Provider
Office Reference Manual

Iowa Dental Wellness Plan (DWP)
Healthy and Well Kids in Iowa (Hawki)
2026

Please refer to your Participation Agreement for plans you contract in.

DentaQuest USA Insurance Company, Inc.
PO Box 2906
Milwaukee, WI 53201-2906
www.DentaQuest.com

* DentaQuest is an independent company providing dental benefit management services on behalf of the Iowa Department of Health and Human Services.

CHANGE CONTROL RECORD

Date	Section	Page(s)	Change
7/14	NDN	8	New Nondiscrimination Notice

DentaQuest USA Insurance Company, Inc.
Address and Telephone Numbers

DentaQuest Corporate Office Address
96 Worcester Street
Wellesley Hills, MA 02481

Iowa Provider Services
DentaQuest Provider Services Call Line:
(866) 515-6981

Email Addresses
Claims Questions:
denclaims@DentaQuest.com

Eligibility or Benefit Questions:
denelig.benefits@DentaQuest.com

Provider Partner Email Address:
(Your advocate for issue resolution, communication and navigating any challenges that arise)
IowaProviders@dentaquest.com

Fraud Hotline
(800) 237-9139

Review requests should be sent to
DentaQuest – UM Department
PO Box 2906
Milwaukee, WI 53201-2906

Credentialing
DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906
Fax: (262) 241-4077

Credentialing Hotline:
(800) 233-1468

General TTY Number:
(800) 466-7566

DentaQuest Iowa Member Services:
(866) 629-6074

Electronic Claims should be sent to:
Direct entry on the web –
www.dentaquest.com

Or,

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

Provider Appeals:
DentaQuest – Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: (262) 834-3452

Iowa Medicaid Member Services:
(800) 338-8366

Iowa Department of Health and Human Services:
(800) 972-2017

How to get assistance from DentaQuest

1. The Provider Portal

The Provider Portal is your one-stop shop for real-time information and tools to manage your practice efficiently:

- View and download the Provider Office Reference Manual
- Check member eligibility
- Access and download patient rosters
- Submit and track claims and pre-authorizations
- Review fee schedules

The same real time information used by our Call Center team is available at your fingertips 24/7 through the portal

For issues with the portal please call the Provider Portal Support line at 1-866-515-6981

2. Provider Services Call Line

DentaQuest representatives are available to answer questions regarding eligibility, claims and Specialty Referrals

1-866-515-6981 (Live July 1st)

TTY 711

3. Your Provider Partner

If you've already explored the portal and support channels but still need assistance, your Provider Partner is here to help. They are your advocate for issue resolution, communication and navigating any challenges that arise.

Email:
lowaproviders@dentaquest.com
to contact your Provider Partner Team.

Not sure? Email:
lowaproviders@dentaquest.com

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DentaQuest

DentaQuest USA Insurance Company, Inc.

The Iowa Patient's Bill of Rights and Responsibilities

SUMMARY OF THE IOWA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Iowa law requires that your health care Provider or health care facility recognizes your rights while you are receiving dental care and that you respect the health care Provider's or health care facility's right to expect certain behavior on the part of you the patient. You may request a copy of the full text of this law from your health care Provider or health care facility. A summary of your rights and responsibilities is as follows:

- Be treated with dignity and respect and have their personal health and dental information kept private in accordance with state and federal privacy laws.
- Receive care without discrimination based on race, color, national origin, disability, age, sex, gender identity, or any other protected category.
- Receive services in compliance with Title VI, Section 504 the ADA, and Section 1557 of the (ACA).
- Receive information about their dental benefits, treatment options, and how to access care in a manner and format they can understand.
- Receive interpreter services, translated materials, and auxiliary aids at no cost.
- Patients have the right to be informed of their rights and responsibilities.
- Participate in decisions about their dental care and to accept or refuse recommended treatment.
- Request and obtain a second opinion from a qualified dental Provider **at no cost**.
- Patients have the right to review their dental records and request amendments in accordance with applicable privacy law (HIPAA).
- Exercise their rights without fear of adverse treatment by the plan or any Provider.
- Be free from restraint or isolation used as coercion, discipline, convenience, or retaliation.
- Receive care in a manner that does not negatively affect their status or the quality of services they receive.
- Receive all covered dental services as required by federal access and timeliness standards.
- Receive emergency dental services without prior authorization, including from out-of-network Providers.
- Receive notice when their treating dentist leaves the network and receive assistance transitioning their care.
- File a complaint, grievance, or appeal regarding DentaQuest, a Provider, or any decision affecting their care. Request a State Fair Hearing in accordance with Iowa Medicaid requirements.
- Have their dignity and privacy respected and be supported in living, working, learning, and participating fully in their community.
- A patient is responsible for providing to his or her dental care Provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the dental care Provider.
- A patient is responsible for reporting to his or her dental care Provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by his or her dental care Provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the dental care Provider or dental care facility.
- A patient is responsible for their actions if they refuse treatment or do not follow the dental care Provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her dental care are fulfilled as promptly as possible.
- A patient is responsible for following dental care facility rules and regulations affecting patient conduct.

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a Sun Life company

DentaQuest USA Insurance Company, Inc.
Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.

2. Recommend a course of treatment and alternatives to a Member, even if the course of treatment is not a covered benefit or approved by DentaQuest.

3. File an appeal or complaint pursuant to the procedures of DentaQuest.

4. Supply accurate and relevant information to a Member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by DentaQuest.

6. If a recommended course of treatment is not covered, e.g., not approved by DentaQuest, the participating Provider must notify the Member of their cost in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

7. To be informed of the status of their credentialing or recredentialing application, upon request.

DentaQuest shall disseminate bulletins as needed to incorporate any needed changes to this ORM.

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

IOWA NONDISCRIMINATION NOTICE

Purpose

This notice explains your right to be treated fairly. DentaQuest must follow federal and State laws, including Section 1557 of the Affordable Care Act. These laws protect people from unfair treatment.

Who This is For

- Current Iowa Medicaid members

Fair Treatment

We treat everyone fairly. We do not treat people differently, exclude them, or deny services because of:

- Race
- Color
- Where they are from
- Disability
- Sex
- Age
- Religion
- Any other reason protected by law

Get Free Help

We will help you understand your care. You can get free help:

If you have a disability:

- Sign language interpreters
- Information in large print, braille, audio, or electronic formats

If you speak another language:

- Interpreters
- Written materials in other languages

Contact Us

Call DentaQuest's Member Services for help: 1-888-278-7310, TTY: 711

How to Report Unfair Treatment

If you believe we treated you unfairly or did provide you the help listed above, you can file a complaint.

You can file a complaint in any of these ways:

1. DentaQuest's Civil Rights Department/Fair Treatment Team
    - **Mail:**
      DentaQuest
      Attn: Civil Rights Department/Fair Treatment Team
      P.O. Box 8206
      Des Moines, IA 50301

- **Phone:** 1-888-278-7310, TTY: 711
- **Email:** FairTreatment@greatdentalplans.com

2. Iowa Civil Rights Commission
   - **Online:** File A Complaint | Iowa Civil Rights Commission
   - **Mail or in person:**
     Iowa Civil Rights Commission
     6200 Park Avenue, Suite 100
     Des Moines, Iowa 50321-1270
   - **Phone:** 515-281-4121
   - **Email:** icrc@iowa.gov

3. U.S. Department of Health and Human Services, Office for Civil Rights.
   - **Mail:**
     U.S. Department of Health and Human Services
     200 Independence Avenue, S.W.
     Room 509F, HHH Building
     Washington, D.C. 20201
   - **Online:** https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
   - **Phone:** 1-800-368-1019, TDD: 1-800-537-7697

OFFICE REFERENCE MANUAL TABLE OF CONTENTS

CONTENTS

1.00 INTRODUCTION

The information contained in this Provider Office Reference Manual is intended as a resource for you and your staff with contact information to request Provider materials such as digital copies of this Provider manual. It lists DentaQuest's standard administrative guidelines for claims processing as well as information regarding DentaQuest's standard policies. In all cases, specific group contract provisions, limitations, and exclusions take precedence. Provides you and your staff with contact information to assist Members with requesting Member materials, such as the Member handbook.

The introductory pages provide general information about DentaQuest's policies. The remaining pages are organized according to the most current edition of the Current Dental Terminology (CDT), published by the American Dental Association (ADA). For complete code descriptions, we strongly encourage you to purchase the most recent edition of the official CDT manual from the ADA by calling 1-800-947-4746 or visiting www.ada.org. the presence of a code in the CDT does not automatically mean that it is a covered benefit.

You authorize DentaQuest, its affiliates, and its Plans to include your name and practice information in Provider directories, in marketing, administrative and other materials, and for legal and regulatory purposes. DentaQuest and Plans may be obligated to include your name and practice information in their Provider directories if required by applicable law. Additionally, your information (which may include sensitive personal information) may be used by DentaQuest, its affiliates, and Plans (as applicable) for the purposes described in your Provider Services Agreement or this ORM, including but not limited to credentialing, recredentialing, and claims adjudication. DentaQuest and its affiliates may also disclose your information to third parties, including brokers and service Providers, that help us conduct our business, including the provision of services, or as allowed by law. If we disclose your personal information to third parties, we require them to protect the privacy and security of your information.

Providers must provide adequate access to all covered services for all Members, including those with limited English proficiency or mental disabilities.

NOTE: DentaQuest reserves the right to add, delete or change the policies and procedures described in this reference guide at any time.

2.00 GENERAL DEFINITIONS/GLOSSARY OF TERMS

1916(c) HCBS waiver: Refers to the seven (7) 1915(c) HCBS waivers operated by the Agency. Current waivers include: (i) AIDSHIV (ii) Brain Injury; (iii) Children's Mental Health; (iv) Elderly; (v) Health and Disability; (vi) Intellectual Disabilities; and (vii) Physical Disabilities. For purposes of clarification, this definition remains in effect even in the event of a change in waiver authority affecting these covered populations.

1915(i) State Plan HCBS: Refers to the State Plan HCBS program operated by the

agency for adults and transition age youth that have been assessed to have functional limitations related to a psychiatric illness.

340B Program: The federal 340B Drug Pricing program managed by HRSA's Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so that these facilities can offer some medications to their patients at reduced prices.

ABA: Applied Behavior Analysis.

ABP: Alternate Benefit Plan.

Abandonment Rate: Percentage of unanswered calls abandoned by the caller after thirty (30) seconds of the call entering the queue (E.g., caller hangs up before speaking to anyone after waiting more than thirty (30) seconds in a queue.)

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. See: 42 C.F.R. § 438.2; 42 C.F.R. § 455.2. (From CMSC).

Access: As used in 42 C.F.R. part 438 subpart E and pertaining to External Quality Review, the term "access" refers to the timeliness of the Contractor's ability to provide services, the convenience and ease of obtaining services, the adequacy of the Contractor's network, and the availability and timeliness of the services needed. See 42 C.F.R. § 438.10. (From CMSC).

Actuary: An individual who meets the qualification standards established by the American Academy of Actuaries for an Actuary and follows the practice standards established by the Actuarial Standards Board. In 42 C.F.R. part 438, Actuary refers to an individual who is acting on behalf of the Agency when used in reference to the development and certification of capitation rates. See: 42 C.F.R. § 438.2. {From CMSC}.

Adverse Benefit Determination: Any of the following:

a) The denial or limitation of authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
b) The reduction, suspension, or termination of a previously authorized service.
c) The denial, in whole or in part, of payment for a service, but excluding a denial solely because the claim does not meet the definition of a Clean Claim.
d) The failure to provide services in a timely manner, as defined by the

Agency.
e) The failure of the Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and/or (c) when the standard is ninety (90) calendar days.
f) For a resident of a rural area with only one PAHP, the denial of an Enrolled Member's request to exercise their right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network.
g) The denial of an Enrolled Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrolled Member financial liabilities.
See: 42 C.F.R. § 438.400(b). (From CMSC).

Agency: The Iowa Department of Health and Human Services.

Annual Benefit Maximum (ABM): A $1,000 maximum State Fiscal Year (July 1 to June 30) benefit limit that applies to every Dental Wellness Plan adult Member, age twenty-one (21) and older. By program design, certain services are excluded from the ABM calculation including emergency dental services. ABM is determined using the Medicaid FFS rates, regardless of reimbursement rate to Providers.

Annual Dollar Limit: A dollar limitation on the total amount of specific benefits that may be paid in a twelve (12) month period under the Contract. See: 42 C.F.R. § 438.900. (From CMSC).

Appeal: A review by the Contractor of an Adverse Benefit Determination. See: 42 C.F.R. § 438.400(b). (From CMSC).

ARRA: The American Recovery and Reinvestment Act.

BCCEDP: Breast and Cervical Cancer Early Detection Program.

Behavioral Health Services: Mental health and substance use disorder treatment services.

Behavioral Health Management: Indications for Behavior Management include patients who require immediate diagnosis and/or limited treatment and cannot cooperate due to a mental or physical disability.

**American Academy of Pediatric Dentistry. Guideline on Behavior Management Reference Manual 2002-2003.*

Benefits: The package of dental and oral Health Care Services that define the covered services available to Enrolled Members under the Contract.

BHIS: Behavioral and Health Intervention Services.

CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Capitation Payment: A payment the Agency makes periodically to the Contractor on behalf of each beneficiary enrolled under the Contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The Agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. See 42 C.F.R. § 438.2. (From CMSC).

Case Management: Provides service coordination and monitoring. Available as a 1915 (c) Habilitation service when the individual is not enrolled in an Integrated Health Home and does not otherwise qualify for targeted case management.

Care Coordination: Care Coordination is the overall system of dental and oral health management encompassing, but not limited to: UM, disease management, continuity of care, care transition, Quality management and service verification.

Choice Counseling: The provision of information and services designed to assist beneficiaries in making Enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Contractors. Choice Counseling does not include making recommendations for or against Enrollment into a specific Contractor. See: 42 C.F.R. § 438.2. (From CMSC).

CCO: Consumer Choices Option.

CDAC: Consumer Directed Attendant Care.

COA: Certificate of authority issued by the Iowa Insurance Division.

Centers for Medicare and Medicaid Services (CMS): The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as HCFA.

CHIP: Children's Health Insurance Program.

Claim: A formal request for payment for Benefits received or services rendered.

Clean Claim: Clean claim means one that can be processed without obtaining additional information from the Provider of the service or from a third party. Includes a claim with errors originating in the Contractor's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. See: 42 CFR § 447.45(b).

Client Participation: The amount a member is required to contribute to the cost of

care provided in an institutional or home and community-based setting. Institutional settings subject to Client Participation include skilled nursing facilities, nursing facilities, intermediate care facilities for the intellectually disabled (ICF/ID), and residential care facilities. Members in acute hospital care are eligible for Medicaid as Qualified Medicare Beneficiary (QMB) are not subject to Client Participation. Client Participation is determined by the Agency when the member's income is higher than allowable thresholds. Client Participation is paid at the beginning of a coverage month. If a member is institutionalized, the facility makes arrangements with the member to collect Client Participation. Client Participation is not cost sharing subject to the requirements of 42 CFR § 447.50 through 42 CFR § 447.82.

Clinical Practice Guidelines: Care tips based on medical and dental research that we review each year.

CMH: Children's Mental Health.

CMHC: Community Mental Health Centers.

CMSC: The CMS State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval (also known as the CMS Checklist), available at: https://www.medicaid.gov/medicaid/downloads/check-list-state-ensuring-document

Code of Federal Regulations (C.F.R.): The C.F.R. is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It can be found at: www.ecfr.gov

Cold-Call Marketing: Any unsolicited personal contact by the Contractor with a Potential Enrolled Member for the purpose of marketing. See: 42 C.F.R. § 438.104(a). (From CMSC).

Community-Based Case Management: Community-Based Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a Medicaid Member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides Community-Based Case Management services to assist Members in gaining timely access to the full range of needed services.

Comprehensive Risk Contract: A Risk Contract between the Agency and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services:

a) Outpatient hospital services
b) RHC services
c) FQHC services
d) Other laboratory and X-ray services
e) NF services

f) EPSDT services
g) Family planning services
h) Physician services
i) Home health services

See: 42 C.F.R. § 438.2. (From CMSC).

Contractor: The entity identified on the first page of the Contract.

Continuity of Care: Steps to keep your care going when something changes, like your dentist leaving the network. We may let you see the same dentist for a short time, so your care does not stop.

Co-Payment: A cost-sharing arrangement in which an Enrolled Member pays a specified charge for a specified service, also called a co-pay.

Corrective Action Plan (CAP): A plan designed to ameliorate an identified deficiency and prevent recurrence of that deficiency. The CAP outlines all steps, actions and timeframes necessary to address and resolve the deficiency.

CPT: Current Procedure Terminology.

Credentialing: The Contractor's process for verifying and monitoring Providers' licensure, liability insurance coverage, liability claims, criminal history and Drug Enforcement Administration (DEA) status.

Credible Adjustment: An adjustment to the MLR for a partially credible Contractor to account for a difference between the actual and target MLRs that may be due to random statistical variation. See: 42 C.F.R. § 438.8(d). (From CMSC).

Cultural Competence: The U.S. Department of Health and Human Services, Office of Minority Health defines cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups." Competence implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs as presented by Enrolled Members and their communities. Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location.

Cumulative Financial Requirements: Financial requirements that determine whether or to what extent Benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, Cumulative Financial Requirements do not include aggregate lifetime or annual dollar limits because

these are distinct from the meaning of financial requirements.) See: 42 C.F.R. § 438.900. (From CMSC).

Days: Calendar days unless otherwise specified.

Day Habilitation: Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration.

Dental Home: Your main dentist or dental office for checkups, cleanings, and most other care.

Dental Plan: see PAHP.

Dentist: A licensed professional who treats teeth, gums, and the mouth.

Dental Wellness Plan (DWP): Medicaid Dental Coverage that is not Hawki split into:

(i) DWP-Kids (DWP-K) those non-Hawki Members eighteen (18) years and younger
(ii) DWP-Adults (DWP-A) those non-Hawki Members nineteen (19) years and older

Designee: An organization designated by the Agency to act on behalf of the Agency in the administration of the program under this Contract.

DHHS: United States Department of Health and Human Services.

DIA: The Iowa Department of Inspections and Appeals.

Disaster: An occurrence of any kind that severely inhibits the Contractor's ability to conduct daily business or severely affects the required performance, functionality, efficiency, accessibility, reliability or security of the Contractor's system. This may include natural Disasters, human error, computer virus or malfunctioning hardware or electrical supply.

Discharge Planning: The process, begun at admission, of determining an Enrolled Member's continued need for treatment services and of developing a plan to address ongoing needs.

Discrimination: Termination of Enrollment or refusal to reroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by beneficiaries whose medical condition or history indicates a probable need for substantial future medical services. See: 42 C.F.R. § 438.701(b). (From CMSC).

Disenrollment: The removal of an Enrolled Member from the Contractor's

Enrollment either through loss of eligibility or some other cause.

Dispensing Fee: Payment provided for the costs incurred by a pharmacy to dispense a drug. The fee reflects the pharmacist's professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid Member.

DRG: Diagnosis Related Group.

Drug Rebate: Payments provided by pharmaceutical manufacturers to State Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services or with the individual state.

Drug Utilization Review (DUR): A Quality review of covered outpatient drugs that assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Drug Utilization Review (DUR) Commission: A Quality assurance body of ten (10) Members that seeks to improve the Quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid Members in Iowa.

Dual Eligible: A Member enrolled in both Medicaid and Medicare.

Durable Medical Equipment (DME): Durable medical equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits: Benefits defined in section 1905(r) of the Act, and applying to individuals under the age of twenty-one (21), including screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. See: Section 1905(r) of the Social Security Act. (From CMSC).

EBP: Evidence Based Practice.

EDI: Electronic Data Interchange.

Electronic Visit Verification (EVV) System: An electronic system into which Providers can check-in at the beginning and checkout at the end of each period of services delivery to monitor Member receipt of HCBS and which may also be utilized for submission of Claims.

Emergency Communication: An urgent or emergent situation that requires immediate communication by the Managed Care Plan to Providers and Enrolled Members to ensure their health and safety. These situations include but may not be limited to extreme weather events, natural disasters, violence, terrorism, or other mass casualty events.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) Serious impairment to bodily functions;
c) Serious dysfunction of any bodily organ or part.

See: 42 C.F.R. § 438.114(a). (From CMSC).

Emergency Dental Condition: A sudden, serious mouth problem that needs care right away, like heavy bleeding, strong pain, or infection. No approval is needed first.

Emergency Medical Transportation: Ambulance services for emergency medical conditions.

Emergency Room Care: Emergency services that a Member receives in an emergency room.

Emergency Services: Covered inpatient and outpatient services that are follows:

a) Furnished by a Provider that is qualified to furnish these services under Title XIX of the Social Security Act.
b) Needed to evaluate, treat, or stabilize an Emergency Medical Condition.
See: 42 C.F.R. § 438.114(a). (From CMSC).

Enrolled Member: See Enrollee/Member.

Enrolled Member: A person who has been determined eligible by the Agency for Medicaid or Hawki and who is currently enrolled with the Contractor. See: 42 C.F.R. § 438.2. (From CMSC).

Enrolled Member Encounter Data: The information relating to the receipt of any item(s) or service(s) by an Enrolled Member under the Contract that is subject to the requirements of 42 C.F.R. § 438.242 and 42 C.F.R. § 438.818. See: 42 C.F.R. § 438.2. (From CMSC).

Enrollee: The process by which a Member becomes an Enrolled Member of the Contractor.

Enrollment Activities: Activities such as distributing, collecting, and processing

Enrollment materials and taking Enrollments by phone, in person, or through electronic methods of communication. See: 42 C.F.R. § 438.10(a). (From CMSC).

Enrollment Broker: An individual or entity that performs Choice Counseling or Enrollment Activities, or both. See: 42 C.F.R. § 438.810(a). (From CMSC).

EOB: Explanation of Benefits.

ETL: Extraction, Transformation, and Load.

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment): A Medicaid benefit for children and teens under 21. It covers regular checkups and any care needed to fix problems found.

Exception to Policy (ETP): Special approval for a service not usually covered, used only after other choices have been tried.

Excluded Services: Services that are not covered under the Members identified plan.

Expedites Grievances: If an Enrolled Member requests to switch plans to stay with their established Provider, because their Provider is leaving the Contractor's network for any reason than the MCP must "expedite" the grievance. This is the only scenario where using expedited grievances is required.

External Quality Review: As used in 42 C.F.R. part 438 subpart E, the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on Quality, timeliness, and Access to the Health Care Services that the Contractor (described in 42 C.F.R. § 438.310(c)(2)), furnishes to Enrolled Members. See: 42 C.F.R. § 438.320. (From CMSC).

External Quality Review Organization (EQRO): As used in 42 C.F.R. part 438 subpart E, an organization that meets the competence and independence requirements set forth in 42 C.F.R. 438.354, and performs External Quality Review, other External Quality Review-related activities and may also perform EQR-related activities set forth at 42 C.F.R. § 438.358, or both. See: 42 C.F.R. § 438.320. (From CMSC).

FBR: SSI Federal Benefit Rate.

Federally Qualified HMO: An HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Service (PHS) Act. See: 42 C.F.R. § 438.2. (From CMSC).

FFS: Fee-for-Service.

Financial Relationship: As used in 42 C.F.R. part 438 subpart E:

a) A direct or indirect ownership or investment interest (including an option or unintended interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest; or

b) A compensation arrangement with an entity.

See: 42 C.F.R. § 438.320. (From CMSC).

Financial Requirements: Deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See: 42 C.F.R. § 438.900. (From CMSC).

FMAP: Family Medical Assistance Program

FQHC: Federally Qualified Health Center.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law. See: 42 C.F.R. § 455.2. (From CMSC).

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the Quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrolled Member's rights regardless of whether remedial action is requested. Grievance includes an Enrolled Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. See: 42 C.F.R. § 438.400(b). (From CMSC).

Grievance and Appeal System: The processes the Contractor implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. [42 C.F.R. § 438.400(b)] {From CMSC}.

Habilitation Services and Devices: Per 441 IAC 78.27(249A) Habilitation services are to assist members who have functional deficits typically seen in persons with a chronic mental illness. These home and community based services assist in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Hawki Program: Healthy and Well Kids in Iowa, the Iowa program to provide health care coverage for uninsured children or eligible families as authorized by Title XXI of the federal Social Security Act.

HCEA: Health Care Financing Administration.

Health Care Services: As used in 42 C.F.R. part 438 subpart E, all Medicaid services provided by the Contractor in any setting, including but not limited to medical care, behavioral health care, and LTSS. For purposes of this Contract, Health Care Services primarily refers to dental and oral health care services. See: 42 C.F.R. § 438.320. (From CMSC).

Healthcare Effectiveness Data and Information Set (HEDIS): A set of Performance Measures developed by the NCQA. The measures were designed to help health care purchasers understand the value of health purchasers and measure plan performance.

Health Insurance: Financial coverage to cover a portion of the cost of a policyholder's medical and/or dental bills. May be a public coverage program such as Medicare, Medicaid, MCO's, CHIP. Indian Health Services. May be Private Healthcare such as provided by an employer or purchased in the marketplace.

HIPP: Health Insurance Premium Payment Program.

HIT: Health Information Technology.

HMO: Health Maintenance Organization licensed by the Iowa Insurance Division.

Home-Based Habilitation: Habilitation services means the 1915(i) State Plan Home and Community Based Services. Habilitation services are provided to maintain persons with functional deficits typically associated with chronic mental illness in their own homes and communities.

Home and Community-Based Services (HCBS): Services that are provided as an alternative to long-term care institutional services in a NF or an ICF/ID or to delay or prevent placement in a NF.

Home Health Care: Home health care is a wide range of health care services that can be given in a Member's home for an illness or injury.

Hospice Services: Services to provide comfort and support for Members in the last stages of a terminal illness, and their families.

Hospitalization: Medically necessary care determined to require a hospital stay.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

HRSA: Health Resources Services Administration.

IMPA: Iowa Medicaid Portal Access.

IHH (Integrated Health Homes (IHH)): Integrated and coordinated care for individuals with serious mental illness or serious emotional disturbance for all primary, acute, behavioral health, and long-term services and supports to meet the whole person.

Incentive Arrangement: Any payment mechanism under which the Contractor may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the Contract. See: 42 C.F.R. § 438.6. (From CMSC).

Indian: Any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

a) Is a member of a Federally recognized Indian tribe;
b) Resides in an Urban center and meets one (1) or more of the four (4) criteria:
c) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
d) Is an Eskimo or Aleut or other Alaska Native;
e) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
f) Is determined to be an Indian under regulations issued by the Secretary;
g) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
h) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Care Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native

See: 42 C.F.R. § 438.14(a). (From CMSC).

Indian Health Care Provider (IHCP): A health care program operated by the IHS or by an I/T/U/ as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). See: 42 C.F.R. § 438.14(a). (From CMSC). .

Informational Letter (IL): Iowa Medicaid publishes provider bulletins called Informational Letters that are necessary to clarify and explain new and existing program and policy.

In-Network Dentist: A dentist who has a contract with the plan. This is also called a participating provider. It usually costs you less.

Iowa Health and Wellness Plan (IHAWP): The Iowa Health and Wellness Plan covers Iowans, ages nineteen (19) to sixty-four (64), with incomes up to and including one hundred and thirty-three percent (133%) of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's

implementation of the Affordable Care Act or Medicaid expansion.

