210) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7220) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7230) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7240) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	One of (D7241) per 1 Lifetime Per patient per tooth. Subject to pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	Will not be paid to the dentists or group that removed the tooth. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	21 and older	Teeth 1 - 32, 51 - 82	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7252	partial extraction for immediate implant placement	21 and older	Teeth 1 - 32	No	No	One of (D7252) per 1 Lifetime Per patient per tooth. Not reimbursed when billed on the same day as D7111, D7140, D7241, D7250. Major Services.	
D7259	nerve dissection	21 and older	Teeth 1 - 32	No	No	One of (D7259) per 1 Lifetime Per patient per tooth. Major Services	
D7260	oroantral fistula closure	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7261	primary closure of a sinus perforation	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7272	tooth transplantation (includes reimplantation from one site to another)	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 - 32	Yes	No	One of (D7280) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	21 and older	Teeth 1 - 32	Yes	No	One of (D7282) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7284	excisional biopsy of minor salivary glands	21 and older		No	No	Not allowed to be billed on the same day as D7286. Major Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		No	Yes	Subject to pre-payment review. Only covered if there is a suspicious lesion. Basic/Preventative Service	Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		No	Yes	Subject to pre-payment review. Only covered if there is a suspicious lesion. Basic/Preventative Service	Pathology report
D7287	cytology sample collection	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7290	surgical repositioning of teeth	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7291	transseptal fibrotomy, by report	21 and older	Teeth 1 - 32	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7292	surgical placement of temporary anchorage device [screw retained plate] requiring flap	21 and older		No	Yes	One of (D7292, D7293, D7298, D7299, D7300) per 1 Lifetime Per patient. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7293	surgical placement of temporary anchorage device requiring flap	21 and older		No	Yes	One of (D7292, D7293, D7298, D7299, D7300) per 1 Lifetime Per patient. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7294	surgical placement of temporary anchorage device without flap	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7295	Harvest of bone for use in autogenous grafting procedure	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7298	removal of temporary anchorage device [screw retained plate], requiring flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D7292, D7293, D7298, D7299, D7300) per 1 Lifetime Per patient. Subject to pre-payment review. Major Service	narr. of med. necessity, pre-op x-ray(s)
D7299	removal of temporary anchorage device, requiring flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D7292, D7293, D7298, D7299, D7300) per 1 Lifetime Per patient. Subject to pre-payment review. Major Service	narr. of med. necessity, pre-op x-ray(s)
D7300	removal of temporary anchorage device without flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Yes	One of (D7292, D7293, D7298, D7299, D7300) per 1 Lifetime Per patient. Subject to pre-payment review. Major Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7310	alveoloplasty 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	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of 4 extractions in the affected quadrant. Not allowed with surgical extractions. Subject to Pre-payment review. Basic/Preventative Service	pre-operative x-ray(s)
D7311	alveoloplasty 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	Yes	One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Maximum of 3 extractions in the affected quadrant. Not allowed with surgical extractions. Subject to Pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty 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	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty 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	Yes	One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7350	vestibuloplasty - ridge extension	21 and older	Per Arch (01, 02, LA, UA)	No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7412	excision of benign lesion, complicated	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7413	excision of malignant lesion up to 1.25 cm	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7415	excision of malignant lesion, complicated	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	21 and older		No	No	One of (D7440) per 12 Month(s) Per patient. Basic/Preventative Service	
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	No	One of (D7450) per 12 Month(s) Per patient. Basic/Preventative Service	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	No	One of (D7451) per 12 Month(s) Per patient. Basic/Preventative Service	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No	No	One of (D7460) per 12 Month(s) Per patient. Basic/Preventative Service	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No	No	One of (D7461) per 12 Month(s) Per patient. Basic/Preventative Service	
D7465	destruction of lesion(s) by physical or chemical method, by report	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	Pathology report
D7471	removal of exostosis - per site	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7471) per 12 Month(s) Per patient per quadrant. Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Basic/Preventative Service	
D7472	removal of torus palatinus	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D7472) per 12 Month(s) Per patient per arch. Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7473	removal of torus mandibularis	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D7473) per 12 Month(s) Per patient per arch. Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Basic/Preventative Service	
D7485	surgical reduction of osseous tuberosity	21 and older		No	No	One of (D7485) per 12 Month(s) Per patient. Basic/Preventative Service	
D7490	radical resection of maxilla or mandible	21 and older		No	No	One of (D7490) per 12 Month(s) Per patient. Basic/Preventative Service	
D7509	marsupialization of odontogenic cyst	21 and older	Teeth 1 - 32, A - T	No	No	One of (D7509, D7510, D7511, D7520, D7521, D7599) per 1 Lifetime Per patient per tooth. Narrative of medical necessity to include treatment prognosis and plans for follow up. Will not be reimbursed on same surgical area on same date of services as any other definitive treatment codes.	narrative of medical necessity
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32	No	Yes	One of (D7510, D7511) per 1 Lifetime Per patient per tooth. May be reimbursable by report when narrative of medical necessity can be documented. Will not be reimbursed in same surgical area and on same visit as any other definitive treatment codes, except for covered services necessary for diagnosis. Subject to pre-payment review. Basic/Preventative Service	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	Teeth 1 - 32	No	Yes	One of (D7510, D7511) per 1 Lifetime Per patient per tooth. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review. Basic/Preventative Service	narr. of med. necessity, pre-op x-ray(s)