Iowa Health Information Network (IHIN): Iowa's Health Information Exchange.

Iowa Insurance Division (IID): The state regulator which supervises all insurance business transacted in the state of Iowa.

Iowa Medicaid: The division of Health and Human Services (HHS) that administers the Iowa Medicaid Program.

IVR: Interactive Voice Response.

Large Print: Printed in a conspicuously visible font size as defined by the HHS Office of Civil Rights at 45 C.F.R. § 92.8(b)(1)(i). See: 42 C.F.R. § 438.10(d)(2). (From CMSC).

Limited English Proficient or Limited English Proficiency (LEP): Potential Enrolled Members and Enrolled Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance services for a particular type of service, benefit, or encounter. See: 42 C.F.R. § 438.10(j). (From CMSC).

LSO: Limited Service Organization licensed by the Iowa Insurance Division.

Long-Term Services and Supports (LTSS): Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider-owned or controlled residential setting, a NF, or other institutional setting. See: 42 C.F.R. § 438.2. (From CMSC).

LTSS Residential Provider: A residential provider who provides services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses, including, but not limited to: (i) NF's; (ii) ICF/IDs; (iii) 1915(i); (iv) 1915(c); and (iii) Residential Community-based neurobehavioral rehabilitation (CNRS) providers.

M-CHIP: Refers to Medicaid CHIP, or Medicaid expansion. M-CHIP provides coverage to children ages six (6) to eighteen (18) whose family income is between one hundred and twenty percent (122%) and one hundred and sixty seven percent (167%) of the Federal Poverty Level (FPL), and infants whose family income is between two hundred and forty percent (240%) and three hundred and seventy five percent (375%) of the FPL.

Managed Care Organization (MCO): An entity that has, or is seeking to qualify for,

a Comprehensive Risk Contract under 42 C.F.R. part 438, and that is (1) A Federally qualified HMO that meets the advance directives requirements of 42 C.F.R. part 489, subpart I; or (2) Any public or private entity that meets the advance directives requirements of 42 C.F.R. part 489, subpart I; or (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; (ii) Meets the solvency standards of 42 C.F.R. § 438.116. See: 42 C.F.R. § 438.2. {From CMSC}.

Managed Care Plan (MCP): A term used when the contract section applies to both the Managed Care Organization and the Pre-Paid Ambulatory Health Plan.

Mandatory Enrollment: Enrollment where one (1) or more groups of beneficiaries are enumerated in section 1905(a) of the Social Security Act must enroll with the Contractor to receive covered Medicaid Benefits. See: 42 C.F.R. § 438.54(b)(2). (From CMSC).

Medicaid Benefits. See: 42 C.F.R. § 438.54(b)(2). (From CMSC).

Marketing: Any communication, from the Contractor to a Medicaid beneficiary who is not enrolled with the Contractor, that can reasonably be interpreted as intended to influence the beneficiary to enroll with the Contractor, or either to not enroll or to disenroll from another Contractor's Medicaid product. Marketing does not include communication that is directed to Enrollees only. See: 42 C.F.R. § 438.104(a). (From CMSC).

Marketing Materials: Materials that:

a) Are produced in any medium, by or on behalf of the Contractor; and
b) Can reasonably be interpreted as intended to market the Contractor to Potential Enrolled Members.

See: 42 C.F.R. § 438.104(a). (From CMSC).

MCO, PIHP, PAHP, PCCM, or PCCM entity: The acronyms include any of the entity's employees, Network Providers, agents, or contractors. See: 42 C.F.R. § 438.10(a). (From CMSC).

MED: Medicare Exclusion Database.

Medicaid: A means tested federal-State entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.

Medicaid Expansion: See Iowa Health and Wellness Plan (IHAWP) and/or MCHIP.

Medical Loss Ratio (MLR) Reporting Year: A period of twelve (12) months consistent with the rating period selected by the Agency. See: 42 C.F.R. § 438.8(b). (From CMSC).

Medical Records: All medical, dental, oral, behavioral health, and long-term care histories; records; reports and summaries; diagnoses; prognosis; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, dental, oral, behavioral health and long-term care documentation in written or electronic format; and analyses of such information.

Medical/Surgical Benefits: Benefits for items or services for medical conditions or surgical procedures, as defined by the Agency and in accordance with applicable Federal or State law, but do not include mental health or substance use disorders Benefits. Any condition defined by the Agency as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines). Medical/Surgical Benefits include LTSS services. See: 42 C.F.R. § 438.910. (From CMSC).

Medically Accepted Indication: Any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one (1) or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Social Security Act.

Medicaid Exempt: Includes individuals with disabling mental disorders (including adults with serious mental illness, individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one (1) or more activities of daily living, or individuals with a disability determination based on Social Security criteria. The phrase “Medically exempt” as used in this Contract is intended to have the same meaning as the term “Medically Frail” as defined in 42 C.F.R. § 440.315(f).

Medically Necessary Services: Those Covered Services that are, under the terms and conditions of the Contract, determined through Contractor UM to be:

a) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Enrolled Member;
b) Provided for the diagnosis or direct care and treatment of the condition of the Enrolled Member enabling the Enrolled Member to make reasonable progress in treatment;
c) Within standards of professional practice and given at the appropriate time and in the appropriate setting;
d) Not primarily for the convenience of the Enrolled Member, the Enrolled Member's physician or other Provider; and

e) The most appropriate level of Covered Services, which can safely be provided.

Medicare: A nationwide federally administered Health Insurance program that covers the cost of Hospitalization, medical care and some related services. Medicare has two (2) parts: Part A (also called the supplemental medical insurance program) covers inpatient costs; Part B covers outpatient costs. Part C is Medicare Advantage. Part D is optional coverage for prescription drugs.

Member: A Medicaid recipient or a recipient of services provided under the State Children's Health Insurance Program covered by the Agency who is subject to Mandatory Enrollment or is currently enrolled in the Contractor's coverage under the Contract for the program.

Member Months: The number of months an Enrolled Member or a group of Enrolled Members is covered by the Contractor over a specified time period, such as a year. See: 42 C.F.R. § 438.8(b). (From CMSC).

MFCU: Medicaid Fraud Control Unit. A division within the Iowa Department of Inspections & Appeals whose primary goal is to prevent abuse of taxpayer resources through professional investigation of criminal activity. MFCU staffs experienced criminal investigators, auditors, and attorneys to achieve this goal.

MHDS: Mental Health and Disability Services.

MHPAEA: Mental Health Parity and Addiction Equity Act.

MMIS: The Agency's Medicaid Management Information System, a mechanized Claims processing and information retrieval system that all Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medical Providers and Enrolled Members.

Money Follows the Person Rebalancing Demonstration (MFP): A federal grant that will assist Iowa in transitioning individuals from an NF or ICF/ID into the community and in rebalancing long-term care expenditures.

NAIC: National Association of Insurance Commissioners.

Natural Supports: Services and supports identified as wanted or needed by the consumer and provided by persons not for pay (e.g., family, friends, neighbors, coworkers and others in the community) and organizations or entities that serve the general public.

NCQA: National Committee for Quality Assurance.

Necessary Dental Services: Services are needed to protect and keep your mouth healthy.

Network: The group of dentists who contract with the plan. If a needed covered service is not in the network, we may set up out-of-network care, and you will not pay more just because the dentist is out of network.

Network or Provider Network: A group of participating health care Providers (both individual and group practitioners) linked through contractual arrangements to the Contractor to supply a range of dental health care services.

Network Adequacy: Refers to the Network of dental health care Providers for the program that is sufficient in numbers and types of Providers to ensure that all services are accessible to Enrolled Members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, Provider/Enrolled Member ratios, geographic accessibility and travel distance, waiting times for appointments, hours of operation and the overall network availability.

Network Provider: Any Provider, group of Providers, or entity that has a Network Provider agreement with the Contractor and receives Medicaid funding directly or indirectly to order, refer or render Covered services as a result of the Agency's Contract with the Contractor. All Network Provider is not a subcontractor by virtue of the Network Provider agreement. See: 42 C.F.R. § 438.2. (From CMSC).

NF: Nursing Facility.

NFP: Nurse Home Visitation and Mothers Health Protection Act.

NMHPA: Newborn and Mothers Health Protection Act.

Non-Claims Costs: Those expenses of administrative services that are not:

a) Incurred Claims;
b) Expenditures on activities that improve health care Quality; or
c) Licensing and regulatory fees; or
d) Federal and State taxes.

See: 42 C.F.R. § 438.8(b). (From CMSC).

Non-Emergent Use of Emergency Room: Illnesses or injuries that are generally not life-threatening and do not need immediate treatment at an Emergency Department.

Non-Participating Provider: A Provider that is enrolled with Iowa Medicaid, is credentialed, but not contracted, with a managed care plan.

Notice: Notice means a written statement of the action the Contractor has taken or intends to take, the reasons for the action, the Enrolled Member's right to file an

Appeal and request a fair hearing with the Agency, and the procedures for exercising that right.

NPPES: National Plan and Provider Enumeration System.

OIG: Office of Inspector General.

Other Disclosing Entity: Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XIX of the Social Security Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, RHC, or HMO that participates in Medicare (title XVIII);

b) Any Medicare intermediary or carrier; and

c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it Claims payment under any plan or program established under title V or title XIX of the Social Security Act. See: 42 C.F.R. § 455.101. (From CMSC).

Oral Health Assessment (Oral Health Survey): A short survey for member to participate in that provides information about their mouth health. It helps find risks and connect the member with care and resources.

Oral Surgeon (Specialist): A dentist who does surgery on the mouth and jaw.

Orthodontist (Specialist): A dentist who fixes bite and alignment problems, like with braces.

Out-of-Network Provider: Any Provider that is not directly or indirectly employed by or does not have a Provider agreement with the Contractor or any of its Subcontractors pursuant to the Contract between the Agency and the Contractor.

Outcomes: As used in 42 C.F.R. part 438 subpart E, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. See: 42 C.F.R. § 438.320. (From CMSC).

Overpayment: Any payment made to a Network Provider by the Contractor to which the Network Provider is not entitled under Title XIX of the Social Security Act or any payment to the Contractor by the Agency to which the Contractor is not entitled under Title XIX of the Social Security Act. See: 42 C.F.R. § 438.2. (From CMSC).

PACE: Program for All Inclusive Care for the Elderly.

Participating Provider: A Provider that is enrolled with Iowa Medicaid and is credentialed and contracted with a managed care plan.

Periodontist (Specialist): A dentist who treats gums and the bones that support teeth.

PASRR: Preadmission Screening and Resident Review.

Pass-Through Payment: Any amount required by the Agency to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the Contractor and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific Enrolled Member covered under the Contract; a Provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 C.F.R. § 438.6 for services and services and Enrolled Members covered under the Contract; a sub-capitated payment arrangement for a specific set of services and Enrolled Members covered under the Contract, graduate medical education payments. See: 42 C.F.R. § 438.6. (From CMSC).

Performance Improvement Projects (PIPs): Projects to improve specific Quality Performance Measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effects on health outcomes and Enrolled Member satisfaction.

Performance Measures: Performance Measures are specific, operationally defined performance indicators that utilize data to track performance, Quality of care, and to identify opportunities for improvement in care and services.

Person-Centered Planning Process: A process led by the member, where possible, and includes the member's representative in a participatory role, as needed and as defined by the member, unless State law confers decision-making authority to the legal representative. In addition to being led by the member receiving services and supports, the Person-Centered Planning Process:

a) Includes people chosen by the member;
b) Provides necessary information and support to ensure that the member directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
c) Is timely and occurs at times and locations of convenience to the member;
d) Reflects cultural considerations of the member and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are LEP, consistent with 42 C.F.R. § 435.905(b);

e) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
f) Providers of HCBS for the member, or those who have an interest in or are employed by a Provider of HCBS for the member must not provide Case Management or develop the Person-Centered Service Plan, except when the Agency demonstrates that the only willing and qualified entity to provide Case Management and/or develop Person-Centered Service Plans in a geographic area also provides HCBS. In these cases, the Agency must devise conflict of interest protections including separation of entity and Provider functions within Provider entities, which must be approved by CMS. Members must be provided with a clear and accessible alternative dispute resolution process;
g) Offers informed choices to the member regarding the services and supports they receive and from whom;
h) Includes a method for the member to request updates to the plan as needed;
i) Records the alternative home and community

Person-Centered Service Plan: A person-centered plan must reflect the services and supports that are important for the member to meet needs identified through an assessment of functional need, as well as what's important to the member with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the member, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

a) Reflect that the setting in which the member resides is chosen by the member. The Agency must ensure that the setting chosen by the member is integrated in, and supports full Access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of Access as individuals not receiving Medicaid HCBS;
b) Reflect the member's strengths and preferences;
c) Reflect clinical and support needs as identified through an assessment of functional need;
d) Include individually identified goals and desired outcomes;
e) Reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals, and the Providers of those services and supports, including Natural Supports. Natural Supports are unpaid supports that are provided voluntarily to the member in lieu of 1915(c) HCBS Waiver services and supports;
f) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
g) Be understandable to the member receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the

written plan to be understandable, it must be written in plain language and in a manner that is accessible to members with disabilities and persons who are LEP, consistent with 42 C.F.R. § 435.905(b) of this chapter;
h) Identify the individual and/or entity responsible for monitoring the plan;
i) Be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and Providers responsible for its implementation;
j) Be distributed to the member and other people involved in the plan;
k) Include those services, the purpose or control of which the member elects to self-direct;
i) Prevent the provision of unnecessary or inappropriate services and supports;
m) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of 42 C.F.R. § 431.301, must be supported by a specific assessed need and justified in the Person-Centered Service Plan.

See: 42 C.F.R. § 431.301(c)(2). {From CMSC}.

Pharmaceutical and Therapeutics (P&T) Committee: A committee of nine (9) Members appointed by the Governor that is charged with developing and providing ongoing review of the PDL pursuant to Iowa Code section 249A.20A.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy services.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Physician/Provider Administered Drugs: Drugs other than vaccines covered under section 1927(k)(2) of the Social Security Act that are typically furnished incident to a physician/Provider's services.

a) Physician/Provider Administered Drugs are administered by a medical professional in a physician's or other qualified medical Provider's office or other outpatient clinical setting.
b) Physician/Provider Administered Drugs are incident to a physician's or other qualified medical Provider's services that are separately billed to Medicaid or its Designee.
c) Reimbursement for Physician/Provider Administered Drugs is allowed only if the drug qualifies for rebate in accordance with 42 USC 1396r-8.

Plan: An individual or group plan that provides, or pays the cost of, medical care.

PMIC: Psychiatric Medical Institutions for Children.

Policies and Procedures Manual (PPM): The document to be released by the Agency detailing the policies and procedures of the program.

POS: Point of Sale.

Post-Stabilization Care Services: Covered services, related to an Emergency Medical Condition that are provided after an Enrolled Member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Enrolled Member's condition. See: 42 C.F.R. § 438.114(a). (From CMSC).

Potential/Enrolled Member: A Medicaid beneficiary who is subject to Mandatory Enrollment or may voluntarily enroll to more than one Contractor but has not yet an Enrolled Member of the Contractor. See: 42 C.F.R. § 438.2. (From CMSC).

PPACA: The Patient Protection and Affordable Care Act.

PPS: Prospective Payment System.

Preauthorization: To ensure that services are medically necessary, Iowa Medicaid Medical Services conducts a pre-review and/or a pre-procedure review program for the Medicaid program. (IAC 441 — 79.11, 78.4(1)(j)) Approval by Iowa Medicaid medical services will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department.

Preferred Drug: A drug on the PDL that provides medical equivalency to the Medicaid Member in a cost-effective manner (as defined by virtue of OBRA 90 and Supplemental Rebate) and does not require a Prior Authorization unless conditions are applied. As referenced drug is designated "P" on the PDL.

Preferred Drug List (PDL): A list comprised of drugs recommended to the Iowa Department of Health and Human Services by the Iowa Medical P&T Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Premium: A Health Insurance premium is the amount that policy holders pay for health coverage.

Prepaid Ambulatory Health Plan (PAHP): An entity that—

a) Provides services to Members under contract with the Agency, and on the basis of Capitation Payments, or other payment arrangements that do not use State Plan payment rates.

b) Does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrolled Members; and

c) Does not have a Comprehensive Risk Contract.

See: 42 C.F.R. § 438.2. (From CMSC).

Prepaid Inpatient Health Plan (PIHP): An entity that—

a) Provides services to Members under contract with the Agency, and on the basis of Capitation Payments, or other payment arrangements that do not use State Plan payment rates.

b) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Members; and

c) Does not have a Comprehensive Risk Contract.

See: 42 C.F.R. § 438.2. (From CMSC).

Prescription Drug Coverage: Preferred drugs by Medicaid Plans. Prescription records are required for all drugs as specified in Iowa pharmacy and drug laws, including Iowa Code sections 124.308, 126, 155A.27, and 155A.29. For Medicaid purposes, prescriptions are required for nonprescription drugs and are subject to the same provisions. This includes the record-keeping requirements on refills. Maintain prescriptions on file in such a manner that they will be readily available for audit by the Department. Prior Authorization may be required. Prescribers should review the therapy of their Medicaid patients for utilization of nonpreferred drugs and whenever medically appropriate, change patients to preferred drugs. New therapy should be initiated on a preferred drug unless a nonpreferred drug is medically necessary. A member receives the prescription when prescribed by a legally qualified practitioner (which includes physician, dentist, podiatrist, physician assistant, therapeutically certified optometrist, or advanced registered nurse practitioner). (IAC 79.1(7c)(2)).

Prevalent: A non-English language determined to be spoken by a significant number or percentage threshold percentage is five percent (5%) of Enrollees in a service area. See: 42 C.F.R. § 438.10(a). (From CMSC).

Prevocational Services: Prevocational services means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

PPC: Preventive services, which encourage access to care, health education, counseling to address risk factors, and services for disease prevention in individuals without symptoms.

Primary Care: All Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, OB/GYN, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them. See: 42 C.F.R. § 438.2. (From CMSC).

A Primary Care Physician/Dentist: A doctor or dentist who:

- Serves as the patient's main healthcare/dental provider
- Provides routine care and treatment

- Coordinates care with specialists when needed

Primary Care Provider (PCP): A Primary Care physician, dentist, or other licensed health practitioners practicing in accordance with State law who is responsible for providing preventive and primary dental and/or oral health care to patients; for initial referrals for Specialty care; and for maintaining the continuity of patient care.

Primary Care Services: Health care and laboratory services customarily furnished by, or through, the Enrolled Member's PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, dental health maintenance, and dental health promotion, either by the PCP or through appropriate referral to specialists and/or ancillary Providers.

Prior Authorization (PA): The process of obtaining prior approval as to the appropriateness of a service or medication; prior Authorization does not guarantee coverage.

Private Insurance: Does not include a QHP, as defined in 45 C.F.R. § 155.20. See: 42 C.F.R. § 438.104(a). (From CMSC).

Prosthodontist (Specialist): A dentist who makes dentures, crowns, and bridges.

Professional Standards: Quality Standards. The generally accepted requirements followed by the members of an industry and the ethical or legal duty of a professional to exercise the level of care, diligence, and skill prescribed in the code of practice of their profession, or as other professionals in the same discipline would in the same or similar circumstances.

Program: The Iowa Dental Wellness Plan and Hawki Dental programs provided through this plans benefits.

Program Contractors: The vendors selected to operate the Program, including the Contractor and the other awarded entity(s).

Program Integrity (PI): Program Integrity (PI) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Prospective Drug Utilization Review (Pro-DUR): A process in which requests for a drug product for a particular patient is screened for potential drug therapy problems before the product is dispensed.

Protected Health Information (PHI): Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. parts 160 and 164.

Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. See: 42 C.F.R. § 438.2. (From CMSC).

Provider-Preventable Conditions: Situations in which Medicaid payment is prohibited for services that should have been avoidable as defined in 42 C.F.R. § 447.26.

Psychosocial Necessity: The clinical, rehabilitative, or supportive mental health services that meet all of the following conditions:
i) are appropriate and necessary to help the symptoms, diagnoses or treatment of a mental health diagnosis; (ii) prevent or reduce from the diagnosis or direct care and treatment of a mental disorder, (i) are within the standards of good practice for mental health treatment; (ii) are provided for the diagnosis or direct care and treatment of a mental disorder; (iii) are within standards of good practice for mental health treatment; (iv) are required to meet the mental health needs of the member and not primarily for the convenience of the member, the Provider, or the contractor; and (v) are the most appropriate type of service which would reasonably meet the needs of the member in the least costly manner after consideration of: (a) the impact of previous treatment and service interventions; (b) services being provided concurrently by other delivery systems; (c) the potential for services/supports to avert the need for more intensive treatment; (d) the potential for services/supports to allow the member to maintain functioning improvement attained through previous treatment; (e) unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of Natural Supports including a place to live) and (f) the member's choice of Provider or treatment location.

QHP: Qualified Health Plan.

Quality: As used in 42 C.F.R. part 438 subpart E and pertaining to External Quality Review, the degree to which the Contractor increases the likelihood of desired Outcomes of its Enrolled Members through:

1) The structure and operations characteristics;
2) The provision of services that are consistent with current professional, evidence-based knowledge;
3) Interventions for performance improvement. See: 42 C.F.R. § 438.320. (From CMSC).

RAC: Recovery Audit Contractor.

Rating Period: A period of twelve (12) months selected by the Agency for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a). See: 42 C.F.R. § 438.2. (From CMSC).

Readily Accessible: Electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. See: 42 C.F.R. § 438.10(a). (From CMSC).

Recommended Drug List (RDL): A voluntary list of drugs recommended to the Department of Health and Human Services by the Iowa Medicaid P&T Committee that informs prescribers of cost-effective alternatives that do not require Prior Authorization.

Rehabilitation Services and Devices: All services determined to be medically necessary and reasonable for the member to improve health status. All services must meet a significant need of the member and cannot be met by a significant other, a friend, or medical staff; must meet accepted standards of medical practice by prior authorization. All services must be specified and effective treatment for a member's medical or disabling condition. A licensed skilled therapist must complete a plan of treatment every thirty (30) days and indicate the type of service required. every thirty (30) days and indicate the type of service required.

Reporting Manual: The document to be distributed by the Agency detailing the reporting requirements for the Program. Reference the State of Iowa Department of Health and Human Services, Iowa Medicaid Prepaid Ambulatory Health Plan (PAHP) Reporting Manual.

Reprocessed Claim: The adjustment of certain already-processed claims until the Claim is correct or no further changes are required. The re-processing process includes all activities identified to pay or deny the Claim after its initial adjudication through the Claims payment system. This includes payment of the Claim once adjustments have been completed.

Retrospective Drug Utilization Review (Retro-DUR): The process in which patient drug utilization is periodically reviewed to identify patterns of Fraud, Abuse, gross overuse, or inappropriate or unnecessary care.

RHC: Rural Health Clinic.

Risk Contract: A contract between the Agency and Contractor under which the Contractor assumes risk for the cost of the services covered under the Contract; and incurs loss if the cost of furnishing the services exceeds the payments under the Contract. See: 42 C.F.R. § 438.2. (From CMSC).

Risk Corridor: A risk sharing mechanism in which the Agency and the Contractor may share in profits and losses under the Contract outside of a predetermined threshold amount. See: 42 C.F.R. § 438.6. (From CMSC).

Routine Care: Medical care which is not urgent or emergent in nature and can wait

for a regularly scheduled physical appointment without risk of permanent damage to the patient's life or health condition. Routine Care is typically performed within thirty (30) days.

Rural: Any area that is not designated as a Metropolitan Statistical Area (MSA).

SAMI: System for Award Management.

A sanctioned individual: In accordance with section 1128(b)(8) of the Social Security Act, a Sanctioned Individual is a person who:

Has a direct or indirect ownership or control interest of five percent (5%) or more in the entity; and:
Has had a conviction of relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
Has been excluded from participation under a program under title XVIII or under a state health care program
Has an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in the entity, and:
Has had a conviction relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
Has been excluded from participation under title XVIII or under a state health care program
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No longer has direct or indirect ownership or control interest of five percent (5%) or more in the entity that was identified or controlled interest, in anticipation of or following a conviction, assessment, or exclusion against the person, to an immediate family member or a member of the household of the person who continues to maintain an ownership or control interest who:
Has had a conviction relating to Fraud, obstruction of an investigation or audit, controlled substance misdemeanor or felony, program related crimes, patient Abuse, or felony healthcare Fraud; or
Has been assessed a civil monetary penalty under section 1128A or 1129 of the Social Security Act; or
Has been excluded from participation under title XVIII or under a state health care program

See: Section 1128(b)(8) of the Social Security Act. (From CMSC).

Second Opinion: Subsequent to an initial medical opinion, a Second Opinion is an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally recommending a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

SED: Severe Emotional Disturbance.

Service Authorization: A managed care Enrolled Member's request for the provision of a service. See: 42 C.F.R. § 431.201. (From CMSC).

Service Level (SL): In relation to call centers, service level is defined as the percentage of calls answered within a predefined amount of time.

SIM: State Innovation Model.

Single Case Agreement: A single case agreement (SCA) is defined as a contract between an out-of-network (not enrolled with Iowa Medicaid) health care provider and the Managed Care Plan (MCP).

Skilled Nursing Care: Medicare Benefit Manual Policy 30.3 Direct

Skilled Nursing Services to Patients: Skilled nursing services are services provided when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse are required.

Specialist: A licensed general dentist, who is certified or trained in a specific field of dentistry, including oral surgery, prosthodontia, pediatrics, periodontology, orthodontia, and endodontia.

SRC: State Resource Centers.

SSA: Social Security Administration.

SSI: Supplemental Security Income.

State: The State of Iowa, including, but not limited to, any entity or agency of the State, such as the Iowa Department of Health and Human Services, the MFCU, the Division of Insurance, and the Office of the Attorney General. It also refers to the Single State Agency as specified in 42 C.F.R. § 431.10.

State Fair Hearing: The process set forth in 42 C.F.R. part 431, subpart E. See: 42 C.F.R. § 438.400(b). (From CMSC).

State Plan: An agreement between the State and the federal government

describing how the State administers its Medicaid and CHIP programs.

Subcontractor: A third party who contracts with the Contractor or another Subcontractor to perform a portion of the duties in the Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the Contractor. See: 42 C.F.R. § 438.2.

Substance Use Disorder Benefits: Benefits for items or services for substance use disorders, as defined by the Agency and in accordance with applicable Federal and State law. Any disorder defined by the Agency as being and being a substance use disorder must be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the ICD, or State guidelines). Substance use disorder Benefits include LTSS services. See: 42 C.F.R. § 438.910. (From CMSC).

Targeted Case Management (TCM): Individual Community-Based Case Management services targeted to persons with chronic mental illness, mental retardation or developmental disabilities as defined in Iowa Code § 225C.20 with standards set forth in the Iowa Admin. Code, ch. 441-24 and ch. 441-90.

Third Party: An individual, entity, or program, excluding Medicaid, that is or may be liable to pay all or part of the expenditures for medical assistance provided by a Medicaid payer to the recipient. A Third Party includes, but is not limited to:

a) A third-party administrator;
b) a pharmacy benefits manager;
c) a health insurer;
d) a self-insured plan;
e) a group health plan, as defined in s. 607(1) of the Employee Retirement Income Security Act of 1974;2
f) a service benefit plan;
g) a managed care organization;
h) liability insurance, including self-insurance;
i) no-fault insurance;
j) workers compensation ;
k) laws or plans; or
l) other parties that by law, contract, or agreement are legally responsible for payment of a Claim for a health care item or service

TPL: Third Party Liability.

Transportation: Rides to dental visits that may be covered by your Medicaid program or health plan.

Treatment Limitations: Includes limits on Benefits based on the frequency of treatment, number of visits, Days of coverage, Days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs,

which are expressed numerically (such as fifty (50) outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of Benefits for treatment under a plan or coverage. (See: 42 C.F.R. § 438.910(d)(2) for an illustrative list of NQTLs). A permanent exclusion of all Benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. See: 42 C.F.R. § 438.900. (From CMSC).

UAT: User Acceptance Testing.

Urban: A Metropolitan Statistical Area (MSA) as defined by the federal Executive Office of Management and Budget.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Usual and Customary Standards for the Community: The standard utilized by the Agency to review the Contractor's compliance with Network adequacy standards where Provider availability is insufficient to meet the Contractor's required time and distance standards. The Agency reviews the availability of Medicaid-enrolled Providers in a geographic area to determine if the Usual and Customary Standards for the Community has been met.

Utilization Management (UM): The process of managing costs and use of services through effective planning and decision-making to assure that services provided are appropriate and cost-effective; it is composed of the following elements: (1) deciding who will be served; (2) assessing service needs and identifying desired Outcomes; (3) deciding what services to provide; (4) selecting service Providers and determining costs; and (5) implementing, monitoring, changing and terminating services.

Utilization Review:
An element of UM, it is the evaluation of the medical necessity, appropriateness, and efficiency of the use of Health Care Services, procedures, facilities, and practitioners. It involves a set of techniques used by or on behalf of purchasers of health care Benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on Professional Standards/ Industry Standards. Utilization Review is done at the individual Enrolled Member level as well as a system level.

Validation: As used in 42 C.F.R. part 438 subpart E, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. See: 42 C.F.R. § 438.320. (From CMSC).

Value Added Services (VAS): Optional Benefits provided by the Contractor outside of the standard Medicaid benefit package. Contractors use value added services as an incentive to attract Members to their plan. Historically, dental value-added services have been in the form of gift cards toward dental hygiene items.

Value Based Purchasing (VBP): Linking Provider payment to improved performance by health care Providers is called VBP. This form of payment holds health care Providers accountable for both the cost and Quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing Providers, in a way consistent with overcoming goals announced by U.S. Department of Health and Human Services on January 26, 2015.

Warm Transfer: A telecommunications mechanism in which the person answering the call facilitates transfer to a Third Party, announces the caller and issue and remains engaged as necessary to provide assistance.

Withhold Arrangement: Any payment mechanism under which a portion of a capitation rate is withheld from the Contractor and a portion of or all of the withheld amount will be paid to the Contractor for meeting targets specified in the Contract. The targets for a Withhold Arrangement are distinct from general operational requirements under the Contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are liquidated damages and not a Withhold Arrangement. See: 42 C.F.R. § 438.6. (From CMSC).

3.00 PLAN ELIGIBILITY

Any person enrolled in DentaQuest's Iowa programs is eligible to receive Covered Services and has the following rights under the Iowa Medicaid Contract, the Iowa Administrative Code, Iowa law, and 42 CFR §438.100:

The rights to -

i. Receive information in accordance with s. 438.10.
ii. Be treated with respect and consideration for his or her dignity and privacy.
iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand. (The information requirements for services that are not covered under contract because of moral or religious objections are set forth in s. 438.10(g)(2)(ii)(A) and (B).
iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records, and request

that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

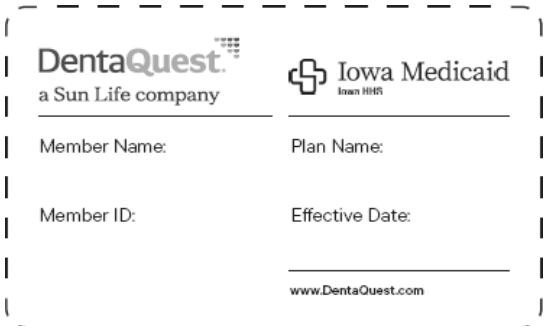
3.01 Member Identification Card

Members will receive an identification (ID) card at enrollment. Participating Providers are responsible for verifying that Members are eligible at the time of services are rendered and determining if Members have other health insurance.

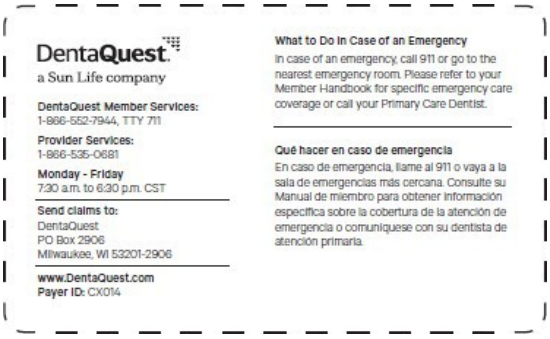
Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

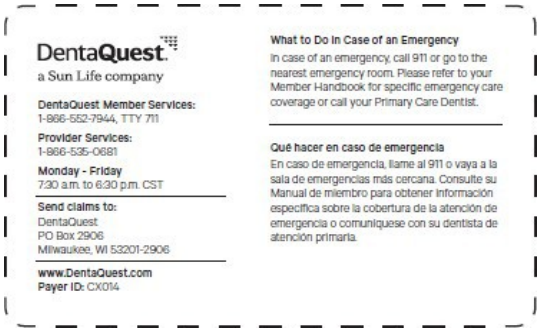
Sample ID Card

Front:



Back:





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. Therefore, an identification card does not guarantee that a person is currently enrolled in DentaQuest.

3.02 DentaQuest's Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Provider Web Portal or Interactive Voice Response (IVR) system. The eligibility information received from either system will be the same information you would receive

by calling DentaQuest's Provider Services Department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Services Representative.

Access to eligibility information via the DentaQuest Provider Web Portal:
DentaQuest's Provider Web Portal currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service, and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply go to the website at www.DentaQuest.com. Once you have entered the website, click the link called "Login."

You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instructions on how to complete Provider Self Registration, contact DentaQuest's Provider Services Department at (866) 515-6981. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You can check up to 30 patients at a time and print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line:
To access the IVR, simply call DentaQuest's Provider Services Department at (866) 515-6981 and press 2 for eligibility. The IVR system will be able to answer all your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Provider Services Representative to answer any additional questions, i.e., Member history, which you may have. Using your telephone keypad, you can request eligibility information by entering your 6-digit DentaQuest location number, the Member's recipient identification number, and an expected date of service. If the system is unable to verify the Member information you entered, you will be transferred to a Provider Services Representative.

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

Directions for using DentaQuest's IVR to verify eligibility:
Entering system with Tax and Location ID's

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

If you are having difficulty accessing either the IVR or website, please contact the Provider Services Department at (866) 515-6981. They will be able to assist you in utilizing either system.

4.00 PRIMARY CARE PROVIDERS AND SPECIALTY PROVIDERS

For the Medicaid program, Primary Care Providers (PCPs) include general dentists. Specialty Providers include endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists.

4.01 Keep your Practice Profile Current

Providers are responsible for contacting DentaQuest to report any changes in their practice.

Keeping your contact information updated is essential for ensuring appropriate access to care for our Members. DentaQuest is committed to monitoring the impact on our network dental practices and Members' ability to access care.

DentaQuest conducts surveys each quarter to ensure you provide timely access to appointments and that your demographic information is up to date in our system. Remember, the most up-to-date information is important to us, but more significantly it impacts our Members. It is essential that DentaQuest maintains an accurate Provider database to ensure proper payment of claims, to comply with Provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on Provider choices to our Members.

Any limitations to or changes in daily operations, including scheduling and available services and the extent to which the office may be available for services, should be reported to DentaQuest immediately. Optimum patient care, especially during periods of crisis, requires accurate and prompt communication from our partners.

Any changes should be reported to DentaQuest by completing our Provider Update Form (Provider Update Form - Provider Operations) and sending by fax to (262) 241-4077 or via e-mail to Standardupdates@dentaquest.com.

4.02 PCP Referral for Specialty Treatment

Participating primary care dentists will make referrals for specialty care and other covered services and, when applicable, allow Enrollees to directly access a specialist as appropriate for Enrollee's condition.

Providers shall track and follow upon Enrollee referrals and maintain dental records documenting referrals.

Standing referrals will allow Enrollees direct access to specialist as appropriate and shall be permitted to self-refer for emergency services and/or services provided by Indian Healthcare Provider to AI/AN Enrollees.

Remember to Verify Member Eligibility:

Please verify Member eligibility on the date of service when treating Members. You can easily verify Member eligibility through the Provider Web Portal (PWP). Log onto www.DentaQuest.com and click on "Dentist." You can also verify Member eligibility through the IVR system 24 hours a day, 7 days a week by calling (866) 515-6981 and following the prompts. *Verification of Eligibility is not a guarantee of payment.

Members have the right to obtain a second opinion from a qualified dental Provider regarding a diagnosis, treatment plan, or recommended procedure. Second opinions must be provided at no cost to the Member.

If a second opinion cannot be provided within the DentaQuest network within the required timeframes, DentaQuest will arrange for a second opinion from an out-of-network Provider at no cost to the Member. Providers must supply appropriate clinical records when requested to support a second-opinion evaluation.

Participating Providers are expected to cooperate with requests for second opinions, including providing timely documentation, radiographs, and treatment history as needed.

4.03 Non-Payment and Balance Billing Prohibition

Providers may not bill, charge, seek compensation from, or collect any payment from a Member for any covered service. This includes, but is not limited to:

- Any difference between the Provider's billed charge and the amount paid by DentaQuest ("balance billing").

- Services that DentaQuest has authorized or services for which DentaQuest is financially responsible.

- Services provided under a Transition of Care arrangement, emergency care, or a Single Case Agreement (SCA).

- Denied claims resulting from Provider billing errors, late submissions, missing documentation, or Provider noncompliance with Medicaid requirements.

- Cost sharing may include copayments, however, DentaQuest has waived the application of copayment requirements. Therefore, Providers may not bill, charge, seek compensation from, or collect any payment from an enrolled Member for any covered service.

Providers must accept DentaQuest's payment as payment in full for all covered services.

Billing the Member for Noncovered- Services
A Member may be billed only when ALL the following conditions are met:

- The service is not covered under Member's benefit.

- The Member is informed before the service is performed.

- The Member signs a written waiver acknowledging financial responsibility; and

- The waiver is not signed under emergency or distress conditions.

If the service is denied for medical necessity, benefit limits, or prior authorization reasons, Providers may NOT bill the Member unless DentaQuest has issued a written denial and the Member has knowingly agreed in writing to pay.

Administrative Denials
Members may not be billed when a claim is unpaid due to:

- Provider error
- Incorrect coding
- Missing or inadequate documentation
- Late filing
- Provider not properly enrolled or credentialed
- Refunds

If a Member is billed inappropriately, the Provider must refund the Member within 30 days and correct any related claim issues.

4.04 Provider Directory Requirements

DentaQuest maintains an accurate Provider Directory to help Members locate participating dental Providers. Contracted Providers must submit complete and accurate information and notify DentaQuest of any changes promptly to ensure the directory remains current.

The Provider Directory includes the following information for each Provider:

- Provider name and credentials
- Practice name (if different)
- Office address(es)
- Telephone number(s)
- Office hours
- Whether the Provider is accepting new patients
- Specialty or subspecialty
- Age groups served
- NPI
- ADA accessibility information (e.g., wheelchair access, accessible restrooms, step free entry)
- Languages spoken by the Provider and office staff
- Information on interpreter services, if offered

Providers must notify DentaQuest within five (5) business days of any changes to directory information, including:

- Address or phone number changes
- Office hours
- Accepting new patients' status
- ADA accessibility features
- Language capabilities
- Changes in practice name, ownership, or service location
- Temporary or permanent office closures

DentaQuest updates directory information as follows:

- Monthly: contact information, address changes, accepting -new patients-' status, language capabilities, accessibility features
- Quarterly: Provider additions and terminations, specialty updates, credentialing changes
- Within thirty (30) days: corrections to inaccurate information once validated
- Providers must complete directory accuracy attestations when requested by DentaQuest, and at least annually.

The Provider Directory is available online and in alternate formats upon request, including large print, electronic formats, and threshold languages.

4.05 Emergency and Post-stabilization Dental Services

Emergency access is available regardless of the Member's location, or the day/time the need arises. Members experiencing an emergency may seek care from any licensed dental Provider, including out-of-network or noncontracted Providers, and will not be required to obtain prior authorization before receiving emergency services.

Emergency Dental Services means an Enrollee or Member needs to see a Provider immediately because the individual is experiencing an 'Emergency Dental Condition,' and requires services to be furnished by a qualified Provider under applicable rules and regulations.

- Provider needed to evaluate or stabilize an emergency dental condition.

- Emergency services are services for the treatment of any dental issue needing attention immediately for the relief of pain, severe bleeding, infection, or serious injury to the teeth, gums, or jaw.

Coverage and Payment: Emergency services will cover and pay for emergency services regardless of whether the Provider that furnishes the services has a contract with DentaQuest; and may not deny payment for treatment obtained under either of the following circumstances:

- An Enrollee or Member had an emergency dental condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in applicable CMS rules and regulations.

- A representative of DentaQuest instructs the Enrollee or Member to seek emergency services.

- DentaQuest will allow Enrollees or Members to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the Enrollee to the Provider that furnishes the services.

Urgent Care is not emergency care. Urgent care is needed when a Member or Enrollee has an injury or illness that must be treated immediately. Urgent care can be used when a Member's life is not in danger, but a Member may still need to see a doctor immediately. Members may need to go to an urgent care if the Member or Enrollee needs care and the individual's Provider's office is closed.

Post-stabilization dental services refer to procedures and treatments provided after an Emergency Dental Condition has been stabilized. These services are considered nonemergency and must be deemed medically necessary by the treating physician or dentist.

Coverage Guidelines:

- Participating Providers: DentaQuest will cover all medically necessary post-

stabilization dental services performed by participating Providers without prior authorization.

- Nonparticipating Providers: DentaQuest may elect not to cover nonemergency poststabilization dental services rendered by nonparticipating Providers, except under the following circumstances:
    - The post-stabilization dental service was pre-approved by DentaQuest.
    - DentaQuest did not respond to the treating Provider's request for pre-approval within one (1) hour of receiving the request.

- The treating Provider was unable to contact DentaQuest to request pre-approval.

Emergency & Post-stabilization Services Criteria

A. **Emergency vs. Routine:** This policy specifically distinguishes between an emergency dental situation requiring immediate, post-stabilization intervention and standard dental care, which is typically Member or Enrollee covered services. This policy does not include all the reasons for an emergency dental condition, but some reasons for an emergency dental condition may be bleeding that won't stop; visible infection; sudden and painful injury to the teeth and gums; or swelling of the face or gums that aren't usually there.

B. **Documentation**: Providers must submit documentation (e.g., radiographs) to support the medical necessity of the treatment.

C. **Limitations**: Coverage is generally restricted to the stabilization of the acute condition and does not usually cover long-term restorative care (like crowns or implants) unless specifically covered under a medical policy. DentaQuest reserves the determination to limit what constitutes an emergency dental condition on the basis of lists of diagnoses or symptoms; and refuse to cover emergency services based on the emergency room Provider, hospital, or fiscal agent not notifying the Enrollee's primary care Provider, DentaQuest or applicable State entity of the Enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

D. An Enrollee who has an emergency dental condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

E. **Coverage and Payment**: DentaQuest is responsible for covered, necessary services that follow the stabilization of an emergency condition. The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on DentaQuest as responsible for coverage and payment. Post-stabilization care services are covered and paid for

in accordance with regulatory requirements and contractual obligations.

F. **Covered Services:** Typical covered services include but are not limited to:
   - Dental splints used for reducing jaw fractures or treating dislocated jaw joints.
   - Services to treat an oral/dental infection resulting from an emergency condition.
   - Procedures required to stabilize or immobilize teeth after trauma.
   - Medically necessary dental services performed prior to or alongside necessary medical treatments (e.g., in preparation for organ transplant or heart valve replacement).

Emergency Claim Identification – Box 35 Keywords
To ensure emergency and urgent dental claims are routed correctly, Providers must enter an accepted emergency indicator in **Box 35** of the 2012 (or newer) ADA Dental Claim Form. DentaQuest's claims system recognizes the following keywords:

- **EMERGENCY**
- **URGENT**
- **EMERGENCY/URGENT**
- **EXPEDITED**
- **URGENT REQUEST**
- **EMERGENCY TREATMENT**
- **POST-STABILIZATION**

These keywords ensure the claim is routed for emergency adjudication and handled according to the prudent layperson standard outlined above. Providers must also submit clinical documentation supporting the emergency condition. Claims missing an accepted keyword may not be processed under emergency guidelines.

4.06 Post Stabilization Care

Post Stabilization Care refers to services provided after the Member's emergency condition has been stabilized, but continued treatment is needed to maintain, improve, or resolve the stabilized condition.

Continuation of Post-Stabilization Services
Post-stabilization services shall be covered and provided without interruption following an emergency medical condition until one of the following conditions is met:

- The Member is stabilized and the condition is maintained such that no material deterioration is likely to occur;

- The Member can be safely transferred to a DentaQuest participating Provider or facility; or

- DentaQuest and the treating Provider have agreed upon a plan of care and DentaQuest has assumed responsibility for the Member's ongoing care.

Coverage shall not be terminated solely based on the point at which stabilization is initially achieved but shall continue as clinically appropriate in accordance with the above criteria.

Prior Authorization Requirements
Prior authorization shall not be required for post-stabilization services when:

- The Member remains clinically unstable for transfer; or
- Services are necessary to maintain stabilization while transfer arrangements are pending; or
- DentaQuest has not responded to a request for authorization within required timeframes.

For non-participating Providers, DentaQuest shall not delay or deny post-stabilization services solely due to lack of prior authorization when immediate care is required to maintain stabilization or to prevent deterioration.

The one-hour response requirement for authorization requests shall not operate to delay or impede the provision of medically necessary post-stabilization services.

The processes described in this Exhibit for review or documentation of post-stabilization services shall not be construed as a requirement for prior authorization as a condition of coverage.

Transfer and Care Coordination
DentaQuest is responsible for coordinating the safe and appropriate transfer of Members following stabilization when transfer is indicated. This includes:

- Identifying and securing acceptance from a DentaQuest participating Provider or facility;
- Coordinating logistics of transfer in collaboration with the treating Provider;
- Ensuring that no delay in care occurs while transfer arrangements are made; and
- Maintaining communication with the treating Provider until transfer or assumption of care is completed.

The treating Provider is not required to delay care or transfer decisions pending direction from DentaQuest.

I-Smile
I-Smile is a program that connects Iowa families with dental, medical, and local resources for a lifetime of health and wellness. Dental hygienists are located across the state to help children get dental care.

This program helps in many areas to get Iowa children access to dental care and good oral health. DentaQuest of Iowa works with the local coordinators. We can help you find your local coordinator if you have questions or would like more information.

I-Smile works to:

- Provide dental screenings, sealants, and fluoride in schools.
- Help families find a dentist, make appointments, and connect with local resources.
- Provide oral health education for children and parents.

For more information about the I-Smile program and to find your local Coordinator, visit https://hhs.iowa.gov/programs/programs-and-services/dental-and-oral-health/i-smile

Treating Provider Authority

The determination of whether a Member is stabilized, requires continued post-stabilization services, or is safe for transfer shall be made by the treating Provider. Such determinations shall be binding for purposes of coverage and care continuation unless otherwise mutually agreed upon between DentaQuest and the treating Provider.

Member Protections

Members shall not be held financially liable for:

- Emergency services;
- Post-stabilization services; or
- Services furnished during the coordination or execution of a transfer.

This protection applies regardless of the network status of the treating Provider when services meet the definition of emergency or post-stabilization care.

Documentation Requirements

To ensure compliance with Iowa Medicaid requirements and audit standards, the following documentation must be maintained for all post-stabilization cases:

- Date and time of stabilization determination by the treating Provider;
- Clinical rationale supporting the need for continued post-stabilization services;
- Records of any authorization requests, including timestamps of request and DentaQuest response;
- Documentation of transfer coordination efforts, including receiving Provider acceptance (if applicable); and
- Evidence that services were not delayed while awaiting authorization or transfer.

Post-Stabilization Review and Authorization Process (Iowa-Specific Operational Requirements)

In order to meet Iowa Medicaid and external quality review requirements, DentaQuest shall implement the following process for the review and handling of post-stabilization service requests.

1. Provider Initiation of Request

Providers, including both participating and non-participating Providers, shall contact DentaQuest Customer Service when requesting review of services related to a post-stabilization condition. Provider communications and guidance materials, including the Office Reference Manual (ORM) and Provider Manual, shall direct Providers to utilize this pathway.

2. Identification and Routing of Post-Stabilization Requests

Upon notification that a request involves a post-stabilization condition, Customer Service shall route the request to appropriate Utilization Management (UM) personnel for clinical review. Requests identified as urgent or related to an active emergency episode shall be prioritized for immediate handling.

3. Clinical Review and Determination

A qualified UM clinician shall conduct a real-time clinical discussion with the treating Provider to determine whether the requested services meet the definition of post-stabilization services, defined as:

- Covered services related to an emergency condition that are provided after stabilization in order to maintain the stabilized condition or to improve or resolve the Member's condition.

4. Verbal Authorization and Documentation

If the requested services qualify as post-stabilization services:

- Approval shall be provided verbally to the treating Provider at the time of the request;
- DentaQuest shall ensure that an authorization record is entered into the system to reflect the approval;
- The authorization shall include clear documentation identifying the services as post-stabilization services.

5. Non-Qualification Determinations

If the requested services do not meet the definition of post-stabilization services:

- The Provider shall be notified verbally of the determination;
- DentaQuest shall document the request and the rationale for the determination; such documentation shall be maintained for audit purposes.

6. Timeliness Requirements
All post-stabilization requests shall be handled in a manner that does not delay the provision of medically necessary services. The review and communication process shall occur in real time whenever possible, consistent with federal and state requirements. Under no circumstances shall the review process delay or impede the provision of medically necessary post-stabilization services.

7. Claims Review and Validation
DentaQuest shall implement claim review processes for post-stabilization services, including:

- Verification of associated authorization records for post-stabilization services when applicable;
- Review of out-of-network claims to confirm alignment with post-stabilization requirements;
- Ensuring that claims are not denied solely due to lack of prior authorization when services meet post-stabilization criteria.

For Iowa Medicaid Members, services that meet the definition of post-stabilization services shall not be denied solely due to lack of prior authorization.

4.07 Single Case Agreements

A Single Case Agreement (SCA) is a temporary, case specific agreement established- between DentaQuest and a nonparticipating (out- of- network) Provider when a Member requires medically necessary services that cannot be provided by a participating Provider within required time and distance standards or when continuity of care necessitates an exception.

SCA Criteria
DentaQuest may initiate a SCA when one or more of the following conditions apply:

- No network Provider is available within required access standards.
- The Member requires services that a participating Provider does not furnish.
- The Member is in active treatment with an out-of-the- network Provider, and continuity of care necessitates- continued treatment.
- The Member has unique clinical needs requiring specialty services available only through an out of- network- Provider.
- DentaQuest determines that arranging services through a SCA is in the Member’s best interest.

OON Reimbursement
Reimbursement for services provided under a SCA will be based on:

- The Iowa Medicaid Fee Schedule, or
- DentaQuest's standard out of-network reimbursement methodology, or
- A mutually agreed upon- case rate negotiated with the Provider.
- Reimbursement may not exceed the applicable Medicaid fee schedule unless otherwise authorized by Iowa Medicaid.

Iowa Medicaid Enrollment Requirements
All Providers delivering services under a SCA must:

- Be enrolled with Iowa Medicaid or
- Meet Iowa Medicaid's requirements for provisional or temporary enrollment for payment purposes.

DentaQuest may not execute an SCA with any Provider who is excluded, terminated, or otherwise ineligible to participate in the Medicaid program.

Authorization Requirements
Services furnished under a SCA require prior authorization and will be reviewed for medical necessity in accordance with Iowa Medicaid regulations and DentaQuest clinical criteria.

4.08 Transition of Care (TOC) – Prior Authorization and Out-of-Network Providers

DentaQuest ensures continuity of care for Members who are new to the plan, transitioning between Providers, or receiving ongoing treatment at the time of enrollment. Transition of care protections apply to services requiring prior authorization and situations in which an out-of-network Provider is delivering active, medically necessary treatment. DentaQuest will honor all Iowa Medicaid approved prior authorization for Members on Medicaid for 90 days after their enrollment with DentaQuest starts. DentaQuest will also pay non-participating, Iowa Medicaid enrolled Providers to help Members transition to care in the first 90 days.

Honoring Existing Prior Authorizations
DentaQuest will honor active and valid Prior Authorizations (PAs) issued by:

- Iowa HHS Fee for Service
- Another managed care or dental plan
- A prior treating Provider
- An out-of-network Provider under an SCA or TOC arrangement
- These authorizations remain valid for the duration of the approved authorization period unless:

  - The service becomes unsafe or clinically inappropriate, or
  - The Member transitions out of eligibility for the dental benefit

- A new PA may only be required once the existing approved period ends, or if the Member's clinical circumstances change.

Active Treatment at the Time of Enrollment
If a Member is undergoing active, medically necessary treatment at the time of enrollment (e.g., ongoing endodontic therapy, orthodontia, surgical case planning, denture fabrication), DentaQuest will:

- Allow the Member to **continue treatment with the current Provider**, including OON Providers, until treatment is completed or appropriately transitioned.
- Ensure no interruption of covered services; and
- Issue temporary authorization or establish a Single Case Agreement (SCA) when necessary to maintain continuity of care.

Out-of-Network Providers and Transition of Care
When a Member is actively receiving services from an out-of-network (OON) Provider at the time of enrollment or network changes, DentaQuest will:

- Authorize continued treatment for the duration of the active treatment period.
- Coordinate with the OON Provider to ensure uninterrupted care.
- Establish a **Single Case Agreement** (SCA) when required; and
- Reimburse the OON Provider based on Medicaid requirements and SCA terms.

The Member will not be financially responsible for covered TOC services delivered by an OON Provider.

When Transition of Care Applies
Transition of Care protections apply when:

- A Member newly enrolled with DentaQuest
- A Member receives a new coverage assignment
- A Provider becomes non-participating or OON
- A Member is in a course of treatment that cannot be safely interrupted
- A previously authorized service is already scheduled or underway

Prior Authorization Requirements During TOC
During a TOC period:

- Prior authorization cannot be denied solely because the treating Provider is OON
- DentaQuest may require documentation of medical necessity
- DentaQuest may not impose stricter criteria than normally required
- Services must be authorized as quickly as the Member's condition requires

Timelines

- TOC arrangements must be coordinated immediately upon identification of active treatment.

- Existing PAs remain valid until the end of the authorization period.
- SCAs related to TOC must be reviewed at least every six (6) months to e26u the Member cannot access appropriate care within the network.

Member Protections
Members are protected from:

- Disruption of medical care
- Balance billing for covered TOC services
- Gaps in service when transitioning between plans or Providers
- DentaQuest will coordinate with all relevant Providers to ensure seamless transition with no lapse in care.