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No	Yes	One of (D7520, D7521) per 1 Lifetime Per patient per tooth. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review. Basic/Preventive Service	narr. of med. necessity, pre-op x-ray(s)
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		No	Yes	One of (D7520, D7521) per 1 Lifetime Per patient per tooth. May be reimbursable by report when narrative of medical necessity can be documented. Subject to pre-payment review. Basic/Preventive Service	narr. of med. necessity, pre-op x-ray(s)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	21 and older		No	No	One of (D7530) per 12 Month(s) Per patient. Basic/Preventative Service	
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	21 and older		No	No	One of (D7540) per 12 Month(s) Per patient. Basic/Preventative Service	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7550) per 12 Month(s) Per patient per quadrant. Basic/Preventative Service	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	21 and older		No	No	One of (D7560) per 12 Month(s) Per patient. Basic/Preventative Service	
D7910	suture small wounds up to 5 cm	21 and older		No	No	One of (D7910) per 12 Month(s) Per patient. Basic/Preventative Service	
D7911	complicated suture-up to 5 cm	21 and older		No	No	One of (D7911) per 12 Month(s) Per patient. Basic/Preventative Service	
D7912	complex suture - greater than 5cm	21 and older		No	No	One of (D7912) per 12 Month(s) Per patient. Basic/Preventative Service	
D7920	skin graft (identify defect covered, location and type of graft)	21 and older		No	No	One of (D7920) per 12 Month(s) Per patient. Basic/Preventative Service	
D7921	Collection and application of autologous blood concentrate product	21 and older		No	No	One of (D7921) per 12 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D7953	bone replacement graft for ridge preservation - per site	21 and older	Teeth 1 - 32	No	No	One of (D7953) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7956) per 12 Month(s) Per patient per quadrant. This procedure does not include flap entry and closure, or when indicated wound debridement, osseous contouring bone replacement or grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures and after tooth extraction. Not to be used with D4266 or D7953.	
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7957) per 12 Month(s) Per patient per quadrant. This procedure does not include flap entry and closure, or when indicated wound debridement, osseous contouring bone replacement or grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures and after tooth extraction. Not to be used with D4267 or D7953.	
D7979	non-surgical sialolithotomy	21 and older		No	No	Basic/Preventative Service	
D7981	excision of salivary gland, by report	21 and older		No	No	One of (D7981) per 12 Month(s) Per patient. Basic/Preventative Service	
D7990	emergency tracheotomy	21 and older		No	No	One of (D7990) per 12 Month(s) Per patient. Basic/Preventative Service	
D7991	coronoidectomy	21 and older		No	No	One of (D7991) per 12 Month(s) Per patient. Basic/Preventative Service	
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	21 and older		Yes	No	One of (D7997) per 12 Month(s) Per patient. Basic/Preventative Service	narrative of medical necessity
D7999	unspecified oral surgery procedure, by report	21 and older		Yes	No	One of (D7999) per 12 Month(s) Per patient. Basic/Preventative Service	narrative of medical necessity

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Local anesthesia is considered part of the treatment procedure and no additional payment will be made for it. General anesthesia and deep sedation is only covered when there is sufficient evidence to support medical necessity. Hospital or surgery center cases require prior authorization.