4.09 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit applies to all Members under age 21 enrolled in the Iowa Dental Wellness Plan (DWP). EPSDT requires DentaQuest and Providers to ensure Members receive preventive, diagnostic, and medically necessary treatment services in accordance with federal Medicaid law.

Overview
Providers must ensure Members under 21 receive:

- Early and periodic dental screenings according to the Iowa Medicaid periodicity schedule.
- Diagnostic services when a screening identifies a potential condition.
- Medically necessary treatment services to correct or ameliorate defects, physical or mental illnesses, or conditions.
- EPSDT services must be provided regardless of standard service limits, benefit limitations, or coverage restrictions that apply to adult Members.

Periodicity
EPSDT screenings must be provided at intervals based on appropriate standards approved by Iowa HHS.

Providers must also offer screenings and services outside the periodic schedule when medically necessary.

Medically Necessary Expansion
EPSDT requires coverage for any medically necessary service for Members under 21, even when:

- The service exceeds standard amount, duration, or frequency limits.
- The service is not typically covered under the State Plan.
- The CDT/CPT code is outside standard benefit coverage.

Providers must:

- Deliver treatment needed to correct or improve a condition, not merely maintain

it.

- Submit documentation supporting medical necessity when requesting authorization beyond standard limits.

Understand that services cannot be denied for Members under 21 solely due to frequency limitations or periodicity rules.

Prior Authorization Requirements

- No prior authorization is required for EPSDT screening services.
- Prior authorization may be required for diagnostic or treatment services; however:
  - Each request must receive individual medical necessity review.
  - DentaQuest must expand coverage if medically necessary.
  - An appropriately licensed dental professional must issue denials.

Documentation Requirements

Provider documentation for EPSDT services must include:

- Screening findings. Diagnostic results.
- Treatment plans and clinical justification.
- Medical necessity for services exceeding standard limits.

Member Protections Members under age 21:

Must have access to all medically necessary dental services required under EPSDT. Cannot be denied service due to adult benefit limits, including frequency edits or annual benefit maximums.

May not be billed for EPSDT covered services.

If the DentaQuest finds that a code is not typically covered by Medicaid, or exceeds the standard service limits, a Waiver of Administrative Rule can be submitted to DentaQuest. An Exception to Policy (ETP) may be considered when medically necessary to meet the Enrolled Member's assessed needs, standard covered services or limitations are not sufficient, and all other reasonable options have been exhausted.

Waiver of Administrative Rules Petition (Exception to Policy): The Iowa Administrative Code 441 IAC 6.1(4) establishes a procedure for any member to petition an agency for a waiver or a variance from the requirements of an administrative rule. In essence, this is a request for a temporary exception or an exemption of a non-covered service from requirements established by a rule.

A member who seeks a waiver of the requirements of Iowa Department of Health and Human Services (HHS) administrative rule may file a "Petition for Waiver of Administrative Rules."

Option 1:
Filling out the form, or by;
- Mail: HHS Appeals Bureau
  321 E 12th Street, 4th Floor
  Des Moines, IA 50319
- Fax: (515) 564-4118
- Email exceptions@hhs.iowa.gov

Option 2: Submitting to DentaQuest at IowaProviders@dentaquest.com

Each petition received by HHS is evaluated based on the unique, individual circumstances set out in the petition. HHS may, in its sole discretion, grant a waiver if it finds, based on clear and convincing evidence, that the standards for the waiver have been satisfied. HHS may place any condition on a waiver that the department finds necessary to protect the public health, safety, and welfare. HHS may also withdraw, cancel, or modify a waiver under certain circumstances. HHS is not authorized to waive any requirement created or duly imposed by statute. Waiver requests are not appealable.

4.10 Office Reference Manual (ORM) Distribution

Upon entering the full credentialing process, Providers will receive directions on how to obtain the Office Reference Manual (ORM) via print (free of charge) and through our portal. During the onboarding process, Providers are coached on where to find the clinical information, claims submission process, recredentialing process, benefit information and all other critical needs as described here in the manual. In addition, DentaQuest has multiple on the ground representatives that are also in the field weekly to assist them in the usage of this distribution. Providers if you need a new ORM or education, please utilize one of the below forums:

- Contact their local Provider Engagement Representative
- Contact the DentaQuest Provider Services Center at (866) 515-6981
- Visit www.DentaQuest.com

4.11 Appointment & Access Standards

Primary Care Dentist Appointment Standards:
Primary Care Dentists (General Dentists) are required to schedule Members within the following timeframes:

- Routine appointments: not to exceed six (6) to eight (8) weeks from the date of a patient's request
- Persistent symptoms: within forty-eight (48) hours
- Urgent: within (one) 1 day
- Emergency: Immediate Care

Specialty Care Appointment Standards:
Specialists are required to schedule Members within the following timeframes:

- Routine care: not to exceed thirty (30) days
- Urgent: within one (1) day
- Emergency: Immediate Care

Emergency and Post-Stabilization Services Access Standards

- **Emergency Care:** All emergency care is immediate, at the nearest facility available, regardless of whether the facility or Provider is under contract with DentaQuest.

- **Post-Stabilization Services:** Required by DentaQuest, to assure Members receive dental treatment when presenting with emergency dental and/or medical needs that require dental services to eradicate. Post-stabilization services will be available to the Enrolled Member in a timely manner to prevent re-Hospitalization or presenting at the emergency room and shall be coordinated by DentaQuest, for the Member, upon notification from the Member, MCO, hospital, physician, or dentist who referred the Member.

5.00 MISCELLANEOUS PROGRAM DETAILS

5.01 Indian Health Care Providers

American Indian (AI)/Alaska Native (AN) Enrollees can receive services from an Indian Health Care Provider as the Enrollee's primary care dentist, if Provider has capacity to provide services.

Tribal facilities may enter into a Care Coordination agreement with non-tribal Providers to furnish certain services for AI/AN. Enrollees and services are eligible for one hundred percent federal funding.

AI/AN is eligible to receive service furnished by an Indian Health Care Provider or through referral is exempt from cost sharing requirements.

5.02 Behavior Management

Indications for Behavior Management include patients who require immediate diagnosis and/or limited treatment and cannot cooperate due to a mental or physical disability.

**American Academy of Pediatric Dentistry. Guideline on Behavior Management Reference Manual 2002-2003.*

5.03 Member Special Needs Considerations

- Providers must make efforts to understand the special needs required by Members. The Member may have challenges that include physical compromises as well as cognitive, behavioral, social, and financial issues. Multiple

comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease (ESRD), isolation, depression, and polypharmacy are some of the challenges facing these Members each day.

- Recognizing the significant needs of Members, Health plans incorporate person-centered care planning, coordination, and treatment in our care coordination program.

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each Member.

- The Member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.

- The Health Plan's case manager leads the Member's MDT and links closely to the Member's PCP to support him/her in ensuring the Member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the Member's care.

- DentaQuest's predictive model, based on claims history and analytics, is used to determine each Member's risk level and level of intervention required to channel the Member to the required level of coordination.

- A comprehensive assessment is completed for each Member to evaluate his or her medical, behavioral, and psychosocial status to determine the plan of care.

6.00 PAYMENT FOR NON-COVERED SERVICES

Participating Providers shall hold Members, DentaQuest, Plan and Health Plan harmless for the payment of non-covered services except as provided in this paragraph. Provider may bill a Member for non-covered services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- The services to be provided.

- DentaQuest and Agency will not pay for or be liable for said services; and

- Members will be financially liable for such services.

To ensure your office can bill the Members, please follow the guidelines below.

- CMS has indicated Members are only to be financially responsible for covered or non-covered services if there is a denied pre-service determination on file.

- Providers must submit a prior authorization request for covered or non-covered services prior to billing Members for them.

- Once prior authorization is received, DentaQuest will review and if appropriate, deny. DentaQuest must deny the prior authorization request before you are able to bill the Member. If DentaQuest does not provide a denial on the prior authorization request, then you cannot bill the Member.

Why is this information important?

- The patient will be personally responsible for full payment if Medicaid denies payment for a specific procedure or treatment only if you have a denied determination from DentaQuest.

- It also gives the patient the opportunity to accept or refuse the item or service and protects the patient from unexpected financial liability if Medicaid denies payment.

- It also offers the patient the right to appeal insurance decision.

Medicaid Members are entitled to receive pre-service notifications from their health and dental plans as to any out-of-pocket expense prior to receiving the service. While a Provider could use the Consent form, it cannot be in lieu of requesting a prior authorization from us. If the Provider does not obtain a written denial from us, they cannot bill the Member.

A recommended Member Consent Form can be found on the DentaQuest Provider Web Portal.

7.00 REVIEW & CLAIM SUBMISSION PROCEDURES (CLAIM FILING OPTIONS) AND ENCOUNTER DATA

Providers have 180 days from the date of service to submit claims to DentaQuest for all Medicaid plans.

For each plan that DentaQuest administers, the plans may require review of certain procedures to ensure that procedures meet the requirements of federal and state laws and regulations and medical necessity criteria. DentaQuest performs the review using one of two processes – “prior authorization” or “prepayment review.”

- “**Prior Authorization**” requires that the Provider obtain permission from DentaQuest prior to performing the service. “Prior Authorization” requires specific documentation to establish medical necessity or justification for the procedure.

- “**Prepayment Review**” is the review of claims by DentaQuest prior to determination and payment. The “Prepayment Review” requires documentation to establish medical necessity or justification for the procedure. For procedures that require “Prepayment Review,” Providers may opt to submit a “Prior Authorization” request prior to performing the procedure. If DentaQuest approves the “Prior Authorization” request, it will satisfy the “Prepayment Review” process.

The Exhibits for each plan in the Provider Office Reference Manual indicate which procedures require Review, which type of Review, and the documentation that the Provider will need to submit to support his or her request. Utilization management decision making is based on appropriate care and service, does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization.

DentaQuest does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff Member supports, or tends to support, denial of benefits. DentaQuest receives dental claims in four formats. These formats include:

- Electronic claims via DentaQuest's website (www.DentaQuest.com)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims
- DentaQuest utilizes claims submissions and information to collect encounter data.

7.00A Clean Claim Timeliness, Missing-Information Notices, and Reprocessing Requirements

Clean Claim Timeliness
DentaQuest processes all clean claims—claims that contain all required data elements and require no additional information or investigation—within thirty (30) calendar days of receipt. Clean claims may be submitted electronically through the DentaQuest web portal, clearinghouse submission, or HIPAA compliant 837D file.

Missing or Incomplete Information
Providers must submit all required documentation to process a claim. Missing information will be communicated via dental remittance advice. Claims that cannot be auto adjudicated in real time may require further review by DentaQuest clinical staff. This may include UM review for circumstances requiring special treatment. er must submit all required documentation to process a claim. Missing information will be communicated via dental remittance advice. Claims that cannot be auto adjudicated in real time may require further review by DentaQuest clinical staff. This may include UM review for circumstances requiring special treatment.

Claims not completed in the required timeframe will be denied and may not be billed to the Member.

Corrected Claims
When resubmitting a corrected claim, Providers must clearly label the claim as "Corrected Claim" and include:

- All supporting documentation.
- The original claim number; and
- Any additional information needed for adjudication.

- Corrected claims must be submitted within 180 days from the date of service or within 90 days from the denial, whichever is later.

Claim Reprocessing
DentaQuest will reprocess claims when:

- A processing, system, or adjudication error is identified.
- Missing information is returned within the stated timeframe.
- A prior authorization or appeal decision is overturned.
- Coordination of benefits (COB) information is updated; or
- Retroactive eligibility updates occur in the state system.
- Reprocessed claims will generate an updated Explanation of Benefits (EOB) detailing the corrected claim disposition and payment outcome.

Claims the Provider May Not Bill to the Member
Members may not be billed when a claim is unpaid due to:

- Missing or incorrect data elements.
- Provider billing or coding errors.
- Failure to provide required documentation.
- Timely filing violations; or
- Provider non-compliance with submission requirements.
- These are Provider responsibilities and cannot be transferred to the Member.

7.01 Electronic Attachments

DentaQuest accepts dental radiographs electronically via Vyne Dental for review requests. DentaQuest, in conjunction with Vyne Dental, allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives, and EOBs. Vyne Dental 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 Vyne Dental, go to https://vynedental.com/fastattach/ or call Vyne Dental at: (463) 219-2972.

7.02 Submitting X-Rays for Prior Authorization or Claims that Require Prepayment Review

- Electronic submission using the new web portal.

- Electronic submission using Vyne Dental is recommended. For more information, please visit https://vynedental.com and click the “Learn More about FastAttach” button. To register, click the “Register Now” button at the top of the home page.

- Submission of duplicate radiographs (which we will recycle and not return).

- Submission of original radiographs with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note that we also require radiographs to be mounted when there are 5 or more radiographs submitted at one time. If 5 or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2012 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs are placed in the same slot of a radiograph holder or mount.

All radiographs should include the Members' name, identification number, and office name to ensure proper handling.

Prior Authorization Timeliness:

- Standard: 99% within 7 days of the request for Service
- Expedited: 99% within 72 hours from receipt
- Requests for extensions approved in accordance with the Contract shall be removed from this timeliness measure

Extensions:
For standard and expedited authorization decisions, DentaQuest may extend the resolution time frame up to an additional 14 calendar days if the Member, or the Provider, requests the extension; or DentaQuest justifies to IAHHS upon request a need for additional information and how the extension is in the Member's interest.

7.03 Electronic Prior Authorization or Claim Submission Including Claims Requiring Prepayment Review Utilizing DentaQuest's Internet Website

Participating Providers may submit Prior Authorizations or Claims including claims requiring Prepayment Review directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Prior Authorizations or Claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's

eligibility prior to providing the service.

To submit prior authorizations or claims via the website, simply log on to www.DentaQuest.com. Once you have entered the website, click on the “Dentist” icon.

From there, choose your ‘State” and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business’s NPI or TIN, State and Zip Code. If you have not received instructions on how to complete Provider Self Registration, contact DentaQuest’s Provider Services Department at (833) 479-1007. Once logged in, select “Claims/Prior Authorizations” and then either “Dental Pre-Auth Entry” or “Dental Claim Entry” depending on whether you are submitting a Prior authorization or a claim.

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

If you have questions on submitting prior authorizations or claims or accessing the website, please contact our Systems Operations Department at (800) 417-7140 or via e-mail at EDITeam@GreatDentalPlans.com.

7.04 Electronic Claim Submission via Clearinghouse

DentaQuest works with Vyne Dental (463) 218-9508, Dental Exchange (800) 576-6412 and Change Healthcare/ Optum(800) 527-8133 for claim submissions to DentaQuest.

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

7.05 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.

7.06 NPI Requirements for Submission of Electronic Claims

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

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this

information to DentaQuest Dental 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 Dental, you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.

- If you are submitting claims to DentaQuest Dental through a clearinghouse or through a direct integration, you need to review your integration to ensure that it follows the revised HIPAA compliant 837D format. This information can be found on the 37D 8Companion Guide located on the Provider Web Portal.

7.07 Coordination of Benefits (COB)

When DentaQuest is the secondary insurance carrier, the Provider must first bill the primary insurer and submit the primary carrier's Explanation of Benefits (EOB) with the claim. For electronic submissions, the primary payment must be reported in the appropriate COB field.

Medicaid is the **payer of the last resort**. Providers must pursue all other available insurance resources before billing DentaQuest. Failure to bill a known primary payer may result in denial of the claim, and the Provider may **not** bill the Member for this denial.

When the primary insurer's payment meets or exceeds the Provider's contracted Medicaid rate or fee schedule amount, DentaQuest will consider the claim paid in full and no additional payment will be made.

Members may not be billed for any amount related to coordination of benefits processing, including delays, partial payments, or denials from a primary payer. These are Provider obligations under Medicaid rules.

If a primary payer issues a retroactive payment for services previously paid by DentaQuest, the Provider must refund the Medicaid payment in accordance with Medicaid overpayment rules.

7.08 Filing Limits

When required, each Provider will submit a claim to DentaQuest within 180 days from the date of service. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing," the Provider cannot bill the Member. If DentaQuest is the secondary carrier, the timely filing

limit begins with the date of payment or denial from the primary carrier.

7.09 Voiding, Canceling or Deleting Claims

DentaQuest is required by CMS to maintain an audit trail for voided, canceled, and deleted claims. As a result, DentaQuest may only cancel, void, or delete claims that are not able to be processed for acceptable reasons. Below are the only acceptable reasons in which a Provider could contact DentaQuest to void, cancel or delete a claim:

- A breakdown of charges is not provided, i.e., an itemized receipt is missing.
- The patient's address is missing.

DentaQuest must deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons. Below are **unacceptable** reasons in which a Provider could NOT contact DentaQuest to void, cancel or delete a claim.

1. A Provider notifies DentaQuest that claim(s) were billed in error and requests the claim be deleted.
2. The Provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review.
3. The patient's name does not match any Health Insurance Claim Number (HICN).
4. A claim meets the criteria to be returned as not able to be processed under the incomplete or invalid claims instructions in the Medicaid Claims Processing Manual, Chapter 1, Section 80.3.2. ff, which is available on the CMS website - https://www.cms.gov/medicare/regulations-guidance/manuals

If a Provider realizes that any of the **unacceptable** scenarios above are applicable, the Provider must submit a formal grievance to DentaQuest so that DentaQuest can recoup funds from the Provider. Once funds have been recouped, the Provider must submit the corrected claim to DentaQuest for proper processing and payment.

7.10 Receipt and Audit of Claims

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

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

7.11 Timely Payment Requirements

Clean claims received by close of business Friday and that can be auto adjudicated will be processed and paid weekly. The Provider must submit all required documentation to process a claim. Missing information will be communicated via dental remittance advice. Claims that cannot be auto adjudicated in real time may require further review by DentaQuest clinical staff. This may include UM review for circumstances requiring special treatment.

7.12 Direct Deposit

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

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

- Complete and sign the Direct Deposit Authorization Form that can be found on the website (www.DentaQuest.com).

- Attach a voided check to the form. The authorization cannot be processed without a voided check.

- Return the Direct Deposit Authorization Form and voided check to DentaQuest.

  Via Mail:
  DentaQuest, LLC - ATTN: Provider Updates
  PO Box 2906
  Milwaukee, WI 53201-2906

  Via Fax:
  (262) 241-4077

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

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

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP).

Providers may access their remittance statements by following these steps:

Steps:

1. Login to the PWP at www.DentaQuest.com
2. Once you have entered the website, click on the “Dentist” icon. From there, choose your “State” and press go.
3. Log in using your password and ID.
4. Once logged in, select “Claims/Pre-Authorizations” and then “Remittance Advice Search.”
5. The remittance will be displayed on the screen.

7.13 Provider Self Reporting- of Overpayments

Reporting Requirements

Network Providers must follow the requirements in **42 C.F.R. § 438.608(d)(2)** for reporting and returning overpayments. Providers must:

- **Report the overpayment** to the Contractor as soon as it is identified.
- **Return the full overpayment amount** to the Contractor **within 60 days** from the date the overpayment was identified.
- **Submit a written explanation** to the Contractor describing the **reason for the overpayment.**

Reporting Mechanism

Providers are expected to send all overpayment information to 11100 W Liberty Drive Milwaukee, WI 53224.

8.00 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:

- 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 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 from 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 recognized by the American Dental Association’s (ADA) Current Dental Terminology (CDT) codes. Effectively, 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 claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Services Department at (866) 515-6981 or via e-mail at denelig.benefits@DentaQuest.com.

8.01 HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.DentaQuest.com. Once you have entered the website, click "LOGIN" in the top right corner. You will then be able to log in using your ID and password. Once you have logged in, click on the link named "Related Documents" where you will find the HIPAA Companion Guide (located under the picture on the right-hand side of the screen).

9.00 MEMBER & PROVIDER GRIEVANCES & APPEALS

DentaQuest adheres to State, Federal, and Plan requirements related to processing inquiries, complaints, and grievances. Enrollees may have the right to request continuation of benefits while utilizing the grievance and appeal system. Unless otherwise required by Agency and Plan, DentaQuest's processes such grievances and appeals consistent with the following:

A. Definitions:

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the Quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrolled Member's rights regardless of whether remedial action is requested. Grievance includes an Enrolled Member's right to dispute an extension of time proposed by DentaQuest to make an authorization decision. See: 42 C.F.R. § 438.400(b). {From CMSC}.

Appeal: An appeal is a review of DentaQuest of an Adverse Benefit Determination, pursuant to 42 CFR 438.400(b).

DentaQuest Standards response times for Member/Provider Grievances and Appeals		
Process	Turn Around Time (Calendar Days / Hours)	Who Can File
Provider Appeal (Internal Only)	30 days	Provider (internal DentaQuest only)
Member Appeal – Standard	30 days from receipt	Member or Authorized Representative
Member Appeal – Expedited	72 hours from receipt	Member or Authorized Representative
Acknowledge Receipt of Grievance or Appeal	3 Business days	Authorized Representative
Appeal Extensions (Standard or Expedited)	+14 days (Member request OR Member interest justification)	DentaQuest or Member
Member Grievance – Standard	30 days from receipt (Iowa contract requirement)	Member or Authorized Representative
Member Grievance – Expedited	72 hours	Member or Authorized Representative
State Fair Hearing	120 days from the Member Appeal Determination	Members only (NOT Providers)

B. Grievance Staff:

DentaQuest's Grievance Specialist receives Member and Provider inquiries, grievances, and appeals. DentaQuest's Grievance Specialist has office hours from Monday through Friday, 8:00am CST to 5:30pm CST. The specialist investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the dental consultant for review and determination (if applicable), and obtains a resolution. The appropriate individuals are notified in writing of the resolution (i.e., DentaQuest, Member, and Provider as applicable), and the grievance is closed and maintained on file for tracking and trending purposes.

The Grievance Specialist receives Member and Provider grievances. The specialist requests appropriate documentation and forwards the documentation to the dental consultant for review and determination. The decision to uphold or overturn the initial decision is communicated to the appropriate individuals. Contact information for DentaQuest is detailed in Section E below.

Provider shall comply with the grievance and appeals processes for the applicable program as set forth in the DentaQuest Office Reference Manual. To cooperate and provide, DentaQuest, government agencies and any external review organizations ("Oversight Entities") with access to each Member's dental records at no cost to the

requesting agency within 24 hours of the request for the purposes of quality assessment, service utilization and quality improvement, investigation of Member Grievances or as otherwise is necessary or appropriate.

C. Provider Grievances/Appeals/Dispute:

Contracted Providers have the right to file an internal appeal with DentaQuest when a claim, prior authorization, prepayment review request, or referral determination is denied. Provider appeals are limited to one internal level and cannot be escalated to a State Fair Hearing under Iowa Medicaid rules. Provider appeals follow the same standard timeframe required for plan-level appeals.

Step 1: Prepare the Appeal Request
Providers must submit a **written appeal request**. The appeal must include:

- Provider name, NPI, Tax ID, mailing address, and phone number
- Member name, Member ID, and date(s) of service
- Claim number or authorization number at issue
- A copy of the Explanation of Benefits (EOB) or denial notice
- A detailed narrative explaining why the denial should be overturned
- Supporting clinical documentation, such as:
    - Radiographs
    - Periodontal charting
    - Clinical notes
    - Treatment plans
    - Any documentation required per the procedure's review criteria
    - Incomplete submissions may delay processing.

Step 2: Submit the Appeal
Appeals must be submitted **by mail or fax** to:
DentaQuest – Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: (262) 834-3452

Providers may also call **(866) 515-6981** (Monday–Friday, 8:00 AM–5:30 PM CST) for questions about filing an appeal but appeals themselves must be submitted **in writing.**

Step 3: Timeliness Requirement
Provider appeals must be submitted **within 60 calendar days** of the denial notice, unless otherwise stated by contract or program requirements.

DentaQuest will review and issue a written decision on the Provider's appeal within 30 calendar days from the date the appeal is received.

Step 4: Appeal Review

- Appeals are reviewed by clinical or administrative staff not involved in the original

decision.
- All documentation submitted is evaluated based on Medicaid regulations, clinical guidelines, and contractual requirements.
- If additional information is required, DentaQuest may contact the Provider; delays in receiving requested documents may affect determination of timeframes.

Step 5: Determination Notice
DentaQuest will issue a written appeal determination to the Provider. The written notice will include:
- Whether the denial is upheld or overturned
- The clinical or administrative rationale for the decision
- Any next steps (e.g., claim reprocessing) if the denial is overturned
- This notice satisfies the plan's final internal step. Provider appeals cannot be escalated to a State Fair Hearing.

How to File an Appeal on behalf of the Member

Standard Appeal (Written) Mail:
DentaQuest
Attn: Appeals
PO Box 8206
Des Moines, IA 50301
Fax: (262) 387-3734

Expedited Appeal (**Urgent**)
Phone: (866) 629-6074(TTY: 711)
Hours: Monday–Friday, 8:30 AM–5:30 PM CST
Fax (Expedited Only): (855) 221-0046

The Provider may request an expedited appeal on behalf of the member if waiting for a standard decision could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

Member Appeal Timeframes
- Standard Appeal Must be resolved within 30 calendar days of receipt.
- Expedited Appeal Must be resolved within 72 hours of receipt.
- Extensions (Both Standard & Expedited) DentaQuest may extend the timeframe by up to 14 calendar days if: The Member requests the extension or DentaQuest determines additional information is needed and the delay is in the Member's best interest If DentaQuest initiates the extension (in writing).
- The Provider or authorized representative acting on behalf of the Enrolled Member, as State law permits, may file an Appeal to the Contractor within sixty (60) Days from the date on the Adverse Benefit Determination Notice.

Appeal Steps

1. Appeal Filed: Provider submits appeal orally or in writing, on behalf of the Member.
2. Acknowledgment: DentaQuest acknowledges receipt and begins review.
3. Review: Conducted by clinical staff, not involved in the original decision.
4. All submitted documentation must be considered.
5. Decision Issued: A Written Notice of Appeal Decision is sent to the Member within required timeframes:
   - Standard: 30 days from receipt
   Expedited: Within 72 hours
   Appeal Extensions (Standard or Expedited): +14 days
6. Right to State Fair Hearing: If the Member disagrees with the appeal outcome, they may request a State Fair Hearing within 120 days of the appeal decision.

D. Provider Grievances concerning non-claims issue:

Provider Grievance (Non-Claims Issues)
A grievance is a non-claims related issue such as customer service, Provider directory errors, administrative problems, incorrect contact information, or operational concerns.

How to File a Grievance
Providers may submit a written grievance **at any time** for issues **not related to claims** or adverse benefit determinations.

Grievance Resolution Steps & Time Frames
DentaQuest will:

1. Acknowledge receipt in writing within three (3) business days, including the expected resolution date.
2. Resolve the grievance within thirty (30) calendar days of receipt.

E. Member Grievances/Appeals:

A Member Appeal is a request to review an Adverse Benefit Determination (ABD) such as:

- Denial or limited authorization of a requested service
- Reduction, suspension, or termination of a previously authorized service
- Denial of payment for a service
- Failure to provide services timely
- Failure to meet required appeal timelines

Members or their authorized representatives may file appeals orally or in writing.

How Members File an Appeal

Standard Appeal (Written) Mail:
DentaQuest

Attn: Appeals
PO Box 8206
Des Moines, IA 50301
Fax: (262) 387-3734

Expedited Appeal (**Urgent**)
Phone: (866) 629-6074(TTY: 711)
Hours: Monday–Friday, 8:30 AM–5:30 PM CST
Fax (Expedited Only): (855) 221-0046

Members may request an expedited appeal if waiting for a standard decision could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

Member Appeal Timeframes

- Standard Appeal Must be resolved within 30 calendar days of receipt.
- Expedited Appeal Must be resolved within 72 hours of receipt.
- Extensions (Both Standard & Expedited) DentaQuest may extend the timeframe by up to 14 calendar days if: The Member requests the extension or DentaQuest determines additional information is needed and the delay is in the Member's best interest If DentaQuest initiates the extension (in writing).
- Standard Appeal Must be submitted within 60 calendar days from the Adverse Benefit Determination Notice.

Appeal Steps

7. Appeal Filed: Member submits appeal orally or in writing.
8. Acknowledgment: DentaQuest acknowledges receipt within 3 calendar days and begins review.
9. Review: Conducted by clinical staff, not involved in the original decision.
10. All submitted documentation must be considered.
11. Decision Issued: A Written Notice of Appeal Decision is sent to the Member within required timeframes:
    - Standard: 30 days from receipt
    Expedited: Within 72 hours
    Appeal Extensions (Standard or Expedited): +14 days
12. Right to State Fair Hearing: If the Member disagrees with the appeal outcome, they may request a State Fair Hearing within 120 days of the appeal decision.

Member Grievances

A Member Grievance is an expression of dissatisfaction about any matter other than Adverse Benefit Determination (ABD). Examples:

- Quality of care concerns
- Customer service issues
- Provider behavior concerns
- Access-to-care issues (not related to ABD) Members may file grievances orally or in writing.

How to File a Member Grievance

Mail:
DentaQuest
Attn: Grievances
PO Box 8206
Des Moines, IA 50301

Fax: (262) 387-3734
Phone: (866) 629-6074 (TTY: 711)
Hours: Monday–Friday, 8:30 AM–5:30 PM CST

Member Grievance Timeframes (TATs)

- **Standard Grievance** - Must be resolved within **30 calendar days** of receipt

- **Expedited Grievance** - When a delay could seriously jeopardize the Member's health, Iowa requires an expedited grievance process. Must be resolved within **72 hours.**

Member Grievance Steps

1. Grievance Submitted: Member files grievance verbally or in writing.
2. Acknowledgment: DentaQuest logs the grievance, sends acknowledgement within 3 calendar days and begins review.
3. Review:
    a) Conducted by staff not involved in the issue.
    b) All verbal and written information must be considered.
4. Decision Issued: DentaQuest sends a written resolution notice within:
    a) 30 calendar days for standard grievances
    b) 72 hours for expedited grievances
5. No State Fair Hearing for Grievances. Members cannot request a State Fair Hearing for a grievance

F. Policy and Procedures:

Copies of DentaQuest's policies and procedures can be requested by contacting Provider Services at (866) 515-6981.

10.00 UTILIZATION MANAGEMENT PROGRAM

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state, or federal government. The source of dollars varies depending on the program. For example, in traditional insurance, the dentist's reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to the dentists as well as the fees for

each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These “budgeted” dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

UM decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff Member supports, or tends to support, denial of benefits.

There will be no payment for Provider-preventable conditions. DentaQuest must ensure its Provider Contracts contain language requiring Providers to report to DentaQuest the following events: the wrong surgical or other invasive procedure performed on a Dental Member; surgical or other invasive procedure performed on the wrong tooth; or surgical or other invasive procedure performed on the wrong patient.

10.01 Community Practice Patterns

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

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

10.02 Evaluation

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

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

10.03 Results

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

10.04 Fraud and Abuse

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

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

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

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

Member Fraud: If a Provider suspects a Member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.
Health care fraud and abuse occurs when someone knowingly submits or helps someone else submit false information related to a health care claim. Typical examples include:

- Filing claims for services not provided
- Forgoing receipts for altering information on original receipts
- Embellishing or lying about services provided or received
- Borrowing a subscriber's health plan identification card
- Altering of diagnosis or other records
- Billing for a more costly service than was performed (upcoding) or billing each stage of a procedure separately (unbundling)

The Utilization Review department performs compliance audits based on grievances, or as the result of a focused review.

To report suspected fraud or abuse, please contact DentaQuest's Fraud Hotline at 800-

237-9139 (or Anonymous Fraud Hotline at (866) 654-3433) or write to:

Utilization Review Department DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

Additional information on DentaQuest's fraud and abuse program can be found at: http://www.dentaquest.com/report-fraud/

All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act grievances. Also, DentaQuest has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

All services, provided directly or indirectly under the Contract, shall be performed within the borders of the United States and its territories and protectorates. This includes but is not limited to dental laboratory services. DentaQuest expects that all Providers will operate in accordance with all Medicaid rules, regulations, and policies.

10.05 Critical Incident Reporting

DentaQuest includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety, or welfare of Members. Participating Providers should:

- Identify a critical and/or advised incident. Examples include major medication error; death, major illness or injury resulting from a dental procedure; wrong surgical procedure, wrong site of wrong patient; surgical procedure to remove foreign objects remaining from a surgical procedure; involvement with law enforcement; altercations requiring surgical intervention and/or elopement/missing patient.

- Report the critical and/or adverse incident to the appropriate entity (e.g., police, adult protective services).

- Call 911 if the Member is in immediate danger.

- Report the critical and/or adverse incident to DentaQuest's Customer Service department at 1-833-479-1007 and/or your Provider Engagement Representative within 24 hours of identifying the incident. Please fill out the Critical Incident Report Form located on the next page, or you can find it on the Provider Web Portal.

- Report suspected abuse, neglect, and exploitation of a Member immediately in accordance with s.39-201 and Chapter 415, F.S.

- As a part of our commitment to Member safety, Providers must notify us of

Provider-Preventable Conditions (PPCs) associated with claims or treatments. These include preventable incidents, such as procedure site discrepancies, which may affect reimbursement of eligibility of that treatment.

DentaQuest has the right to take corrective action as needed to ensure its staff, participating Providers and direct service Providers, comply with the critical incident reporting requirements.

10.06 Quality Improvement Program

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

- Provider credentialing and recredentialing.
- Member satisfaction surveys.
- Provider satisfaction surveys.
- Random Chart Audits.
- Grievances: Monitoring and Trending.
- Peer Review Process.
- Utilization Management and practice patterns.
- Initial Site Reviews and Dental Record Reviews.
- Quarterly Quality Indicator tracking (i.e., grievance 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 Services Department at (866) 515-6981 or via e-mail at **denelig.benefits@DentaQuest.com**.

11.00 CREDENTIALING

DentaQuest's credentialing process adheres to the National Committee for Quality Assurance (NCQA) guidelines and plan requirements for Iowa Medicaid enrolled Providers.

DentaQuest will notify Providers **within seven (7) calendar days** if a credentialing application is incomplete or if additional information is required to continue processing. Notifications will include the specific missing items and instructions for submission.

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

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

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

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

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

The following internal DentaQuest policies govern our credentialing processes:

- Discipline of Providers (Policy 300.013)

- Procedures for Discipline and Termination (Policies 300.017-300.021)300.004 & 300.013 Recredentialing (Policy 300.009)

Network Providers are recredentialed at least every 36 months.

Note: The policies are available upon request by contacting DentaQuest's Provider Services Department at (866) 515-6981or via e-mail at **denelig.benefits@DentaQuest.com.**

DentaQuest follows Iowa Medicaid requirements for timely processing of credentialing applications. The following performance metrics apply to all initial credentialing and recredentialing files:

- **At least 85%** of complete credentialing files will be processed **within thirty (30) calendar days** of receipt.

- **At least 98%** of complete credentialing files will be processed **within forty-five (45) calendar days** of receipt.

- **100%** of complete credentialing files will be processed **within sixty (60) calendar days** of receipt.

A credentialing file is considered complete when all required documentation has been received, including Iowa Medicaid enrollment verification, applicable licensure, DEA (if required), malpractice coverage information, work history, disclosure questions, and any

other documents requested by DentaQuest to complete the file.

Providers may continue providing covered services only as permitted under Iowa Medicaid rules and DentaQuest requirements until credentialing is completed, and participation status is confirmed.

12.00 TERMINATION

DentaQuest at any time may terminate a Provider for cause or at will for no cause.

If a Provider wishes to drop out of a plan, he or she must give DentaQuest sixty (60) days written notice prior to discontinuing seeing Members. Additionally, the Provider must complete any procedures that are in progress or assist DentaQuest in transferring Members to another DentaQuest Provider.

13.00 THE PATIENT RECORD

A. Organization

1. The record must have areas for documentation of the following information:
   - Registration data including a complete health history
   - Medical alert predominantly displayed inside chart jacket
   - Initial examination data
   - Radiographs
   - Periodontal and Occlusal status
   - Treatment plan/Alternative treatment plan
   - Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations
   - 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:
   - Health history
   - Medical alert
   - Examination/Recall data
   - Periodontal status
   - 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:
   - Patient's first and last name
   - Date of birth
   - Sex
   - Address
   - Telephone number
   - Name and telephone number of the person to contact in case of emergency
   - Information regarding the primary language of the Enrollee
   - Information related to the Members' needs for translation services

2. An adequate health history that requires documentation of these items:
   - Current medical treatment
   - Significant past illnesses
   - Current medications
   - Drug allergies
   - Hematologic disorders
   - Cardiovascular disorders
   - Respiratory disorders
   - Endocrine disorders
   - Communicable diseases
   - Neurologic disorders
   - Signature and date by patient
   - Signature and date by reviewing dentist
   - History of alcohol and/or tobacco usage including smokeless tobacco, and drugs/substances
   - Summary of significant surgical procedures.
   - Treating Provider's signature and/or initials must be documented on each date of service
   - Treating Provider's signature and/or initials must contain the professional designation (e.g., DDS, DMD, RDH, CDA)

3. An adequate update of health history at subsequent recall examinations which require documentation of these items:
   - Significant changes in health status
   - Current medical treatment
   - Current medications
   - Dental problems/concerns
   - Signature and date by reviewing dentist

4. A conspicuously placed medical alert inside the chart jacket that documents

highly significant terms from health history. These items are:
- Health problems which contraindicate certain types of dental treatment
- Health problems that require precautions or pre-medication prior to dental treatment
- Current medications that may contraindicate the use of certain types of drugs or dental treatment
- Drug sensitivities
- 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:
   - Blood pressure (Recommended)
   - Head/neck examination
   - Soft tissue examination
   - Periodontal assessment
   - Occlusal classification
   - 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:
   - Blood pressure (Recommended)
   - Head/neck examination
   - Soft tissue examination
   - Periodontal assessment
   - Dentition charting

7. Radiographs which are:
   - Identified by patient name
   - Dated
   - Designated by patient's left and right side
   - 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:
   - Procedure
   - 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:
    - Periodontal pocket depth
    - Furcation involvement

- Mobility
- Recession
- Adequacy of attached gingiva
- Missing teeth

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:
    - Gingival status
    - Amount of plaque
    - Amount of calculus
    - Education provided to the patient.
    - Patient receptiveness/compliance
    - Recall interval.
    - Date

12. Adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:
    - Provider to whom consultation is directed.
    - Information/services requested.
    - Consultant's response

13. Adequate documentation of treatment rendered which requires entry of these items:
    - Date of service/procedure
    - Description of service, procedure, and observation. Documentation in treatment must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    - Type and dosage of anesthetics and medications given or prescribed.
    - Localization of procedure/observation. (tooth, quadrant, etc.)
    - Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:
    - Patient examination
    - Treatment plan
    - Treatment status

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient's record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.

4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted, and are commonly understood in the practice.

13.01 Electronic Health Record

The use of Electronic Health Records is highly encouraged and promotes the ease of administering the DentaQuest dental programs.

14.00 PATIENT RECALL SYSTEM REQUIREMENTS

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

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

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."

- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly for us. Thank you for your help."

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

- Contact the Member prior to the appointment to remind the individual of the time and place of the appointment.

- If the appointment is made through a government-sported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

B. Broken Appointment Program
DentaQuest utilizes multiple interventions to help improve broken appointment rates. Our approach is designed to support both Providers and Members, resulting in continuity of care and better health outcomes.

Program is dependent upon timely filing of claims. It is recommended that claims be submitted as soon as possible so Members can be contacted shortly after missing an appointment.

- Please submit a claim for a broken appointment using one of the following CDT codes:
    - D9986 Missed Appointment
    - D9987 Cancelled Appointment
    - Use Box 35 on the claim to identify a first, second, or more broken appointment.
- Missed and broken appointments will be paid by DentaQuest at $0.00. Providers may not bill Members for missed or broken appointments.
- DentaQuest will outreach to those Members with broken or missed appointments via phone and mail to remind them to reschedule, and education of not missing appointments.

C. Office Compliance Verification Procedures

- In conjunction with its office claim audits described in Section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.
- DentaQuest Dentists are expected to meet minimum standards with regard to appointment availability.
- Emergency care must be provided immediately.
- Urgent care must be available within 24 hours.
- Sick care must be available within one week.
- Routine exams must be provided within four weeks of an Enrollee's request.

Follow-up appointments must be scheduled within 30 days of the present treatment date, as appropriate.

15.00 RADIOLOGY REQUIREMENTS

Note: Please refer to benefit tables for radiograph benefit limitations

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

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

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

3. Adolescent – Permanent Dentition

Prior to the eruption of the third molars. The Panel recommends an individualized

radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

4. Adult – Dentulous

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

5. Adult – Edentulous

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

B. Radiographic Examination of the Recall Patient

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

a) Child – Primary and Transitional Dentition

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

b) Adolescent

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

c) Adult – Dentulous

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

d) Adult – Edentulous

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

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

a) Child – Primary Dentition

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

b) Adolescent

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

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

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition, Adolescent and Dentulous Adult

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

4. Growth and Development Assessment
   a) Child – Primary Dentition
   The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

   b) Child – Transitional Dentition
   The Panel recommends an individualized periapical/occlusal series OR a panoramic radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

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

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

15.01 Criteria for Radiographs

American Dental Association (ADA) and American Association of Pediatric Dentists (AAPD) guidelines promote, that the number and type of radiographs should be based on the risk level of the patient and whether or not the Provider can visualize the entire tooth. The following link describes current ADA and AAPD guidelines for radiographs.
http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_chart.pdf

Panoramic Radiograph vs. Complete Series (FMX)
It is a common occurrence for Providers to perform a panoramic film instead of a full-mouth series. Panoramic films alone are not considered sufficient for the diagnosis of decay and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. In cases where a Provider is combining a panoramic film and bitewings, the benefit will equal that of a full mouth series. This down-paying of services aligns with OHCA's guidelines and the concept of medical necessity (reflective

of the level of service that can be furnished safely and for which not equally effective and more conservative or less costly treatment is available statewide) and, according to the ADA, is a result of requests from the dental community. See Reimbursement of Services Rendered section below.This section details OHCA's guidance on reimbursement of services.

16.00 CLINICAL CRITERIA AND CLINICAL PRACTICE GUIDELINES

Clinical Practice Guidelines
The adopted Clinical Practice Guidelines serve as a resource for dental professionals to guide clinical decisions through the incorporation of evidence-based practices. The clinical practice guidelines help optimize the Member's care within the state of Iowa. DentaQuest's clinical practice guidelines are evidence-based and supported by national dental specialty organizations. They are reviewed and updated in consultation with network providers.

Provider and Member education materials may include the highlighting or focused discussion of individual clinical practice guidelines to support understanding of guideline intent, clinical application, and relevance to the Iowa Medicaid population.

Learn More: You can view our recommended guidelines at Dental Providers |Iowa Dental Providers | DentaQuest and scroll down to our DentaQuest Dental Clinical Criteria & Guidelines section.

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. If radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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

Failure to submit the required documentation on claims may result in a disallowed request and/or a denied payment of a claim related to that request. Prior authorization is required for all orthodontic treatment and implants. Some services require additional documentation with the claim, which is called pre-payment review. These services are detailed in Benefits Tables in the designated columns.

For all procedures, every Provider in the DentaQuest program is subject to random chart/treatment audits. Providers are required to comply with any request for records.

These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest Providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the Patient Record section for more details.

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.

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

The clinical criteria presented in this section are the criteria that DentaQuest will use for making medical necessity determinations for prior authorizations, post payment review, and retrospective review. In addition, please review the general benefit limitations presented in Benefit Tables of this manual for additional information on medical necessity on a per code basis.

These criteria were formulated from information gathered from clinical practice guidelines, practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, dental specialty organizations, Iowa HHS Dental Services Provider Manual, and Iowa Administrative Code. They are designed as guidelines for review and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation. We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria are both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members, and we appreciate your participation in the program.

16.01 Preventive Services

Payment shall be made for the following diagnostic services:

- Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six month period except for persons who, because of a physical or mental condition, need more frequent care. When that's applicable, please enter **"HIGH RISK CONDITION"** in Box 35. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.
- Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)
- Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on Members through 18 years of age and on Members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. When that's applicable, please enter **"HIGH RISK CONDITION"** in Box 35. Documentation supporting the need for sealants on adult members and their corresponding medical condition must be maintained.
- Replacement sealants are covered when medically necessary, as documented in the patient record.
- Space management services are payable for persons 0 through 20 when:
    - Premature loss of teeth would permit existing teeth to shift causing a handicapping malocclusion, or
    - There is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if not corrected.
    - Recementing of space maintainers is reimbursable to a Provider who was not the original treating Provider. Payment to another Provider can only be made after 90 days of the initial placement. This service is limited to children 14 years of age and younger.
- Removal of a fixed space maintainer is payable when performed by a dentist or practice that did not originally provide the appliance.

16.02 Diagnostic Services

Payment shall be made for the following diagnostic services:

- A comprehensive oral evaluation is payable once per Member per dental practice in a three-year period when the Member has not been seen by a dentist in the dental practice during the three-year period.

- A periodic oral examination is payable once in a six-month period.

- A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bitewing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bitewings is considered the

same as a full mouth radiograph survey.

- Supplemental bitewing films are payable only once in a 12-month period.
- Single periapical films are payable when necessary.
- Intraoral radiograph, occlusal.
- Extraoral radiograph.
- Posterior-anterior and lateral skull and facial bone radiograph, survey film.
- Temporomandibular joint radiograph.
- Cephalometric film.
- Diagnostic casts are payable only for orthodontic cases, dental implants, or when requested by a dental consultant.
- Cone beam images may be appropriate when conventional imaging is insufficient to evaluate for needed services and are reimbursable when medically necessary. Documentation of the medical necessity must be submitted with the claim. Examples include:
    - Detection of tumors
    - Positioning of severely impacted teeth
    - Supernumerary teeth
    - Skeletal fracture

  Cone beam images for placement of dental implants are covered only when prior authorization approval for implants has been obtained

16.03 Restorative Services

Payment shall be made for the following restorative services:

- Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.
- Restorations for altering occlusion, altering vertical dimension, or replacing lost tooth structure from attrition, erosion, abrasion, abfraction, corrosion are not reimbursable.
- Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

- Crowns are payable when there is at least a fair prognosis for maintaining the tooth as and a more conservative procedure would not be serviceable.

- **Stainless steel crowns** are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. 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.

- Placement of stainless steel crowns on permanent posterior teeth is allowed only for Members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown. Stainless Steel Crowns on permanent teeth are expected to last five years.

- Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

- 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, and crowns are being planned to alter vertical dimension.

- **Laboratory-fabricated crowns,** other than stainless steel, are limited to permanent teeth and require either prior authorization or prepayment review. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp, or an endodontic treatment.

- In determining the extent of structural loss for crowns, teeth should exhibit the following:
    - Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces or one or more cusps.
    - Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces or one or more cusps.
    - 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.

- Crowns with noble or high noble metals require either prior authorization or prepayment review. Approval shall be granted for Members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

- Crowns for teeth with suspected cracked tooth syndrome will be reviewed with a supporting tooth specific narrative documenting diagnosis, specific cusp involved, character, frequency, and type of sensitivity. Percussion, palpation, thermal testing, and bite tests are required. Crowns are not benefited that are preventative in nature such as to prevent unpredictable or possible future fractures or to eliminate crack or craze lines in the absence of pathology.

- Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

- Authorizations for Crowns will not meet criteria if:
  - A lesser means of restoration is possible.
  - Tooth has subosseous and/or furcation involvement.
  - Tooth has advanced periodontal disease.
  - Tooth is a primary tooth.
  - Tooth has inadequate prior endodontic treatment and retreatment is not planned.

- Crowns are being planned to replace tooth structure lost due to wear, attrition, abfraction, abrasion, erosion, or alter vertical dimension.

- Payment as indicated will be made for the following restoration procedures:

- Amalgam or acrylic buildups, including any pins, are considered a core buildup.

- One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

- Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

- Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

- Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

- Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

- More than four surfaces on an amalgam or composite restoration will be reimbursed as a “four surface” amalgam or composite.

- An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

16.04 Periodontal Services

Payment may be made for the following periodontal services:

- Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

- Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

- Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the Member has demonstrated reasonable oral hygiene. Payment is also allowed for Members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

- Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene.

- Periodontal maintenance therapy requires either prior authorization or prepayment review. Approval shall be granted for Members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater.

- Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

- Localized delivery of antimicrobial agents requires either prior authorization or prepayment review. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the Member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

16.05 Endodontic Services

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- Authorizations for Root Canal therapy will not meet criteria if:
- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a patrial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Payment shall be made for the following endodontic services:

- Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

- Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure

has been demonstrated. Surgical endodontic procedures may be indicated when:

- Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.
- Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials.
- Endodontic retreatment when either prior authorization or prepayment review has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the Member must see a different dentist.

16.06 Oral Surgery Procedures

Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law. The following surgical procedures are payable when performed by a dentist:

- Extractions, both surgical and nonsurgical.
- Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.
- Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.
- Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.
- Root recovery (surgical removal of residual root).
- Oral antral fistula closure (or antral root recovery).
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.
- Surgical exposure of impacted or unerupted tooth to aid eruption.
- Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.
- Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.
- Removal of primary teeth whose exfoliation is imminent is not a covered benefit unless there is a documented and supported clinical indication requiring intervention. In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given. Extractions performed as part of a course of orthodontics are covered only if the orthodontic

case is a covered benefit.
- Surgical extractions of erupted teeth are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure to remove the tooth. Elevation of mucoperiosteal flap and removal of bone and/or sectioning of the tooth for the convenience of the provider is not a surgical extraction.
- Minor smoothing and contouring of ridges in conjunction with the surgical removal of a tooth is considered an inclusive part of the complete surgical extraction procedure.

16.07 Prosthetic Services

Payment may be made for the following prosthetic services:
- An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.
- A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.
- A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the Member has fewer than eight posterior teeth in occlusion, excluding third molars, or the Member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture.
- A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for Members who:
    - Have a physical or mental condition that precludes the use of a removable partial denture, or
    - Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.
    - High noble or noble metals shall be approved only when the Member is allergic to all other restorative materials.
- A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for Members who meet the criteria for a removable partial denture and:
- Have a physical or mental condition that precludes the use of a removable partial denture, or
- Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.
- High noble or noble metals will be approved only when the Member is allergic to all other restorative materials.
- Obturator for surgically excised palatal tissue or deficient velopharyngeal function

of cleft palate patients.

- Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.
- Tissue conditioning is a payable service twice per prosthesis in a 12-month period.
- Two repairs per prosthesis in a 12-month period are payable.
- Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.
- Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the Member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.
- Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for Members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.
- A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.
- An oral appliance for obstructive sleep apnea requires prior approval and must be custom fabricated. Approval shall be granted in accordance with Medicare criteria
- An oral device or appliance that is custom fabricated by a dentist and used to reduce upper airway collapsibility is covered when the Member has a diagnosis of obstructive sleep apnea. This is a benefit through a Member's medical insurance even though the device must be custom fabricated by a dentist.

16.08 Orthodontic Procedures

Reference: Dental Services Provider Manual Iowa HHS

Payment may be made for the following orthodontic procedures:

- Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

- The following procedure codes may be billed as removable or fixed and would be indicated for a Member with a thumb sucking or tongue thrusting harmful habit.
    - D8210 removable appliance therapy

- D8220 fixed appliance therapy

The request for prior authorization must be accompanied with:

- Current diagnostic quality photograph of applicable clinical area
- Narrative describing nature and scope of harmful habit

Orthodontic Records (for use with limited and comprehensive treatments):

The following procedure codes may be billed for orthodontic records. These are paid separately than orthodontic treatment, need to be billed individually, and do not require a prior authorization.

- D0330 panoramic radiographic image or
- D0210 intraoral complete series of radiographic images and
- D0340 2D cephalometric radiographic image-acquisition, measurement and analysis
- D0470 diagnostic casts
- Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.
- Comprehensive orthodontic treatment shall be granted when the Member meets medical necessity by one of the Automatic Qualifying Conditions established by Iowa Medicaid and are as follows:
  - Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology
  - Overjet: 9 mm of more
  - Reverse Overjet: 3.5 mm or more
  - Anterior and/or Posterior crossbite of three or more teeth per arch
  - Lateral or anterior open bite of 2 mm or more on at least four teeth per arch
  - Impinging overbite with evidence of occlusal contact into the opposing soft tissue
  - Impaction where eruption is impeded but extraction is not indicated (excluding third molars)
  - Two or more congenitally missing teeth of at least one tooth per quadrant(excluding third molars)
  - Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars)

Providers must refer to the Iowa Medicaid Dental Wellness Plan, Dental Wellness Plan Kids and Hawki Orthodontic Administrative Guide for complete details on orthodontic coverage. - https://hhs.iowa.gov/media/10611/download?inline"

16.09 Adjunctive Services

Payment may be made for the following:

- Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized Member only when the mental, physical, or emotional condition of the Member prevents the dentist from providing necessary care in the office.
- Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.
- Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.
- Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.
- Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise Provider services unit. Payment will not be made for the writing of prescriptions.
- Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Requires appropriate monitoring by a properly licensed Provider who is acting in compliance with appliable State rules and regulations. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the Member necessitates the use of minimal sedation for dental procedures.
    - Administration of anesthesia is subjected to rounding rules. For codes that use a 15-minute definition, Providers shall round 1 to 7 minutes down to zero units and round 8 to 14 minutes up to one unit, 15-22 minutes down to 1 unit, 23-30 up to 2 units and so on.
- Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain

16.10 Orthodontic Services (Members age 21 and older)

Reference: Iowa Administrative Code 441-78.4(10)

Orthodontic procedures are not covered for Members 21 years of age or older.

16.11 Emergency Services

Reference: Iowa Administrative Code 441-78.4(11); Iowa Administrative Code 441-73.7(249A)

Payment shall be made for emergency services, as defined in and pursuant to the requirements set forth in 42 CFR 438.114

DentaQuest will:

- Cover emergency services without the need for prior authorization and shall not limit reimbursement to network Providers.
- Cover and pay for emergency services regardless of whether the Provider that furnishes the services is enrolled with Iowa Medicaid or has a contract with DentaQuest.
- Pay non-contracted Providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.
- Cover the medical screening examination provided to a Member who presents to an emergency department with an emergency medical condition.

DentaQuest will not deny payment for:

- Treatment obtained when an Enrollee has an emergency medical condition.
- Treatment obtained when a DentaQuest representative instructs the Enrollee to seek emergency services

Coverage and payment

Emergency services.

An Enrollee who has an emergency medical condition will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on DentaQuest.

Post stabilization care services.

(1) Post stabilization care services are covered and paid in accordance with 42 CFR 422.113(c)

16.12 Annual Benefit Maximum

Reference: Iowa Administrative Code 441-78.4(12)

Members 21 years of age or older have an annual benefit maximum of $1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the $1,000 annual benefit maximum is the responsibility of the Member.