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	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9110	palliative treatment of dental pain - per visit	21 and older		No	No	Not allowed with any other services other than radiographs. Cannot be billed when the only other service is writing a prescription. Basic/Preventative Service	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Yes	Not reimbursable with (D9223, D9230, D9243, D9248). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		No	No	One of (D9248) per 1 Day(s) Per patient. Not reimbursable with (D9223, D9230). Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed. Basic/Preventative Service	
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	No	One of (D9310) per 12 Month(s) Per patient. Diagnostic service by dentist other than practitioner providing treatment. Basic/Preventative Service	
D9311	consultation with medical health care professional	21 and older		No	Yes	One of (D9311) per 12 Month(s) Per Provider OR Location. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D9410	house/extended care facility call	21 and older		No	No	One of (D9410) per 1 Day(s) Per patient. Basic/Preventative Service	
D9420	hospital or ambulatory surgical center call	21 and older		No	Yes	One of (D9420) per 1 Day(s) Per patient. Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity
D9932	cleaning and inspection of removable complete denture, maxillary	21 and older		No	No	One of (D9932) per 6 Month(s) Per patient. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9933	cleaning and inspection of removable complete denture, mandibular	21 and older		No	No	One of (D9933) per 6 Month(s) Per patient. Basic/Preventative Service	
D9934	cleaning and inspection of removable partial denture, maxillary	21 and older		No	No	One of (D9934) per 6 Month(s) Per patient. Basic/Preventative Service	
D9935	cleaning and inspection of removable partial denture, mandibular	21 and older		No	No	One of (D9935) per 6 Month(s) Per patient. Basic/Preventative Service	
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	21 and older	Per Arch (01, 02, LA, UA)	No	No	One of (D9939) per 60 Month(s) Per patient per tooth. Not allowed for first six months after delivery of D5820 or D5821. Not to be billed on the same day as D1510, D1520. Basic/Preventive Service.	
D9942	repair and/or reline of occlusal guard	21 and older		No	No	One of (D9942) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	
D9943	occlusal guard adjustment	21 and older		Yes	No	Not allowed within 6 months of initial placement (D9940) ---limit to 1 per year. Basic/Preventative Service	narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9940, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Basic/Preventative Service.	narr. of med. necessity, pre-op x-ray(s)
D9945	occlusal guard--soft appliance full arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9940, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Basic/Preventative Service.	narr. of med. necessity, pre-op x-ray(s)
D9946	occlusal guard--hard appliance, partial arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9940, D9945, D9946) per 12 Month(s) Per patient per arch. Not to be reported for any type of sleep apnea, snoring or TMD appliances. Basic/Preventative Service.	narr. of med. necessity, pre-op x-ray(s)
D9950	occlusion analysis-mounted case	21 and older		No	No	One of (D9950) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	

**Exhibit C Benefits Covered for
Health First Colorado IDD Dental Program - 21 and over**

Adjunctive General Services							
Code	Description	Age Limitation	Teeth Covered	Prior Authorization Required (PAR)	Pre Payment Review (PPR)	Benefit Limitations	Documentation Required
D9952	occlusal adjustment - complete	21 and older		No	No	One of (D9952) per 12 Month(s) Per patient per tooth. Basic/Preventative Service	
D9971	Odontoplasty- per tooth, removal reshaping of enamel surfaces or projections.	21 and older	Teeth 1 - 32	No	No	One of (D9971) per 1 Lifetime Per patient per tooth. Basic/Preventative Service	
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	No	One of (D9996) per 1 Day(s) Per patient. Basic/Preventative Service	
D9999	unspecified adjunctive procedure, by report	21 and older		No	Yes	Subject to pre-payment review. Basic/Preventative Service	narrative of medical necessity