There are exclusions to an adult Medicaid Member's $1,000 ABM, which include:

- Preventive and diagnostic services
- Anesthesia (when billed in conjunction with approved oral surgery procedures)
- The fabrication of dentures and removable partial dentures.
- Emergent dental services. Providers must identify when services are being provided as emergent for exclusion to the Members ABM.

Please Note: Members 19 & 20 in DWP and DWP Kids 0-18 are not subject to an ABM.

A comprehensive list of codes excluded from a Member's ABM can be found on the Dental Wellness Plan webpage - IA HHS Dental Services Provider Manual

17.00 CULTURAL COMPETENCY PROGRAM

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

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

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

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

All providers will be required to attend cultural competency training that will be hosted by DentaQuest. Notification will be send via email and posted on the provider portal with times and dates.

A copy of DentaQuest's Cultural Competency Plan is available at no charge upon request by contacting DentaQuest's Provider Services Department at (866) 515-6981 or via e-mail at: denelig.benefits@DentaQuestusa.com.

18.00 REIMBURSEMENT OF SERVICES RENDERED

Reimbursement will only occur for services that are medically necessary and do not duplicate another Provider's service.

"Medically necessary" is defined as services that meet the following conditions:

- necessary to protect life, prevent significant illness or significant disability or alleviate severe pain
- individualized, specific, and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs
- consistent with generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- reflective of the level of service that can be furnished safely and for which not equally effective and more conservative or less costly treatment is available statewide

In addition, the services must meet the following criteria:

- The services cannot be experimental or investigational; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the Provider.

The fact that a Provider has prescribed, recommended, or approved care, goods, or services do not make such care, goods, or services medically necessary or a covered service.

Oral and Maxillofacial Program (CPT codes)
This service is considered a medical procedure and should be submitted to the Member's medical carrier with the appropriate CPT code.

APPENDIX A – ADDITIONAL RESOURCES

Welcome to the DentaQuest Provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at www.DentaQuest.com. Once you have entered the website, click" Login" located at the top right corner. You will then be able to log in using your User ID and Password. Once logged in, select the link "Related Documents" to access the following resources:

- Acknowledgment of Disclosure & Acceptance of Member Financial Responsibility Consent Form
- Authorization for Dental Treatment
- Dental Claim Form
- Direct Deposit Form
- HIPAA Companion Guide
- Initial Clinical Exam
- Medical and Dental History
- Provider Change Form
- Recall Examination Form
- Request for Transfer of Records
- Incident Report Form

APPENDIX B – LINKS TO ONLINE HIPAA RESOURCES

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Dental Association (ADA)

- The Dental Content Committee develops and maintains standards for the dental claims form and dental procedures codes. www.ada.org

Association for Electronic Health Care Transactions (AFEHCT)

- A healthcare association dedicated to promoting the interchange of electronic healthcare information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/code-setshttps://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/code-sets
- This site is the resource for Medicaid HIPAA information related to the Administrative Simplification provision https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard setting of organizations, and transaction change request system. https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa/standard-setting-related-organizations

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- This site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. The WPC website is www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health care through electronic commerce, which includes the Strategic National Implementation Process (SNIP)

for complying with the administrative- simplification provisions of HIPAA.
www.wedi.org

APPENDIX C – COVERED BENEFITS MEMBER'S COVERED BENEFITS (SEE EXHIBITS)

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations for Members. Providers with benefit questions should contact DentaQuest's Provider Services Department directly at: (866) 515-6981 or visit Comm. 712, Iowa Medicaid Dental Wellness Plan Covered Services.

Dental offices are not allowed to charge Members for missed appointments. Plan DentaQuest 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 and. 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's record, which must be available as required by your Participating Provider Agreement.

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

Oral and Maxillofacial Program (CPT codes). This service is considered a medical procedure and should be submitted to the Member's medical carrier with the appropriate CPT code. The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue Chicago, IL 60611
(800) 947-4746

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

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

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

DentaQuest Review Process
(For Prior Authorization or Claims that Require Prepayment Review)

IMPORTANT

For each plan that DentaQuest administers, the plans may require review of certain procedures to ensure that procedures meet the requirements of federal and state laws and regulations and medical necessity criteria. DentaQuest performs the review using one of two processes – "prior authorization" or "prepayment review." Providers may choose either option when documentation is required to show medical necessity.

- "**Prior Authorization**" requires that the Provider obtain permission from DentaQuest prior to performing the service. "Prior Authorization" requires specific documentation to establish medical necessity or justification for the procedure.

- "**Prepayment Review**" is the review of claims by DentaQuest prior to determination and payment. The "Prepayment Review" requires documentation to establish medical necessity or justification for the procedure. For procedures that require "Prepayment Review," Providers may opt to submit a "Prior Authorization" request prior to performing the procedure. If DentaQuest approves the "Prior Authorization" request, it will satisfy the "Prepayment Review" process.

The Exhibits for each plan in the Provider Office Reference Manual indicate which procedures require Review, which type of Review, and the documentation that the Provider will need to submit to support his or her request. Utilization management decision making is based on appropriate care and service, does NOT reward for issuing denials, and does NOT offer incentives to encourage inappropriate utilization.

The information below explains how and when to submit documentation to DentaQuest. The information refers to the "Review Required," "Benefit Limitations," and "Documentation Required" fields in the Benefits Covered tables (Exhibits). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completion of treatment.

Note: Diagnostic services include the oral examination, 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 radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All working radiographs are considered all-inclusive of the billed procedure. 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 limitations. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs 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.

Iowa Medicaid Dental Wellness Plan (DWP) Adults

Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D0120	periodic oral evaluation - established patient	All ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0140	limited oral evaluation - problem focused	All ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0180) per date of service per patient.	
D0150	comprehensive oral evaluation - new or established patient	All ages		No	No	1 per 3 years, same provider or location. One of (D0120, D0150) per 6 Months per patient. Deny when submitted for the same DOS as D0145 by any provider.	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	All ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0180) per date of service per patient.	
D0180	comprehensive periodontal evaluation – new or established patient	All ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0190	screening of a patient	All ages		No	No		
D0210	intraoral – comprehensive series of radiographic images	All ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0220	intraoral - periapical first radiographic image	All ages		No	No	Limited to one service per day by the same provider OR location.	
D0230	intraoral - periapical each additional radiographic image	All ages		No	No		
D0240	intraoral - occlusal radiographic image	All ages		No	No	Limited to two services per year per patient	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	All ages		No	No	Limited to two services per year per patient	
D0251	extra-oral posterior dental radiographic image	All ages		No	No	Limited to two services per year per patient	
D0270	bitewing - single radiographic image	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0272	bitewings - two radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0273	bitewings - three radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0274	bitewings - four radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0321	other temporomandibular joint radiographic images, by report	All ages		No	No	Limited to 1 per 12 months.	
D0330	panoramic radiographic image	All ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	All ages		No	No		
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw	All ages		Yes	No		Narrative of medical necessity
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	All ages		Yes	No		Narrative of medical necessity
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	All ages		Yes	No		Narrative of medical necessity
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	All ages		Yes	No		Narrative of medical necessity
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	All ages		Yes	No		Narrative of medical necessity

Iowa Medicaid Dental Wellness Plan (DWP) Adults							
Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0383	cone beam CT image capture with field of view of both jaws; with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0384	Cone beam CT image capture for TMJ series including two or more exposures	All ages		Yes	No		Narrative of medical necessity
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	All ages		No	No		Narrative of medical necessity
D0393	Virtual treatment simulation using 3D image volume or surface scan	All ages		No	No		Narrative of medical necessity
D0394	Digital subtraction of two or more images or image volumes of the same modality	All ages		No	No		Narrative of medical necessity
D0395	Fusion of two or more 3D image volumes of one or more modalities	All ages		No	No		Narrative of medical necessity
D0460	pulp vitality tests	All ages		No	No	Limited to one service per day per patient. Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are NOT BILLABLE TO THE PATIENT when performed on the same date by the same dentist/dental office as any other definitive procedure except: limited oral evaluation – problem focused (D0140), protective restoration (D2940), palliative treatment (D9110), radiographic images (D0210 - D0391), and consultation (D9310).	
D0470	diagnostic casts	All ages		No	No	Only billable in conjunction with orthodontic services	
D0601	Caries risk assessment and documentation, with a finding of low risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0603	Caries risk assessment and documentation, with a finding of high risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0999	Unspecified diagnostic procedure, by report	All ages		No	No		Narrative of medical necessity
D1110	prophylaxis - adult	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1120	prophylaxis - child	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1206	topical application of fluoride varnish	All ages		No	No	4 of (D1206, D1208) per year.	
D1208	topical application of fluoride – excluding varnish	All ages		No	No	4 of (D1206, D1208) per year.	
D1351	sealant - per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. Reimbursement for sealants is restricted to work performed on DWP Kids members 18 years and younger and DWP adult members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1353	sealant repair – per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. Reimbursement for sealants is restricted to work performed on DWP Kids members 18 years and younger and DWP adult members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1354	application of caries arresting medicament – per tooth	All ages	1 - 32, A - T	No	No	Limited to two (2) applications per tooth in a 12-month period. Not allowed on the same date of service as D1351 or D1352 on the same tooth. Restorations placed within 90 days of D1354 are reduced by the amount of D1354 if completed by the same dentist/office.	
D1510	space maintainer - fixed, unilateral – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	
D1516	space maintainer - fixed - bilateral, maxillary	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1517	space maintainer - fixed - bilateral, mandibular	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	
D1520	space maintainer - removable, unilateral - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	
D1526	space maintainer - removable - bilateral, maxillary	0-20	Per Arch (01, 02, LA, UA)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1527	space maintainer - removable - bilateral, mandibular	0-20	Per Arch (01, 02, LA, UA)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	

Iowa Medicaid Dental Wellness Plan (DWP) Adults							
Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D1551	re-cement or re-bond bilateral space maintainer - maxillary	0-20		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1552	re-cement or re-bond bilateral space maintainer - mandibular	0-20		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1556	removal of fixed unilateral space maintainer - per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not billable by same provider or location that placed space maintainer.	
D1557	removal of fixed bilateral space maintainer - maxillary	0-20		No	No	Not billable by same provider or location that placed space maintainer.	
D1558	removal of fixed bilateral space maintainer - mandibular	0-20		No	No	Not billable by same provider or location that placed space maintainer.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose	All ages		No	No		
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose	All ages		No	No		
D1703	Moderna Covid-19 vaccine administration – first dose	All ages		No	No		
D1704	Moderna Covid-19 vaccine administration – second dose	All ages		No	No		
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	All ages		No	No		
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	All ages		No	No		
D1710	Moderna Covid-19 vaccine administration – third dose	All ages		No	No		
D1711	Moderna Covid-19 vaccine administration – booster dose	All ages		No	No		
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	All ages		No	No		
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	All ages		No	No		
D1999	Unspecified preventive procedure, by report	All ages		No	No		Narrative of medical necessity
D2140	Amalgam - one surface, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2330	resin-based composite - one surface, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2331	resin-based composite - two surfaces, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2332	resin-based composite - three surfaces, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2335	resin-based composite - four or more surfaces (anterior)	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2390	resin-based composite crown, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2391	resin-based composite – one surface, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2392	resin-based composite - two surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2393	resin-based composite - three surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2394	resin-based composite - four or more surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2710	crown - resin-based composite (indirect)	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D2712	crown - ¾ resin-based composite (indirect)	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2720	crown - resin with high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2721	crown - resin with predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2740	crown - porcelain/ceramic	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2750	crown - porcelain fused to high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2751	crown - porcelain fused to predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2752	crown - porcelain fused to noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2781	crown - 3/4 cast predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2790	crown - full cast high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2791	crown - full cast predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2792	crown - full cast noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	All ages	1-32	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	All ages	1-32	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2920	re-cement or re-bond crown	All ages	1 - 32, A - T	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2921	Reattachment of tooth fragment, incisal edge or cusp	All ages	1-32	No	No	Limited to 1 per 24 months.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	All ages	1-32	No	No	Limited to 1 per 24 months.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	All ages	A - T	No	No	Limited to 1 per 24 months.	
D2930	prefabricated stainless steel crown - primary tooth	All ages	A - T	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2931	prefabricated stainless steel crown - permanent tooth	All ages	1-32	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2932	prefabricated resin crown	All ages	1-32, C-H, M-R	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2933	prefabricated stainless steel crown with resin window	All ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	All ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2940	placement of interim direct restoration	All ages	1 - 32, A - T	No	No	Not allowed with any restorative codes D2000-D2999, bridge codes D6200- D6699, or endodontic codes D3220-D3330, D3346-D3353, D3410- D3450 and extraction codes D7111-D7251.	
D2950	core buildup, including any pins when required	All ages	1-32	No	No	Limited to one service of D2950 per 5 years, per patient, per tooth. Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2951	pin retention - per tooth, in addition to restoration	All ages	1-32	No	No	Limited to one (D2951) per lifetime, per patient, per tooth. Not allowed on primary teeth.	
D2952	post and core in addition to crown, indirectly fabricated	All ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2954	prefabricated post and core in addition to crown	All ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2971	additional procedures to customize a crown to fit under an existing partial denture framework	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)

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D2976	band stabilization – per tooth	All ages	1-32	No	No		
D2980	crown repair necessitated by restorative material failure	All ages	1-32	No	No		
D2990	Resin infiltration of incipient smooth surface lesions	All ages	1-32	No	No	Once per tooth per lifetime.	
D2999	unspecified restorative procedure, by report	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	All ages	1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3221	pulpal debridement, primary and permanent teeth	All ages	1 - 32, A - T	No	No	One of (D3221) per 1 Lifetime Per patient per tooth. The fee for gross pulpal debridement is not billable when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. This will not be paid as phase 1 of a 2-phase root canal process. When the final endo therapy (3310, 3320, 3330) is completed within 60 days (by the same DDS/clinic) of debridement (3221), and narrative supports the 3221 was the start of endo, a fee reduction will occur.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	All ages	1-32	No	No	One of (D3222) per 1 Lifetime Per patient per tooth. The fee for D3222 when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351- D3353 is NOT BILLABLE TO THE PATIENT. The fee for partial pulpotomy for apexogenesis is NOT BILLABLE TO THE PATIENT when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	All ages	6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	All ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	All ages	1-32	No	No	One of (D3332) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3346	retreatment of previous root canal therapy - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	All ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3348	retreatment of previous root canal therapy - molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	All ages	1-32	No	No	One of (D3351) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3352	apexification/recalcification – interim medication replacement	All ages	1-32	No	No	One of (D3352) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	All ages	1-32	No	No	One of (D3353) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3355	Pulpal regeneration - initial visit	All ages	1-32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3356	Pulpal regeneration - interim medication replacement	All ages	1-32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3357	Pulpal regeneration - completion of treatment	All ages	1-32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3410	apicoectomy - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3421	apicoectomy - premolar (first root)	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3425	apicoectomy - molar (first root)	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3425) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3426	apicoectomy (each additional root)	All ages	1-5, 12-21, 28-32	No	No	One of (D3426) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3430	retrograde filling - per root	All ages	1-32	No	No	One of (D3430) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3450	root amputation - per root	All ages	1-32	No	No	One of (D3450) per 1 Lifetime Per patient per tooth. A separate fee for root amputation is NOT BILLABLE TO THE PATIENT when performed in conjunction with an apicoectomy by the same dentist/dental office.	narrative of med. necessity, pre-op x-ray(s)
D3471	surgical repair of root resorption - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3472	surgical repair of root resorption – premolar	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3473	surgical repair of root resorption – molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)

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D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3921	decoronation or submergence of an erupted tooth	All ages	1-32	No	No	One of (D3921) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3999	unspecified endodontic procedure, by report	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	All ages	1 - 32, 51 - 82	No	No	Limit to one service of (D4210, D4211,4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4245	apically positioned flap	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4245) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4249	clinical crown lengthening – hard tissue	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4249) every 24 months, per patient, per quadrant. Definitive crown codes are not reimbursable on the same tooth within 41 days following clinical crown lengthening.	Perio Charting, pre-op radiographs and narr of med necessity
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	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	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4263	bone replacement graft – retained natural tooth – first site in quadrant	All ages	1-32	Yes	No	Limit to one service of (D4263) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	All ages	1-32	Yes	No	Limit to one service of (D4264) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	All ages	1-32	Yes	No	Limit to one service of (D4265) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	All ages	1-32	Yes	No	Limit to one service of (D4266) every 24 months, per patient, per quadrant	Perio Charting, pre-op radiographs and narr of med necessity
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	All ages	1-32	Yes	No	Limit to one service of (D4267) every 24 months, per patient, per quadrant	Perio Charting, pre-op radiographs and narr of med necessity
D4270	pedicle soft tissue graft procedure	All ages	1-32	Yes	No	Limit to one service of (D4270) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	All ages	1-32	Yes	No	Limit to one service of (D4273) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	All ages	1-32	Yes	No	Limit to one service of (D4275) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4276	combined connective tissue and pedicle graft, per tooth	All ages	1-32	Yes	No	Limit to one service of (D4276) every 24 months, per patient, per quadrant	Perio Charting, xray (s), and narr of med necessity. Photos, if available.
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4277) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.

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D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4278) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4283) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4285) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4286	removal of non-resorbable barrier	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4286) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity
D4341	periodontal scaling and root planing - four or more teeth per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	All ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	All ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	All ages		No	No		Narrative of medical necessity
D4910	periodontal maintenance	All ages		No	No	Limit to one service per 3 months, per patient. Not billable within 3 months of scaling and root planing (D4341, D4342).	
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	All ages		No	No		
D4999	unspecified periodontal procedure, by report	All ages		No	No		Narrative of medical necessity
D5110	complete denture - maxillary	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient. One D5130 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient. One D5140 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative 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)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative 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)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	

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D5411	adjust complete denture - mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5511	repair broken complete denture base, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5512	repair broken complete denture base, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5520	replace missing or broken teeth – complete denture – per tooth	All ages		No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5611	repair resin partial denture base, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5612	repair resin partial denture base, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5621	repair cast partial framework, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5622	repair cast partial framework, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5630	repair or replace broken retentive clasping materials – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5640	replace missing or broken teeth – partial denture – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5650	add tooth to existing partial denture – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5660	add clasp to existing partial denture - per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5710	rebase complete maxillary denture	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5711	rebase complete mandibular denture	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5720	rebase maxillary partial denture	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5721	rebase mandibular partial denture	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (direct)	All ages	~~1-32~~	No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5731	reline complete mandibular denture (direct)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5740	reline maxillary partial denture (direct)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5741	reline mandibular partial denture (direct)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5750	reline complete maxillary denture (indirect)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5751	reline complete mandibular denture (indirect)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5760	reline maxillary partial denture (indirect)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5761	reline mandibular partial denture (indirect)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5765	soft liner for complete or partial removable denture – indirect	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service of (D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, and D5765) every 12 months. Not billable until 6 months after delivery.	
D5850	tissue conditioning, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5851	tissue conditioning, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5862	precision attachment, by report	All ages	1-32	No	No		Narrative of medical necessity
D5863	overdenture – complete maxillary – natural tooth borne	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5864	overdenture – partial maxillary – natural tooth borne	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5865	overdenture – complete mandibular – natural tooth borne	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient	narrative of med. necessity, pre-op x-ray(s)
D5866	overdenture – partial mandibular – natural tooth borne	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient	narrative of med. necessity, pre-op x-ray(s)

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D5899	unspecified removable prosthodontic procedure, by report	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D5931	obturator prosthesis, surgical	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5932	obturator prosthesis, definitive	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5933	obturator prosthesis, modification	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5954	palatal augmentation prosthesis	All ages		No	No	Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	pre-operative x-ray(s), narrative of medical necessity
D5958	palatal lift prosthesis, interim	All ages		No	No	Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	pre-operative x-ray(s), narrative of medical necessity
D5992	Adjust maxillofacial prosthetic appliance, by report	All ages		No	No		pre-operative x-ray(s), narrative of medical necessity
D5993	maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report	All ages		No	No		
D5999	unspecified maxillofacial prosthesis, by report	All ages		No	No		pre-operative x-ray(s), narrative of medical necessity
D6010	surgical placement of implant body: endosteal implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6013	surgical placement of mini implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6040	surgical placement: eposteal implant	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6050	surgical placement: transosteal implant	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6055	connecting bar – implant supported or abutment supported	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6056	prefabricated abutment – includes modification and placement	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6057	custom fabricated abutment – includes placement	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6058	abutment supported porcelain/ceramic crown	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6059	abutment supported porcelain fused to metal crown (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6061	abutment supported porcelain fused to metal crown (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6062	abutment supported cast metal crown (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6063	abutment supported cast metal crown (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6064	abutment supported cast metal crown (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6065	implant supported porcelain/ceramic crown	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6066	implant supported crown - porcelain fused to high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6067	implant supported crown - high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6068	abutment supported retainer for porcelain/ceramic FPD	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6072	abutment supported retainer for cast metal FPD (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6074	abutment supported retainer for cast metal FPD (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6075	implant supported retainer for ceramic FPD	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6076	implant supported retainer for FPD - porcelain fused to high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6077	implant supported retainer for metal FPD - high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6082	implant supported crown - porcelain fused to predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6083	implant supported crown - porcelain fused to noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6084	implant supported crown - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6086	implant supported crown - predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6087	implant supported crown - noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6088	implant supported crown - titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6090	repair of implant/abutment supported prosthesis	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6091	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6092	re-cement or re-bond implant/abutment supported crown	All ages	1-32	No	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	All ages	1-32	No	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	
D6094	abutment supported crown - titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6097	abutment supported crown - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6098	implant supported retainer - porcelain fused to predominantly base alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6099	implant supported retainer for FPD - porcelain fused to noble alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6100	surgical removal of implant body	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
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	All Ages	1-32, 51-82	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
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	All Ages	1-32, 51-82	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6105	removal of implant body not requiring bone removal or flap elevation	All Ages	2 - 15, 18 - 31	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	All Ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	All Ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	All Ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	All Ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6114	implant /abutment supported fixed denture for edentulous arch – maxillary	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6115	implant /abutment supported fixed denture for edentulous arch – mandibular	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6116	implant /abutment supported fixed denture for partially edentulous arch – maxillary	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6117	implant /abutment supported fixed denture for partially edentulous arch – mandibular	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6120	implant supported retainer – porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6121	implant supported retainer for metal FPD – predominantly base alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6122	implant supported retainer for metal FPD – noble alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6123	implant supported retainer for metal FPD – titanium and titanium alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6190	radiographic/surgical implant index, by report	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6194	abutment supported retainer crown for FPD – titanium and titanium alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6195	abutment supported retainer - porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6199	unspecified implant procedure, by report	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6205	pontic - indirect resin based composite	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6210	pontic - cast high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6211	pontic - cast predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6212	pontic - cast noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6240	pontic - porcelain fused to high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6241	pontic - porcelain fused to predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6242	pontic - porcelain fused to noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6243	Pontic - Porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6245	pontic - porcelain/ceramic	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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D6250	pontic - resin with high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6251	pontic - resin with predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6252	pontic - resin with noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6545	retainer - cast metal for resin bonded fixed prosthesis	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6549	retainer – resin bonded fixed prosthesis	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6710	retainer crown - indirect resin based composite	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6720	retainer crown - resin with high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6721	retainer crown - resin with predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6722	retainer crown - resin with noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D6740	retainer crown - porcelain/ceramic	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6750	retainer crown - porcelain fused to high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6751	retainer crown - porcelain fused to predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6752	retainer crown - porcelain fused to noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6753	retainer crown - porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6780	retainer crown - 3/4 cast high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6784	retainer crown ¾ - titanium and titanium alloys	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6790	retainer crown - full cast high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6791	retainer crown - full cast predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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D6792	retainer crown - full cast noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6920	connector bar	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient, per arch.	Narr of med necessity
D6930	re-cement or re-bond fixed partial denture	All Ages		No	No	Limit one service every 24 months. Not allowed within 6 months of initial placement.	
D6940	stress breaker	All Ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6950	precision attachment	All Ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6980	fixed partial denture repair necessitated by restorative material failure	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No		Narr of med necessity & full mouth x-rays
D6999	unspecified fixed prosthodontic procedure, by report	All Ages	1-32	No	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D7111	extraction, coronal remnants – primary tooth	All Ages	A-T, AS-TS	No	No	Limit one service per tooth, per lifetime. D7111 is considered part of any other primary surgery in the same surgical area on the same date and therefore is not billable to the member.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7210) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth - soft tissue	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7220) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth - partially bony	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7230) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth - completely bony	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7240) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7241) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7250	removal of residual tooth roots (cutting procedure)	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7250) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	All Ages	1-32, 51-82, A-T, AS-TS	No	No		narrative of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	All Ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	All Ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7280	exposure of an unerupted tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	All Ages		No	No		Pathology Report
D7286	incisional biopsy of oral tissue – soft	All Ages		No	No		Pathology Report
D7287	exfoliative cytological sample collection	All Ages		No	No		Pathology Report
D7295	Harvest of bone for use in autogenous grafting procedure	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7310) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7311) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7321) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	All Ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	All Ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7410	excision of benign lesion up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7411	excision of benign lesion greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7412	excision of benign lesion, complicated	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7413	excision of malignant lesion up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7414	excision of malignant lesion greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7415	excision of malignant lesion, complicated	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7465	destruction of lesion(s) by physical or chemical method, by report	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7471	removal of lateral exostosis (maxilla or mandible)	All Ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7485	reduction of osseous tuberosity	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7490	radical resection of maxilla or mandible	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7509	marsupialization of odontogenic cyst	All Ages		No	Yes		narrative of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7520	incision and drainage of abscess - extraoral soft tissue	All Ages		No	No		narrative of medical necessity. Photo, if available.
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All Ages		No	No		narrative of medical necessity. Photo, if available.
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7540	removal of reaction producing foreign bodies, musculoskeletal system	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction (teeth immobilized, if present)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction (teeth immobilized, if present)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D7630	mandible - open reduction (teeth immobilized, if present)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction (teeth immobilized, if present)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7650	malar and/or zygomatic arch - open reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7660	malar and/or zygomatic arch - closed reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7670	alveolus - closed reduction, may include stabilization of teeth	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	All Ages		No	No	One of (D7710) per 12 Month(s) Per patient.	narrative of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7750	malar and/or zygomatic arch - open reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7760	malar and/or zygomatic arch - closed reduction	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7770	alveolus - open reduction stabilization of teeth	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7771	alveolus, closed reduction stabilization of teeth	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7780	facial bones - complicated reduction with fixation and multiple approaches	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7820	closed reduction of dislocation	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7830	manipulation under anesthesia	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7840	condylectomy	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7850	surgical discectomy, with/without implant	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7860	arthrotomy	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7870	arthrocentesis	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7880	occlusal orthotic device, by report	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7881	occlusal orthotic device adjustment	All Ages		No	No	Limit one service every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7910	suture of recent small wounds up to 5 cm	All Ages		No	No		
D7911	complicated suture - up to 5 cm	All Ages		No	No		
D7912	complicated suture - greater than 5 cm	All Ages		No	No		
D7920	skin graft (identify defect covered, location and type of graft)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7940	osteoplasty - for orthognathic deformities	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7941	osteotomy - mandibular rami	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7944	osteotomy - segmented or subapical	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7945	osteotomy - body of mandible	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7946	LeFort I (maxilla - total)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)

Iowa Medicaid Dental Wellness Plan (DWP) Adults							
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D7947	LeFort I (maxilla - segmented)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7949	LeFort II or LeFort III - with bone graft	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7952	Sinus augmentation via a vertical approach	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7953	bone replacement graft for ridge preservation - per site	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	All Ages		No	No	Two of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narrative of med. necessity
D7962	lingual frenectomy (frenulectomy)	All Ages		No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity
D7963	frenuloplasty	All Ages		No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7970	excision of hyperplastic tissue - per arch	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	All Ages	1-32	No	No	Limit one service per quad, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7972	surgical reduction of fibrous tuberosity	All Ages		No	No	Limit one service per quad, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7980	surgical sialolithotomy	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7981	excision of salivary gland, by report	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7982	sialodochoplasty	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7983	closure of salivary fistula	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7990	emergency tracheotomy	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7991	coronoidectomy	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7995	synthetic graft - mandible or facial bones, by report	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7998	intraoral placement of a fixation device not in conjunction with a fracture	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D8020	limited orthodontic treatment of the transitional dentition	0-20		No	No		Study Models or Photos, Pano.
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		No	Yes		Study Models or Photos, Pano, Lateral Ceph.
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		No	Yes		Study Models or Photos, Pano, Lateral Ceph. Iowa Medicaid Ortho Medical Necessity Form
D8210	removable appliance therapy	0-20		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8220	fixed appliance therapy	0-20		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	0-20		No	Yes		Narrative of medical necessity
D8701	repair of fixed retainer, includes reattachment – maxillary	0-20		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8702	repair of fixed retainer, includes reattachment – mandibular	0-20		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity

Iowa Medicaid Dental Wellness Plan (DWP) Adults							
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D8703	replacement of lost or broken retainer – maxillary	0-20		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8704	replacement of lost or broken retainer – mandibular	0-20		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	0-20		No	Yes		narrative of medical necessity
D9110	palliative treatment of dental pain – per visit	All Ages		No	No		Narrative of medical necessity
D9120	fixed partial denture sectioning	All Ages		No	No		pre-operative x-ray(s), narrative of medical necessity
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9230	administration of nitrous oxide	All Ages		No	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9239	administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9243	administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9244	in-office administration of minimal sedation – single drug – enteral	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9245	administration of moderate sedation – enteral	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	All Ages		No	No	Limit 1 per 12 months per dentist/office. A separate fee for a consultation is NOT BILLABLE TO THE PATIENT when billed in conjunction with an examination/evaluation by the same dentist/dental office. The benefit for a consultation in connection with non-covered services is DENIED. Consultation (D9310) may be benefitted when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.	
D9410	house/extended care facility call	All Ages		No	No		
D9420	hospital or ambulatory surgical center call	All Ages		No	No		Narrative of medical necessity
D9440	office visit - after regularly scheduled hours	All Ages		No	No		
D9610	therapeutic parenteral drug, single administration	All Ages		No	No		
D9910	application of desensitizing medicament	All Ages		No	No		Narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	All Ages		No	No	by the first treating dentist. Benefits for dry socket are NOT BILLABLE TO THE PATIENT and are included in the fee for the extraction by the same dentist/dental office. The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial	Narrative of medical necessity
D9942	repair and/or reline of occlusal guard	All Ages		No	No	Limit one service every three years, per patient.	
D9943	occlusal guard adjustment	All Ages		No	No	Limit one service every three years, per patient.	
D9944	occlusal guard – hard appliance, full arch	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of medical necessity
D9946	occlusal guard – hard appliance, partial arch	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of medical necessity

Iowa Medicaid Dental Wellness Plan (DWP) Adults							
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D9995	teledentistry – synchronous; real-time encounter	All Ages		No	No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	All Ages		No	No		
D9999	unspecified adjunctive procedure, by report	All Ages		No	No		Narrative of medical necessity

Note: Diagnostic services include the oral examination, 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 radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All working radiographs are considered all-inclusive of the billed procedure. 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 limitations. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs 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.

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Either Prior Auth or Pre-Payment Review Required (UM Review)**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	All ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0140	limited oral evaluation - problem focused	All ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0180) per date of service per patient.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	1 per 6 months. Same provider or same location	
D0150	comprehensive oral evaluation - new or established patient	All ages		No	No	1 per 3 years, same provider or location. One of (D0120, D0150) per 6 Months per patient. Deny when submitted for the same DOS as D0145 by any provider.	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	All ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0180) per date of service per patient.	
D0180	comprehensive periodontal evaluation – new or established patient	All ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0190	screening of a patient	All ages		No	No		
D0210	intraoral – comprehensive series of radiographic images	All ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0220	intraoral - periapical first radiographic image	All ages		No	No	Limited to one service per day by the same provider OR location.	
D0230	intraoral - periapical each additional radiographic image	All ages		No	No		
D0240	intraoral - occlusal radiographic image	All ages		No	No	Limited to two services per year per patient	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	All ages		No	No	Limited to two services per year per patient	
D0251	extra-oral posterior dental radiographic image	All ages		No	No	Limited to two services per year per patient	
D0270	bitewing - single radiographic image	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0272	bitewings - two radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0273	bitewings - three radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0274	bitewings - four radiographic images	All ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0321	other temporomandibular joint radiographic images, by report	All ages		No	No	Limited to 1 per 12 months.	
D0330	panoramic radiographic image	All ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	All ages		No	No		
D0364	cone beam CT capture and interpretation with limited field of view – less than one whole jaw	All ages		Yes	No		Narrative of medical necessity
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	All ages		Yes	No		Narrative of medical necessity
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	All ages		Yes	No		Narrative of medical necessity
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	All ages		Yes	No		Narrative of medical necessity
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	All ages		Yes	No		Narrative of medical necessity

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
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D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0383	cone beam CT image capture with field of view of both jaws; with or without cranium	All ages		Yes	No		Narrative of medical necessity
D0384	Cone beam CT image capture for TMJ series including two or more exposures	All ages		Yes	No		Narrative of medical necessity
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	All ages		No	No		Narrative of medical necessity
D0393	Virtual treatment simulation using 3D image volume or surface scan	All ages		No	No		Narrative of medical necessity
D0394	Digital subtraction of two or more images or image volumes of the same modality	All ages		No	No		Narrative of medical necessity
D0395	Fusion of two or more 3D image volumes of one or more modalities	All ages		No	No		Narrative of medical necessity
D0460	pulp vitality tests	All ages		No	No	Limited to one service per day per patient. Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are NOT BILLABLE TO THE PATIENT when performed on the same date by the same dentist/dental office as any other definitive procedure except: limited oral evaluation – problem focused (D0140), protective restoration (D2940), palliative treatment (D9110), radiographic images (D0210 - D0391), and consultation (D9310).	
D0470	diagnostic casts	All ages		No	No	Only billable in conjunction with orthodontic services	
D0601	Caries risk assessment and documentation, with a finding of low risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0603	Caries risk assessment and documentation, with a finding of high risk	All ages		No	No	Should be performed at all comprehensive and recall examinations.	
D0999	Unspecified diagnostic procedure, by report	All ages		No	No		Narrative of medical necessity
D1110	prophylaxis - adult	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1120	prophylaxis - child	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1206	topical application of fluoride varnish	All ages		No	No	4 of (D1206, D1208) per year.	
D1208	topical application of fluoride – excluding varnish	All ages		No	No	4 of (D1206, D1208) per year.	
D1351	sealant - per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. Reimbursement for sealants is restricted to work performed on DWP Kids members 18 years and younger and DWP adult members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1353	sealant repair – per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. Reimbursement for sealants is restricted to work performed on DWP Kids members 18 years and younger and DWP adult members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1354	application of caries arresting medicament – per tooth	All ages	1 - 32, A - T	No	No	Limited to two (2) applications per tooth in a 12-month period. Not allowed on the same date of service as D1351 or D1352 on the same tooth. Restorations placed within 90 days of D1354 are reduced by the amount of D1354 if completed by the same dentist/office.	
D1510	space maintainer - fixed, unilateral – per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	
D1516	space maintainer - fixed - bilateral, maxillary	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1517	space maintainer - fixed - bilateral, mandibular	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	
D1520	space maintainer - removable, unilateral - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	
D1526	space maintainer - removable - bilateral, maxillary	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1527	space maintainer - removable - bilateral, mandibular	All ages	Per Arch (01, 02, LA, UA)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
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D1551	re-cement or re-bond bilateral space maintainer - maxillary	All ages		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1552	re-cement or re-bond bilateral space maintainer - mandibular	All ages		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1556	removal of fixed unilateral space maintainer - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not billable by same provider or location that placed space maintainer.	
D1557	removal of fixed bilateral space maintainer - maxillary	All ages		No	No	Not billable by same provider or location that placed space maintainer.	
D1558	removal of fixed bilateral space maintainer - mandibular	All ages		No	No	Not billable by same provider or location that placed space maintainer.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose	All ages		No	No		
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose	All ages		No	No		
D1703	Moderna Covid-19 vaccine administration – first dose	All ages		No	No		
D1704	Moderna Covid-19 vaccine administration – second dose	All ages		No	No		
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	All ages		No	No		
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	All ages		No	No		
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	All ages		No	No		
D1710	Moderna Covid-19 vaccine administration – third dose	All ages		No	No		
D1711	Moderna Covid-19 vaccine administration – booster dose	All ages		No	No		
D1712	Janssen Covid-19 vaccine administration - booster dose	All ages		No	No		
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	All ages		No	No		
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	All ages		No	No		
D1999	Unspecified preventive procedure, by report	All ages		No	No		Narrative of medical necessity
D2140	Amalgam - one surface, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	All ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2330	resin-based composite - one surface, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2331	resin-based composite - two surfaces, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2332	resin-based composite - three surfaces, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2335	resin-based composite - four or more surfaces (anterior)	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2390	resin-based composite crown, anterior	All ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2391	resin-based composite – one surface, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2392	resin-based composite - two surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2393	resin-based composite - three surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	

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D2394	resin-based composite - four or more surfaces, posterior	All ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2710	crown - resin-based composite (indirect)	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2712	crown - ¾ resin-based composite (indirect)	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2720	crown - resin with high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2721	crown - resin with predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2740	crown - porcelain/ceramic	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2750	crown - porcelain fused to high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2751	crown - porcelain fused to predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2752	crown - porcelain fused to noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2781	crown - 3/4 cast predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2790	crown - full cast high noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2791	crown - full cast predominantly base metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2792	crown - full cast noble metal	All ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	All ages	1-32	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	All ages	1-32	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2920	re-cement or re-bond crown	All ages	1 - 32, A - T	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2921	Reattachment of tooth fragment, incisal edge or cusp	All ages	1-32	No	No	Limited to 1 per 24 months.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	All Ages	1-32	No	No	Limited to 1 per 24 months.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	All ages	A - T	No	No	Limited to 1 per 24 months.	
D2930	prefabricated stainless steel crown - primary tooth	All ages	A - T	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2931	prefabricated stainless steel crown - permanent tooth	All ages	1-32	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2932	prefabricated resin crown	All ages	1-32, C-H, M-R	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2933	prefabricated stainless steel crown with resin window	All ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	All ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2940	placement of interim direct restoration	All ages	1 - 32, A - T	No	No	Not allowed with any restorative codes D2000-D2999, bridge codes D6200- D6699, or endodontic codes D3220-D3330, D3346-D3353, D3410- D3450 and extraction codes D7111-D7251.	
D2950	core buildup, including any pins when required	All ages	1-32	No	No	Limited to one service of D2950 per 5 years, per patient, per tooth. Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2951	pin retention - per tooth, in addition to restoration	All ages	1-32	No	No	Limited to one (D2951) per lifetime, per patient, per tooth. Not allowed on primary teeth.	
D2952	post and core in addition to crown, indirectly fabricated	All ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2954	prefabricated post and core in addition to crown	All ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	

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D2971	additional procedures to customize a crown to fit under an existing partial denture framework	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D2976	band stabilization – per tooth	All ages	1-32	No	No		pre-operative x-ray(s), narrative of medical necessity
D2980	crown repair necessitated by restorative material failure	All ages	1-32	No	No		
D2990	Resin infiltration of incipient smooth surface lesions	All ages	1-32	No	No	Once per tooth per lifetime.	
D2999	unspecified restorative procedure, by report	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	All ages	1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth.	
D3221	pulpal debridement, primary and permanent teeth	All ages	1 - 32, A - T	No	No	One of (D3221) per 1 Lifetime Per patient per tooth. The fee for gross pulpal debridement is not billable when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. This will not be paid as phase 1 of a 2-phase root canal process. When the final endo therapy (3310, 3320, 3330) is completed within 60 days (by the same DDS/clinic) of debridement (3221), and narrative supports the 3221 was the start of endo, a fee reduction will occur.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	All ages	1-32	No	No	One of (D3222) per 1 Lifetime Per patient per tooth. The fee for D3222 when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351- D3353 is NOT BILLABLE TO THE PATIENT. The fee for partial pulpotomy for apexogenesis is NOT BILLABLE TO THE PATIENT when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	All ages	6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	All ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	All ages	1-32	No	No	One of (D3332) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3346	retreatment of previous root canal therapy - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	All ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3348	retreatment of previous root canal therapy - molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	All ages	1-32	No	No	One of (D3351) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3352	apexification/recalcification – interim medication replacement	All ages	1-32	No	No	One of (D3352) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	All ages	1-32	No	No	One of (D3353) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3355	Pulpal regeneration - initial visit	All ages	1-32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3356	Pulpal regeneration - interim medication replacement	All ages	1-32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3357	Pulpal regeneration - completion of treatment	All ages	1-32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3410	apicoectomy - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3421	apicoectomy - premolar (first root)	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3425	apicoectomy - molar (first root)	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3425) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3426	apicoectomy (each additional root)	All ages	1-5, 12-21, 28-32	No	No	One of (D3426) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3430	retrograde filling - per root	All ages	1-32	No	No	One of (D3430) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3450	root amputation - per root	All ages	1-32	No	No	One of (D3450) per 1 Lifetime Per patient per tooth. A separate fee for root amputation is NOT BILLABLE TO THE PATIENT when performed in conjunction with an apicoectomy by the same dentist/dental office.	narrative of med. necessity, pre-op x-ray(s)
D3471	surgical repair of root resorption - anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)

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D3472	surgical repair of root resorption – premolar	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3473	surgical repair of root resorption – molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	All ages	6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	All ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	All ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3921	decoronation or submergence of an erupted tooth	All ages	1-32	No	No	One of (D3921) per 1 Lifetime Per patient per tooth	narrative of med. necessity, pre-op x-ray(s)
D3999	unspecified endodontic procedure, by report	All ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	All ages	1 - 32, 51 - 82	No	No	Limit to one service of (D4210, D4211,4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4245	apically positioned flap	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4245) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4249	clinical crown lengthening – hard tissue	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4249) every 24 months, per patient, per quadrant. Definitive crown codes are not reimbursable on the same tooth within 41 days following clinical crown lengthening.	Perio Charting, pre-op radiographs and narr of med necessity
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	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	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4263	bone replacement graft – retained natural tooth – first site in quadrant	All ages	1-32	Yes	No	Limit to one service of (D4263) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	All ages	1-32	Yes	No	Limit to one service of (D4264) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	All ages	1-32	Yes	No	Limit to one service of (D4265) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	All ages	1-32	Yes	No	Limit to one service of (D4266) every 24 months, per patient, per quadrant	Perio Charting, pre-op radiographs and narr of med necessity
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	All ages	1-32	Yes	No	Limit to one service of (D4267) every 24 months, per patient, per quadrant	Perio Charting, pre-op radiographs and narr of med necessity
D4270	pedicle soft tissue graft procedure	All ages	1-32	Yes	No	Limit to one service of (D4270) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	All ages	1-32	Yes	No	Limit to one service of (D4273) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	All ages	1-32	Yes	No	Limit to one service of (D4275) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4276	combined connective tissue and pedicle graft, per tooth	All ages	1-32	Yes	No	Limit to one service of (D4276) every 24 months, per patient, per quadrant	Perio Charting, xray (s), and narr of med necessity. Photos, if available.
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4277) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4278) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4283) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4285) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4286	removal of non-resorbable barrier	All ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4286) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity
D4341	periodontal scaling and root planing - four or more teeth per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	All ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	All ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	All ages		No	No		Narrative of medical necessity
D4910	periodontal maintenance	All ages		No	No	Limit to one service per 3 months, per patient. Not billable within 3 months of scaling and root planing (D4341, D4342).	
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	All ages		No	No		
D4999	unspecified periodontal procedure, by report	All ages		No	No		Narrative of medical necessity
D5110	complete denture - maxillary	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient. One D5130 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient. One D5140 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative 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)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)

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D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5511	repair broken complete denture base, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5512	repair broken complete denture base, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5520	replace missing or broken teeth – complete denture – per tooth	All ages		No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5611	repair resin partial denture base, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5612	repair resin partial denture base, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5621	repair cast partial framework, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5622	repair cast partial framework, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5630	repair or replace broken retentive clasping materials – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5640	replace missing or broken teeth – partial denture – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5650	add tooth to existing partial denture – per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5660	add clasp to existing partial denture - per tooth	All ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5710	rebase complete maxillary denture	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5711	rebase complete mandibular denture	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5720	rebase maxillary partial denture	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5721	rebase mandibular partial denture	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (direct)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5731	reline complete mandibular denture (direct)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5740	reline maxillary partial denture (direct)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5741	reline mandibular partial denture (direct)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5750	reline complete maxillary denture (indirect)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5751	reline complete mandibular denture (indirect)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5760	reline maxillary partial denture (indirect)	All ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5761	reline mandibular partial denture (indirect)	All ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5765	soft liner for complete or partial removable denture – indirect	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service of (D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, and D5765) every 12 months. Not billable until 6 months after delivery.	
D5850	tissue conditioning, maxillary	All ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	

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D5851	tissue conditioning, mandibular	All ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5862	precision attachment, by report	All ages	1-32	No	No		Narrative of medical necessity
D5863	overdenture – complete maxillary – natural tooth borne	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5864	overdenture – partial maxillary – natural tooth borne	All ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5865	overdenture – complete mandibular – natural tooth borne	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient	narrative of med. necessity, pre-op x-ray(s)
D5866	overdenture – partial mandibular – natural tooth borne	All ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient	narrative of med. necessity, pre-op x-ray(s)
D5899	unspecified removable prosthodontic procedure, by report	All ages		No	No		Narrative of medical necessity
D5931	obturator prosthesis, surgical	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5932	obturator prosthesis, definitive	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5933	obturator prosthesis, modification	All ages		No	No	Limit one service of (D5931, D5932, D5933) every five years, per patient.	pre-operative x-ray(s), narrative of medical necessity
D5954	palatal augmentation prosthesis	All ages		No	No	Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	pre-operative x-ray(s), narrative of medical necessity
D5958	palatal lift prosthesis, interim	All ages		No	No	Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	pre-operative x-ray(s), narrative of medical necessity
D5992	Adjust maxillofacial prosthetic appliance, by report	All ages		No	No		Narrative of medical necessity
D5993	maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report	All ages		No	No		
D5999	unspecified maxillofacial prosthesis, by report	All ages		No	No		Narrative of medical necessity
D6010	surgical placement of implant body: endosteal implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6012	surgical placement of interim implant body for transitional prosthesis: endosteal implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6013	surgical placement of mini implant	All ages	1-32	No	Yes	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6040	surgical placement: eposteal implant	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6050	surgical placement: transosteal implant	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6055	connecting bar – implant supported or abutment supported	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6056	prefabricated abutment – includes modification and placement	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6057	custom fabricated abutment – includes placement	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6058	abutment supported porcelain/ceramic crown	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6059	abutment supported porcelain fused to metal crown (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6061	abutment supported porcelain fused to metal crown (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6062	abutment supported cast metal crown (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6063	abutment supported cast metal crown (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6064	abutment supported cast metal crown (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6065	implant supported porcelain/ceramic crown	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6066	implant supported crown - porcelain fused to high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6067	implant supported crown - high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6068	abutment supported retainer for porcelain/ceramic FPD	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6072	abutment supported retainer for cast metal FPD (high noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6074	abutment supported retainer for cast metal FPD (noble metal)	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6075	implant supported retainer for ceramic FPD	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6076	implant supported retainer for FPD - porcelain fused to high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6077	implant supported retainer for metal FPD - high noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6082	implant supported crown - porcelain fused to predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6083	implant supported crown - porcelain fused to noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6084	implant supported crown - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6086	implant supported crown - predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6087	implant supported crown - noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6088	implant supported crown - titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6090	repair of implant/abutment supported prosthesis	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6091	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6092	re-cement or re-bond implant/abutment supported crown	All ages	1-32	No	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	All ages	1-32	No	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	
D6094	abutment supported crown - titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6097	abutment supported crown - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6098	implant supported retainer - porcelain fused to predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6099	implant supported retainer for FPD - porcelain fused to noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6100	surgical removal of implant body	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
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	All ages	1-32, 51-82	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
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	All ages	1-32, 51-82	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6105	removal of implant body not requiring bone removal or flap elevation	All ages	2 - 15, 18 - 31	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	All ages	Per Arch (01, 02, LA, UA)	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture	Narr of med necessity & full mouth x-rays
D6114	implant /abutment supported fixed denture for edentulous arch – maxillary	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6115	implant /abutment supported fixed denture for edentulous arch – mandibular	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6116	implant /abutment supported fixed denture for partially edentulous arch – maxillary	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6117	implant /abutment supported fixed denture for partially edentulous arch – mandibular	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6120	implant supported retainer – porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6121	implant supported retainer for metal FPD – predominantly base alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6122	implant supported retainer for metal FPD – noble alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays

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D6123	implant supported retainer for metal FPD – titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6190	radiographic/surgical implant index, by report	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6194	abutment supported retainer crown for FPD – titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6195	abutment supported retainer - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6199	unspecified implant procedure, by report	All ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6205	pontic - indirect resin based composite	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6210	pontic - cast high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6211	pontic - cast predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6212	pontic - cast noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6240	pontic - porcelain fused to high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6241	pontic - porcelain fused to predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6242	pontic - porcelain fused to noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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D6243	Pontic - Porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6245	pontic - porcelain/ceramic	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6250	pontic - resin with high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6251	pontic - resin with predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6252	pontic - resin with noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6545	retainer - cast metal for resin bonded fixed prosthesis	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6549	retainer – resin bonded fixed prosthesis	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6710	retainer crown - indirect resin based composite	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6720	retainer crown - resin with high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D6721	retainer crown - resin with predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6722	retainer crown - resin with noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6740	retainer crown - porcelain/ceramic	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6750	retainer crown - porcelain fused to high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6751	retainer crown - porcelain fused to predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6752	retainer crown - porcelain fused to noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6753	retainer crown - porcelain fused to titanium and titanium alloys	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6780	retainer crown - 3/4 cast high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6784	retainer crown ¾ - titanium and titanium alloys	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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D6790	retainer crown - full cast high noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6791	retainer crown - full cast predominantly base metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6792	retainer crown - full cast noble metal	All ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6920	connector bar	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient, per arch.	Narr of med necessity
D6930	re-cement or re-bond fixed partial denture	All ages		No	No	Limit one service every 24 months. Not allowed within 6 months of initial placement.	
D6940	stress breaker	All ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6950	precision attachment	All ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6980	fixed partial denture repair necessitated by restorative material failure	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No		Narr of med necessity & full mouth x-rays
D6999	unspecified fixed prosthodontic procedure, by report	All ages	1-32	No	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D7111	extraction, coronal remnants – primary tooth	All ages	A-T, AS-TS	No	No	Limit one service per tooth, per lifetime. D7111 is considered part of any other primary surgery in the same surgical area on the same date and therefore is not billable to the member.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7210) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth - soft tissue	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7220) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth - partially bony	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7230) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth - completely bony	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7240) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7241) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7250	removal of residual tooth roots (cutting procedure)	All ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7250) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	All ages	1-32, 51-82, A-T, AS-TS	No	No		narrative of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	All ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	All ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	All ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7280	exposure of an unerupted tooth	All ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	All ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	All ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	All ages		No	No		Pathology Report

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D7286	incisional biopsy of oral tissue – soft	All ages		No	No		Pathology Report
D7287	exfoliative cytological sample collection	All ages		No	No		Pathology Report
D7295	Harvest of bone for use in autogenous grafting procedure	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7310) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7311) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7321) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	All ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	All ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7410	excision of benign lesion up to 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7411	excision of benign lesion greater than 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7412	excision of benign lesion, complicated	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7413	excision of malignant lesion up to 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7414	excision of malignant lesion greater than 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7415	excision of malignant lesion, complicated	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	All ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology Report
D7465	destruction of lesion(s) by physical or chemical method, by report	All ages		No	No		Pathology Report
D7471	removal of lateral exostosis (maxilla or mandible)	All ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7485	reduction of osseous tuberosity	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7490	radical resection of maxilla or mandible	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7509	marsupialization of odontogenic cyst	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D7520	incision and drainage of abscess - extraoral soft tissue	All ages		No	No		narrative of medical necessity. Photo, if available.
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All ages		No	No		narrative of medical necessity. Photo, if available.
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7540	removal of reaction producing foreign bodies, musculoskeletal system	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7610	maxilla - open reduction (teeth immobilized, if present)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7620	maxilla - closed reduction (teeth immobilized, if present)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7630	mandible - open reduction (teeth immobilized, if present)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7640	mandible - closed reduction (teeth immobilized, if present)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7650	malar and/or zygomatic arch - open reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7660	malar and/or zygomatic arch - closed reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7670	alveolus - closed reduction, may include stabilization of teeth	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7671	alveolus - open reduction, may include stabilization of teeth	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7710	maxilla - open reduction	All ages		No	No	One of (D7710) per 12 Month(s) Per patient.	narrative of med. necessity, pre-op x-ray(s)
D7720	maxilla - closed reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7730	mandible - open reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7740	mandible - closed reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7750	malar and/or zygomatic arch - open reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7760	malar and/or zygomatic arch - closed reduction	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7770	alveolus - open reduction stabilization of teeth	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7771	alveolus, closed reduction stabilization of teeth	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7780	facial bones - complicated reduction with fixation and multiple approaches	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7810	open reduction of dislocation	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7820	closed reduction of dislocation	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7830	manipulation under anesthesia	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7840	condylectomy	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7850	surgical discectomy, with/without implant	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7860	arthrotomy	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7870	arthrocentesis	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7880	occlusal orthotic device, by report	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7881	occlusal orthotic device adjustment	All ages		No	No	Limit one service every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7910	suture of recent small wounds up to 5 cm	All ages		No	No		

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D7911	complicated suture - up to 5 cm	All ages		No	No		
D7912	complicated suture - greater than 5 cm	All ages		No	No		
D7920	skin graft (identify defect covered, location and type of graft)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7940	osteoplasty - for orthognathic deformities	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7941	osteotomy - mandibular rami	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7944	osteotomy - segmented or subapical	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7945	osteotomy - body of mandible	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7946	LeFort I (maxilla - total)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7947	LeFort I (maxilla - segmented)	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7949	LeFort II or LeFort III - with bone graft	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7952	Sinus augmentation via a vertical approach	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7953	bone replacement graft for ridge preservation - per site	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7955	repair of maxillofacial soft and/or hard tissue defect	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7961	buccal / labial frenectomy (frenulectomy)	All ages		No	No	Two of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narrative of med. necessity
D7962	lingual frenectomy (frenulectomy)	All ages		No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity
D7963	frenuloplasty	All ages		No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7970	excision of hyperplastic tissue - per arch	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	All ages	1-32	No	No	Limit one service per quad, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7972	surgical reduction of fibrous tuberosity	All ages		No	No	Limit one service per quad, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7980	surgical sialolithotomy	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7981	excision of salivary gland, by report	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7982	sialodochoplasty	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7983	closure of salivary fistula	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7990	emergency tracheotomy	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7991	coronoidectomy	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7995	synthetic graft - mandible or facial bones, by report	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7998	intraoral placement of a fixation device not in conjunction with a fracture	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	All ages		No	No		narrative of med. necessity, pre-op x-ray(s)

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D8020	limited orthodontic treatment of the transitional dentition	All ages		No	No		Study Models or Photos, Pano.
D8070	comprehensive orthodontic treatment of the transitional dentition	All ages		No	Yes		Study Models or Photos, Pano, Lateral Ceph.
D8080	comprehensive orthodontic treatment of the adolescent dentition	All ages		No	Yes		Study Models or Photos, Pano, Lateral Ceph. Iowa Medicaid Ortho Medical Necessity Form
D8210	removable appliance therapy	All ages		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8220	fixed appliance therapy	All ages		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	All ages		No	Yes		Narrative of medical necessity
D8701	repair of fixed retainer, includes reattachment – maxillary	All ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8702	repair of fixed retainer, includes reattachment – mandibular	All ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8703	replacement of lost or broken retainer – maxillary	All ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8704	replacement of lost or broken retainer – mandibular	All ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	All ages		No	Yes		narrative of medical necessity
D9110	palliative treatment of dental pain – per visit	All ages		No	No		Narrative of medical necessity
D9120	fixed partial denture sectioning	All ages		No	No		pre-operative x-ray(s), narrative of medical necessity
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9230, D9239, D9243, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9230	administration of nitrous oxide	All ages		No	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9239	administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9243	administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9244, D9245, D9246, D9247	Narrative of medical necessity
D9244	in-office administration of minimal sedation – single drug – enteral	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9245	administration of moderate sedation – enteral	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9230, D9239, D9243, D9244, D9245, D9246, or D9247	Narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	All ages		No	No	Limit 1 per 12 months per dentist/office. A separate fee for a consultation is NOT BILLABLE TO THE PATIENT when billed in conjunction with an examination/evaluation by the same dentist/dental office. The benefit for a consultation in connection with non-covered services is DENIED. Consultation (D9310) may be benefitted when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.	
D9410	house/extended care facility call	All ages		No	No		

Iowa Medicaid Dental Wellness Plan (DWP) Kids							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Either Prior Auth or Pre-Payment Review Required (UM Review)**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9420	hospital or ambulatory surgical center call	All ages		No	No		Narrative of medical necessity
D9440	office visit - after regularly scheduled hours	All ages		No	No		
D9610	therapeutic parenteral drug, single administration	All ages		No	No		
D9910	application of desensitizing medicament	All ages		No	No		Narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	All ages		No	No	The fee for treatment of routine postsurgical complications is NOT BILLABLE TO THE PATIENT when done by the first treating dentist. Benefits for dry socket are NOT BILLABLE TO THE PATIENT and are included in the fee for the extraction by the same dentist/dental office. The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are NOT BILLABLE TO THE PATIENT.	Narrative of medical necessity
D9942	repair and/or reline of occlusal guard	All ages		No	No	Limit one service every three years, per patient.	
D9943	occlusal guard adjustment	All ages		No	No	Limit one service every three years, per patient.	
D9944	occlusal guard – hard appliance, full arch	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of medical necessity
D9946	occlusal guard – hard appliance, partial arch	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	All ages		No	No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	All ages		No	No		
D9999	unspecified adjunctive procedure, by report	All ages		No	No		narrative of medical necessity

Note: Diagnostic services include the oral examination, 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 radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis. All working radiographs are considered all-inclusive of the billed procedure. 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 limitations. All radiographs must be of good diagnostic quality properly mounted, dated and identified with the recipient's name and date of birth. Substandard radiographs 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.

Iowa CHIP Healthy and Well Kids in Iowa (Hawki)							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Either Prior Auth or Pre-Payment Review Required (UM Review)**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	All Ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0140	limited oral evaluation - problem focused	All Ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0180) per date of service per patient.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	1 per 6 months. Same provider or same location	
D0150	comprehensive oral evaluation - new or established patient	All Ages		No	No	1 per 3 years, same provider or location. One of (D0120, D0150) per 6 Months per patient. Deny when submitted for the same DOS as D0145 by any provider.	
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	All Ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0171, D0180) per date of service per patient.	
D0171	Re-evaluation – post-operative office visit	All Ages		No	No	One of (D0120, D0140, D0145, D0150, D0170, D0171, D0180) per date of service per patient.	
D0180	comprehensive periodontal evaluation – new or established patient	All Ages		No	No	One of (D0120, D0145, D0150, D0180) per 6 months.	
D0190	screening of a patient	All Ages		No	No		
D0210	intraoral – comprehensive series of radiographic images	All Ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0220	intraoral - periapical first radiographic image	All Ages		No	No	Limited to one service per day by the same provider OR location.	
D0230	intraoral - periapical each additional radiographic image	All Ages		No	No		
D0240	intraoral - occlusal radiographic image	All Ages		No	No	Limited to two services per year per patient	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	All Ages		No	No	Limited to two services per year per patient	
D0251	extra-oral posterior dental radiographic image	All Ages		No	No	Limited to two services per year per patient	
D0270	bitewing - single radiographic image	All Ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0272	bitewings - two radiographic images	All Ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0273	bitewings - three radiographic images	All Ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0274	bitewings - four radiographic images	All Ages		No	No	Limited to one service of D0270, D0272, D0273, D0274 per 12 months per patient	
D0330	panoramic radiographic image	All Ages		No	No	Limited to one service of D0210 or D0330 every five years per patient.	
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	All ages		No	No		
D0460	pulp vitality tests	All Ages		No	No		
D1110	prophylaxis - adult	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1120	prophylaxis - child	All ages		No	No	Limited to one D1110, D1120 per patient per six-month period, except for members who need more frequent care because of a physical or mental condition	
D1206	topical application of fluoride varnish	All ages		No	No	2 of (D1206, D1208) per year.	
D1208	topical application of fluoride – excluding varnish	All ages		No	No	2 of (D1206, D1208) per year.	
D1351	sealant - per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1353	sealant repair – per tooth	All ages	1 - 5, 12 - 21, 28 -32, A, B, I - L, S, T	No	No	1 of (D1351, D1353) per tooth, per patient, every 3 years. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration.	
D1354	application of caries arresting medicament – per tooth	All ages	1 - 32, A - T	No	No	Limited to two (2) applications per tooth in a 12-month period. Not allowed on the same date of service as D1351 or D1352 on the same tooth. Restorations placed within 90 days of D1354 are reduced by the amount of D1354 if completed by the same dentist/office.	
D1510	space maintainer - fixed, unilateral – per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	

Iowa CHIP Healthy and Well Kids in Iowa (Hawki)							
Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D1516	space maintainer - fixed - bilateral, maxillary	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1517	space maintainer - fixed - bilateral, mandibular	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	
D1520	space maintainer - removable, unilateral - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limit to one service of (D1510, D1520) per lifetime, per patient, per quadrant.	
D1526	space maintainer - removable - bilateral, maxillary	All ages	Per Arch (01, 02, LA, UA)	No	No	Limit to one service of (D1516, D1526) per lifetime, per patient, per arch.	
D1527	space maintainer - removable - bilateral, mandibular	All ages	Per Arch (01, 02, LA, UA)	No	No	One of (D1517, D1527) Per patient, per lifetime, same arch.	
D1551	re-cement or re-bond bilateral space maintainer - maxillary	All ages		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1552	re-cement or re-bond bilateral space maintainer - mandibular	All ages		No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of per arch per lifetime. The fee for re-cementation or re-bonding by the same dentist/dental office who placed the appliance is NOT BILLABLE TO THE PATIENT.	
D1556	removal of fixed unilateral space maintainer - per quadrant	All ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not billable by same provider or location that placed space maintainer.	
D1557	removal of fixed bilateral space maintainer - maxillary	All ages		No	No	Not billable by same provider or location that placed space maintainer.	
D1558	removal of fixed bilateral space maintainer - mandibular	All ages		No	No	Not billable by same provider or location that placed space maintainer.	
D1999	Unspecified preventive procedure, by report	All Ages		No	No		Narrative of medical necessity
D2140	Amalgam - one surface, primary or permanent	All Ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	All Ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	All Ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	All Ages	1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2330	resin-based composite - one surface, anterior	All Ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2331	resin-based composite - two surfaces, anterior	All Ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2332	resin-based composite - three surfaces, anterior	All Ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2335	resin-based composite - four or more surfaces (anterior)	All Ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2390	resin-based composite crown, anterior	All Ages	6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2391	resin-based composite – one surface, posterior	All Ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2392	resin-based composite - two surfaces, posterior	All Ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2393	resin-based composite - three surfaces, posterior	All Ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2394	resin-based composite - four or more surfaces, posterior	All Ages	1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392,D2393, D2394) per 24 Month(s) Per patient per tooth, per surface	
D2710	crown - resin-based composite (indirect)	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2712	crown - ¾ resin-based composite (indirect)	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2720	crown - resin with high noble metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2721	crown - resin with predominantly base metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2740	crown - porcelain/ceramic	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2750	crown - porcelain fused to high noble metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D2751	crown - porcelain fused to predominantly base metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2752	crown - porcelain fused to noble metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2753	Crown – porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2781	crown - 3/4 cast predominantly base metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2790	crown - full cast high noble metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2791	crown - full cast predominantly base metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2792	crown - full cast noble metal	All Ages	1-32	Yes	No	Limit to one service of (D2710, D2712, D2720, D2721, D2740, D2750, D2751, D2752, D2780, D2781, D2790, D2791, D2792) every 5 years, per patient, per tooth.	pre-operative x-ray(s), narrative of medical necessity
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	All Ages	1-32	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2920	re-cement or re-bond crown	All Ages	1 - 32, A - T	No	No	Limit to one service every 24 months, per patient, per tooth. Not allowed within 6 months of initial placement or previous re-cement.	
D2921	Reattachment of tooth fragment, incisal edge or cusp	All Ages	1-32	No	No	Limited to 1 per 24 months.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	All Ages	1-32	No	No	Limited to 1 per 24 months.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	All ages	A - T	No	No	Limited to 1 per 24 months.	
D2930	prefabricated stainless steel crown - primary tooth	All ages	A - T	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2931	prefabricated stainless steel crown - permanent tooth	All Ages	1-32	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	Narrative of medical necessity
D2932	prefabricated resin crown	All Ages	1-32, C-H, M-R	No	No	Limit to one service per 24 months, per patient, per tooth. D2930 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394.	
D2933	prefabricated stainless steel crown with resin window	All Ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	All Ages	C - H, M - R	No	No	Limit to one service per 24 months, per patient, per tooth. D2933, D2934 will deny if the following procedure codes have been billed within the last 12 months, same tooth, same provider: D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335 or D2390.	
D2940	placement of interim direct restoration	All Ages	1 - 32, A - T	No	No	Not allowed with any restorative codes D2000-D2999, bridge codes D6200- D6699, or endodontic codes D3220-D3330, D3346-D3353, D3410- D3450 and extraction codes D7111-D7251.	
D2950	core buildup, including any pins when required	All Ages	1-32	No	No	Limited to one service of D2950 per 5 years, per patient, per tooth. Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2951	pin retention - per tooth, in addition to restoration	All Ages	1-32	No	No	Limited to one (D2951) per lifetime, per patient, per tooth. Not allowed on primary teeth.	
D2952	post and core in addition to crown, indirectly fabricated	All Ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2954	prefabricated post and core in addition to crown	All Ages	1-32	No	No	Limit to one service of (D2950, D2952, D2954) per 5 years, per patient, per tooth. Not allowed on primary teeth.	
D2971	additional procedures to customize a crown to fit under an existing partial denture framework	All Ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D2976	band stabilization – per tooth	All Ages	1-32	No	No		
D2980	crown repair necessitated by restorative material failure	All Ages	1-32	No	No		
D2999	unspecified restorative procedure, by report	All Ages	1-32	No	No		narrative of med. necessity, pre-op x-ray(s)
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	All Ages	1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth.	

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D3221	pulpal debridement, primary and permanent teeth	All Ages	1 - 32, A - T	No	No	One of (D3221) per 1 Lifetime Per patient per tooth. The fee for gross pulpal debridement is not billable when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. This will not be paid as phase 1 of a 2-phase root canal process. When the final endo therapy (3310, 3320, 3330) is completed within 60 days (by the same DDS/clinic) of debridement (3221), and narrative supports the 3221 was the start of endo, a fee reduction will occur.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	All Ages	1-32	No	No	One of (D3222) per 1 Lifetime Per patient per tooth. The fee for D3222 when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351- D3353 is NOT BILLABLE TO THE PATIENT. The fee for partial pulpotomy for apexogenesis is NOT BILLABLE TO THE PATIENT when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	All Ages	6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	All Ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	All Ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	All Ages	1-32	No	No	One of (D3332) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3346	retreatment of previous root canal therapy - anterior	All Ages	6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	All Ages	4, 5, 12, 13, 20,21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3348	retreatment of previous root canal therapy - molar	All Ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3347) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3351	apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	All Ages	1-32	No	No	One of (D3351) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3352	apexification/recalcification – interim medication replacement	All Ages	1-32	No	No	One of (D3352) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	All Ages	1-32	No	No	One of (D3353) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3410	apicoectomy - anterior	All Ages	6 - 11, 22 - 27	No	No	One of (D3410) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3421	apicoectomy - premolar (first root)	All Ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3421) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D3425	apicoectomy - molar (first root)	All Ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3425) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, xray(s)
D3426	apicoectomy (each additional root)	All Ages	1-5, 12-21, 28-32	No	No	One of (D3426) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, xray(s)
D3471	surgical repair of root resorption - anterior	All Ages	6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3472	surgical repair of root resorption – premolar	All Ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3473	surgical repair of root resorption – molar	All Ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	All Ages	6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	All Ages	4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	All Ages	1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3921	decoronation or submergence of an erupted tooth	All Ages	1-32	No	No	One of (D3921) per 1 Lifetime Per patient per tooth	narrative of med. necessity, xray(s)
D3999	unspecified endodontic procedure, by report	All Ages	1-32	No	No		narrative of med. necessity, xray(s)
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4210, D4211, D4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	All Ages	1 - 32, 51 - 82	No	No	Limit to one service of (D4210, D4211,4212) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity. Photos, if available

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4240, D4241) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4245	apically positioned flap	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4245) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4249	clinical crown lengthening – hard tissue	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4249) every 24 months, per patient, per quadrant. Definitive crown codes are not reimbursable on the same tooth within 41 days following clinical crown lengthening.	Perio Charting, pre-op radiographs and narr of med necessity
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	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	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limit to one service of (D4260, D4261) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4263	bone replacement graft – retained natural tooth – first site in quadrant	All Ages	1-32	Yes	No	Limit to one service of (D4263) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	All Ages	1-32	Yes	No	Limit to one service of (D4264) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	All Ages	1-32	Yes	No	Limit to one service of (D4265) every 24 months, per patient, per quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4270	pedicle soft tissue graft procedure	All Ages	1-32	Yes	No	Limit to one service of (D4270) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	All Ages	1-32	Yes	No	Limit to one service of (D4273) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	All Ages	1-32	Yes	No	Limit to one service of (D4275) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4276	combined connective tissue and pedicle graft, per tooth	All Ages	1-32	Yes	No	Limit to one service of (D4276) every 24 months, per patient, per quadrant	Perio Charting, xray (s), and narr of med necessity. Photos, if available.
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	All Ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4277) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	All Ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4278) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All Ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4283) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
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	All Ages	1 - 32, 51 - 82	Yes	No	Limit to one service of (D4285) every 24 months, per patient, per quadrant	Perio Charting and narr of med necessity. Photos, if available.
D4341	periodontal scaling and root planing - four or more teeth per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity
D4342	periodontal scaling and root planing - one to three teeth per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Limited to once per quadrant (D4341 or D4342) per 24 months per patient.	Perio Charting, pre-op radiographs and narr of med necessity

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	All Ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	Perio Charting, pre-op radiographs and narr of med necessity
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	All Ages		No	No	Limit to one service per 24 months, per patient. Not covered with history of D1110, D4341, D4342, D4346, D4910 in previous 24 months.	
D4910	periodontal maintenance	All Ages		No	No	Limit to one service per 3 months, per patient. Not billable within 3 months of scaling and root planing (D4341, D4342).	
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	All Ages		No	No		
D4999	unspecified periodontal procedure, by report	All Ages		No	No		Narrative of medical necessity
D5110	complete denture - maxillary	All Ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5120	complete denture - mandibular	All Ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5130	immediate denture - maxillary	All Ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient. One D5130 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5140	immediate denture - mandibular	All Ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient. One D5140 per lifetime.	narrative of med. necessity, pre-op x-ray(s)
D5211	maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All Ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5212	mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth)	All Ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative 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)	All Ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative 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)	All Ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All Ages		No	No	Limit one service of (D5110, D5130, D5211, D5213, D5225, D5863, D5864) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	All Ages		No	No	Limit one service of (D5120, D5140, D5212, D5214, D5226, D5865, D5866) every five years, per patient.	narrative of med. necessity, pre-op x-ray(s)
D5410	adjust complete denture - maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5411	adjust complete denture - mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5421	adjust partial denture - maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5422	adjust partial denture - mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5511	repair broken complete denture base, mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5512	repair broken complete denture base, maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5520	replace missing or broken teeth – complete denture – per tooth	All Ages		No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5611	repair resin partial denture base, mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5612	repair resin partial denture base, maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5621	repair cast partial framework, mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5622	repair cast partial framework, maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5630	repair or replace broken retentive clasping materials – per tooth	All Ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5640	replace missing or broken teeth – partial denture – per tooth	All Ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5650	add tooth to existing partial denture – per tooth	All Ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	

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Code	Description	Age Limitation	Teeth Covered	Either Prior Auth or Pre-Payment Review Required (UM Review)	Prior Authorization Required	Benefit Limitations	Documentation Required
D5660	add clasp to existing partial denture - per tooth	All Ages	1-32	No	No	Limit two services of (D5410, D5411, D5421, D5422, D5512, D5511, D5520, D5611, D5612, D5621, D5622, D5630, D5640, D5650, D5660, D5710, D5711, D5720, D5721, D5850, D5851) per year, per patient. Not covered within 6 months of placement.	
D5710	rebase complete maxillary denture	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5711	rebase complete mandibular denture	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5720	rebase maxillary partial denture	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5721	rebase mandibular partial denture	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5730	reline complete maxillary denture (direct)	All Ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5731	reline complete mandibular denture (direct)	All Ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5740	reline maxillary partial denture (direct)	All Ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5741	reline mandibular partial denture (direct)	All Ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5750	reline complete maxillary denture (indirect)	All Ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5751	reline complete mandibular denture (indirect)	All Ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5760	reline maxillary partial denture (indirect)	All Ages		No	No	Limit one service of (D5730, D5740, D5750, D5760, D5765) every 12 months. Not billable until 6 months after delivery.	
D5761	reline mandibular partial denture (indirect)	All Ages		No	No	Limit one service of (D5731, D5741, D5751, D5761, D5765) every 12 months. Not billable until 6 months after delivery.	
D5765	soft liner for complete or partial removable denture – indirect	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service of (D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761, and D5765) every 12 months. Not billable until 6 months after delivery.	
D5850	tissue conditioning, maxillary	All Ages		No	No	Limit two services of (D5410, D5421, D5512, D5520, D5612, D5622, D5630, D5640, D5650, D5660, D5710, D5720, D5850) per year, per patient. Not covered within 6 months of placement.	
D5851	tissue conditioning, mandibular	All Ages		No	No	Limit two services of (D5411, D5422, D5511, D5520, D5611, D5621, D5630, D5640, D5650, D5660, D5711, D5721, D5851) per year, per patient. Not covered within 6 months of placement.	
D5862	precision attachment, by report	All Ages	1-32	No	No		Narrative of medical necessity
D6065	implant supported porcelain/ceramic crown	All Ages	1-32	Yes	No	Limit of one per 5 years per tooth. Dental Implants and related services to patient who are missing significant oral structures due to cancer, traumatic injuries or developmental defects such as cleft palate and cannot use a conventional denture.	Narr of med necessity & full mouth x-rays
D6241	pontic - porcelain fused to predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6242	pontic - porcelain fused to noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6243	Pontic - Porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6245	pontic - porcelain/ceramic	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays

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D6740	retainer crown - porcelain/ceramic	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6750	retainer crown - porcelain fused to high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6751	retainer crown - porcelain fused to predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6752	retainer crown - porcelain fused to noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6753	retainer crown - porcelain fused to titanium and titanium alloys	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6780	retainer crown - 3/4 cast high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6790	retainer crown - full cast high noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6791	retainer crown - full cast predominantly base metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6792	retainer crown - full cast noble metal	All Ages	1-32	Yes	No	Limit one service of the following (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, D6545, D6549, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6784, D6790, D6791, D6792) every five years, per patient, per tooth. Fixed bridges for anterior teeth will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture. Posterior fixed bridges will only be allowed when the patient has a physical or mental condition that precludes the use of a removable partial denture, when the patient would qualify for a partial denture or the fixed bridge opposes a full or partial denture and is needed for balanced occlusion.	Narr of med necessity & full mouth x-rays
D6920	connector bar	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service every five years, per patient, per arch.	Narr of med necessity

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D6930	re-cement or re-bond fixed partial denture	All Ages		No	No	Limit one service every 24 months. Not allowed within 6 months of initial placement.	
D6940	stress breaker	All Ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6950	precision attachment	All Ages	1-32	Yes	No	Limit one service every five years, per patient, per arch.	Narr of med necessity & full mouth x-rays
D6980	fixed partial denture repair necessitated by restorative material failure	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No		Narr of med necessity
D7111	extraction, coronal remnants – primary tooth	All ages	A-T, AS-TS	No	No	Limit one service per tooth, per lifetime. D7111 is considered part of any other primary surgery in the same surgical area on the same date and therefore is not billable to the member.	
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7140) per 1 Lifetime Per patient per tooth.	
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7210) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7220	removal of impacted tooth - soft tissue	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7220) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7230	removal of impacted tooth - partially bony	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7230) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7240	removal of impacted tooth - completely bony	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7240) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7241) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7250	removal of residual tooth roots (cutting procedure)	All Ages	1-32, 51-82, A-T, AS-TS	No	No	One of (D7250) per 1 Lifetime Per patient per tooth.	narrative of med. necessity, pre-op x-ray(s)
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	All Ages	1-32, 51-82, A-T, AS-TS	No	No		narrative of med. necessity, pre-op x-ray(s)
D7260	oroantral fistula closure	All Ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7261	primary closure of a sinus perforation	All Ages	Per Quadrant (10, 20, UL, UR)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7280	exposure of an unerupted tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7282	mobilization of erupted or malpositioned tooth to aid eruption	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	All Ages	1 - 32	No	No		narrative of med. necessity, pre-op x-ray(s)
D7284	Excisional biopsy of minor salivary gland	All Ages		No	No		Narrative of medical necessity and pathology report
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	All Ages		No	No		Pathology Report
D7286	incisional biopsy of oral tissue – soft	All Ages		No	No		Pathology Report
D7287	exfoliative cytological sample collection	All Ages		No	No		Pathology Report
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7310) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7311) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7320) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	All Ages	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D7321) per 1 Lifetime Per patient per quadrant.	narrative of med. necessity, pre-op x-ray(s)
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology report
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	All Ages		No	No	Pathology laboratory report is required. If no report is submitted, the fee for this procedure is not billable to the patient.	Pathology report
D7471	removal of lateral exostosis (maxilla or mandible)	All Ages	Per Arch (01, 02, LA, UA)	No	No		narrative of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)

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D7473	removal of torus mandibularis	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7485	reduction of osseous tuberosity	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7509	marsupialization of odontogenic cyst	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D7910	suture of recent small wounds up to 5 cm	All Ages		No	No		
D7911	complicated suture - up to 5 cm	All Ages		No	No		
D7912	complicated suture - greater than 5 cm	All Ages		No	No		
D7961	buccal / labial frenectomy (frenulectomy)	All Ages		No	No	Two of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	Narrative of med necessiy, Photo, if available.
D7962	lingual frenectomy (frenulectomy)	All Ages		No	No	Limit one service per arch, per lifetime, per patient.	Narrative of med necessiy, Photo, if available.
D7963	frenuloplasty	All Ages		No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7970	excision of hyperplastic tissue - per arch	All Ages	Per Arch (01, 02, LA, UA)	No	No	Limit one service per arch, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	All Ages	1-32	No	No	Limit one service per quad, per lifetime, per patient.	narrative of med. necessity, pre-op x-ray(s)
D7999	unspecified oral surgery procedure, by report	All Ages		No	No		narrative of med. necessity, pre-op x-ray(s)
D8020	limited orthodontic treatment of the transitional dentition	All Ages		No	No		Study Models or Photos, Pano.
D8070	comprehensive orthodontic treatment of the transitional dentition	All Ages		No	Yes		Study Models or Photos, Pano, Lateral Ceph.
D8080	comprehensive orthodontic treatment of the adolescent dentition	All Ages		No	Yes		Study Models or Photos, Pano, Lateral Ceph. Iowa Medicaid Ortho Medical Necessity Form
D8210	removable appliance therapy	All Ages		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8220	fixed appliance therapy	All Ages		No	No	harmful habits only	Narrative of med necessiy, Photo of affected area.
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	All Ages		No	Yes		Narrative of medical necessity
D8701	repair of fixed retainer, includes reattachment – maxillary	All Ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8702	repair of fixed retainer, includes reattachment – mandibular	All Ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8703	replacement of lost or broken retainer – maxillary	All Ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8704	replacement of lost or broken retainer – mandibular	All Ages		No	No	Limit one service per lifetime, per patient, per arch.	narrative of medical necessity
D8999	unspecified orthodontic procedure, by report	All Ages		No	Yes		narrative of medical necessity
D9110	palliative treatment of dental pain – per visit	All Ages		No	No		
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9224, D9225, D9239, D9243	Narrative of medical necessity
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9224, D9225, D9239, D9243	Narrative of medical necessity
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9239, D9243	Narrative of medical necessity

Iowa CHIP Healthy and Well Kids in Iowa (Hawki)							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Either Prior Auth or Pre-Payment Review Required (UM Review)**	**Prior Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	All ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9239, D9243	Narrative of medical necessity
D9239	administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225, D9239	Narrative of medical necessity
D9243	administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof	All Ages		Yes	No	Not allowed on the same date of service with D9222, D9223, D9224, D9225	Narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	All Ages		No	No	Limit 1 per 12 months per dentist/office. A separate fee for a consultation is NOT BILLABLE TO THE PATIENT when billed in conjunction with an examination/evaluation by the same dentist/dental office. The benefit for a consultation in connection with non-covered services is DENIED. Consultation (D9310) may be benefitted when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.	
D9995	teledentistry – synchronous; real-time encounter	All Ages		No	No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	All Ages		No	No		
D9999	unspecified adjunctive procedure, by report	All Ages		No	No		Narrative of medical necessity